



ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Optimizing Patient Connectivity: Synergizing Access and Flow Across the ZSFG Campus

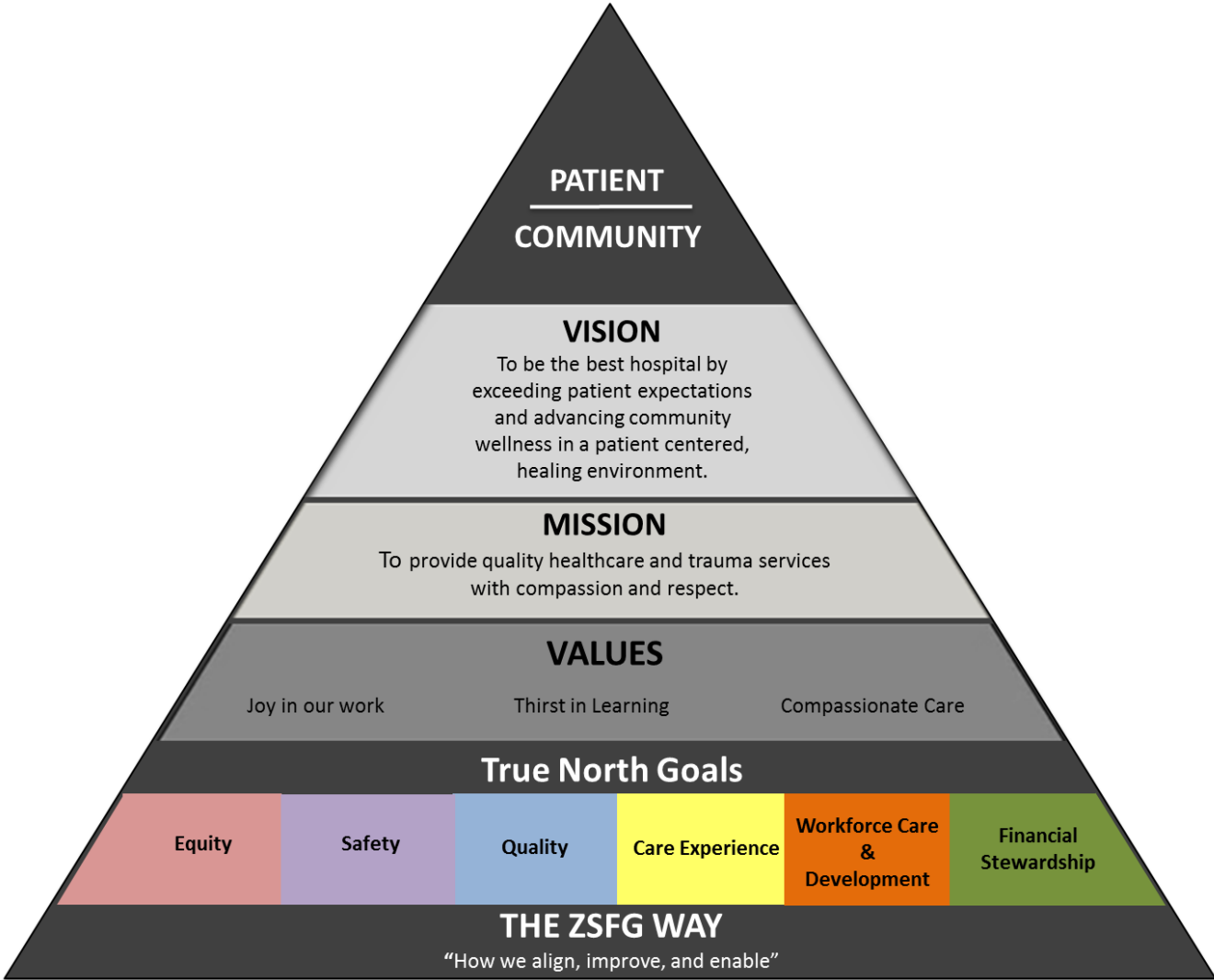
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ZSFG TRUE NORTH



ZSFG Strategic A3



Executive Strategy A3 Title: Optimizing Patient Connectivity: Synergizing Access and Flow Across the ZSFG Campus
Owners: Gabriel Ortiz, Gillian Otway

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I. Background: What problem are you talking about and why focus on it now?

Inadequate and fragmented flow in the U.S. healthcare system is a significant and growing challenge that leads to prolonged patient waiting times, overcrowded facilities, and delayed medical care and treatment. This bottleneck in our healthcare system can result in compromised patient outcomes and increased dissatisfaction among the S.F. community who rely on our system for their healthcare needs. Optimizing flow and access across the ZSFG campus is critical as it not only enhances the overall efficiency of the healthcare delivery system but also ensures that patients receive timely and appropriate medical attention. Addressing this issue is essential for creating a healthcare environment that is responsive, accessible, equitable, and capable of meeting the diverse needs of our patient population.

II. Current Conditions: What is happening today and what is not working?

Zuckerberg San Francisco General Hospital (ZSFG) faces challenges in flow and access for patients on its campus due to a combination of factors. The hospital's location in a densely populated urban area contributes to increased patient demand. Limited physical space and outdated facilities can impede the smooth flow of patients through various operational areas, leading to bottlenecks and delays. Additionally, the complexity of healthcare services provided at ZSFG, ranging from emergency care to specialized treatments and specialty care clinic services, may create logistical challenges in coordinating patient movements. High ambulance traffic, given the extensive specialty services that are available, makes ZSFG an EMS ambulance referral center of choice, even when other medical centers in SF might have bed capacity. Once admitted, limited community resources pose discharging a challenge. As a result, we are faced with high numbers of lower level of care patients awaiting an appropriate community disposition, high census, and backlog of patients in ED, ICU, and Peri-operative care areas. With respect to specialty services and primary care, we experience high waiting times for ambulatory clinic services. Partly this is due to limited clinic appointments, but no-shows and out-of-work referrals all contribute to these wait times. With respect to intra-operative procedures, similar experience of high demand for services is experienced, outpacing the current operating room availability despite lots of attention on maximizing the efficiency of the 8 operating rooms that are currently staffed (i.e., increasing block utilization and first case on-time starts). Addressing these issues requires strategic planning, infrastructure improvements, and possibly increased resources to create care capacity, learn and advocate for needed resources that may not be available today, and optimize flow for patients needing medical care at ZSFG. Several connected and interdependent factors have contributed to or exacerbated our ongoing impaired flow and access: Economic downturn, burnout, vacancy rates, opioid epidemic, reductions of services at local health centers, among other factors.

Problem Statement: What specific, measurable problem will serve as your baseline performance?

The dual challenges of inadequate access and inefficient flow exacerbate disparities in healthcare delivery. Insufficient access to medical services and poor flow management hinder timely patient care in the right place, perpetuating health inequalities and underscoring the pressing need for comprehensive improvement.

III. Targets and Goals: What specific measurable outcomes are desired and by when?

Selected Metrics	Baseline	Benchmark	Target by [When]
ED Ambulance diversion rate	44.9%	< 10.0%	35.0% (December 2025)
% of emergency room patients who left without being seen (LWBS)	6.7%	2.0%	4.0% (December 2025)
Proportion of adult specialty care clinics with a TNAA for new, non-urgent patient appointments \leq 21 days	82.0%	100.0%	90.0% (December 2025)
LLOC med-surg patient days	1,603 days	950 days	1100 days (December 2025)
% completion of add-on operating room cases within designated time frame as determined by primary service	85%	100%	95.0% (December 2025)

IV. Impact: What impact did you have on your processes/outcomes? (Baseline/Target/Actual/YTD)

While metrics are off target, fundamental aspects to allow success are in process of being implemented. These include but are not limited to SFHP grant to add more night/weekend clinic hours, hiring of new ED NP to support triage work, re-visiting LLOC barriers to make more actionable with DoCC and Med/Surg leaders, and planning for expanding to the 9th Operating Room to decrease procedure wait times.

V. Further Analysis:

Key Performance Indicators: Identified quality metrics are based in relevant clinical areas that are interdependent and key in driving patient access/flow across the care continuum.

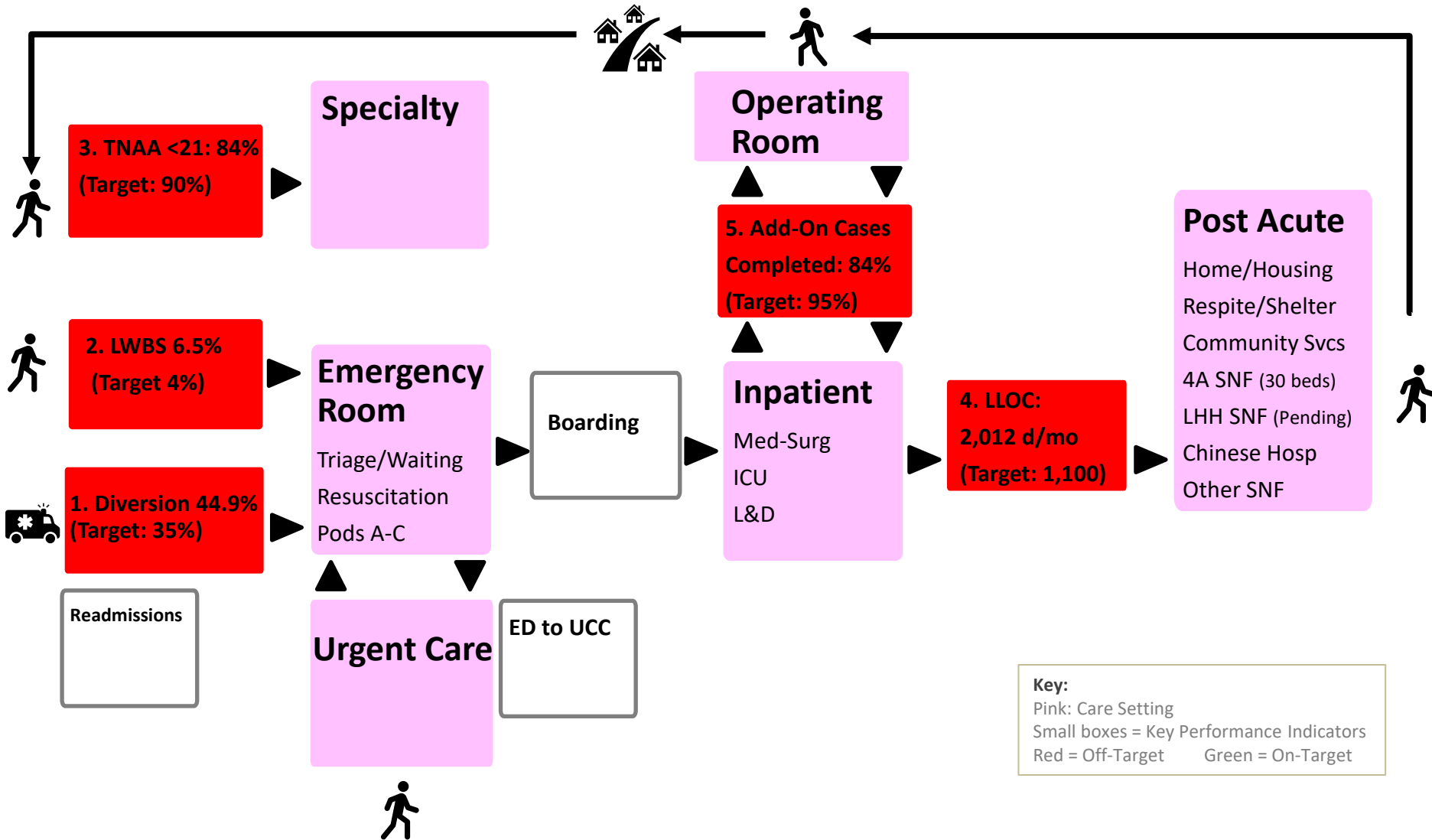
- Lower diversion target from 50% to 35%
- Lower rising ED LWBS Rate to 4%
- Continue to improve specialty TNAA to 90%
- Continue to lower LLOC rate to <1100
- Improve OR add-on completion rate to 95%

VI. Plan: What, where and how will you implement, and by whom and when?

Metric	Countermeasure(s)	Owner	Date/Status
Ambulance diversion rate	Fill all ED and med-surg nurse and NP vacancies and request travel nurses/P103s to backfill staff leaves and vacancies.	David Staconis Gillian Otway	12/31/24 Ongoing
Ambulance diversion rate	Develop, implement, and monitor new standard work for activating and de-activating ambulance diversion.	Jeffrey Schmidt Christopher Colwell David Staconis	12/15/24 Ongoing
Ambulance diversion rate	Create a standardized process and decision-making algorithm for admitting and consulting on ED patients.	Christopher Colwell Malini Singh	1/31/24 Completed
LWBS	ED waiting room Kaizen completed 3/31/24. Developed policy to administer medications and vaccines in the ED waiting room. Now, deepening and refining the approach.	Merjo Rocha, Christopher Wabody, David Staconis Matthew Talmadge	12/31/24 Ongoing
LLOC med-surg patients	Develop a unified, network strategy to identify, evaluate, and manage medical-surgical lower level of care patients. Incorporate SFHP, CalAIM, and Case Management to support movement.	Amy Du Neda Ratanawongsa	7/1/25 Ongoing
LLOC med-surg patients	Now that CMS re-certification successfully obtained, partner on standing up referrals and admissions workflows from ZSFG to LHH.	Roland Pickens, Troy Williams Neda Ratanawongsa	9/30/24 Ongoing
Bed Capacity	Increasing staffing of beds on H58 to increase capacity	Gillian Otway, Tarvi Bhakta	12/1/25 Ongoing
Specialty care clinic TNAA	Create additional clinic appointment capacity (e.g., weekend clinics, group visits, clinic moves such as 5R, Ward 81, 4C, 4J).	Delphine Tout Christina Bloom	6/1/25 Ongoing
Specialty care clinic TNAA	Develop and implement standard work for repatriating out-of-county/network patients back to primary healthcare system.	Amy Du, Reanna Mourgos Delphine Tout	10/1/24 Ongoing
OR add-on case daily completion	Open an additional 9 th OR dedicated to completing daily inpatient add-on cases.	Dini Palaniappan Patty Coggan	12/1/25 Ongoing
OR add-on case daily completion	Implement daily, morning huddles w/ services & D1 to triage inpatient add-on cases (i.e., Ortho, Trauma, Neurosurgery)	Dini Palaniappan Patty Coggan	12/1/25 Ongoing

BACKGROUND: Why do we care?

- Fragmented flow leads to:
 - prolonged patient waiting times,
 - overcrowded facilities, and
 - delayed medical care and treatment.
- Poor patient experience and satisfaction.
- This issue is essential for creating a healthcare environment that is responsive, accessible, equitable, and capable of meeting the diverse needs of our patient population.



CURRENT CONDITIONS ANALYSIS

- High Demand:
 - High demand for ED services, Hospital beds, and Specialty Care appointment slots.
 - Demand seems to be increasing over time.
- Capacity:
 - As demands increase, current capacity fails to match the demand.
- Coordination of Complex Workflows:
 - Multiple care areas and departments that are interconnected and interdependent, as represented on the process map (i.e., ED, Urgent Care, Specialty Care Clinics, Inpatient Care, Care Coordination, Peri-Operative, 4A SNF).

CURRENT CONDITIONS ANALYSIS

(cont'd)

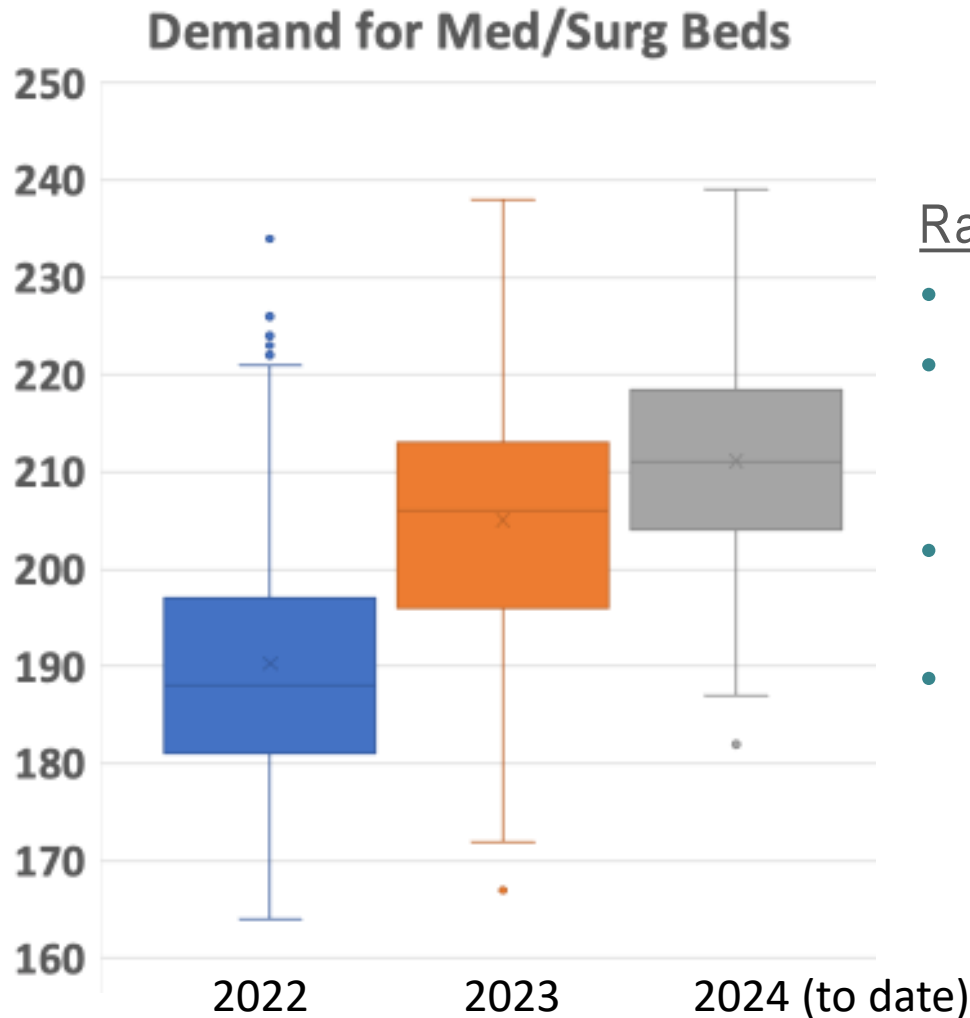
- As a result, we are faced with:
 - High LLOC.
 - High census.
 - Boarding in ED, ICU, and Peri-operative care areas
 - Long wait times for ambulatory clinic services (TNAA).
 - Long wait times for intra-operative surgical procedures.

CURRENT CONDITIONS ANALYSIS

(cont'd)

- External factors have also contributed to flow and access challenges:
 - Economic downturn
 - The opioid epidemic
 - Impact of SB 43 and mental health crisis
 - Reductions of services in external and community facilities
 - Extra admissions related to COVID-19 infection
 - Homelessness, among other factors

Current State: Increasing demand for inpatient services



Ramifications:

- High LLOC
- Back-up into other care areas (ED boarding and LWBS)
- High referrals to Specialty Care
- Increasing surgery/procedure demands

PROBLEM STATEMENT

- The challenges of excess demands, inadequate access/capacity, and inefficient flow exacerbate the disparities in healthcare delivery.

Key Performance Indicators (KPIs)

Operational Area: Selected Driver Metric	Baseline	Benchmark	Target (by When)
ED: Ambulance diversion rate	44.9%	< 10.0%	35.0% (Dec 2025)
ED: LWBS (% of emergency room patients who left without being seen)	6.5%	2.0%	4.0% (Dec 2025)
Specialty Care: TNAA (Proportion of adult specialty care clinics with a TNAA for new, non-urgent patient appointments \leq 21 days)	84%	100%	90% (Dec 2025)
Inpatient: LLOC med-surg patient days	2,012 days	950 days	1,100 days (Dec 2025)
Peri-Op: % completion of add-on operating room cases	84%	100%	95.0% (Dec 2025)

KPIs and Key Driver Diagram

KPIs:

ED/DoCC

Diversion and LWBS

Inpt/DoCC

LLOC

Peri-Op

Add-on Wait times

4ASNF & Specialty Care

TNAA

Shape the Demand

Std Work for Ambulance Diversion

Discharge short stay from ED

Level-loading C&S cases

Out-of-Network referrals

4A DC before Noon

B5 Front desk check-in and sorting

eConsult response

Match Capacity to Demands

Hire ED NP and Nurses

Med/Surg Nurses for Boarders in Pod C

Discharge short-stay pt from ED

Hire RNs to staff H58

Winter Surge Plan

First Case On time Start

Block Time Utilization

Hiring RN and Techs

9th Operating Room

Arthroplasty Workgroup

ED to UCC for low acuity patients

SFHP Grant for night/Weekend clinics

Redesign the System

Triage/Waiting Rm Kaizen

Transfer patients to local hospitals with inpatient capacity

Fast Track

Census Sharing & Overlap Dx Pilot

IP MDR Tool

LLOC/Complex Care Rounds

Leadership Case Reviews

Avoidable Days analysis

Unused block time PDSA for add-on cases

Enhanced Recovery after Surgery (ERAS Pathway)

Urgent Care Fast Track

B5 Wayfinding

No show rates

Video Visits

Key External Countermeasures

- LHH recertification and partnership in accepting new admissions.
- SFHN Cal-AIM efforts and ECM complex care team to partner on discharging patients with complex needs to community settings.
- SFHN leadership engagement on creative solutions to LLOC issues.

Thank you for your attention and feedback.

