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Initiatives des médecins généralistes envers les patients vulnérables durant le premier confinement

Une enquête transversale du consortium ACCORD

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ACCORD
Assembler, Coordonner, Comprendre, Rechercher, Débattre en soins primaires

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Conflits d'intérêt

- L'oratrice déclare l'absence de conflit d'intérêt concernant cette étude

Justification et contexte

COVID-19 - 1er confinement :

- Injonction paradoxale
- Chute du recours aux soins [1,2]
- Encouragement à contacter les patients fragiles [3] (8 avril 2020)

Besoin de soins

Système en mutation :

- Diversification des modes d'exercice
- Diffusion de l'exercice de groupe [4]
- Structuration des offres territoriales [5]
- Développement des soins préventifs

Relation de soins « unilatérale »

Offre de soins

1. Rapport « Charges et Produits », Assurance Maladie, juill 2020
2. GIS EPI-PHARE, juin 2020
3. Ministère de la Santé, 8 avril 2020
4. Chaput, DREES, 2019
5. LMSS, 2016

Objectifs

- Décrire (i) si, et (ii) **comment les médecins généralistes en France avaient pris des initiatives pour identifier et contacter les patients vulnérables** pendant le premier confinement

- (iii) Identifier les facteurs individuels et organisationnels associés à ces initiatives.

Méthode : contexte

Un consortium

Deux vagues

Trois populations

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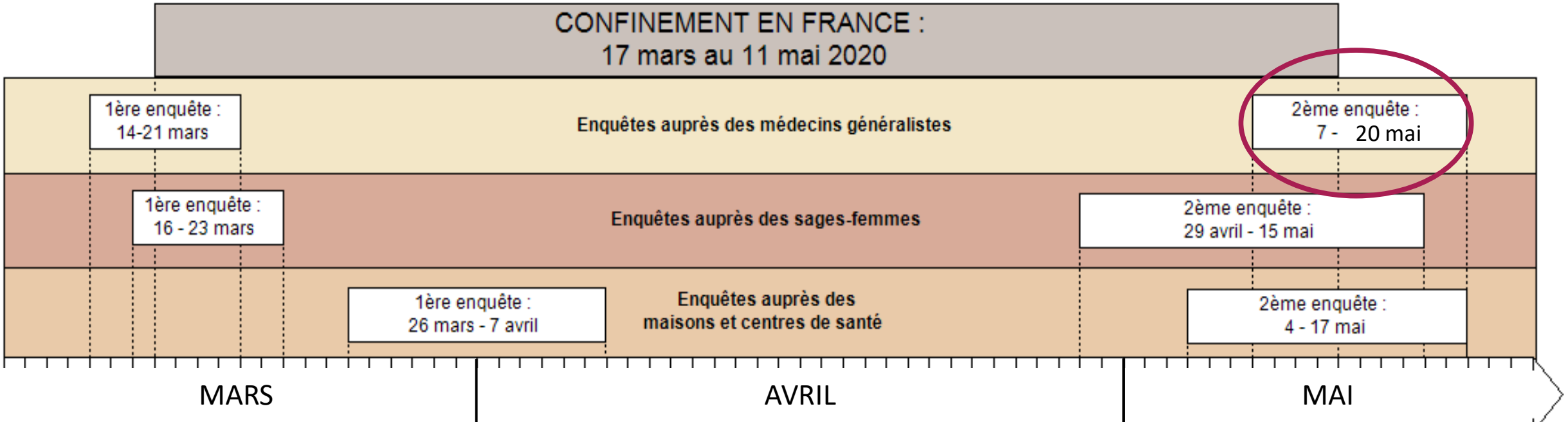


Méthode : recueil

- Deuxième vague d'enquête auprès des médecins généralistes (MG)

- Etude observationnelle par questionnaire en ligne (Limesurvey®) IRB n°00010804 / CNIL n° 2218060v0
- 62 questions sur les pratiques et les adaptations des MG :
  - Caractéristiques sociodémographiques
  - Données de pratiques habituelles
  - Pratique pendant la période d'étude
  - Mode et lieu d'exercice
- Diffusé via les partenaires d'ACCORD et aux répondeurs de la première enquête
- Du 7 au 20 mai 2020

q32

Avez-vous pris l'initiative de rappeler certains de vos patients (vulnérables, avec maladies chroniques, etc) ?

Non, aucun patient ☐

Oui, ceux auxquels j'ai pensé ☐

Oui, j'ai constitué une liste à partir de certains critères (ALD, IMC...) ☐

Autre (précisez) ☐

Autre (précisez)

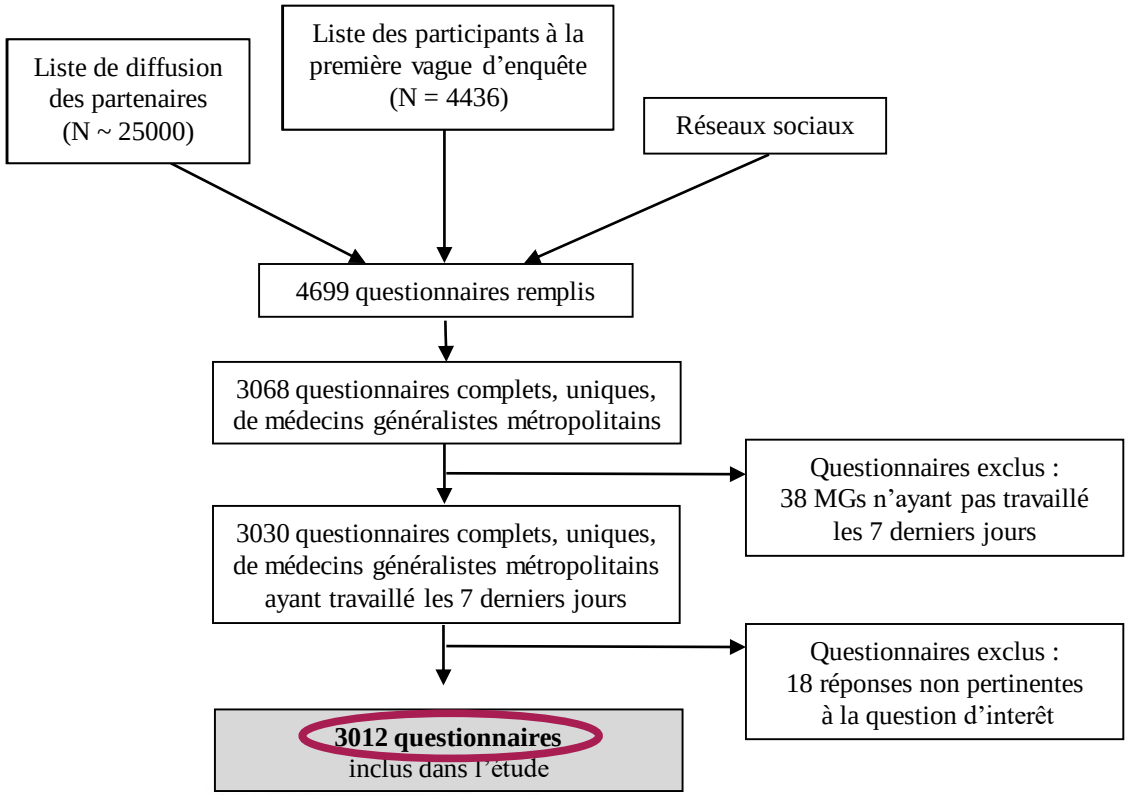
Méthode : analyses

q32

- Deuxième vague d'enquête auprès des médecins généralistes (MG)

Exclusion	Recodage	Quantitatif	Qualitatif
• Doublons et questionnaires incomplets • MG hors métropole • MG n'ayant pas travaillé les 7 derniers jours • Données manquantes q32	• Q32 (i) : Non/Oui • Groupe CS+MSP • Nouvelle variable Seul Groupe monopro ≤5 Groupe monopro >5 Groupe pluripro ≤5 Groupe pluripro >5	1. Descriptive 2. Univariée 3. Multivariée	Analyse inductive générale et catégorisation

Résultats



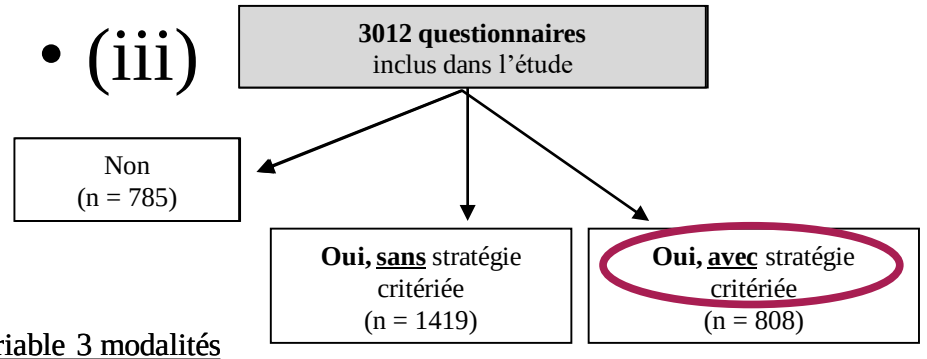
Echantillon

- 5,6% des MGs en France
- Plus de femmes (55,1% vs 44%)
- Moins d'exercice isolé (15,6% vs 39%)
- Plus de jeunes (<40 ans, 37,6% vs 17%)

Chaput et al. DREES, 2019.
Données assurance maladie.

Résultats : analyses quantitatives

- (i) 73,9 % déclarèrent des initiatives
- (iii)



Variable 3 modalités
Analyse multivariée

aOR = **1,41**
IC95% [1,14-1,75]

aOR = **1,94**
IC95% [1,51-2,48]

aOR = **1,84**
IC95% [1,43-2,36]

Variable dichotomique
Analyse univariée

aOR = **0,72**
IC95% [0,65-0,93]

aOR = **1,33**
IC95% [1,04-1,69]

aOR = **1,94**
IC95% [1,26-1,98]

Résultats : analyses qualitatives

- (ii) 115 réponses uniques analysées

Vulnérabilité

- Agées
- Maladie chronique (traitée)
- ALD
- Visites à domicile
- Critères sociaux

Organisation

- Agenda
- Dossiers médicaux
- Réseau informel

- Emails, sms, sites web
- Collaborations

Infirmier (SP), Secrétaire, Etudiant, Pharmacien

Mission

- « Rester en contact »
- Plus qu'un simple appel
- Un rôle de veilleur

- Rester disponible

Discussion : forces et limites

- Echantillon
  - Femmes
  - Jeunes
  - En groupe
  - MSU
- Désirabilité sociale
- Matériel qualitatif limité

- Echantillon
  - Taille
  - Innovations
- Analyse multivariée (STROBE)
- Précocité
- Rareté sur le sujet

Discussion

Vulnérabilité

Une conception multicritère[1], hétérogène

- Parfois juste
  - Isolement [2]
- Parfois partielle
  - oubli des jeunes [3]

Outils d'identification

- Lacunes sur les données psychosociales
  - Malgré des recos [4,5]
  - Temps+compétences [6]
- Lacunes techniques [7]

Déterminants des initiatives

- Maitre de stage
  - Biais «CNGE/COVID» ?
  - Différentes pratiques [8]
  - Un levier mobilisable?
- Exercice en groupe
  - Outil agile pour des tâches[9] nouvelles/complexes
  - Potentiel de développement[10]

Interprofessionnalité

Terreau d'initiatives?

Santé publique

Médecin généraliste

1. Grabovschi, 2013 2. Holmes, 2020 3. Revil, 2020
4. Collège MG, 2014 5. Oubaya, 2014 6. Garnotel, 2021
7. Tarrant, 2014 8. Letrillart, 2016 9. Mousquès, 2015
10. Chaput, 2019

Merci

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BACK UP

Analyses quantitatives

- Echantillon

Appendix 2. Practice location of the survey participants (n=3,012), in comparison to the general practitioners' population in metropolitan France in 2019.

N (%)	Study sample N = 3,012	GPs' population in metropolitan France N = 53,339
French regions		
Auvergne-Rhône-Alpes	439 (16.3)	6,774 (12.7)
Bourgogne-Franche-Comté	151 (5.6)	2,240 (4.2)
Bretagne	117 (4.4)	2,880 (5.4)
Centre-Val de Loire	96 (3.6)	1,760 (3.3)
Corse	0 (0.0)	267 (0.5)
Grand Est	221 (8.2)	4,694 (8.8)
Hauts-de-France	226 (8.4)	4,907 (9.2)
Île-de-France	424 (15.8)	8,161 (15.3)
Normandie	136 (5.1)	2,507 (4.7)
Nouvelle-Aquitaine	295 (11.0)	5,547 (10.4)
Occitanie	235 (8.7)	5,494 (10.3)
Pays de la Loire	219 (8.1)	2,934 (5.5)
Provence-Alpes-Côte d'Azur	130 (4.8)	5,174 (9.7)
Missing data	*323*	*None*

GP: general practitioner

* Data from the French health insurance system (CNAMTS) (2019)

Table 1. Main characteristics of the survey participants (n=3,012) compared with general practitioners' population in metropolitan France in 2020.

N (%)		Study sample N = 3,012	GPs' population in metropolitan France* N = 53,339
Gender			
	Women	1,659 (55.1)	23,576 (44.2)
	Men	1,353 (44.9)	29,763 (55.8)
Age group			
	<40 years	1,127 (37.5)	9,068 (17.0)
	[40-55[	864 (28.8)	15,255 (28.6)
	≥55 years	1,010 (33.7)	29,016 (54.4)
	Missing data	11	
Type of practice			
	Alone	469 (15.6)	20,802 (39.0)**
	Monodisciplinary practice	1,300 (43.4)	
	Only GPs	*1,228 (41.0)*	
	GPs and other specialists	*72 (2.4)*	
	Multidisciplinary practice	1,228 (41.0)	
	Independent multidisciplinary group	*1,099 (36.7)*	
	Care centre	*129 (4.3)*	
	Missing data	*15*	

GP: general practitioner

* Data from the French health insurance system (CNAMTS) (2019)

** Data from the French direction of research, studies, evaluation and statistics (DREES) (2019)

BACK UP

Analyses quantitatives (dichotomique)

- (i) 73,9 % déclarèrent des initiatives

N (%)		No initiative N = 785	Yes, with or without criteria-based strategy N = 2,227	*p*
Type of practice				< 0.01
	Alone	146 (31.1)	323 (68.9)	
	Monodisciplinary practice	338 (26.0)	962 (74.0)	
	Independent multidisciplinary group	278 (25.3)	821 (74.7)	
	Care centre	18 (14.0)	111 (86.0)	
	Missing data	5	*10*	
Size of practice				0.04
	Alone	146 (31.1)	323 (68.9)	
	≤5 professionals	322 (25.6)	937 (74.4)	
	[6-20[	271 (25.0)	813 (75.0)	
	≥20 professionals	45 (22.6)	154 (77.4)	
	Missing data	*1*	*0*	
Gender				0.001
	Women	394 (23.7)	1,265 (76.3)	
	Men	391 (28.9)	962 (71.1)	
Teaching activities				0.002
	Yes	501 (24.4)	1,556 (75.6)	
	No	284 (29.7)	671 (70.3)	
Quantitative change of activity (last 7 days)				< 0.001
	<50%	128 (26.8)	150 (54.0)	
	50 to 99%	406 (26.0)	1,157 (74.0)	
	Same number	208 (26.1)	587 (73.8)	
	More patients	43 (24.4)	133 (75.6)	
Number of patients who died due to COVID-19				< 0.01
	None	292 (29.7)	691 (70.3)	
	1-2 patients	261 (27.7)	681 (72.3)	
	>2 patients	225 (21.0)	845 (79.0)	
	Missing data	*7*	*10*	

BACK UP

Analyses quantitatives (trois modalités, multivariée)

Table 4. Individual and organizational factors potentially associated with the initiative of contacting vulnerable patients during the first COVID-19 lockdown in 2020: multivariate multinomial model (total n=3,012 French general practitioners)

N (%)	Call without criteria-based strategy N = 1,419		Call with criteria-based strategy N = 808		*p* heterogeneity
	aOR (95CI)	*p* association	aOR (95CI)	*p* association	
Women	1.37 (1.13-1.66)	< 0.001	1.41 (1.14-1.75)	0.001	0.001
Age group					0.030
<40 years	0.80 (0.63-1.01)	0.063	0.79 (0.61-1.03)	0.083	
[40-55[	Ref	-	Ref	-	
≥55 years	1.07 (0.84-1.35)	0.60	0.83 (0.63-1.08)	0.16	
Teaching activities	1.00 (0.81-1.22)	0.98	1.94 (1.51-2.48)	< 0.001	< 0.001
Complementary activity in local hospital	0.81 (0.54-1.23)	0.32	0.97 (0.62-1.50)	0.88	0.53
Complementary activity as nursing home manager	0.93 (0.75-1.15)	0.51	0.81 (0.64-1.03)	0.090	0.22
Usual annual activity					0.17
<3,500 procedures per year	0.97 (0.76-1.23)	0.78	1.22 (0.93-1.60)	0.15	
Between 3,500 and 6,000	Ref	-	Ref	-	
>6,000 procedures per year	0.92 (0.73-1.17)	0.51	0.84 (0.63-1.11)	0.21	
Quantitative change of activity (last 7 days)					0.86
<50%	0.94 (0.73-1.21)	0.63	1.11 (0.83-1.49)	0.48	
50 to 99%	Ref	-	Ref	-	
Same number	0.92 (0.74-1.14)	0.44	0.99 (0.78-1.26)	0.91	
More patients	0.98 (0.67-1.45)	0.93	0.90 (0.57-1.42)	0.65	
Number of patients who died due to COVID-19					< 0.001
None	Ref	-	Ref	-	
1-2 patients	1.10 (0.88-1.36)	0.41	1.19 (0.93-1.53)	0.17	
>2 patients	1.60 (1.28-1.99)	< 0.001	1.84 (1.43-2.36)	< 0.001	
Type and size of practice					< 0.001
Alone	0.72 (0.55-0.93)	0.014	0.70 (0.51-0.97)	0.030	
Monodisciplinary practice with 2-5 professionals	Ref	-	Ref	-	
Monodisciplinary practice with >5 professionals	0.73 (0.49-1.07)	0.10	0.98 (0.63-1.51)	0.91	
Multidisciplinary practice with 2-20 professionals	0.88 (0.71-1.08)	0.22	1.33 (1.04-1.69)	0.022	
Multidisciplinary practicewith >20 professionals	0.99 (0.65-1.50)	0.94	1.94 (1.26-2.98)	0.0026	

BACK UP

Analyses qualitatives

Figure 2. Results of the qualitative analysis on the initiatives taken by 123 general practitioners in France to get in touch with vulnerable patients during the first COVID-19 lockdown in 2020.

HETEROGENEOUS AND DYNAMIC PROCESS	
Selection criteria for patients to contact	**Interprofessional collaboration**
Age	I needed help in this process
Having a disease	Collaboration
100% coverage due to chronic disease	Interprofessional trust
Vulnerability	Interprofessional distribution of new tasks
Requiring follow-up by homevisits	Division of tasks among GPs
Combination of different criteria	GP selects patients, others make the calls
Individual assessment	Identification by a medical secretary (patients contact her)
Ongoing health issue ("hot patient")	Identification by a public health nurse*
Cancelling or postponing a medical appointment	Identification by a community pharmacist
Isolated patient	Identification by a nurse
Psychological or social issues	Identification through an interprofessional network
Taking a regular treatment	Calls delegated to other health professionals
Contracted or suspected COVID-19	Calls by a public health nurse
Listed as frail during the heatwave alert period	Calls by an intern
Young age was considered as protective	Calls by a national health system agent
No criterion, "the one I thought about"	Calls by municipal agent
Contacted everyone (being on the GP's patient list)	Contact through the community or caregivers
Tools	Calls by a medical secretary
I need time to do it	Calls by a health mediator
Agenda (list of past or planed appointments)	**GP-patient relationship**
Information system or medical records	It is a mission for the general practitioner
Platforms for contact management and video-consultation	To keep in contact
Professional web portal of the French national health system	Regular contact with patients
Had a list before the COVID-19 pandemic	despite the lockdown
Message to all patients by email	Phoning to avoid exposing them to the virus
Message to all patients by telephone	A GP needs to know his/her registered patients
Passive communication via a website	To look after their patients
Remote consultations	GP did not consider he/she needs to reach out
Participated in a trial about reaching out (coviquest)	Many patients directly contacted their GP

Résumé

- **Background:** In France, the first COVID-19-related lockdown resulted in a major decrease in healthcare service utilization. This raised concerns about the access to care and the continuity of care, especially for vulnerable patients.

- **Objectives:** To describe the initiatives taken by French general practitioners (GPs) to contact vulnerable patients during the lockdown. To identify individual and organizational factors associated with these initiatives.

- **Methods:** Observational study using an online questionnaire to GPs on how they adapted their practices and organization to the COVID-19 pandemic situation, their individual characteristics, and their practice type (individual, group, multidisciplinary) and size. A question explored whether GPs took initiatives to contact vulnerable patients registered at their practice, and responses were categorized in: no initiative; selection of patients to contact using criteria ("criteria-based strategy"); initiative of contact without criteria-based strategy. Key components of the reported initiatives were described by inductive analysis of verbatim material. Multivariate multinomial regression identified factors associated with each category.

- **Results:** Among the 3,012 participant GPs, 2,227 (73. 9%) reported initiatives to contact some patients: 1,419 (47.1%) without criteria-based strategy, and 808 (26.8%) with a strategy using various clinical/psychological/social criteria. Women GPs and GPs with more than two patients who died due to COVID-19 were about 40% and 70% more likely to declare initiatives of contacts, respectively. GPs with teaching duties used specific criteria-based strategies nearly 2 times more often than the other GPs. Compared with those working in small monodisciplinary practice, GPs working alone were about 30% less likely to implement initiatives of contacts, while GPs working in multidisciplinary practice with 2 to 20 professionals and with more than 20 professionals were 33% and 94% more likely to implement criteria-based contact strategies, respectively.

- **Conclusion:** French GPs took various initiatives to keep in touch with vulnerable patients, more frequently when working in group practices, and used more structured approaches when working in multidisciplinary practices. These findings highlight the importance of primary care organization to ensure access to care and continuity of care, especially for vulnerable people, and to develop population-targeted approaches, in pandemic times and in daily practice.