visiting the rehabilitation doctor in 2012, she needed some global clinical examination (epilepsy, neuro-orthopedic and cognitive sequelae) and further readaptation management (workplace and living place for disabled persons, aid for travelling, financial support to family).

These cases of collaborative work show the useful referral to rehabilitation for these patients and their family. More clinical with no-delay-visits are needed to state the disability and to propose aid of various sort. Also, proper rehabilitation programs (because of both cognitive and motor loss of autonomy) must be further explored. Finally, links between pediatric and adult management and dedicated pathways must arouse.

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Payment for performance: Proposals for PRM
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Keywords: Payment for performance; France; Health Insurance; Funding PRM

Payment for performance (P4P) is a new and important aspect of the Medical Convention signed in 2011 between the National Health Insurance and the Medical Unions, who represent private practitioners in France. Money saved by reducing practice variance will supply additional funding for medical activity. P4P will have two targets:

– medical organization, especially computerized management;
– quality of medical practice which will be assessed by a series of indicators, either contained by the Health Insurance database or self-declared by each specialist.

Every specialty is asked to set up some proposals, which will be negotiated with the National Health Insurance.

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PRM demographic evolution
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Keywords: PRM; Medical demography; Residencyship; Fellowship

We are 1835 PRM specialists in France in early 2011 based on data from the Atlas of Medical Demography: situation on 1 January 2011 (National Council of the College of Physicians). Thus, we represent just under 1% of total 49 medical and surgical specialties, including 34 medical disciplines.

The exercise is the most common employee and increasing (1325 employees of which 64.8% hospital, Mixed 167, Liberal 340). The pyramid is still unbalanced with a large number of specialists PRM aged 55 or over. This “generation leaving” has raised fears the collapse of many specialists PRM. Fortunately after a low water at least 30 new specialists PRM per year in 2006–2009, the numbers of new specialists in 2010 were 41 (with input including doctors qualified via the DIU Rehabilitation Practice). Projections are nearly a hundred new PRM each year from 2014 with the impact of the filiarisation since 2010. This “new wave” must be given easier access to various modes of exercise of PRM. Of new golf courses have been approved for the DES and replacements must be developed as currently very few opportunities for replacement are proposed. We will also be faced with an access to post boarding more difficult because the number of physician assistants positions has stagnated despite the considerable increase of the residents. After the actions of demography, this fellowship –as more rewarding and more training- is a new challenge for our specialty bodies.

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Program-based case-mix classification system vs. per-diem based system in post-acute care: Which model for financing rehabilitation?
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Keywords: Rehabilitation; Prospective Payment System; Post-acute care; Fee for service; Case-mix classification; Differentiation; Integration

The final model of pricing activity (T2A) in the french sector of subacute care and rehabilitation (SSR) is still not known. If prospective payment in french acute care Hospitals is modelled on the Diagnosis Related Groups (DRG) of Fetter, the case-mix classification system in post-acute care (PMSI-SSR) is a French invention based on the model of Resource Utilization Groups (RUG). These have been developed in the U.S. Long Care Hospitalization Facilities and are the source of Iso-Resource Groups (GIR) used in the French medico-social sector. While in the United States and other countries a sector post-acute rehabilitation is identified and has a specific funding separate from the sub-acute care sector, France has chosen a common classification.

At a time of profound re-engineering of SSR, which follows the disappearance of the segmentation between rehabilitation and sub acute care, one may question the relevance of the day as a weighted basis in the PMSI SSR. The origins of this choice and the expected impact of this classification during the transition to the T2A in SSR may face the international literature. This impact must be analyzed in the context of managed competition developed between all stages of the chain of care. Rehabilitation will be preserved only accessible by a classification of case-mix groups identifying the medical complexity of the programs needed and expected resource consumption. The relative cost of treatment should be compared to an average cost scale in ensuring the feasibility of rehabilitation programs in accordance with the state of art. The joint health economics should serve to care pathways combining accessibility, specialization, territorial scale and continuity of care.

Further reading

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