Coordinating Care for Older People (COPA): Team work integrating health and social care professionals in community care

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SEVENTH FRAMEWORK PROGRAMME

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Introduction: key-issues addressed

1. To allow the target population (frail older people living in the community) a longer and safer home stay while limiting hospitalization through Accident and Emergency (A&E) departments and to optimize hospital discharge.
2. By using a specific design to locally foster a common culture leading to inter professionals and institutional agreements; regarding content and implementation of new care pathways to fill the gaps between health and social professionals
3. Key issues : Inter professional exchanges/development/agreement about views on care and pathways

Why was this project developed/implemented?

- Frail older people living in the community are at high risk of experiencing adverse events such as unnecessary hospitalizations especially via A&E departments due to lack of communication and coordination between hospital and primary care professionals (PCPs)
- Securing the participation of PCPs was considered a key element for success. This was achieved through a series of focus groups which enables to sort out their expectations and wills and build new care processes and user's pathway.
- PCPs would have the final responsibility for all decisions, but would be backed up by case managers (CMs) for their more complex patients.
- Integration of specialized care would be achieved through outreach visits by hospital based geriatricians that would also help in organizing "direct" access.
- CMs and Geriatricians would fill all information gaps between hospital staff and PCPs while involving patients and families in discharge.

Main features of the example (Description)

Pilot developed under the supervision of two public health physicians located in the University hospital. Other stakeholders are a private hospital and all voluntary health and social agencies in the vicinity, as well as self-employed professionals caring for older people. Recruitment of the target population was based on common agreed criteria and assessment tools (RAI-HC). Copa consists in two different programmes:

1) LTCM programme

- target patients from PCPs (50% of clients 65+) pro-actively recruited based on a review of their medical charts by CM and RGP. The program stops when patient is definitely institutionalized or dead

2) TCMP programme

- recruitment is passive from other PCPs patients' whose informal carers are judged overburdened. The program stops when they consider the crisis is over.

Specific features of both programmes

- One case manager (nurse) assigned to each PCP - with an average file of 10 GPs and 40 patients per case manager with the following tasks:
  - organisation and monitoring of care under the "supervision" of physycians
  - ask the hospital geriatrician to reassess patients if necessary and help in case of direct hospitalisation
  - organise discharge with Ics
  - available at any time

What are/were the effects?

The pilot duration was 18 months and included a comparative assessment with two control groups:

- Among 249 OP screened, 106 (96.4%) able to give consent entered COPA, 73 (69%) through LTCMP and 33 through TCMP. They are characterized by a specific but complex mix of ADL/IADL impairments associated with cognitive deficit, isolation and multi-morbidities
- The first control group was recruited from home and cared for by‘ genuine geriatric network’
- The second control group was recruited at discharge and receiving usual home care (informal carers being implicitly ‘care coordinators’)

Results

- Significantly less hospitalisation (through emergency room)/ CTRL2; CTRL1)
- No reduction of institutionalisation and death rates
- GPs participation increased as did their satisfaction
- User's opinion positive but no reduction in carer's burden

Strengths and opportunities

- The local construction of a team working culture helps for building new pathways
- Some evidence of success regarding reduced hospitalization (total rate and through A&E visit)
- Extra rewards for participants (not necessarily based on financial incentives) could help to maintain and sustain local dynamic:
  - new regulating agencies (ARS) may help in promoting and financing this type of interagency process
- Taking a more “preventative approach (target population less frail) could be more successful

Limitations

- The development process needs a strong leadership and expertise and a continuous commitment from professionals
- The choice of the target population: too frail to really benefit from COPA
- In this professionally led experiment, neither older people nor informal carers were involved or empowered
- Lack of recognition at national level

Conclusion

- **For practice:**
  - It is possible through a bottom up, well designed building process to meet the primary care physicians expectations and thus counter their potential opposition of being left aside .This process is time consuming and needs cost investments.
- **For policy:**
  - In order to get national support and be successfully scaled up, such a pilot would need a well designed cost-efficiency analysis as part of the overall assessment as it constitutes a strong argument for decision makers.

Questions:

- Is the example relevant for your country and why (not)?
- What is crucial for its implementation?