FFN NEWSLETTER

ISSUE 5, OCTOBER, 2013

2ND FFN GLOBAL CONGRESS: REPORT

by Colin Currie, Chair, FFN Hip Fracture Registry Special Interest Group

The 2nd Global Congress, held in Berlin from 29th to 31st August, showed very clearly how the Fragility Fracture Network has grown in strength, reach and impact since its inaugural Fragility Fractures Network Expert Meeting – also held in Berlin, and only two years ago.

With more than 400 participants from 36 nations, it was the biggest FFN meeting so far, and one with an extensive, diverse and thought-provoking programme that combined expert briefings, workshops based on the practicalities of care improvement, and selected free papers and posters.

While the main themes of the Congress were policy change and the rehabilitation aspects of fragility fracture care, the plenary sessions and workshops ranged more widely, reflecting in detail all aspects of the three broad aims of the FFN: best multidisciplinary practice in the care and prevention of fragility fractures; research seeking better treatments for osteoporosis, sarcopenia and fracture; and policy change at national and global level to address the still-growing epidemic of fragility fractures.

No brief report such as this can do justice to the range and detail of the Congress's Scientific Programme. Acknowledged international authorities tackled the big topics, with a welcome debut appearance by anaesthetist colleagues in the first plenary session; and at the other end of the spectrum there were nervous but engaging two-minute presentations by more junior people whose posters were judged to be in the best fifteen. In between were free paper sessions reflecting a wealth of initiatives on all aspects of fragility fracture care in a wide range of national contexts; and no less than twelve workshops – probably the most interactive sessions of all – covering clinical topics, fracture prevention, service development and evaluation issues, audit and the improvement of care, and changing policy and practice.

FFN members who didn't make it to Berlin and would like to know more, and those who did but missed topics of interest as a result of overlapping parallel sessions, will have access to the great majority of the Congress's PowerPoint presentations via the FFN website.

Berlin was warm and welcoming in late summer, and this year's venue one of historic importance: the Langenbeck-Virchow-Haus, commemorating two giants of 19th-century medicine, and part of the Humboldt-Charite campus: the largest university hospital complex in Europe.

But the atmosphere of the meeting was refreshingly informal. At an evening networking event one seasoned observer, a colleague from industry and the survivor of dozens of international meetings, commented that the Congress was unique for its interactions: not only between the many disciplines involved in the FFN, but also between experts and their audiences. 'Not so much them and us,' as he put it. 'More us and us.'

That comment made much sense, because both in the plenary sessions and the workshops activists, experts and enthusiasts – from a wide range of nations and disciplines, but working towards a common purpose – felt free to talk as well as to listen, to challenge and respond, and to compare and share experience and ideas: what works, and what might work, and how things learned in Berlin might be used, and perhaps even be useful, back home.

As a meeting, it also easily passed the coffee-break test. People emerged from plenary sessions and workshops, grabbed a coffee, and sought out people who had talked, people they'd met last year, and people who were interested in what they were interested in. And they talked, how they talked. So, by the broader test of the noise level during the coffee breaks as a proxy measure of interactivity, the FFN 2nd Global Congress was again a great success.

But there was no sense of complacency. If the FFN is to move forward, then the 3rd Global Congress must be even better than the 2nd. To that end, the final Saturday-morning session in Berlin – with the title 'How Can We Improve the Congress?' – looked ahead, with discussion that was both thoughtful and lively, and good ideas emerging as a result. There are already some grounds for optimism that the 3rd Global Congress – now scheduled for September 04—06, 2014 in Madrid – will indeed prove even better than the 2nd.

THE PRESIDENT'S MESSAGE

by David Marsh, President

As you can see from the report on this page, the Second Global Congress represented as big a step forward from the First Congress as the latter had done from the Expert Meeting that launched the FFN in 2011. The unique balance between acute fracture management and prevention of the next fracture, plus the strong multidisciplinary ethos, gives the FFN message great appeal in all parts of the world. This is reinforced by the work we have done since the First Congress, especially in the emerging economies of SE Asia and Latin America, where the demographic trajectory projects a truly frightening prospect for exponential increases in hip fracture incidence in the next 10-20 years. The seeds of the FFN have been sown in Japan, S Korea, Taiwan, Hong Kong, Brazil, Colombia and Lebanon with work now beginning in China, India, Chile and Dubai.

Meanwhile, work continues in Europe, and the third Global Congress will be in Madrid, 4-6 September 2014. A call for abstracts will be issued in the New Year but, in the meantime, any suggestions for how to maximise the value of this event will be gratefully received. Please send them to Denis Eggler at ff-network@mci-group.com.

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FFN GENERAL ASSEMBLY — AUGUST 30, 2013

On August 30, 2013 the FFN General Assembly took place during the 2nd FFN Global Congres in Berlin. 67 members attended the the General Assembly. The following items were presented and discussed:

Annual Report 2012

- Noted a well-attended 1st FFN Global Congress, attended by a wide range of relevant clinicians and scientists, many countries represented.
- Membership numbers rising, strong support from five industry sponsors noted
- Discussion of use of any financial surplus on the development of the FFN website; travelling scholarships for nurses, AHP's; support for Special Interest Groups
- In discussion, individual membership of FFN – as opposed to collective membership via national societies – was defended on the grounds that in order to succeed FFN must remain a network of individual enthusiasts and leaders

The annual report 2012 was approved.

Activity report

A range of successful meetings was presented – some jointly with national organisations.

Room for further progress in the development of strong FFN presence in some regions of the world.

Nominations Committee

- A major role of the nominations committee was to balance both regional interests and specialty representation – clearly a challenging matter, and one that raised the inevitable problem of a "democratic deficit".
- In discussion the balance between nomination and election to senior posts was recognised, with further discussion required
- Time-limited appointments, with the possibility of re-election once, would ensure turnover; and continuity could be promoted through the inclusion on the Executive Committee of the president, the president elect and the past president.

The FFN Board could, through the exercise of judgement in matters of governance, effect useful progress without resort to formal constitutional change.

Future activities

The future activities included a summit in Dubai, and a meeting in Chile in April 2014 to take the form of a pan-Latin America FFN event; a meeting in Beirut in September 2014, and possible other events still at the planning stage

Next Global Congress

The 3rd FFN Global Congress will take place in Madrid, September 4-6, 2014, building on the obvious success of Berlin 2013, and taking account of further suggestions raised in the course of that meeting. Futher information can be found on www.ffn-congress.com.

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Experience has shown that a focus on hip fracture management is effective in raising standards in the prevention and management of fragility fractures generally. Also that real-time monitoring of hip fracture episodes is a good way to create that focus. With this in mind, please pay special attention to the article on page 2 about the Hip Fracture Registry Special Interest Group and feel free to join in that work. This SIG is working hard and we will report on progress in future Newsletters.

IMPRESSIONS OF THE 2ND FFN GLOBAL CONGRESS

FFN
Fragility Fracture Network
of the Bone and Joint Decade

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THE FFN HIP FRACTURE REGISTRY SPECIAL INTEREST GROUP

by Colin Currie, Chair, FFN Hip Fracture Registry Special Interest Group

With hip fracture now seen as the tracer condition for the global epidemic of fragility fractures, and with hip fracture registries – or audits, the terms for practical purposes being interchangeable – growing in numbers and effectiveness, the FFN saw quite early on the need for a Special Interest Group to promote the wider implementation of audit as a means of improving care.

It is clear that hip fracture audit has made much progress over the last 25 years. Starting with Rikshoft in Sweden in 1988, and with developments following elsewhere in Europe and then further afield as a result of clinical enthusiasm and substantial advances in IT and communications, there are audits now established or emerging in the UK, Ireland, Australia and New Zealand, Canada and Hong Kong.

The FFN Special Interest Group was set up by the FFN board in February 2013, with an interim steering committee tasked in the first instance to produce a Minimum Common Dataset. The aim was to develop a concise – and therefore easy and cheap to complete – dataset which would nevertheless allow comparisons with more extensive and detailed datasets already in use. This proved fairly straightforward, since many of these datasets were derived largely from that of Rikshoft. The Minimum Common Dataset that resulted can be shown on one page of A4 (see page 5 below – though the print may be rather small).

It should be clear that the main, indeed the only, purpose of hip fracture audit is to improve hip fracture care and secondary prevention. Happily there is now increasing evidence that this can be achieved. The UK National Hip Fracture Database (NHFD) was launched in 2007, alongside a jointly-sponsored Blue Book on the care of patients with fragility fracture, as a collaboration between the British Orthopaedic Association and the British Geriatrics Society. Since its launch the NHFD has documented more than 250,000 cases, and continues to grow at roughly 5000 cases per month. Care is audited against six clinical standards set out in the Blue Book, and the latest NHFD National Report – available now for downloading at www.nhfd.co.uk – again shows sustained improvements in care and outcomes.

Obviously not all hip fracture audits will be on such a scale, but the aim of the Special Interest Group (SIG) is the development of audit around the world, at national level where possible, at individual hospital level where appropriate, and with the clear intent of ensuring that – in order to maintain transparency and thus promote better care – such audits are broadly comparable.
A first call for expressions of interest in joining the SIG attracted quite a large response, and in the light of further progress another invitation and questionnaire will go out shortly to all FFN members. Thereafter, SIG members will be invited to comment on the proposed Minimum Common Dataset; and, if they so wish, to submit any datasets they have in use already so that their compatibility with the MCD can be explored.

Early reaction to the Minimum Common Dataset (MCD) has been broadly favourable. It was formally launched in a plenary session at the FFN's 2nd Global Congress, and a subsequent Special Interest Group workshop session highlighted progress in audit work in British Columbia (Canada); Adelaide (Australia); and Hong Kong SAR (China). And the following week the work of the SIG and the experience of the UK NHFD featured prominently in a major meeting – the International Workshop-Symposium on Fragility Fracture Registries – Hong Kong, where work towards a comprehensive audit of the 6000 hip fractures occurring there each year is far advanced.

There is no doubt that hip fracture audit is already well on the way to becoming an international success story; and the Fragility Fracture Network – with its commitment to supporting the improvement of multidisciplinary fracture care – has the opportunity to promote the widest possible implementation of effective hip fracture audit as a means of making that happen. The next phase of the SIG's work will certainly be challenging; but, we hope, rewarding too.

AUDIT TOOL 1.0 HIP FRACTURE REGISTRY (SPECIAL INTEREST GROUP)

Please find following the link to the audit tool 1.0 for minimum common dataset of the hip fracture registry.

If you are interested to join the Special Interest Group please contact ff-network@mci-group.com.

GO TO THE FRAGILITY FRACTURE NETWORK: HIP FRACTURE REGISTRY SPECIAL INTEREST GROUP

AUDIT TOOL 1.0 FOR MINIMUM COMMON DATASET

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ADDRESSING THE CARE GAP IN SECONDARY FRACTURE PREVENTION IN A SOUTH EAST ASIAN HOSPITAL

by Manju Chandran, MD, FACP, FACE, FAMS
Senior Consultant and Director
Singapore General Hospital

Effective initiation of osteoporosis diagnosis and treatment for patients with fragility fractures through "optimal" program.

Though fractures often represent the first opportunity for care of osteoporosis, a significant care gap still exists worldwide in the management of these sentinel events. OPTIMAL (Osteoporosis Patient Targeted and Integrated Management for Active Living) is a clinician champion driven, case manager run secondary fracture prevention program set up in the 6 public hospitals and later expanded to include the 18 polyclinics existing in the island country of Singapore.

The aim of the Ministry of Health funded program is to prevent the occurrence of a second fragility fracture through a judicious combination of case finding, medication subsidy, physiotherapy and case manager follow up. At Singapore General Hospital which is the largest public tertiary teaching hospital in Singapore, the program was set up as a mutual collaborative effort between the Osteoporosis and Bone Metabolism Unit of the Department of Endocrinology and the Departments of Orthopaedics, Emergency Medicine, Rheumatology, Geriatrics, Obstetrics and Gynaecology, Physical Medicine and Rehabilitation and Family Medicine. At the time of commencing of the OPTIMAL program at SGH, preliminary steps by the Osteoporosis and Bone Metabolism Unit to implement an Osteoporosis Prevention and Treatment Initiative at the hospital had already been taken and the existent hip fracture pathway protocol had been updated.
This helped ease the implementation of the program and facilitated "buy in" by the various departments involved. The OPTIMAL Case Manager who in our hospital is a specialist nurse is informed each time that a physician from any of the above departments identifies patients who are 50 years of age or older with a fragility fracture. Fracture case records from the emergency department are also screened on a bi-weekly basis to identify patients with low trauma fractures seen in the department. The case manager thus is not only referred cases but is also responsible for case finding. Recommendations are made to the referring physician to order in recruited patients, a laboratory work up to rule out the more common causes of secondary osteoporosis prevalent in our population. Recommendations are also made for performing a baseline DXA of the hip and spine in all patients and to repeat the DXA at the end of 2 years to facilitate monitoring of bone mineral density change if any.

Education about osteoporosis and reduction of falls and fracture risk is provided individually to each patient. Patients are provided counselling about risks and benefits of medications. Patients who are not wheel chair bound are encouraged to be enrolled into one of 3 exercise programs - a group strength and balance retraining program (OTAGO) or individual physiotherapy or a community based program such as group Tai Chi.

OPTIMAL maintains a centralized computerized data base for the entry of all data including demographic details, past medical and surgical including fracture and falls history, risk factors for osteoporosis, current medication use, dietary calcium intake, DXA results and interpretation, life style and treatment recommnedations and arrangements for follow up. The findings from an initial audit of the program at Singapore General Hospital have been published (1).

In the 4 years following inception, the OPTIMAL program at our hospital has successfully identified and evaluated most patients with fragility fractures. However the implementation of the program presented several real-life challenges. Multiple clinical interventions including case finding, bone density measurement, evaluation of secondary causes and initiation of pharmacological and non pharmacological treatment had to be synchronized. Most importantly, coordination with funding bodies, involving multiple departments and senior management leadership in the "buy in" and finding dedicated and enthusiastic case managers to make programs viable and sustainable all proved to be challenging.

Even with subsidies, some patients find medication cost prohibitively expensive and this may have contributed to some patients being non compliant despite close follow up in our fracture prevention program. Discharging patients to polyclinics and primary care after initial assessment and therapy initiation, remains inadequate in our program. Integrating GP's into the program and providing more seamless transition programs may help overcome this problem. Cost effectiveness of the program remains to be proven. Our goal is to make sure that no fragility fracture patient is missed and to strive to ensure that in every patient the first fracture even if it does happen, will really be the last.

References:
Secondary prevention of osteoprotic fractures-an "OPTIMAL" model of care from Singapore. Chandran M, Tan MZ, Cheen M, Tan SB, Leong M, Lau TC. Osteopros Int. 2013 Apr 25. [Epub ahead of print]

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Stryker, Andreas Speitling

Synthes, Peter Fehlmann

Contact:

FFN Central Office
c/o MCI Schweiz AG
Flughofstrasse 54
8152 Glattbrugg

Tel: +41 44 809 42 80
Fax: +41 44 809 42 01

ff-network@mci-group.com
www.ff-network.org

Founded: August 2011

Number of Members: 362 (paid and unpaid)

Number of Executive Committee Members: 7

Number of Board Members: 11

Number of Cooptees to the Board: 5

Number of Industry Partners 2013: 7

Fragility Fracture Network: Hip Fracture Registry Special Interest Group
Audit Tool 1.0 for Minimum Common Dataset (Draft)

Patient characteristics

First Name	Surname	Date of Birth	Gender
			☐ Male ☐ Female

Pre-fracture Residence	Pre-facture Mobility
☐ Home ☐ Institution ☐ Acute Care ☐ Unknown	☐ Freely mobile without aids ☐ Mobile outdoors with one aid ☐ Mobile outdoors with two aids or frame ☐ Some indoor mobility but never goes outside without help ☐ No functional mobility (using lower limbs) ☐ Unknown
Abbreviated Mental Test Scores (AMTS) Pre op	**ASA grade**
AMTS ☐ /10 ☐ Not done ☐ Patient refused	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Unknown
Side of fracture	**Pathological**
☐ Left ☐ Right ☐ Both	☐ No ☐ Malignancy ☐ Atypical ☐ Unknown
Type of fracture	**Bone protection medication prior to admission**
☐ Intracapsular undisplaced ☐ Intracapsular displaced ☐ Intertrochanteric ☐ Subtrochanteric ☐ Other Note: Basal/basicervical #s are to be classed as Intertrochanteric	☐ Yes ☐ No

Acute care data

Date & time of admission	Patient ID / Hospital number
☐☐:☐☐ hrs am/pm	
Date & time of primary surgery	**No Operation**
☐☐:☐☐ hrs am/pm	☐ No operation was performed

Operation Performed	Type of Anaesthesia	Pressure Ulcers
☐ Cannulated screws ☐ Sliding hip screw ☐ Intra- medullary nail ☐ Hemi- arthoplasty ☐ Total hip replacement ☐ Other	☐ General ☐ Spinal ☐ Other regional- e.g. nerve block	☐ Yes ☐ No

Physician / Geriatrician involvement	First Day Mobilization	Mortality
☐ Physician ☐ Geriatrician ☐ Not seen	☐ Yes ☐ No	☐ Pre- surgery ☐ Post- surgery

Discharge

Date & time of discharge from acute ward	Discharge destination	Bone protection medication
_____ __:__ hrs am/pm	☐ Home ☐ Institution ☐ Acute Care ☐ Rehabilitation ☐ Dead ☐ Unknown	☐ Commenced ☐ Continued ☐ Discontinued

Follow Up – 120 days (Optional)

Hip-related Readmission	Mortality	EQ5D	Mobility	Residence	Bone protection
☐ Yes ☐ No **Re-operation** ☐ Yes ☐ No	☐ Yes ☐ No	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Freely mobile without aids ☐ Mobile outdoors with one aid ☐ Mobile outdoors with one aid frame ☐ Some indoor mobility but never goes outside without help ☐ No functional mobility (using lower limbs) ☐ Unknown	☐ Home ☐ Rehabilitatio ☐ Institution	☐ Yes ☐ No