COMPARATIVE PERSPECTIVES ON GERIATRICS-SURGERY CO-MANAGEMENT PROGRAM BY SPECIALTY AND STAFF ROLE

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Co-management programs between geriatrics and surgical specialties have gained popularity in the last few years. Little is known about how these programs are perceived across surgical specialties and staff roles. We conducted a mixed methods study to assess perspectives on a geriatrics-surgery co-management program (GSCP) at a hospital where geriatricians co-manage patients 65 or older admitted to Orthopedic Trauma, General Trauma, and Neurosurgery. We used semi-structured interviews (n=13) and online surveys (n=45) to explore program value, facilitators, use, understanding, and impact by specialty and staff roles (physicians, advanced practice providers, nurses, case managers, social workers). Interview transcripts were analyzed using qualitative thematic analysis, and survey data were analyzed using Kruskal-Wallis, ANOVA, and Fisher's exact tests. Interviews revealed three themes: 1) GSCP is valued because of geriatricians' expertise in older adults, relationship with patients and families, and skill in addressing social determinants of health; 2) GSCP facilitators include consistent availability of geriatricians, clear communication, and collaboration via shared data-driven goals; and 3) GSCP use varies by surgical specialty and role depending on expertise and patient complexity. Survey data analysis affirmed interview themes and showed significant differences (p-values<0.05) between perspectives of surgical specialties and roles on GSCP use, understanding, impact, and which specialty should manage specific clinical issues. Findings suggest that while there are similarities across surgical specialties and roles regarding the value of, and facilitators for, a GSCP, specialties and roles differ in use, understanding, and perceived program impact on care. These findings suggest strategies for optimizing this intervention across groups.

GERIATRIC COMANAGEMENT REDUCES HOSPITAL-ACQUIRED GERIATRIC SYNDROMES IN OLDER VASCULAR SURGERY INPATIENTS

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Aims Based on our meta-analysis, surveys and qualitative studies of geriatricians in Australia and New Zealand, we designed and implemented a novel inpatient model to co-manage older vascular surgical inpatients at a tertiary academic hospital in Sydney. This model, called Geriatrics co-management of older vascular surgery patients (Gerico-V), embedded a geriatrician into the vascular surgery unit who introduced a range of interventions targeting older people. Here we evaluated this model of care. Methods We undertook a prospective before-and-after study of consecutive patients aged ≥65 years admitted under vascular surgery. One hundred and fifty-two GeriCO-V patients were compared with 150 patients in the pre- GeriCO-V group. The primary outcomes were hospital-acquired geriatric syndromes, delirium, and length of stay. Results The GeriCO-V group had more frail (43% vs 30%), urgently admitted (47% vs 37%), and non-operative patients (34% vs 22%). These differences were attributed to COVID-19. GeriCO-V patients had fewer hospital-acquired geriatric syndromes (49% vs 65%; P =.005) and incident delirium (3% vs 10%; P = .02), in unadjusted and adjusted analyses. Cardiac (5% vs 20%; P <.001) and infective complications (3% vs 8%]; P = .04) were fewer in the GeriCO-V group. LOS was unchanged. Frail patients in the GeriCO-V group experienced significantly less geriatric syndromes and delirium. Conclusions The Gerico-V model of care led to reductions in hospital-acquired geriatric syndromes, delirium, and cardiac and infective complications. These benefits were seen in frail patients. The intervention requires close collaboration between surgeons and geriatricians, and may be translated to other surgical specialties.

REFERRAL PROCESSES AND DISPOSITIONS IN A MULTIDISCIPLINARY TEAM FOR OLDER ADULTS WITH COGNITIVE VULNERABILITY

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Multidisciplinary team care for community-dwelling older adults with multiple chronic conditions has proven value. Older adults receiving team care experience better outcomes than by solo practitioners alone, and teams are being established as outgrowths of primary care and other clinical settings. Yet little is known about the inner workings of multidisciplinary teams, both in terms of how referral patterns among team members are established and the extent to which older adults and their families accept referrals from team leaders to other clinical disciplines within teams. In this presentation, we provide details about referral patterns and rates of acceptance by study participants in an ongoing clinical trial testing a multidisciplinary team designed to provide care management to older adults (age >65) with cognitive vulnerability due to dementia, depression, and/or delirium (3D Team). Nurse practitioners lead the 3D Team, conduct in-home clinical assessments and make referrals to other team members based on study protocols specifying participants' eligibility for each 3D Team member. Results are based on the first 209 older adults randomized to the 3D Team. Pharmacist: all 209 members accepted having their medications reviewed and reconciled. Registered Dietician: of 134 referrals, 52 (38.8%) accepted. Occupational Therapist, of 117 referrals, 65 (55.6%) accepted. Physical Therapist: of 109 referrals, 92 (84.4%) accepted. Community Health Educator: of 106 referrals, 101 (95%) accepted. LCSW for