ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on September 27, 2016
(09/12/16 Leadership MEC and 09/15/16 Business MEC)

ADMINISTRATIVE/LEAN MANAGEMENT/A3 REVIEW

EHR-Email-Based Care Transitions Communication From ZSFG Inpatient Services to SFHN and SFCC Primary Care

Dr. Jack Chase, Director of Operations Family Medicine Inpatient Services, discussed a project that started four years ago as a pilot in the FCM's Inpatient Service. The project aims to link the hospital's inpatient services in a more robust and consistent way with outpatient primary care. The project utilizes the current Information Technology System in place at ZSFG, and creates a standardized way by which the inpatient admitting provider can communicate about a patient's admission with the PCP or outpatient team. For the majority of the patients, LCR has information on the patient's primary care provider and clinic. An inpatient attending will be prompted in the LCR to complete the Care Transitions Orderset, which include three new pieces of information: estimated date of discharge, brief history at admission and plan of care, and specific questions or message to PCP. This process will provide more specific and timely/actionable information about the patient's admission through a group email notice to the inpatient providers and the patient's primary care provider or team care unit in the clinic. Dr. Chase highlighted that this communication process is intended to promote multidisciplinary care coordination across primary and inpatient systems, timely/actionable/specific information, and efficient arrangement of successful-follow up. Pilot data involving the Family Medicine Inpatient Service care coordination to six outpatient CPC Clinics from 2014 to present indicated more compliance with post-hospitalization follow up appointments within 7 days of discharge from patients with FMIS (Family Medicine Inpatient Service) intervention. A survey conducted on inpatient provider experience indicated that more than 80% of FMIS providers use the system, and that more than 80% noted improvement in scheduling follow-ups. A survey conducted on the outpatient provider experience indicated that 86% have received communication at admit and discharge within 1-2 days and that 93% of the providers recommended that all inpatient services adopt a similar system.

Lean Management Education/A3 Review–

True North Tactic and Tactical A3: Optimize Patient Flow throughout ZSFG
Owners: Jim Marks and Terry Dentoni
Background: Patient flow within and between Departments is characterized by long wait times that impact the hospital's ability to provide timely access to care for patients. For FY14-15, in the ED, ZSFG is on ambulance diversion 42% of the time, patients leave the ED without being seen 8.3% of the time and patients wait on average 225 minutes before being admitted to the hospital aftr the decision to admit. Within the hospital, average lengths of stay are long (4.9 days), patients are discharged late in the day (3.05 PM on average) and lower level of care patients (LLOC, average 20 patients/day) not requiring hospitalization reduce available beds. The net impact is poor patient access to timely care, reduced quality of care, poor patient and staff satisfaction and a negative financial impact.

Dr. Marks presented the A3 status report (A3-SR) to report progress towards achieving A3 metric targets and deeper understanding of the problem as a result of work done over FY15-16.

The presentation included the following:

- Target Statement – Dr. Marks highlighted three main metrics with one year and 3 year target goals – Reduce ED left without being seen (LWBS) rate, Decrease the ED ambulance diversion rate, and Reduce out of Medical Group costs.
- Countermeasures and Implementation- A3 thinking workshops for ED and inpatient leaders, ED Value Stream mapping (VSM) and follow on rapid improvement workshops, Inpatient VSM and follow on rapid improvement workshops, Implement a daily management in the ED and Urgent Care, Restructure the LLOC meeting.
- Impact (baseline/target/actual/ytd) – ED median DC LOS decreased 12.9 % (31 minutes) from a baseline of 249 minutes to 218 minutes but did not meet target of 210 minutes; This reduction was

driven by implementation of a Fast Track process for low acuity Emergency Severity Index (ESI) 4/5 patients with a 21% decrease in their median LOS from a baseline of 187 min. to 147 min; This reduction contributed to a reduction in LWBS from a baseline of 8.3% to 5.9% which met the target of 6%. This represents approximately 1700 patients who were seen in the ED who previously would have left; When there is limited hospital capacity, ED time from decision to admit to ED departure increases, driving up ED admitted patient LOS, reducing ED capacity and increasing the ambul;ance diversion rate; No other flow metric moved significantly towards target.

- Further analysis and stratification of gaps, learnings – Patient flow and LOS determine required ED capacity; Variability in staffing and LOS results in the flow of patients into the ED regularly exceeding ED room capacity, Stratification of ED volume by ESI and LOS identifies where to focus to reduce LOS; Stratification of admitted patients indicates that LOS from decision to admit to leave ED is long and highly variable; other additional learnings were shared.
- New countermeasures and adjustments – Continue to hire ED staff; Level load the ED (create moderate ESI3 area and adjust ESI4/5 area); Better understand and measure hospital capacity to predict and create capacity before needed; Combined ED/Inpt Flow rapid improvement workshop to reduce ED LOS of admitted patients and reduce consult time; Refine A3 flow target LOS metrics based on takt time (rate of arrival of patients into the ED) and room capacity to eliminate waiting.

Dr. Marks ended the presentation with a discussion of what it would take to achieve patient flow (as defined by no diversion and no LWBS) and the solutions. Members thanked and commended Dr. Marks' summary. The presentation gave members a deeper understanding of patient flow problems at ZSFG.

SERVICE REPORT:

Laboratory Medicine– Barbara Haller, MD, MPH, Interim Service Chief

The ZSFG Laboratory Medicine provides comprehensive Laboratory Testing, limited phlebotomy services, Transfusions Services for ZSFG and LHH, 27/7 Technical and Clinical Consultation, and management of Point of Care Testing at ZSFG. Highlights include:

- Change in Department Leadership to support the new Core Laboratory Division (Chemistry and Hematology combined in an automated laboratory that is expected to be in place in a couple of years)
- 1.4M Lab Tests (Billable tests) in 2015/16
- Under Performance Improvement and Patient Safety Initiatives –Patient satisfaction survey was recently conducted in the Phlebotomy Service, as well as a provider survey in 2015. Overall results were positive and encouraging. Through a grant from the UCSF Caring Wisely Project, the Service now has in place the GeneXpert which is a real-time PCR screen for MTB and rifampin resistance. Results are available in about 3 hours. The goal is to guide patient management and decrease isolation days.
- Participation in ED Kaizen Event, and implementation of improvements to shorten the turnaround time for lab orders in the ED.
- Strengths/Weaknesses – Strengths include experienced/loyal staff, strong/committed leadership team, consultative services, excellent teaching programs, UCSF Affiliation and toxicology capabilities. Weaknesses include the challenging/aging infrastructure and shortage of available Clinical Lab Scientists.
- Challenges – Budget Management, Leadership succession, pre-analytical phase of testing (specimen collection and Accessioning), increasing point of care testing, IT management of Lab/POCT records in multiple EMRs, and modernization of the Lab (Core Lab).
- 2016-2018 Goals – Implement SMART (Specimen Management Routing and Tracking), Complete design and installation of Core Laboratory Automation, Participate in multiple IT initiatives (new hospital and ambulatory EMR, CalRedie, Sunquest version update), Implement Specimen Collection Manager, Relocate laboratory operations in Bldg. 100 to Bldg., 5,and Implement Laboratory Compliance Program.

Dr. Haller discussed future space considerations (future Core Lab locations, OPD move to the new Urgent Care Location) and ongoing planning for implementation of a Core Laboratory that will provide Total

Laboratory Automation (TLA) at ZSFG. Dr. Haller also compared and contrasted the services provided by the DPH Laboratory with the ZSFG Lab Medicine Service, including hours of operations and duplicated tests. Dr. Haller informed members that there will be future discussions to re-visit and review the duplicated services offered by the two laboratories.