ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

A3: Decrease ED Diversion Rates and Increase Access to Care

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SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Department of Public Health

A3 Problem Solving Template

Version	Date:		
1.7	12/08/16		

Title: Decrease ED Diversion Rates and Increase access to care

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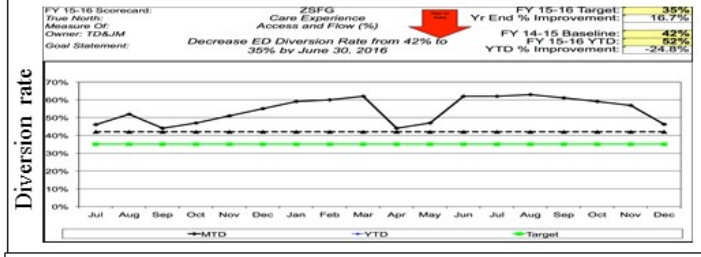
I. Background (why this, why now)

ED divert is multifactorial with many causes both within and outside the ED: Lack of convenient, affordable primary care for basic problems, gaps in behavioral health resources for people who are acutely mentally ill and those who are acutely intoxicated, insufficient post- acute capacity leading to approximately 20 pts/day who don't require hospital care., suboptimal ambulance routing, lack of "level-loading" .These factors have contributed to an 30% increase in ED diversion at ZSFG since 2010. When we divert ambulances, our patients end up at other hospitals. This has an impact on patient safety and quality of care and results in increased costs to the organization. It also results in our failure to meet our responsibility to our community.

II. Current Conditions

- On divert 62.5% of the time in Jul and Aug 2016
- ED visits up in SF 3% since 2010, up 7% at ZSFG during that time.
- 30% increase in SF ED diversion rates since 2010
- No standard work for going on/off divert
- Inconsistencies in criteria used by CN for going on/off divert
- No effective countermeasures when on divert to get off divert



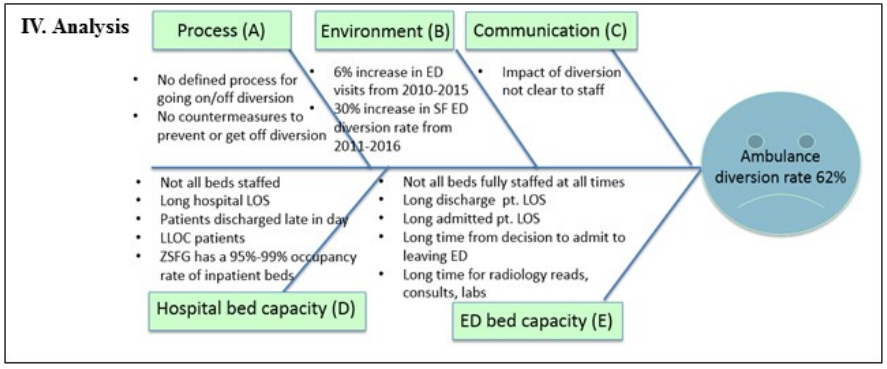
Problem Statement (Gap)

Our high Emergency Department diversion rate limits access to care for our patients reducing safety, quality, care experience and increasing out of medical group costs.

III. Goals & Targets

- Decrease diversion by 20% from 62.5% to 50% or more by June 2017
- Reduce diversion by 50% from 62.5% to 31% by Dec 2017

IV. Analysis



V. Proposed Countermeasures

Root Cause	Countermeasure	Impact	Effort
A	Create Standard Work for going on and ending diversion	Medium	Low
A, C	AIC, CN and AOD will meet before going on diversion.	Medium	Low
A, C	While on diversion the AIC, CN & AOD will meet every two hours to discuss ending diversion.	Medium	Low
A, D, E	Identify top contributors for going on diversion	High	Medium
A, E	Develop processes to expedite the decision to admit patients.	High	High
A, E	Develop a standardized consultation process.	High	High
B, D, E	Evaluate Interventions related to decreasing ED volume of lower acuity patients, earlier discharge of inpatients and post-acute care alternatives for LLOC patients	High	High
A, E	Investigate alternative location for intoxicated patients that have been assessed as medically stable.	High	High
A, E	Collaborate with Radiology and Lab leadership to develop standard work to increase turn around time for diagnostics.	High	High
D, E	Collaborate with psychiatry leadership to develop standard work to expedite consultations and transfers to PES if necessary.	High	High

VI. Plan

Action	Who	When
Create Standard Work for going on and ending diversion	Schmidt/Colwell	12/2/16
Review ED Diversion policy with Charge Nurses and Faculty	Schmidt/Colwell	12/8/16
Implement pre-diversion huddle with AOD, AIC and CN.	JS, CC, DS, MP	12/12/16
Develop pareto chart to analyze causes of ED diversion to prioritize high impact countermeasures	Schmidt/Colwell	3/17
Participate in the Hospital Council ED cross-functional working team	Schmidt/Colwell	TBD

VII. Follow-Up

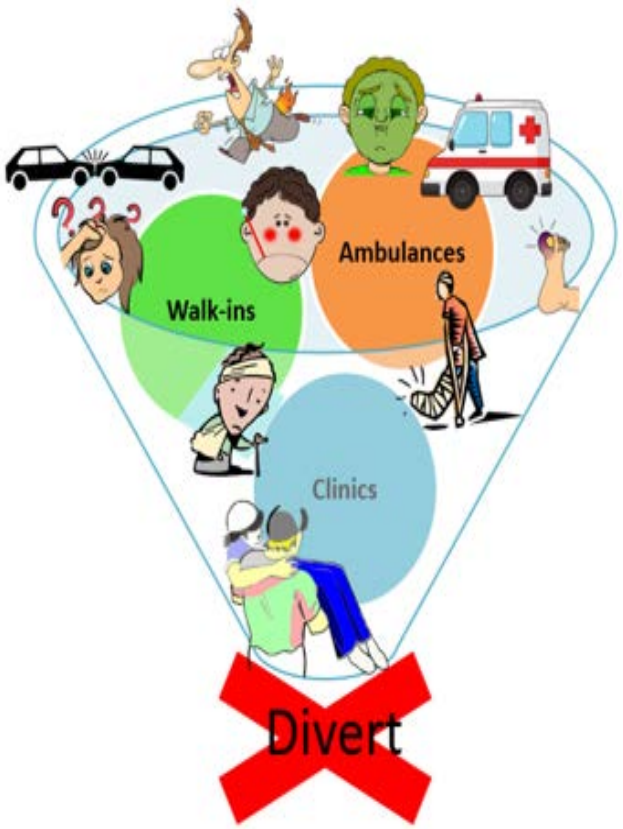
1. Weekly/monthly run chart tracking diversion rate shared with AIC, CN, ED staff and ED leadership
2. At least bi-weekly reporting of progress on the action plan at ED Improvement Steering Committee
3. Monthly reporting of diversion run chart to ZSFG Executive team

Background

- *ED diversion is multifactorial and is a community problem*
- There are many root causes both within and outside ED, for example:
  - Lack of convenient, affordable primary care for basic problems, as coverage through the ACA has risen.
  - Gaps in treatment resources for people who are acutely mentally ill and who are acutely intoxicated
  - Insufficient post-acute capacity leading to approximately 20pts/day at ZSFG alone who don't require hospital care.
- These factors and more have contributed to an *11% increase in ambulance diversion* over the last year.

Current Conditions

- All hospitals in SF are on divert 26% of the time, ZSFG is on divert 62.5% of the time.
- ED visits up 3% since 2010, up 7% at ZSFG during that time
- 30% increase in SF ED diversion rates since 2010
- At ZSFG, no standard work for going on/coming off divert, and no effective countermeasures when on divert
- At ZSFG, substantial blocks to flow within and leaving ED



Problem Statement (Gap)

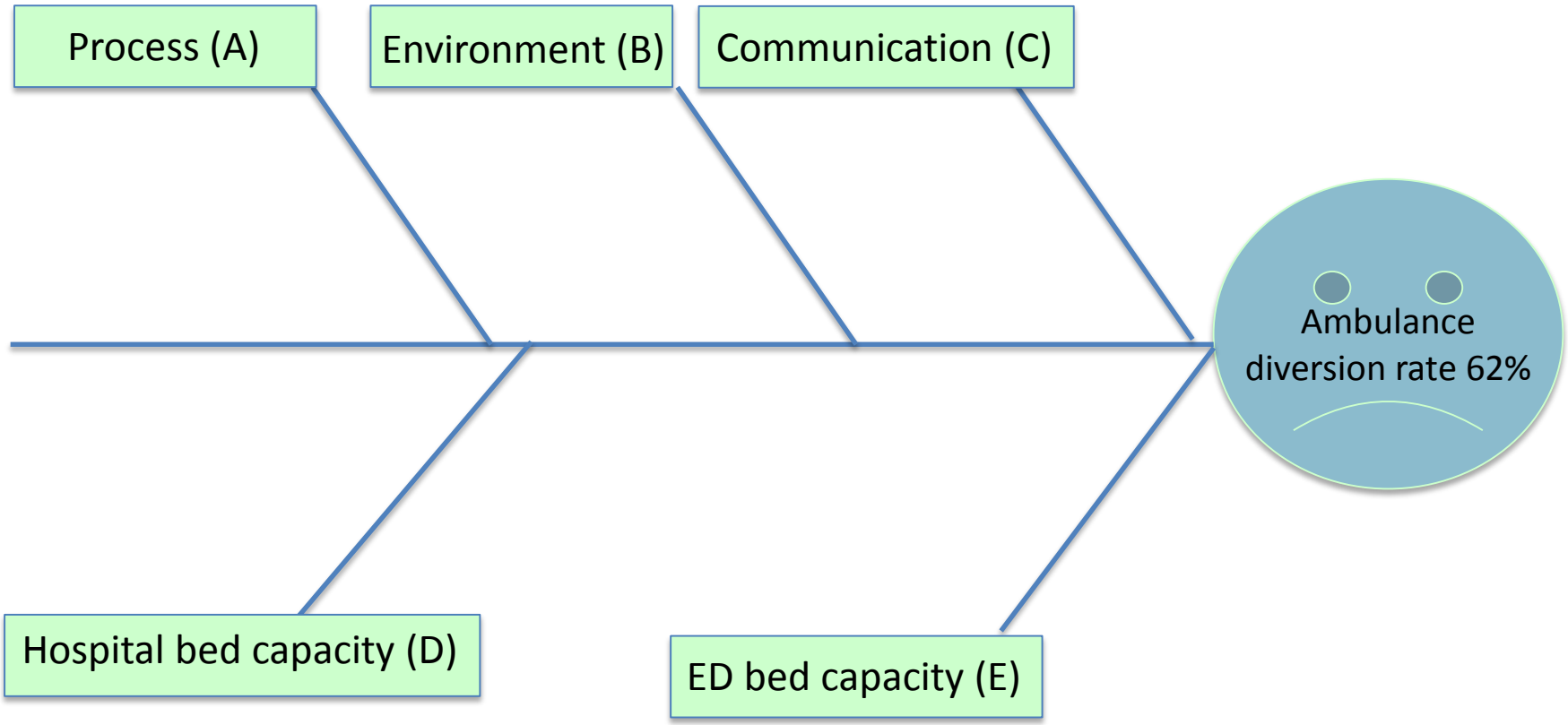
Our high Emergency Department diversion rate limits access to care for our patients reducing safety, quality, care experience and increasing out of medical group costs.

Goals and Targets

- Decrease diversion by 20% from 62.5% to 50% or more within 6 months

- Reduce diversion by 50% from 62.5% to 31% within 1 year.

Analysis


Process (A)
Environment (B)
Communication (C)
Ambulance diversion rate 62%
Hospital bed capacity (D)
ED bed capacity (E)

Countermeasures and Plan (1)

- Collect data to analyze ALL root causes of ED diversion at ZSFG
- Create standard work for going on and coming off diversion
- Create standard work for AIC, CN and AOD while on diversion
- Develop standard work to expedite admission decisions

Countermeasures and Plan (2)

- Explore alternatives for earlier discharges for LLOC patients
- Investigate alternative locations for intoxicated patients who are medically stable
- Participate in Hospital Council's ED working group in order to explore policy changes and community resources that hospitals can work on together to address root causes.

Questions?