Abstract:

**Problem statement:** Fragmentation in geriatric hip fracture care is a growing concern in light of the aging population. Geriatric hip fracture patients at our institution have traditionally been admitted to multiple different services and units, leading to unnecessary variation in inpatient care. Such inconsistency results in delays in surgery, discharge, and functional recovery; hospital-acquired complications; failure to adhere to best practices in osteoporosis management; and poor coordination with outpatient providers. A unified care delivery model is needed.

**QI approach:** Through the Institute for Healthcare Quality, Safety, and Efficiency, we assembled a committed leadership team, consisting of the Orthopedic Trauma Director, the Medicine Consult Service Director, the 8W clinical nurse manager, a process improvement specialist, a data analyst, and a project coach with geriatrics expertise, along with extended interprofessional team members. In October 2014, we implemented 3 key interventions: (1) admission of all floor-status geriatric hip fracture patients to the Orthopedics Service with hospitalist co-management, (2) priority placement on the Orthopedics Unit, and (3) user-centered admission and postoperative order sets that standardized pain control, delirium prevention, osteoporosis management, and discharge planning.

**Outcomes:** Our UCH Geriatric Hip Fracture Program has decreased average length of stay from 7.3 to 5.0 days and has maintained this improvement for 69 patients through July 2015. The percentage of patients on the Orthopedics Service has increased from 69% to 99%, while the percentage on the Orthopedics Unit has increased from 67% to 87%. Admission order set compliance stands at 97%. Over 90% of patients now receive appropriate osteoporosis work-up and treatment. Approximately 86%, 35%, and 39% of patients have completed follow-up appointments in the Orthopedics Clinic, Metabolic Bone Clinic, and UHealth Primary Care Clinics (if internal PCP) within 30 days, respectively.

**Next steps:** In July 2015, we introduced a standardized process to schedule PCP appointments prior to discharge, with initial improvement from 17% to 89%. Next, we will be developing an ED care pathway, which will include fascia iliaka blocks to decrease patients' opioid burden. We also plan to start tracking post-discharge outcomes, such as 30-day readmissions and functional status, re-fracture rate, and mortality at 1 year.