Session IV:
Geriatric Hip Fractures

1:10 pm – 2:40 pm

Moderators: Stephen L. Kates, MD and Michael Suk, MD, JD

1:10 pm – 1:20 pm	Top 5 papers or ideas that challenge conventional wisdom about hip fracture care: • CT scan of head after fall in elderly patients with hip fracture • What is the appropriate number of times to follow up a hip fx in clinic • Use of telemedicine in hip fracture care *Daniel S. Horwitz, MD*
1:20 pm – 1:30 pm	Bundled Payments for Hip Fractures: Is It Possible? Should Hemiarthroplasty be Included a Total Hip Bundle? *Simon C. Mears, MD, PhD*
1:30 pm – 1:40 pm	Discussion
1:40 pm – 1:50 pm	Geriatric Fracture Bundling – What's Next? *Michael Suk, MD, JD*
1:50 pm – 2:00 pm	Best Practices of Top Fragility Fracture Programs *Stephen L. Kates, MD*
2:00 pm – 2:10 pm	Discussion
2:10 pm – 2:20 pm	Why a Hospital Administration Does and Does Not Want a Geriatric Fracture Program *Simon C. Mears, MD, PhD*
2:20 pm – 2:30 pm	How to Calculate the Total Cost of Care in Geriatric Fracture Care *Susan V. Bukata, MD*
2:30 pm – 2:40 pm	Discussion

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Clinical indications of computed tomography (CT) of the head in patients with low-energy geriatric hip fractures.
Maniar H1, McPhillips K1, Torres D2, Wild J2, Suk M1, Horwitz DS3

J Am Acad Orthop Surg. 2016 Jun;24(6):e50-8. doi: 10.5435/JAAOS-D-15-00325.
Nail Length in the Management of Intertrochanteric Fracture of the Femur.
Horwitz DS1, Tawari A, Suk M.

J Orthop Trauma. 2016 Dec;30(12):687-690.
The Role of Radiographs and Office Visits in the Follow-Up of Healed Intertrochanteric Hip Fractures: An Economic Analysis.
Kempegowda H1, Richard R, Borade A, Tawari A, Howenstein AM, Kubiak EN, Suk M, Horwitz DS.

Injury. 2016 Dec;47(12):2755-2759. doi: 10.1016/j.injury.2016.10.011. Epub 2016 Oct 17.
Improvement in osteoporosis detection in a fracture liaison service with integration of a geriatric hip fracture care program.
Borade A1, Kempegowda H1, Tawari A1, Suk M1, Horwitz DS2.

Osteoporos Int. 2017 Jan;28(1):269-277. doi: 10.1007/s00198-016-3711-7. Epub 2016 Jul 21.

Improved 1-year mortality in elderly patients with a hip fracture following integrated orthogeriatric treatment.

Folbert EC[1], Hegeman JH[2], Vermeer M[3], Regtuijt EM[4], van der Velde D[2], Ten Duis HJ[5], Slaets JP[6].

Stud Health Technol Inform. 2015;210:469-73.

Feasibility of post-acute hip fracture telerehabilitation in older adults.

Bedra M[1], Finkelstein J[1]

Bundled Payments for Hip Fracture: Is it Possible? Should hemiarthroplasty included in a total hip bundle?

Simon C. Mears, MD, PhD, University of Arkansas for Medical Sciences

Bundled payment models give one payment of the entire 90 day period around surgery. They include costs of hospitalization, providers and all postoperative care including readmission. Current arthroplasty bundles including the elective BPCA and the mandatory CCJR include hip arthroplasty when used to treat fracture (both hemiarthroplasty and total hip. The SHFFT model is a mandatory bundle that includes fractures of the hip and femur. This will be started in July in areas already participating in CCJR. Care of fracture patients undergoing arthroplasty has been shown to be 82% more that for elective patients. Savings for elective bundles include care reorganization, preoperative patient selection and maximization, decrease length of hospital stay, less readmissions, decreased use of post discharge facilities and home care. Most of these care improvement methods are impossible in the non-elective hip fracture patient.

Care improvement for the fracture patient includes the use of a hip fracture service and co-management to decrease costs of care during the hospitalization. This approach has been shown to reduce readmissions and complications. In a few cases, the healthy arthroplasty patient may be discharged home.

In conclusion, not only is it possible, but bundled payment models for hip fracture are mandatory in areas of the country. These patients are more expensive than elective patients even with the best of care. In order to limit losses, centers will need a well-functioning hip fracture program and will need to work with SNF facilities to redesign post discharge care. While hemiarthroplasty is different than elective arthroplasty, its inclusion in current bundled payment models is unlikely to change. Hopefully the new administration will reconsider that risk stratification approaches are necessary for hip fracture patients.

1. Kester BS, Williams J, Bosco JA, Slover JD, Iorio R, Schwarzkopf R. The association between hospital length of stay and 90-day readmission risk for femoral neck fracture patients: Within a total joint arthroplasty bundled payment initiative. *J Arthroplasty*. 2016;31:2741-2745.
2. Schairer WW, Lane JM, Halsey DA, Iorio R, Padgett DE, McLawhorn AS. The Frank Stinchfield Award: Total hip arthroplasty for femoral neck fracture is not a typical DRG 470: A propensity-matched cohort study. *Clin Orthop Relat Res*. 2017;475:353-360.
3. Rozell JC, Courtney PM, Dattilo JR, Wu CH, Lee GC. Should all patients be included in alternative payment models for primary total hip arthroplasty and total knee arthroplasty? *J Arthroplasty*. 2016;31(9 Suppl):45-49.
4. Nichols CI, Vose JG, Nunley RM. Clinical Outcomes and 90-Day Costs Following Hemiarthroplasty or Total Hip Arthroplasty for Hip Fracture. J Arthroplasty. 2017 Jan 24. pii: S0883-5403(17)30055-4. doi: 10.1016/j.arth.2017.01.023. [Epub ahead of print]

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Why a hospital administration does and does not want a hip fracture service

Simon C. Mears, MD, PhD, University of Arkansas for Medical Sciences

To develop a hip fracture service, it is critical to have the full enthusiasm of hospital administration. Resources, including hospitalists, IT, access to data, therapists, coordinators are critical to developing a well-functioning service. In developing a plan for administration, it is important that the physician develop a business plan that can be delivered quickly and succinctly to the hospital C suite.

Reasons that hospital may be in favor of a developing a fracture service include

- To make money when they are currently losing it
- To improve quality metrics is, they are not currently doing a good job
- To develop a signature program with accreditation that can create more business
- They are currently in the CJR/ SHFFT bundled payment program and highly likely to lose money without improvements in hip fracture care

Reasons that a hospital may not be in favor of a developing a fracture service include

- Low case volume (not indicated if < 50 cases, only makes money when >300 cases per year)
- Not enough operating rooms for early surgery
- Not enough hospital beds to support hip fracture growth
- Unreliable surgeons
- Unreliable medical support
- The hospital is losing money and cannot support any new programs

In conclusion, it is important to understand why or why not a hospital may be in support of a hip fracture program. This information is critical when presenting a pitch for a hip fracture service to hospital administration.

1. Kates SL, Shields E, Behrend C, Noyes KK. Financial Implications of Hospital Readmission After Hip Fracture. Geriatr Orthop Surg Rehabil. 2015 Sep;6(3):140-6.
2. Kates SL, O'Malley N, Friedman SM, Mendelson DA. Barriers to implementation of an organized geriatric fracture program. Geriatr Orthop Surg Rehabil. 2012 Mar;3(1):8-16.
3. Kates SL, Mendelson DA, Friedman SM. The value of an organized fracture program for the elderly: early results. J Orthop Trauma. 2011 Apr;25(4):233-7.
4. Swart E, Vasudeva E, Makhni EC, Macaulay W, Bozic KJ. Dedicated Perioperative Hip Fracture Comanagement Programs are Cost-effective in High-volume Centers: An Economic Analysis. Clin Orthop Relat Res. 2016 Jan;474(1):222-33.

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