

COPA

A model of integrated care for the elderly in France

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Hôpital général juif
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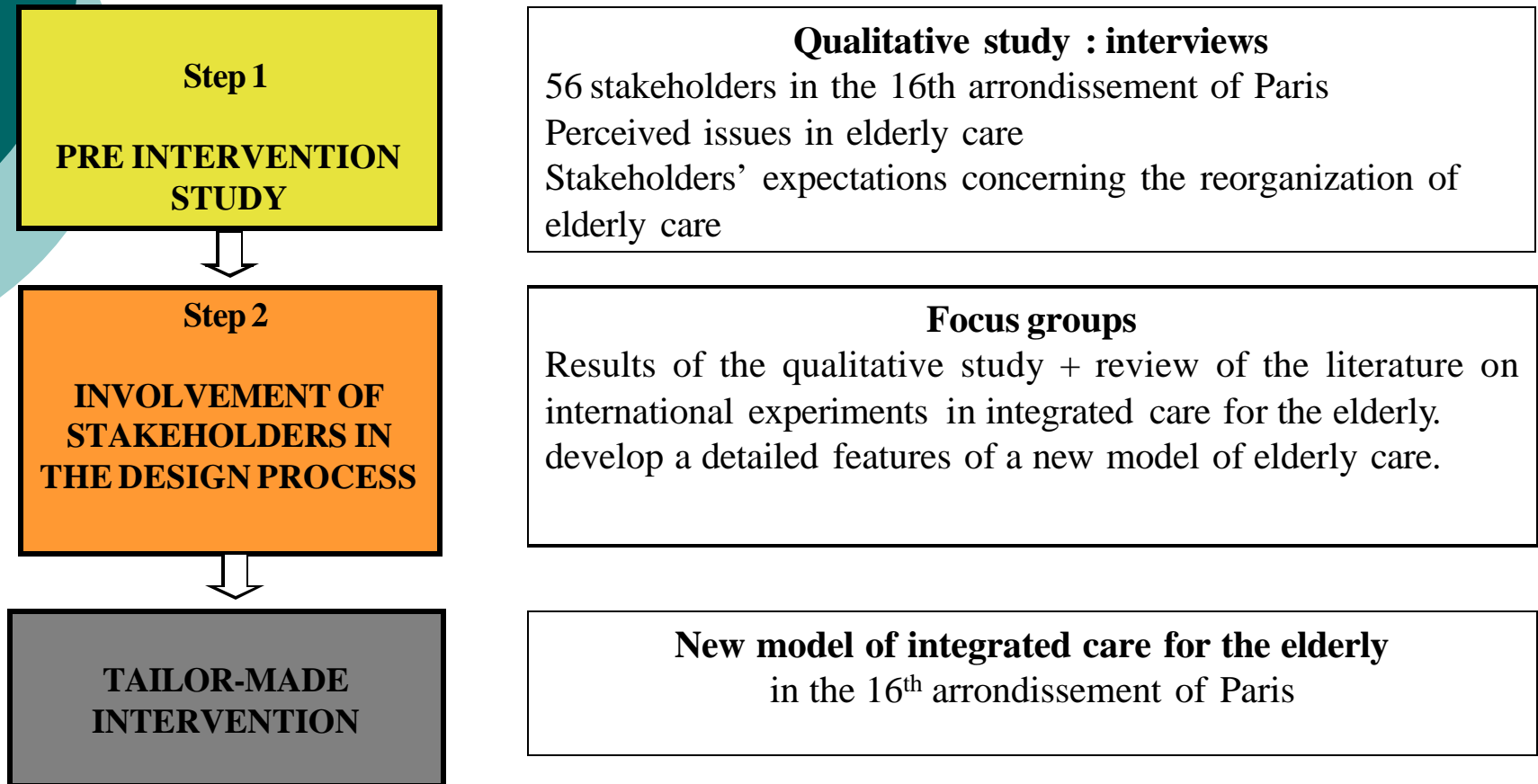


UVSQ Laboratoire
Santé Vieillesse

Introduction

- Despite strong evidence for the efficacy of integrated systems (Kodner 2002, Johri 2003, Béland 2006, Beswick 2008)
- Securing the participation of health professionals has proven difficult
 - particularly primary care physicians (PCPs) (Reuben 02, Beland 06, Johri 03)
- Novel approaches are needed.
 - Involving health professionals and, in particular, PCPs in the design of integrated models should help overcome barriers and resistance.
- From SIPA to COPA

Design process



Vedel I, De Stampa M, Bergman H, Ankri J, Cassou B, Blanchard F, Lapointe L. Health care professionals and managers' participation in developing an intervention: A pre-intervention study in the elderly care context. Implementation science; In Press



The COPA model: *Goals*

- Better fit between services/needs of the elderly
- Reduce inappropriate health care use (ER and hospital utilization)
- Prevent long-term nursing-home institutionalization

Vedel I, De Stampa M, Bergman H, Ankri J, Cassou B, Mauriat C, Blanchard F, Bagaragaza E, Lapointe L. A Novel Model of Integrated Care for the Elderly. *Aging Clinical and Experimental Research*; In Press.



The COPA model

Target population

- Elderly with complex needs
 - 65+ experiencing a mix of IADL and ADL impairments, cognitive deficiency, isolation and medical conditions
 - Selection of participants :
 - Recruited through their PCP
 - CA+ score (InterRAI)=6/9 :
 - 4 items on ADL, cognitive deficiency, poor perceived health and shortness of breath, 2 social items (living alone and unavailability of a caregiver).



The COPA model

A key role for the PCP


- Participate in patient recruitment
 - Recruitment through PCPs
 - Not through home care services or Emergency department
- High patient/PCP ratio
- Participate in care planning (priority setting)
- Are responsible for medical decisions
- Make referrals to specialists
- Recommend the planned hospitalization of a patient (avoiding the emergency department)
- Increased participation in decision-making during their patient's stay in hospital.



The COPA model

Multidisciplinary primary care team

- Integration of health care professionals into a multidisciplinary primary care team
 - That includes case managers who collaborate closely with the PCP
- Only one case manager is assigned to each PCP
 - and each case manager works with only a few PCPs
- Standardized geriatric needs assessment (InterRAI MDS-HC).
- PCPs – Case managers develop the care plan development based upon clinical objectives
- Case managers implement the care plan and coordinate health and social services on an ongoing basis
- Ongoing collaboration between PCPs and case managers



The COPA model

Integration of primary medical care and specialized care

- Community-based geriatricians
 - Involved as consultants following a request from a PCP (no prescription) and organize direct hospitalizations.
 - While maintaining the PCP's responsibility for medical decisions
- Planned Hospitalizations
- Participation of case managers in the planning of services to be provided post-discharge



The COPA model

Other characteristics

- Training
- Evidence based interdisciplinary protocols
- In the next future :
 - Nurse on call 24/7
 - Electronic Health record

Results (1)

- Method
 - Quasi-experimental study.
 - Two control groups from neighbouring boroughs
 - Inclusion criteria: 65+, CHIP+ =6
 - Primary outcome : health services utilization
 - Secondary outcomes : mortality, functional status, quality of life and caregiver burden
 - Qualitative study :
 - Participation and satisfaction of professionals
 - Satisfaction of patients and family
- Preliminary descriptive results of the 12-month period

Results (2)

- Patients characteristics (n=106)
 - Age: 86 years old
 - Women: 63.2%
 - Cognitive impairment: 73%
 - Need help with bathing: 93%
 - Number of medication: 6.6
- Face-to-face meeting between the case manager and the PCP: 27.4%
- At-home evaluation by a geriatrician requested by the PCP: 42,5 %
- PCPs satisfaction

Results (3)

Outcomes	N=106	National data
Hospitalization.	29.2%	62%
Planned hospitalization	22.6%	~ 0%
Unplanned hospitalization	6.6%	
Ratio planned hosp/ total hosp	77.4%	
Average length of stay (days)	31?26.5	
ER visit.	9.4%	40%
Discharge to a nursing home	5.7%	
Mortality	7.5%	
Ratio: death at home / total deaths	50.0%	26%

Conclusion (1)

- Distinctive features:
 - key role of the PCP
 - in the patient recruitment and in the care plan development
 - case managers who collaborate closely with the PCP
 - Population with complex needs
 - (vs one single chronic disease)
 - Integration of primary medical care and specialized care
 - through the use of community-based geriatricians
 - Care transitions Hospital - Home
- Diffusion in other geographical zone (Marseille, St Malo)
- Adaptation for other countries (Genève, Bruxelles)

Conclusion (2)

- Limit of focusing on the frailest
 - Effective mainly for ? disability/complexity
 - Does not take into account the heterogeneity of older persons
- Issues / Implementation
 - Tension between
 - take time for development, confidence building among a variety of professionals willingness to rapidly implement an intervention
 - Managing multiple interest (public, private)
 - Adapting to current practices (PCPs lack of time)
- Issues / Sustainability
 - Permanence of funding (interest for new well marketed models in France)



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