COPA
A model of integrated care for the elderly in France

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Health System Performance Research Network
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McGill

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La Chaire Dr Joseph Kaufmann en gériatrie

UVSQ Laboratoire Santé Vieillissement

McGill

Desautels Faculty of Management
Faculté de gestion Desautels

Hôpital général juif
Jewish General Hospital

Aging and Chronic Disease

- Dramatic increase in the number of old, in particular old/old
- Increase in prevalence of chronic disease
  - 1 in 5 baby boomers will develop dementia
  - Cardiovascular: most important cause of hospital admission
  - Diabetes: increasing prevalence with age: 10% over 65
  - Cancer: increasing incidence and mortality with age
- A global challenge
  - ↑ chronic diseases +↑ life expectancy **=** Aging with ↑ disability

Multiple Chronic Diseases

- Drivers of morbidity, mortality, utilization and costs
- A challenge to quality of life
- Patients with multiple chronic illnesses:
  - Increased mortality
  - Longer hospital stays
  - More depression
  - More medications
  - Poorer function, quality of life

Focus on very complex older persons

- Generally over 75
- Disabilities in ADL/IADL
- Acute and chronic medical problems
- Importance of social network- family caregivers
- Need for a complex combination of medical and social services-acute and continuing care
- Frequent transitions, high utilisation and costs: community, hospital, rehab, NH
  - 20% of older persons=3% population=30% costs

Increasing prevalence of older patients with complex needs

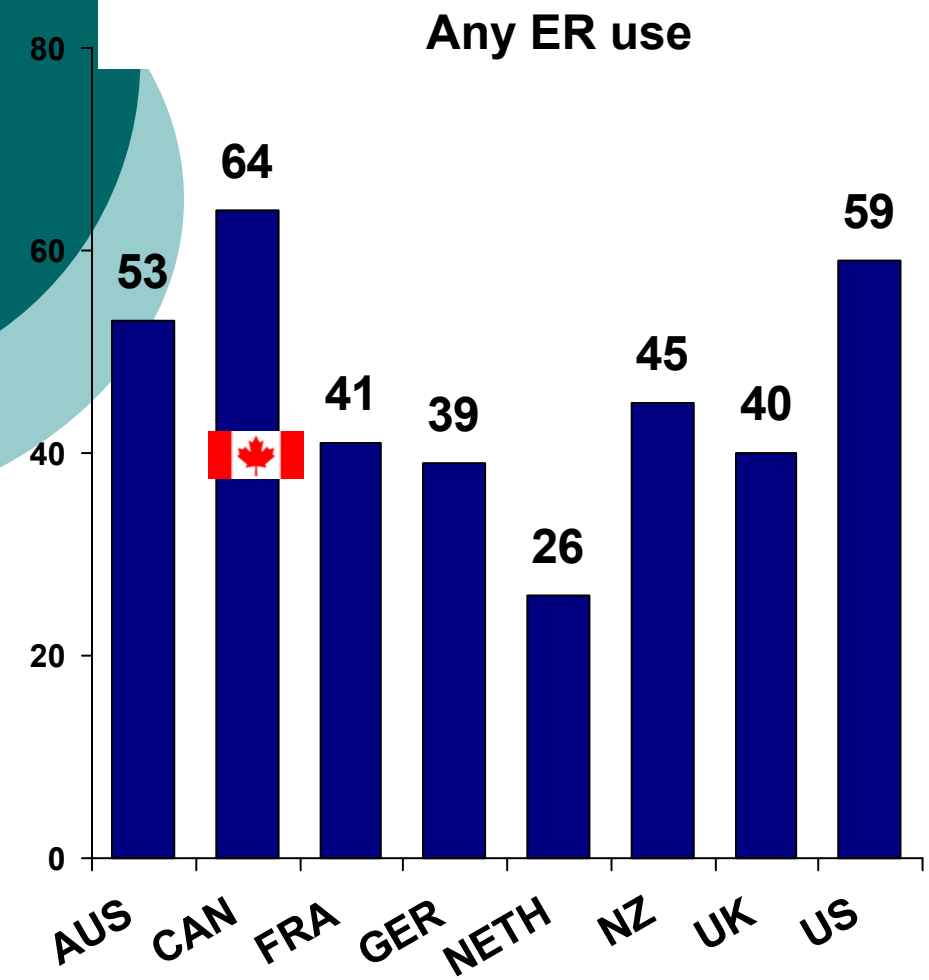
but.. are we getting it right?

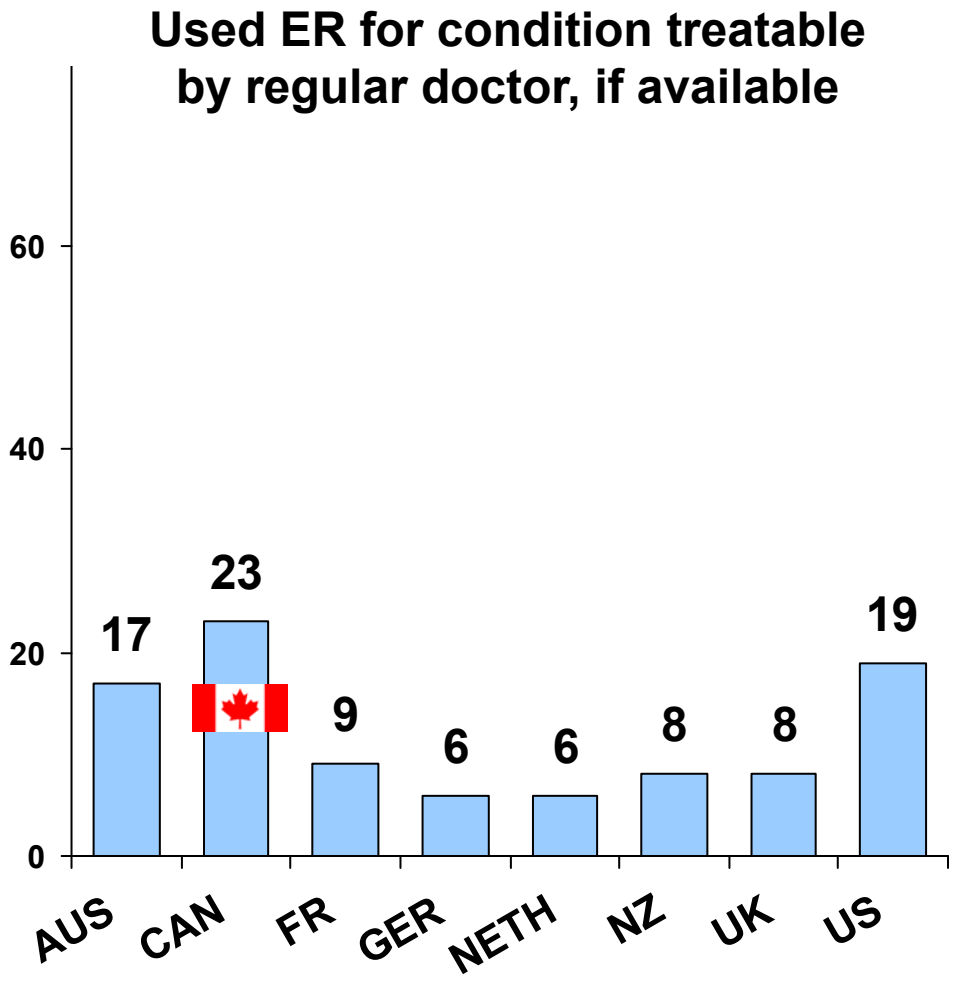
Traditional Model: Poor Access

- Adults with chronic disease have difficulty getting:
  - a prompt appointment
  - getting phone advice
  - or getting care nights/weekends without going to the ED
- Emergency departments as the main entry point

ER Use in Past Two Years

Base: Adults with any chronic condition %





Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Traditional Model: Poor Care Coordination

- Fragmentation
  - Primary/secondary/tertiary care
  - Social/health-medical care
  - Acute/chronic care
- PCP report they receive no information from specialist / hospitals
- Specialists reported they receive no information from PCP
- Results of test not available / Duplication of test

Traditional models: What Seniors Receive?

- AMI – 50-75% receive B-blockers, 43-50% counseled for smoking
- CHF – 65-68% ACE on discharge
- Stroke – 57% of A-fib on anti-coagulants
- Diabetes – 48-70% have eye exam
- Falls – 3% of fallers have fall examination
- Depression – 26% of those with depressive symptoms treated or referred
- Cognition – 52% of new patients tested

- Medications – 18% of those prescribed new drug had documented education

Sources: Jencks et al., JAMA, 2003; 289:305
ACOVE, Ann Int Med, 2003; 139:740

Innovative approaches are needed

From the tyranny of the urgent…

To the practice of the future

- What is needed is person-focused care over time, NOT disease-focused care.

- Treating multiple chronic diseases is much more than treating one chronic disease after one another

Integated care services for older patients with complex needs

Eg. SIPA, COPA

SIPA (système intégré personnes âgées)

- Objectives:
  - improve health and functional status, quality of care, satisfaction
  - decrease inappropriate hospital and nursing home care
  - control costs

Bergman, Béland, Lebel et al CMAJ. 1997; 157:1116-1121
Béland, Bergman, Lebel et al J of Gerontol, Med Sci. 2006,vol 61A, No. 4, 367–373

SIPA: Characteristics (1)

- A responsive organization able to:
  - mobilize resources flexibly and rapidly to meet needs,
  - avoid inappropriate health services utilization
- Increased intensity of community care
- Early detection and intervention (medical, rehabilitation, social)
- Rapid communication/response; on call; provider linkage

SIPA: Characteristics (2)

- Integrate/coordinate health, social and supportive care
- Utilisation of protocols
- Case management with more responsive care
- Align governance and financial incentives with clinical goals

RCT SIPA

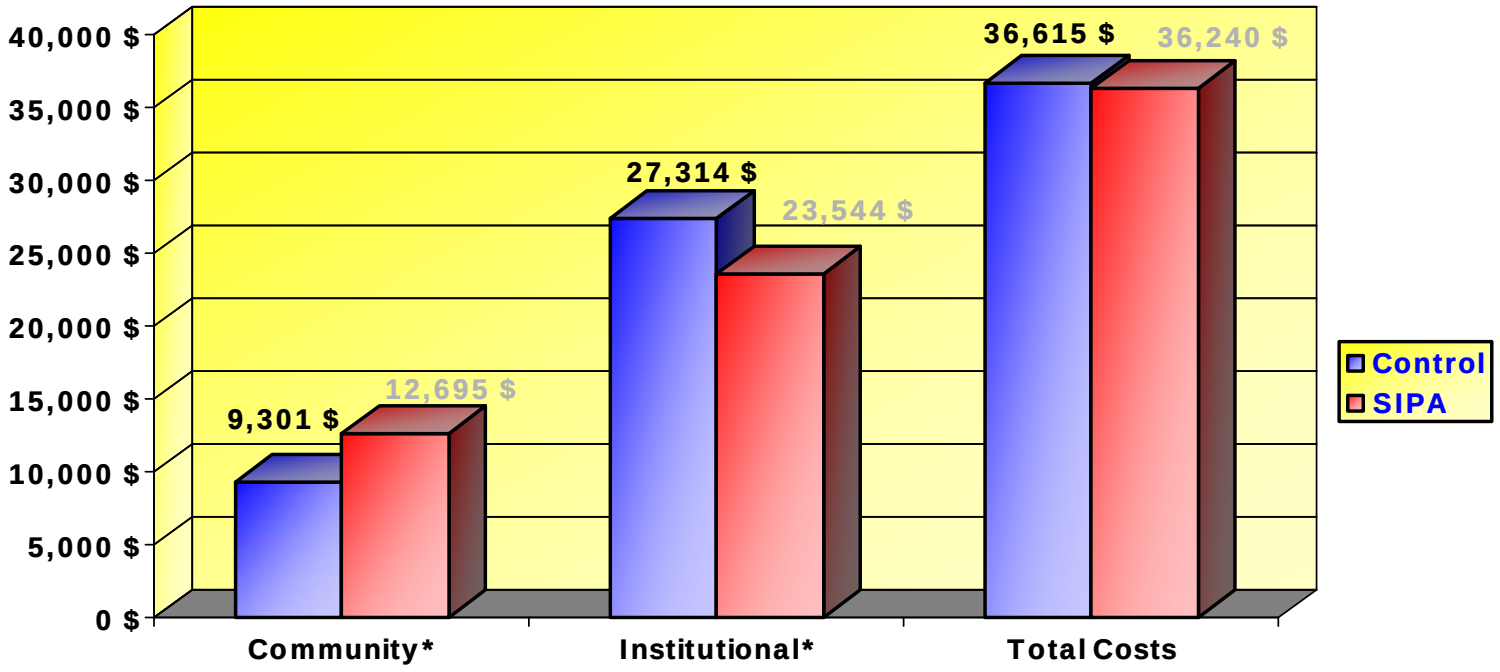
- A randomized controlled trial
- 1230 frail elderly randomized to
  - SIPA system of care
  - or usual care
- 2 sites in Montreal, Canada
- Follow-up: 22 months

Results

- ↑ satisfaction/perception of quality for family caregivers ; no difference for patients
- Health outcomes – no difference
- Mortality – no difference
- No increase in burden or private costs to patients and caregivers

Community and Institutional Costs

costs per older person (mean)



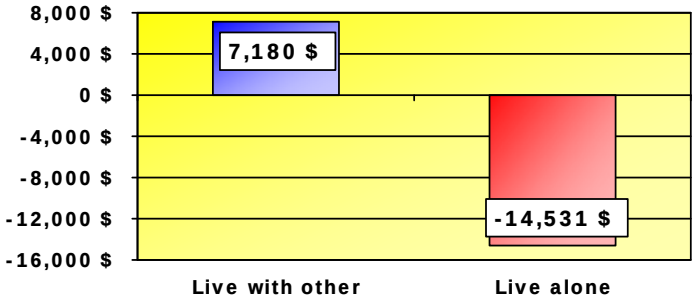
*Significant at the p≤0,05

Services communautaires: Médicaments, visites médicales, soutien à domicile, résidences protégées, appareils techniques, hôpitaux de jours.

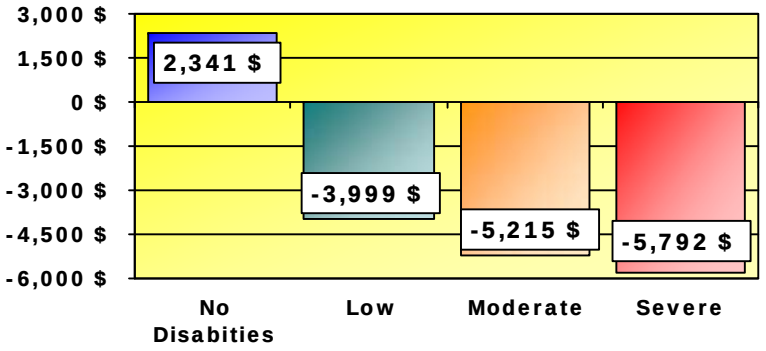
Services institutionnelles: Hospitalisation de courte durée, hospitalisation d'un jour, hébergement, urgences hospitalières, réadaptations institutionnelles, soins palliatifs

Secondary analysis

c. Living Status and Nursing Home Costs



d. Disabilities in ADL and Hospital Costs



From SIPA to COPA

Quebec > France

COPA: COordination Personnes Âgées

Implementation issues

- 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)

De Stampa M, Vedel I, et al. Fostering Participation of General Practitioners in Integrated Health Services Networks: Incentives, Barriers, and Guidelines. BMC Health Service Research 2009, 9:48.

Not answered questions (yet!)

- Adequate Target population?
  - Better results for patients with very complex needs + social isolation
- Debate: locus of integrated services?
  - rooted into primary care
  - or implemented independently of the PCP
- Respective role of primary care and geriatric care?
  - Risk of ↑ mortality if no clear responsibilities and tasks sharing between PCP and geriatricians (Phelan 2007)

From SIPA to COPA

- Involving health professionals and, in particular, PCPs in the design process
- Target older people with very complex needs and social isolation
- Based on primary medical care, not on home care services or ED
  - Key role for the primary care physician
- Transitional care: planned hospitalization discharge planning
- One borough of Paris (16th)
  - 150,000 inhabitants
  - 75+: 11.4%

Vedel I, De Stampa M, Bergman H, et al. A Novel Model of Integrated Care for the Elderly. Aging Clinical and Experimental Research 2009; 21(6):414-423.

Development strategy

- Understand the PCPs' and other healthcare professionals' practices and expectations
- Facilitate change: get the buy-in of healthcare professionnals
- Bottom-up development process

Vedel I, De Stampa M, Bergman H, et al. Health care professionals and managers' participation in developing an intervention: A pre-intervention study in the elderly care context. Implementation science 2009, 4:21

Step 1

Recruitment: 58 healthcare professionals and managers

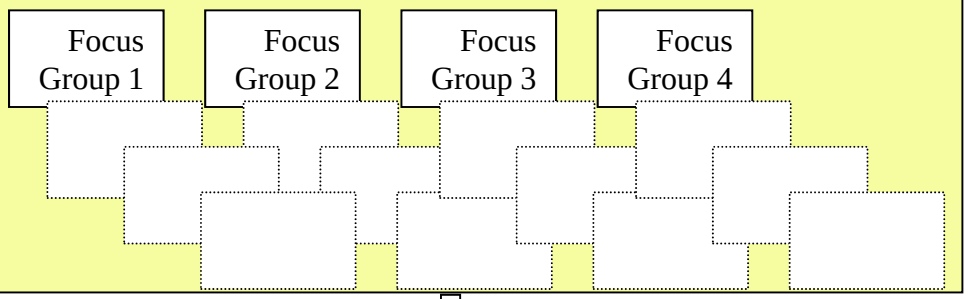
2 PCPs declined

Interviews: 56 participants
Documentation, observation

Results: Current practices, perceived issues and expectations regarding elderly care. Processes leading to adverse outcomes.

Step 2

Focus groups: 56 participants



Results: proposal for change including
-objectives of the intervention
-expected key features of the intervention

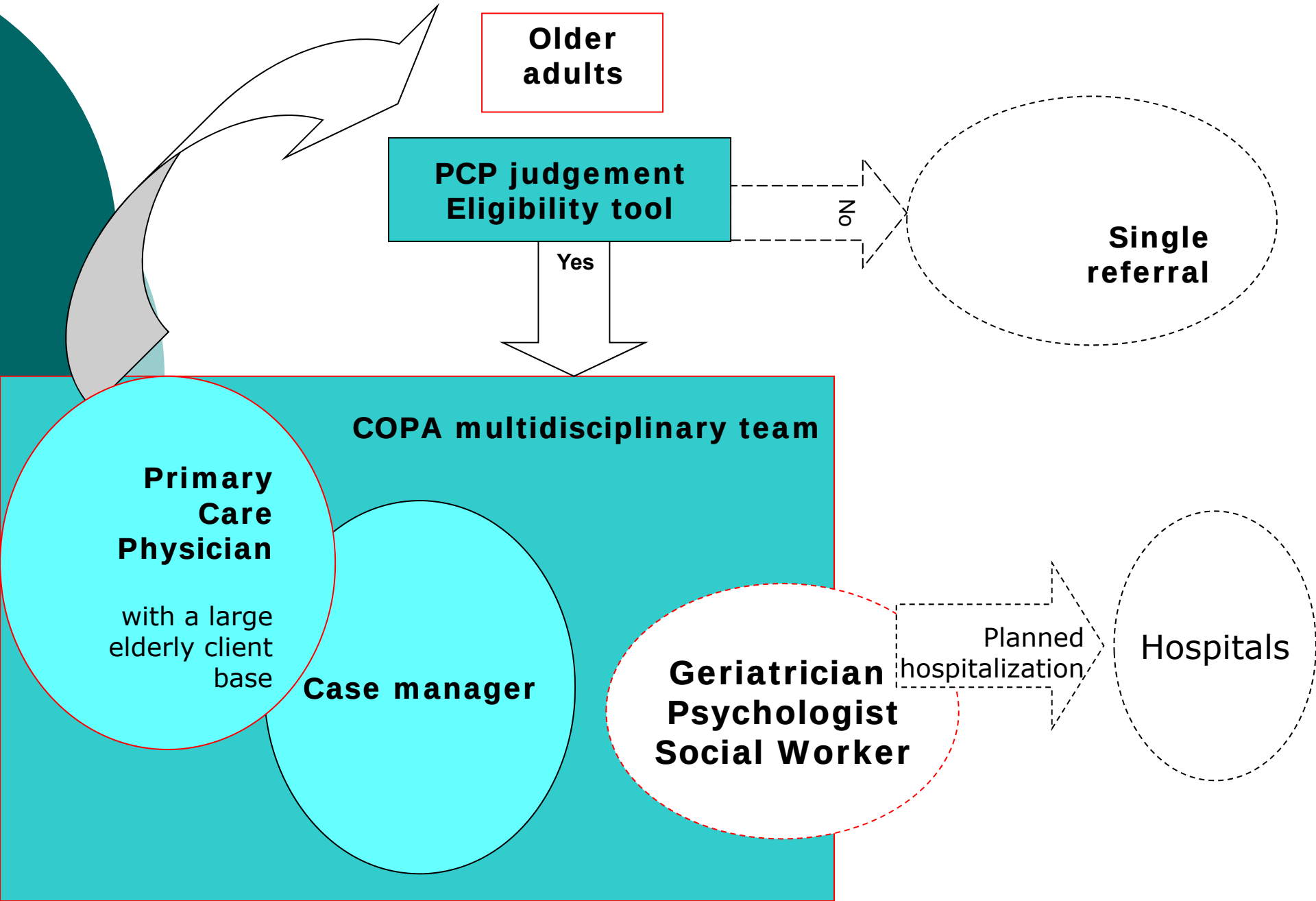
Step 3

Validation: 56 participants
+ 2 PCPs who initially declined to participate

Results: Consensus, appropriateness of the intervention

Objectives of COPA

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


Older adults
PCP judgement Eligibility tool
No
Single referral
Yes
COPA multidisciplinary team
Primary Care Physician
with a large elderly client base
Case manager
Geriatrician
Psychologist
Social Worker
Planned hospitalization
Hospitals

Target population

- Older people 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).

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)
- Remain 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

Multidisciplinary primary care team(1)

- Case manager, PCP, geriatrician, psychologist, social worker, occupational therapist
- Close collaboration between Case managers and PCPs
  - Only one case manager is assigned to each PCP
    - and each case manager works with only a few PCPs
  - PCPs' development and approval of the care plan
  - Ongoing collaboration between PCPs and case managers
    - Regular phone contact PCP- Case manager

Multidisciplinary primary care team(2)

- Standardized geriatric needs assessment (InterRAI MDS-HC)
- PCPs – Case managers develop the care plan based upon clinical objectives
- Case managers implement the care plan and coordinate health and social services on an ongoing basis

Integration of primary medical care and specialized/hospital care

- Community-based geriatricians
  - Involved as consultants following a request from a PCP (no prescription)
  - The PCP remains responsible for medical decisions
  - Organize planned hospitalizations
- Transitional care: smooth patients' care transition
  - Between primary care and hospitals (and vice-versa)
  - Planned hospitalizations
  - Participation of case managers in the planning of services to be provided post-discharge

Other characteristics

- Multidisciplinary seminars / continuing education
- Evidence based interdisciplinary protocols (falls, dementia, CHF…)
- In development
  - Nurse on call 24/7 (link with Hospital-at-Home)
  - Electronic health record

Financial / Managerial characteristics

- Primary care physicians:
  - fee-for service
  - + capitation: 400€/patient/year
- $ Medicare: budget for experimental interventions
- Consortium of managers from hospitals and home-based services

Evaluation study

- Mixed-method research design
  - Quasi-experimental study
    - Inclusion criteria: 65+, CA+ ≥6, community-dwellling
      - 105 older adults in the intervention group
      - and 323 in the control group (neighbouring boroughs)
    - Follow-up: 1 year
    - Outcome : hospitalization
      - Secondary outcomes : mortality, functional status, quality of life and caregiver burden
  - Qualitative study :
    - Participation and satisfaction of professionals
    - Satisfaction of patients and family
    - Adoption / diffusion of the model: Diffusion of innovation Theory (Rogers 2003)

Study Population

Characteristics	Intervention Group (n=105)	Control Group (n=323)	*P*-Value
Age, mean +/- SD	85.9 +/-6.2	87.3 +/-7.3	0.07
Women, n (%)	78 (74.3)	233 (72.1)	0.7
Living alone, n (%)	69 (65.7)	232 (71.8)	0.1
Instrumental Activities of Daily Living Scale (IADL) (0-42), mean +/- SD	16.7 [4.7]	16.7 [4.3]	0.99
Activities of Daily Living Scale (ADL) (0-6), mean +/- SD	1.5 [1.6]	2.6 [2.0]	<0.05
Cognitive Performance Scale (CPS) (0-6), mean +/- SD	2.6 [1.7]	2.4 [2.0]	0.3
Depression Rating Scale (DRS), n (%)	45 (42.8)	142 (43.9)	0.8
Aggressive Behaviour Scale (ABS), n (%)	21 (20)	50 (15.5)	0.3
Pain Scale, n (%)	62 (59)	188 (58.2)	0.8
Prior hospitalizations in last 3 months, n (%)	43 (40.9)	162 (50.1)	0.08

Hospitalizations (planned, unplanned)

Hospital Admissions	N	Odds ratio (95% Confidence Interval)	
		Unadjusted	Adjusted
Having at least one unplanned hospitalization	56	0.46 [0.20-1.06]	0.39 [0.16-0.98]
Having only planned hospitalizations	19	2.48 [0.94-6.58]	3.59 [1.02-12.7]
Total hospital admissions	75	0.81 [0.42-1.56]	0.75 [0.36-1.58]

*Adjusted for age, sex, ADL, CPS, prior hospitalization

Other results

- No differences:
  - Mortality rates
  - Functional disabilities (IADL or ADL)
  - Cognitive status, falls, pain, continence, nutrition, skin conditions
- Lower risks of:
  - depression (OR=0.42 [0.20-0.90])
  - dyspnea (OR=0.26 [0.09-0.77])

Discussion

Challenges

- Issues / Implementation
  - Tension between
    - take time for development, confidence building among a variety of professionals
    - willingness to rapidly implement an intervention
  - Managing multiple interest
  - Adaptating to current practices (PCPs lack of time)

- Issues / Sustainability
  - Permanence of funding (interest for new well marketed models)- experimental funding

Limits

- Limit of focusing on the frailest
  - Effective mainly for ↑ disability/complexity
  - Does not take into account the heterogeneity of older persons
- France: MD solo practitioners
  - Integrate / colocate case managers within FHT (Ontario) or GMF (Quebec)

Conclusion: key elements (1)

- Integrated system rooted in primary care – participation of PCP
- Specialized services (geriatricians, hospitals) in support of primary care
- Targeted population

Vedel I, Monette M, Béland F, Monette J, Bergman H. Ten years of integrated care: Backwards and forwards: The case of the province of Quebec, Canada. International Journal of Integrated Care 2011;11

Conclusion: key elements (2)

- Comprehensive assessment of patients' needs
- Dyad Case managers (nurses practitioners) - family physicians
- Coordination of patients' trajectories and patients' transitions across multiple health and social services and multiple settings (e.g. FHT, hospitals, nursing homes)
- Information exchanges between professionals, providers and settings

Conclusion: key elements (3)

- Change management
  - To adapt – not to adopt
  - Involve healthcare professionals from the beginning
  - Representatives from the different stakeholders

Funding (for research)

- Conseil Régional Ile-de-France
- Haute Autorité en Santé-Caisse Nationale de Solidarité Autonomie
- CIHR
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