

# National Quality Improvement Conference

## Value-based Care for Hip Fracture Patients in St. Andrews's Community Hospital (HIP-VBC)

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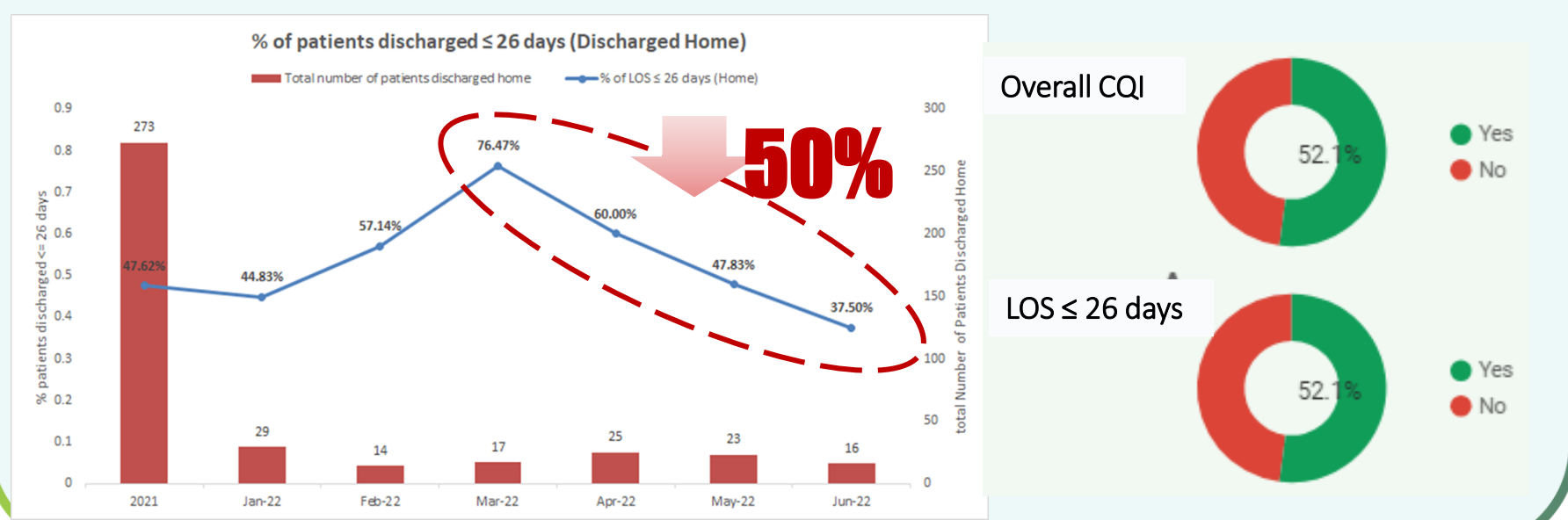
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### Problem Statement

- Length of Stay (LOS) of hip fracture patients was identified as the main Clinical Quality Indicator<sup>#</sup> (CQI) for improvement. The average LOS was 33 days vs. national LOS of ≤ 26 days.
- Between Mar 2022 and Jun 2022, the % of patients who were discharged home ≤ 26 days dropped drastically from 76% to 38%.



### Potential Solutions

#### Problems

- Variations in care plan
- Patient / Caregiver had no clear understanding of end to end journey
- Patient not independent or confident to self-ambulate after discharge
- Delay in decision making & discharge planning
- Poor communication amongst the MDT members

#### Solutions & Benefits

<p>Standardised enhanced care pathway amongst the interdisciplinary team</p>	<p>Standardised patient &amp; caregiver education at CGH &amp; SACH through the hip fracture patient journey pamphlet</p>	<p>Continued rehab at Day Rehab Centers beyond discharge through patients' / caregivers' education</p>	<p>Offer after office hours discharge if family members are working</p>	<p>Enhanced "Patient Handover" form to incl. "weight-bearing" status, follow-up appt., STO &amp; temperature data</p>
<ul style="list-style-type: none"> <li>✓ Early mobilization</li> <li>✓ Reduced pain during rehab</li> <li>✓ Reduced unnecessary LOS</li> </ul>	<ul style="list-style-type: none"> <li>✓ Managed patients' &amp; caregivers' expectations</li> <li>✓ Standardized communication</li> </ul>	<ul style="list-style-type: none"> <li>✓ Right-siting of care to community rehab</li> <li>✓ Reduced unnecessary LOS</li> </ul>	<ul style="list-style-type: none"> <li>✓ Enhanced patients' and caregivers' experience</li> <li>✓ Reduce unnecessary LOS</li> </ul>	<ul style="list-style-type: none"> <li>✓ Enabled seamless shared care across CGH &amp; SACH</li> <li>✓ Reduced rework</li> </ul>

### Project Aim

Improve the percentage of hip fracture patients who are discharged home with LOS ≤ 26 days **from 52% to 63%\*** in 6 months.

<sup>#</sup> The number of patients who met all quality indicators (i.e. received "perfect care") as determined by the clinicians, divided by the total number of patients.

\* Based on the baseline data, 11% of the patients who were discharged home were discharged within 27-30 days. The team postulated that this group of patients stayed beyond 26 days due to process issues rather than clinical or social issues.

### Lessons Learnt

#### Challenges

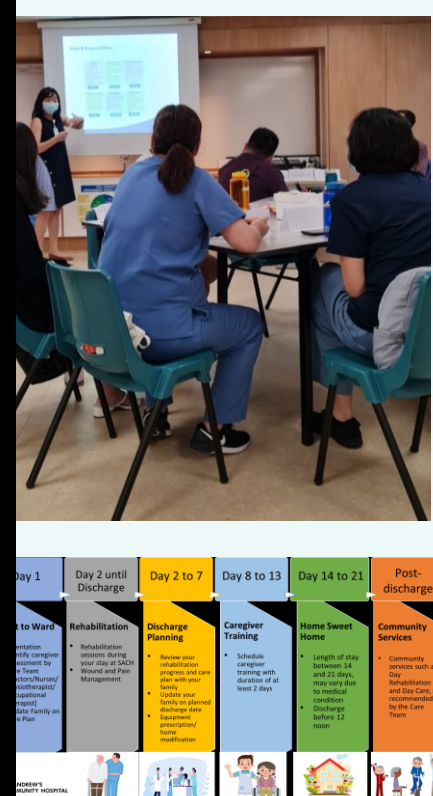
2. Coming up with viable and sustainable solutions

1. Understanding patients' needs

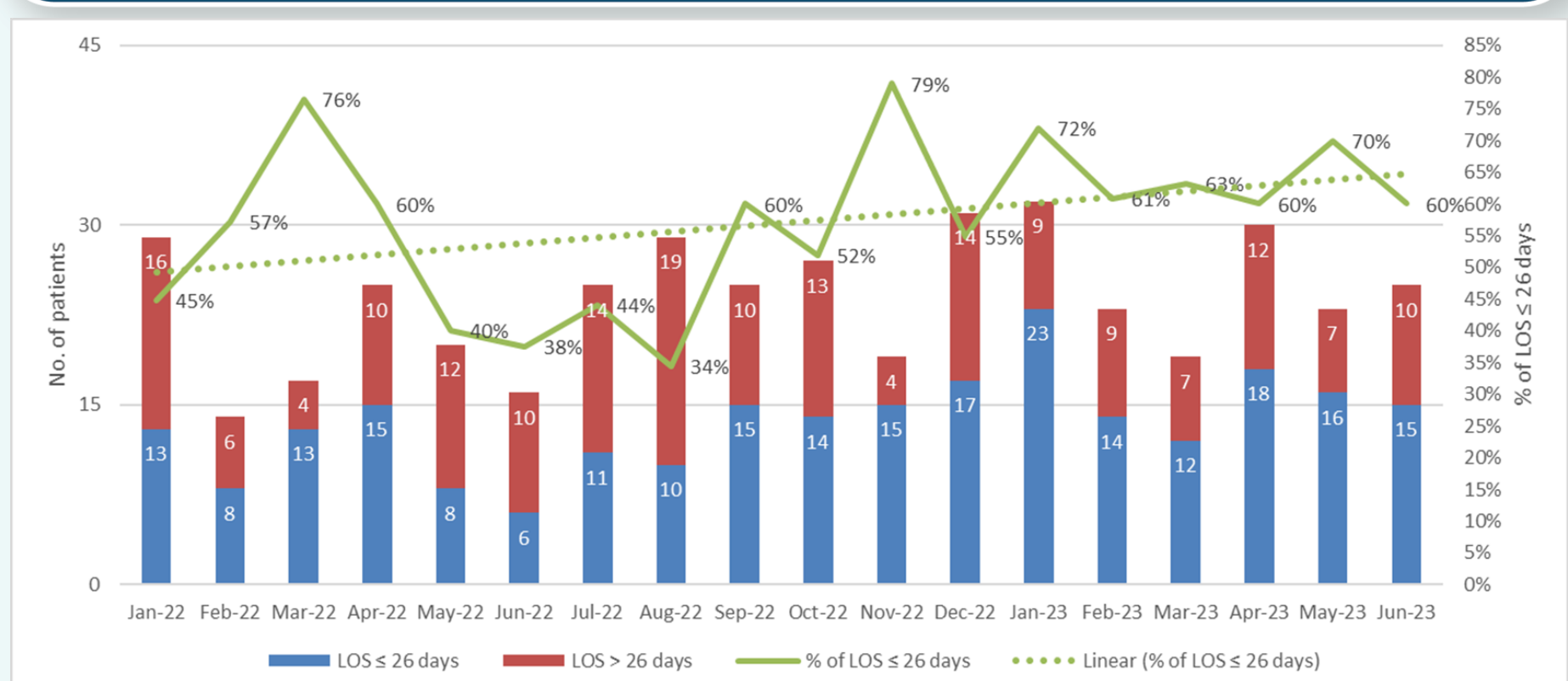
#### Counter-measures

A multipronged approach by a cross institutional multidisciplinary team yields promising results. The team analyzed the processes, identified operational wastage, & other issues that resulted in unnecessary hospital stay.

Solicited patients' feedback on the content of the patient's journey pamphlet. Redesigned it to include expected LOS & the discharge timing.



### Outcomes & Impacts



**52% → 63%**  
More patients discharged home ≤ 26 days

**33 days → 26 days**  
Reduction in ALOS per patient

**\$558,000**  
Cost avoided p.a. due to bed days saved

#### Balancing Indicators

Monitoring Indicators	Jan 22 – Jun 22	Dec 22 – Jun 23
1. Rehab Efficiency Score	0.7	0.85
2. % of Cases Referred to DRC	68%	78%
3. % of Withdrawn Referred Cases	49%	24%

Patients are assured that there is continuity of rehab post-discharge and unnecessary LOS are avoided. Improved staff satisfaction due to a reduction in rework between SACH and CGH, and communication amongst multi-disciplinary teams.