NSW Health

Leading Better Value Care

Osteoporotic refracture prevention

Organisational models

This document provides decision-makers with options to improve care in different service delivery settings. Building on *Osteoporotic refracture prevention: Clinical priorities (2020)* which describes *what* to improve in care for people with osteoporosis, the focus here is on *how* to improve care. These documents are informed by research evidence about the best clinical care and the effectiveness of different delivery models, empirical evidence about current service delivery levels, and experiential evidence from clinicians and patients.

IMPROVING KEY PRIORITY AREAS

Identification and triage

- Routinely review emergency presentations and fracture clinic lists, using electronic tools
- Do radiology screens for incidental findings of vertebral fractures
- Establish a stratification process to guide patient pathways
- Collaborate with hip fracture teams
- Use a single phone call to screen patients and facilitate intake

Assessment and diagnosis

- Use validated tools to assess falls risk from a patient and clinician perspective
- Have standing orders and protected appointment times for bone mineral density and pathology
- Liaise with private providers if DEXA or pathology is not available on site
- Capture test results and risk scores in the medical record
- Have a medical officer deliver the diagnosis

Treatment initiation

- Use existing resources to deliver patient education
- Use templates for care coordination and referral pathways
- Take a shared decision-making approach

Coordination of ongoing care

- Plan three month follow-up on the management plan via telehealth
- Support and document medication initiation and ongoing use
- Develop shared care with GPs to coordinate ongoing review
- Proactively set dates for future medical appointments and tests
- Promote healthy behaviours with community-based support

IMPROVING THE OVERALL PATIENT JOURNEY

- Employ a fracture liaison coordinator to identify and recruit patients, and coordinate care within the service and externally
- Produce individually tailored written management plans for all patients when initiating and reviewing care
- When possible, utilise a multidisciplinary team to assess and provide holistic and value-based care
- Identify relevant hospital and community services and develop links and pathways for patients (including specialist or multidisciplinary interventions)
- Build efficiencies through administrative support, electronic reminders and streamlined processes
- Measure and act upon patient reported experience and outcome measures (PROMIS-29 and Falls Efficacy Scale International (FES-I))

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OPTIONS FOR ORGANISATIONAL CONFIGURATIONS

The osteoporotic refracture prevention model of care is defined by core elements. Team members may include the fracture liaison coordinator, a medical officer, administrative support and other collaborators within and outside the local health district (for example, allied health, primary care and other practitioners in the community setting). In rural sites where the rate of presentation with minimal trauma fracture is very low, coordination of care at a regional or district level may be more appropriate. Although methods for implementing the model may vary across different contexts, there are two main options.

Regardless of which option is selected, there are common elements of care:

- Processes for identification, triage and recruitment of patients
- Assessment of bone health, falls risk and whole-of-person health
- Provision of osteoporosis education and self-management support
- Development of a management plan including non-pharmacological bone health and falls prevention
- Ongoing review of adherence to management plan and adjustment where required
- Use strategies such as outreach or telehealth to provide efficient care

Option 1: Coordinated multidisciplinary configuration

A medically led service with fracture liaison coordinated care using whole-of-person, chronic care principles to allow for thorough assessment of falls and fracture risk. Shared decision-making guides the development of management plans, which provide patient education, conservative care strategies and initiation of medication. This model is well suited to services with access to specialist and/or multidisciplinary care, particularly in metropolitan and larger sites.

Why choose this model?

- streamlines care provision, minimising barriers and improving the patient experience
- facilitates access to specialist medical care where required
- ensures clinicians are knowledgeable regarding osteoporosis
- maximises the benefits of holistic, interdisciplinary care

If you choose this, then...

- match resourcing to clinical demand
- tailor team configuration and define their roles
- ensure sufficient physical space is available for the clinic

Option 2: GP shared care configuration

The fracture liaison coordinator leads the service. This includes conducting assessments and producing personalised management plans, outlining referrals for multidisciplinary input, and liaising with GPs regarding bone health assessment (DEXA/pathology) and medical intervention. Proactive follow-up assesses and encourages adherence to the agreed plan, particularly pharmacotherapy.

This model is appropriate in regional or rural sites where specialist medical care is not available.

Why choose this model?

- access to an on-site specialist medical officer is limited or not available
- can be included in a hub and spoke model
- facilitates rapid implementation and promotes integrated models of care

If you choose this, then...

- ensure referral pathways are available into relevant LHD or community services
- develop strong relationships with other services
- prioritise review of patient adherence to management plan
- provide medical input for governance and advocacy

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0327 (02/20; ACI/D20/340)