

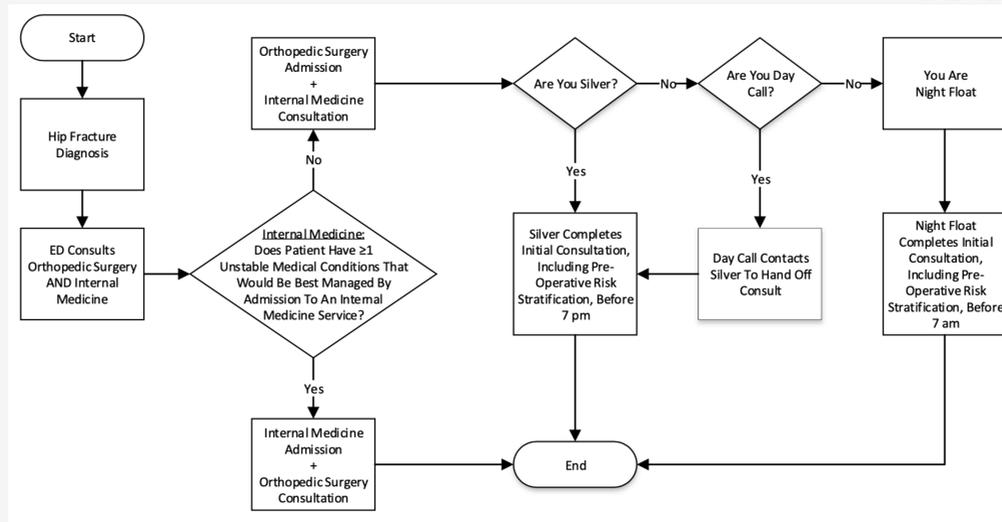
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Introduction

Hip fractures are common in the elderly population and are a common cause of mortality. Hip fracture prognosis is poor and one-year mortality rates are between 20-30%^{4,5}. Current managements require expedient preoperative evaluation and clearance and recommend surgical intervention within 24-48 hours of presentation.¹ Co-management services of elderly hip fracture have been shown to improve outcomes, reduce complications, and reduce healthcare costs. This study aims to analyze the co-management of elderly patient by orthopedic surgeons and internal medicine at the University of New Mexico Hospital. The aim of this quality improvement project was to decrease time between hip fracture diagnosis and surgical intervention to <24 hours and decrease post-operative complications and length of stay.

Methods

Data of elderly patients with hip fracture injury was collected retrospectively from August 2019 to January 2020. Quality measures: length of hospital stay, time to obtain x-ray from emergency department (ED), post-operative physical therapy time, time from emergency department to operating room (OR), and peri-operative complications data were collected.

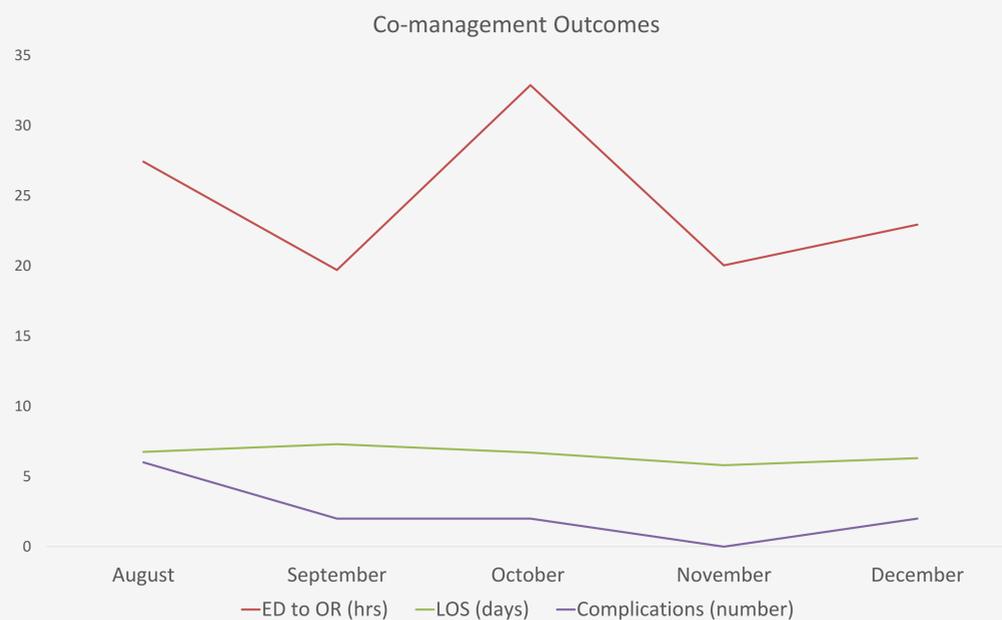


Results

On average 12 patients a month are admitted for operative treatment of hip fractures. Average age is 76 years old. Since implementation of the hip fracture protocol time from ED to OR has remained unchanged (24 hours pre to 27 post) and length of stay modestly decreased (7.3 days pre to 7 days post). Complication rate has decreased from 33% to 11%.

Conclusion/Discussion

Implementation of a comanaged hip fracture service has not drastically changed ED to OR time; however, pre-implementation times were already near the goal of <24 hours. Length of stay does not appear to be affected. Involvement of case management and physical therapy is underway to help decrease length of stay. Complication rate has decreased, possibly due to closer surveillance of medical co-morbidities and preventative measures. The working relationship between orthopedics and internal medicine has anecdotally improved. Future directions include analysis of peri-operative opioid use and implementation of routine peripheral nerve blocks as well as incorporating physical therapy into the protocol so that patients may be readily seen post-operatively. Early results are promising for the first 5 months. More time utilizing this protocol and comparison to more prior time points may reveal more robust differences.



References

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