Ortho-Geriatric Model of Care
Sharing the care for our most Vulnerable
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- What is the shared care model for the Hip fracture patient
- The Ortho-geriatric Model of Care at St Vincent’s Public Hospital
- Our team and how we make it work!
- Benefits of a Shared Care Model
- The Shared Care model: Challenges
Collaborative care for the hip fracture patient: what is the best model of care?
Models of collaborative care

- **Routine geriatric Consultation**: Care on an orthopaedic ward, consistent Consultation between Orthopaedic and geriatric team but **not integrated or shared responsibility**

- **Geriatric Ward**: Care within Geriatric ward with orthopaedic surgeon acting as consultant, with **responsibility resting with geriatrician**

- **Shared Care**: Integrated care model, pt is on an orthopaedic ward with **shared responsibility** between geriatrician and orthopaedic surgeon, with **much inter-disciplinary communication**
‘It Takes a village!’: The Shared Care Model at St Vincent’s
‘It takes a village’: The Shared Care Model at St Vincent’s Hospital:

- Shared Care Model in Place Since 2008 at St Vincent’s for Ortho-geriatric patients
- Represent Gold Standard of care
- Equal responsibility between geriatrician and Orthopaedic Surgeon
‘It takes a village’: The Shared Care Model at St Vincent’s Hospital:

- Lead by one Geriatrician on a permanent basis (Good Continuity of care)
- Involves MDT Case conference weekly and 3 ward rounds per week with consultant and surgical team
- Daily review by Geriatric Registrar
'It takes a village': The Shared Care Model at St Vincent’s Hospital:

- Geriatrician involved from ED admission: contributes to Surgical planning discussions
- Rehab/ long term care planning driven by geriatric team but in tandem with surgical team not isolation (ie Surgical team always on rounds)
Holistic approach: Improving outcomes

- complex analgesic
- medical
- cognitive
- nutritional
- social and rehabilitation
Current outcomes for hip fracture patients

- Prognosis poor: Mortality at one year 20-30%
- Those who were independent prior: one year after 25% remained in nursing homes
- 60% required assistance in one or more activities of daily living
How does the shared care model improve outcomes?

- Geriatric care during the acute phase is aimed not only at medical treatment but at **restoring function** after the event.
- All Three models of collaborative care show benefit as compared to single team care.
- **Shared care model** (Shared responsibility) shows to have **most** benefit to outcomes.
Rapid optimisation of fitness for surgery
Early identification of individual goals for multidisciplinary rehabilitation
Early effective planning for palliative care (if fracture due to or triggers terminal illness)
Comprehensive bone health review
How does the shared care model improve outcomes?

- Reduced length of stay
- Streamlined transition to rehab (Or Return to care facility)
- Increased rate of return to baseline functioning (Improved scores on quality of life and cognitive recovery)
- Decreased mortality/Morbidity (shown by some studies inconsistent results)
- Early and comprehensive treatment of delirium and deterioration
Improved outcomes for staff

- Excellent Learning opportunity for Junior Surgical staff
- Promotes holistic view of patient care
- More accurate coding for funding
- Re-enforces MDT approach to care: all disciplines input heard and respected
Making it work: Challenges of providing a shared care model

- Senior support: Needs good knowledge and acceptance by all senior consultants
- Collaborative approach: Ongoing Communication between surgical and geriatric team (Not simply Handing over to Geri’s post-op!)
Making it work: Challenges of providing a shared care model

- Requires good MDT team work
- Need to provide clear explanation to patients about the shared care approach
- Requires unified clinical approach: Need to avoid mismatch of messages to patient about care plan