How To Get Grandma Fixed

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We don’t always get it right, but with hip fractures, we did…..

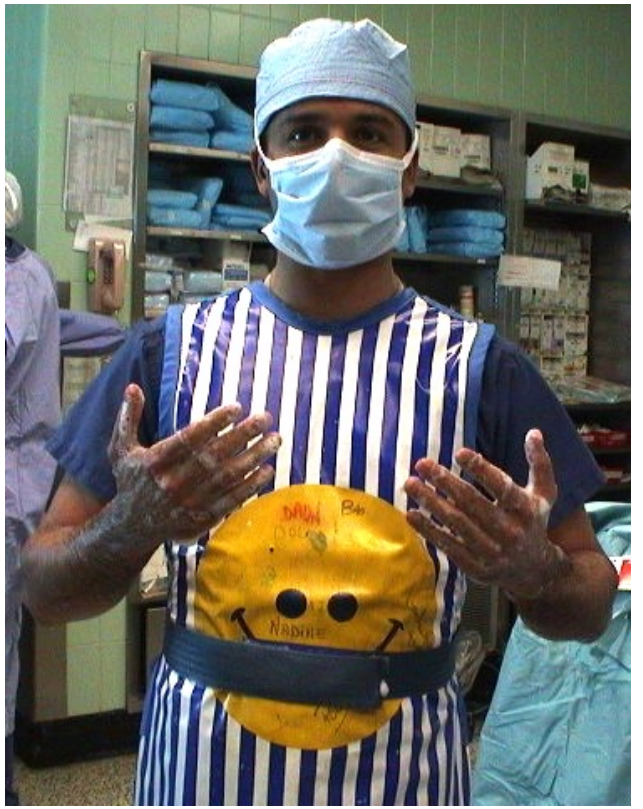
- *“Good surgeons **know how** to operate, better ones **know when** to operate, and the best **know when not** to operate… ”*
  - *1999* BMJ article

Solution: Its Very Simple

- Unfettered OR Access
  - No OR, no surgery
- Appropriate Staff
  - Avoid “Groundhog day”
- Incentivize “stake-holders”
  - Its amazing how incentive works!

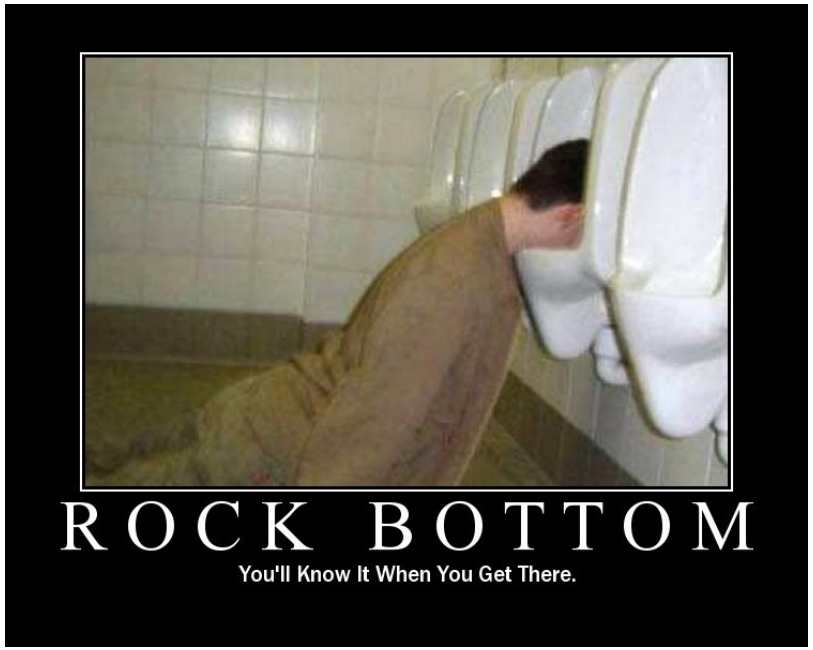
Why Me?

- Started off at University of Pittsburgh
- Used, abused, worked more than residency
- Interest in administrative/business aspects



- Recruited to save failing Level I center in Ohio
  - Medical and Surgical residencies. No ortho residency.
  - Lacked fellowship trained orthopaedic traumatologist
  - Poorly functioning orthopaedic program
  - Lacked protocols, processes, and PI for orthopaedics
  - No “scholarly activity”

- Established “ortho trauma room”
- Published on “economics of orthopaedic trauma”
- Established functioning and ongoing research department



- Recruited to save Ortho residency on probation in Atlanta
  - Previously known as Georgia Baptist (now gone)
  - Orthopaedic program on ACGME probation
  - At risk for losing Level II.
  - Aspiration to go to Level I.

- Established “ortho trauma room”
- Established processes and PI
- Support/collaboration with community surgeons
- Provided “scholarly activity/pubs” to get Level I
- Help with supply chain contracts ($ savings)

Recruitment to NH-GMC

- Had poorly run orthopaedic trauma
  - Lack of fellowship trained orthopaedic trauma surgeon
  - Lack of operational processes and PI compliant with ACS
  - Poor interaction with community surgeons

- Provided requisite fellowship expertise
- Work w TPM/TMD to be ACS compliant
- Collaborate w community surgeons for “win-win”
- Provided outreach/CME activity
- Operational processes recommended

Northside Merger – A New Era

- Influx of resources
- Administrative inertia to pass ACS visit
- Compliance with new ACS guidelines

ACS Guidelines

- ACSCOT Orthopaedic Section
  - A group of orthopaedic traumatologists who are also ACS members
  - Collaborate to determine best practices for orthopaedic trauma
  - We write the section in the various books
  - I helped write Orange Book section, soon to be Gray Book

Evidence Based Recommendations?

- Antibiotic administration – YES
  - This is also common sense.
  - Numerous studies identify time to 1st antibiotic administration correlates to infection for open fractures.
  - Applies to ALL FRACTURES but tibia is the proxy
  - ATB is the “chemotherapy of contamination”

  - Best practices: Get a gram of Orthozolin in asap

Evidence Based Recommendations?

- Time to Open Fracture Treatment – YES and NO
  - 20yrs ago a pinprick open injury was an “emergency”
  - Based on horrible Level IV studies from 1980s
  - Canada started the new trend with a study of rural areas.
    - Time to trauma center was correlated to outcome (proxy to “appropriate expertise”)
    - The longer to OR, the more aggressive the debridement needed
  - Off hour surgery is associate with more complications
  - Urgency depends on many factors.

  - Best practices: Urgency versus appropriate timing and staff

Evidence Based Recommendations?

- Femur fracture stabilization within 24hr – NO
  - But this is common sense. Its painful
  - Interferes with nursing care and trauma care
  - If they are too sick for a nail, they can get an exfix
  - The key is to avoid the 2nd hit
  - The risk is fat embolus and ARDS

  - Best practices: Don’t delay. Rare they cant get something in 24hrs

Evidence Based Recommendations?

- Hip Fractures – YES
  - Numerous studies: early stabilization (fixation or replacement) reduce mortality and morbidity
  - What we don't know: should it be 24hrs, 48hrs, or as long as it takes to get optimized
  - It also depends on collaboration with hospitalist and trauma services.
  - Similar approach to femur fractures except geriatric patients
  - Want to kill a patient? Admit them to orthopaedic service

  - Best pratices: As soon as optimized. First available surgeon to do.

What's The Secret Recipe?

- Real fellowship trained surgeons
  - "I'm the black hole of fractures, infections, non-unions, pelvis…"
  - "First time you say no to a transfer, will be the last time you said yes"
- Resources
  - Institutional commitment. If its not there, it wont happen.
  - Daily, unfettered OR access. Its not rocket science.
  - Residency program or adequate APP support "in-house" is best

What's The Secret Recipe?

- Collaboration with trauma and medical services
  - "How can we help each other"
  - Incentivize hospitalists and trauma surgeons to facilitate throughput
  - Literature is clear: multispecialty collaboration is highest quality
- Call panel supervision and collaboration
  - Interpersonal interaction to allow "available surgeon" to perform
  - Make it easy for the community surgeons to participate
  - Quarterly review and OPPE of call panel by Ortho liason (I do that)

Its Really Not That Hard……

- Thank you
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