Peninsula Circle of Care

A Partnership between Mills-Peninsula Health Services, Palo Alto Medical Foundation Mills-Peninsula Division, Peninsula Family Service, Gordon and Betty Moore Foundation, an Anonymous Donor, our Clients and our Community

Engaging Front Line Nurses

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Focus

- Model: IHI's "Key Changes to Create an Ideal Transition Home"
- Use of LEAN continuous improvements

❖Daily Rounds
  - o Progress Toward Discharge

❖Teachback
  - o Documentation and Audits

❖Discharge Appointments
  - o Desk organization

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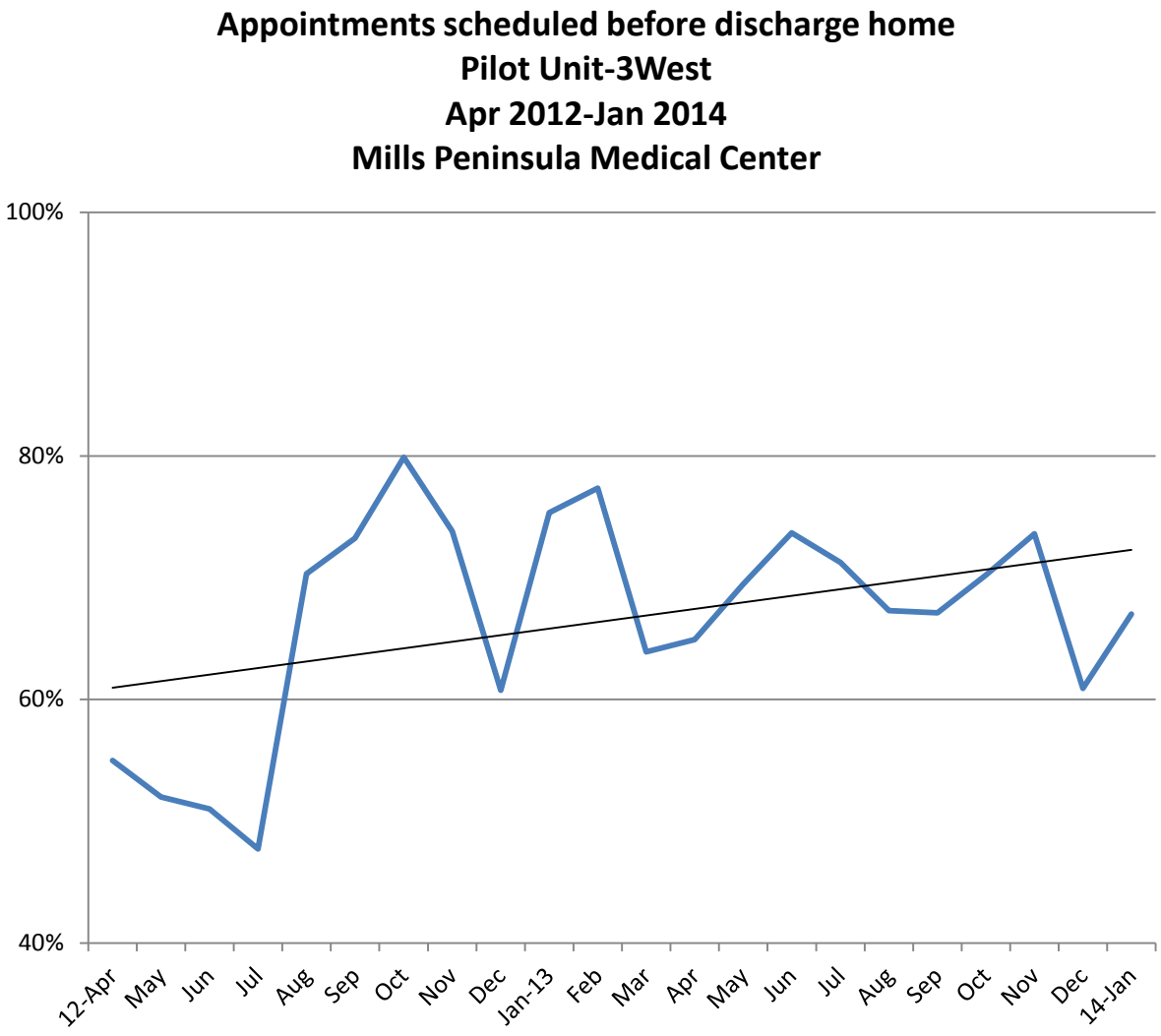
Tools

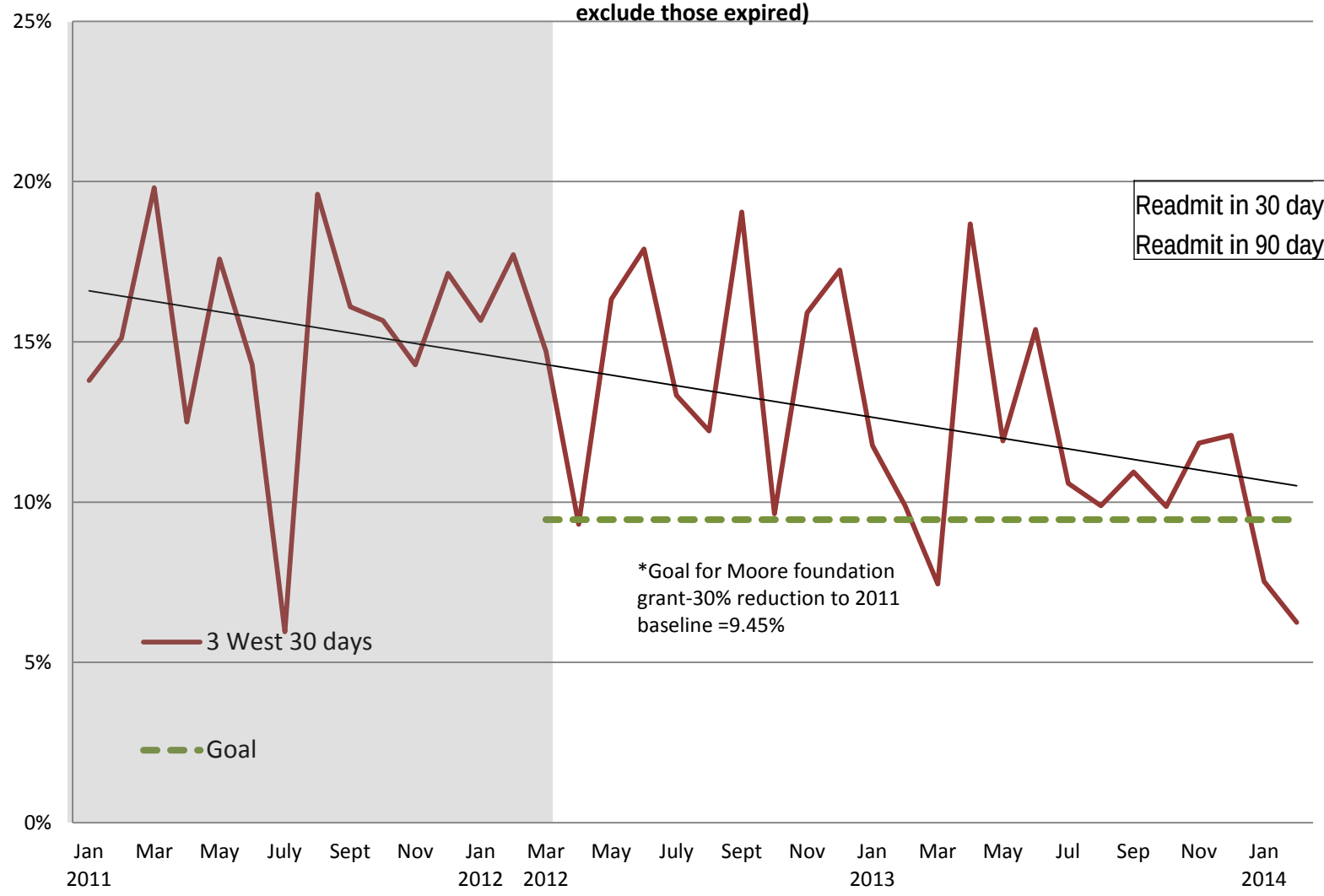
- Hospital Discharge Planning Toolkit available
  - From pilot unit learning and barriers
  - Used for PCOC expansion to other units
  - Includes tools & metrics
- Teachback binder
- Bedside Rounds/Progress Toward Discharge checklist (see handouts)

Results: Discharge Appointments



Results: Readmission Rates

MPHS All-Cause 30 day readmission rates (%) for all inpatients
Pilot Unit: 3 West
Jan 2011 to Feb 2014
(>64 years old with discharge disposition to home/home health, exclude elective admission, and exclude those expired)



	2011 Vs 2013 Relative Change	2011 Vs 2014 Relative Change
Readmit in 30 days (%)	-24.1%	-55.0%
Readmit in 90 days (%)	-13.3%	n/a