



Peninsula Circle of Care

# 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

*Areena Chaudhry, RN, BSN, MPA Nurse Manager*

*3 West Unit, Mills Peninsula Health Services*

*May 6, 2014*



# Focus

- Model: IHI's "Key Changes to Create an Ideal Transition Home"
- Use of LEAN continuous improvements
  
- ❖ Daily Rounds
  - Progress Toward Discharge
- ❖ Teachback
  - Documentation and Audits
- ❖ Discharge Appointments
  - Desk organization



Peninsula Circle of Care

Toolkit

For

Hospital Discharge Planning

# Tools

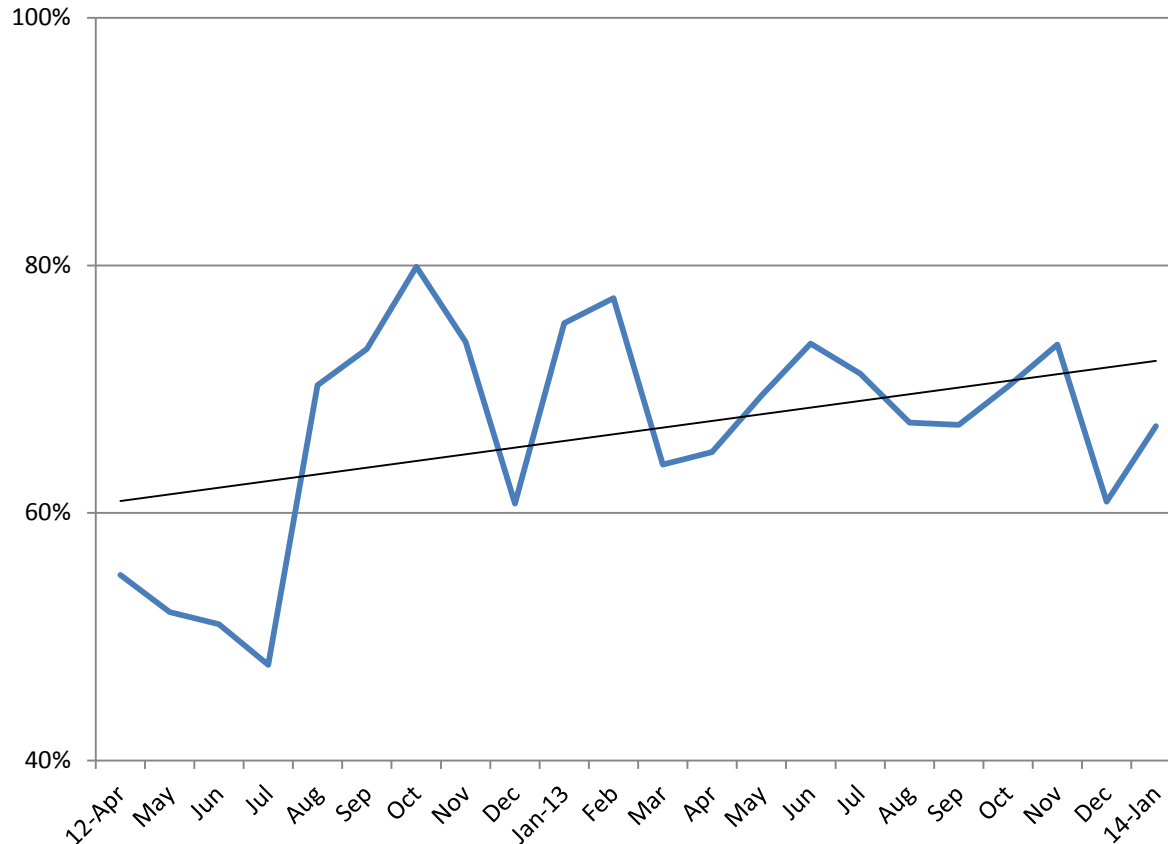
- Hospital Discharge Planning Toolkit available
  - From pilot unit learning and barriers
  - Used for PCOC expansion to other units
  - Includes tools & metrics
- Teachback binder
- Bedside Rounds/Progress Toward Discharge checklist (see handouts)

## Table of Content

Program Overview.....	page 3
• How to use this Toolkit?	
• Acknowledgements	
• Background and Rationale <ul style="list-style-type: none"><li>○ Evidence Based Model</li></ul>	
• Description of Areas of Interventions.....	page 6
○ Patient Preferences on Admission	
○ Rapid Rounds	
○ Patient Education and Teach Back	
○ PCP Follow-up Appointments	
○ AVS Improvements	
• Results to Date.....	page 8
Program Structure.....	page 9
• The LEAN process	
• Implementation <ul style="list-style-type: none"><li>○ Leadership Engagement</li></ul>	
The Toolkit.....	page 12
• Interventions and New Standards <ul style="list-style-type: none"><li>○ Patient Preferences upon Admission</li><li>○ Rapid Rounds</li><li>○ Education and Teach Back</li><li>○ PCP Follow-up Appointments</li><li>○ AVS Improvements</li></ul>	
• Process Outcome Measures: What works!.....	page 26
References.....	page 26
Appendix	
(1) The patient's ideal Journey to Wellness	
(2) The Coleman Model	
(3) Peninsula Circle of Care Brochure	
(4) Tools	

# Results: Discharge Appointments

Appointments scheduled before discharge home  
Pilot Unit-3West  
Apr 2012-Jan 2014  
Mills Peninsula Medical Center



# 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)

