CO54-001-e

Compliance visits for physical medicine and rehabilitation services

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Introduction.-- The compliance visits for the Follow-up Care and Rehabilitation (FCR) services are in response to the 2008 decrees, which unified the activities encompassed in “follow-up care” and those of “physiotherapy and rehabilitation” into a single activity called “Follow-up Care and Rehabilitation.” The latter consists of a versatile common foundation which is able to go hand in hand with specialized services. Physical Medicine and Rehabilitation services coincide with FCR via the specialized services of “musculoskeletal disorders” and “nervous system disorders.” These decrees have raised the standards expected of FCR tasks, equipment, and employees.

The visits carried out by the Regional Health Agencies (RHA) took place between 2011 and 2013 depending on the region. The visits revealed the difficulties encountered by the health care facilities in complying with the standards dictated by the authorizations issued in 2010. The hospital federations attracted national attention over these issues. The Ministry of Health (through the Directorate-General for the Provision of Healthcare) therefore decided to undertake an initial report of the conformity visits in this sector. Materials and methods.-- The objective of this initial report of the conformity visits in the FCR sector is to catalog the primary instances of reticence to apply the new standards or the non-compliances observed, and with this information, identify the underlying causes.

For this purpose, the Directorate-General for the Provision of Healthcare has devised a 3-part investigation:

- the first part covers the purely quantitative aspects of the visits (state of the premises at the moment of the visit, number and type of non-compliant FCR services);
- the second part identifies the principle instances of reticence or elements of non-compliance under regulatory provisions. These regulatory provisions have been divided into the following five categories:
  - tasks common to all FCR services;
  - premises and equipment (including technical platforms);
  - employees;
  - continuity of care;
  - contractual commitments/other FCR tasks.
- the third part makes inquiries into the main underlying causes of the reticence to apply the standards or instances of non-compliance. These inquiries are organized around the following issues:
  - absence of implementation/global FCR workplace culture;
  - absence of trained/qualified employees;
  - insufficient funding and/or space for premises and equipment/adequate technical platforms;
  - insufficient employees through a lack of funding or demographic constraints;
  - problematic continuity of care caused by demographical constraints or unfamiliarity with partners.

This investigation was fulfilled by each Regional Health Agency in March 2013 regarding all conformity visits carried out before 31 January 2013 and sent to the Directorate-general for the Provision of Healthcare. The processing of this investigation is in progress on the national level.

Results.-- The national and regional results will be available within a few weeks and presented in October 2013 during the French Physical Medicine and Rehabilitation Society conference.

Remarks.-- The reticence to apply the standards and the instances of non-compliance have ostensibly led to an insufficient, less efficient, or even risky (for the patient) level of health care quality. Respect of the standards is the number one condition for providing quality care.

Conclusion.-- The investigation will give us an outline of the difficulties encountered by the health care facilities, and will attempt to explain why these difficulties occurred. These compliance visits ought to be considered as a tool for improving the quality of care, the standards having been enacted for this purpose.

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Oral communications

English version

CO54-002-e

Conceptual approach of SSR coordination: Coordination in 3D

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Keywords: Coordination in SSR: Trajectoire; Rehabilitation Introduction.-- Explaining what the activity of a SSR coordination doctor consists of rapidly becomes a headache, as the complexity of this function concerns multiple disciplinary fields it is vain to want to schematize.

Context.--The decrees of 2008, regulating the activity of continued care and rehabilitation (SSR), have defined a function of SSR coordination. If the mission can be summarized in objectives of “facilitation” of flows from MCO to SSR, the concept of coordination makes the action complex and difficult to define in this field, multiple coordination’s place.

Objectives.-- Convinced that “what is well conceived is stated clearly and the words to say it come easily”, we propose a design of coordination, after eleven years of experience in Rhône-Alpes.
COS4-004-e
Prospective payment system in post-acute care: Impasse or opportunity for reform?
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Keywords: Rehabilitation; Post-acute care; Prospective payment system; Casemix; Financing

Objectives.— The transition to a prospective payment system (PPS) in French hospital sector of post-acute care (SSR) has been postponed to 2016. Assuming that the current impasse is linked to the construction methodology for the medico-economic groups (GME), the objective of this study is to provide, through analysis of the work of countries involved in the construction of pricing activity in post-acute sector, a method of classifying patients suitable for SSR and in particular the fair valuation of PRM activities.

Methodology.— We analyzed the available foreign works on the Internet concerning the organization and financing of post-acute care. We selected the models developed in the USA, Belgium, Switzerland and Australia. Comparisons with the French system focuses on the health model selected, the identification of rehabilitation in the process of segmentation of activities, capture tool, taking into account outpatient care, construction methodology of patients classification systems and unit payment.

Results.— The classification GME built by French agency for information on hospitalization (ATIH) foreshadows a payment “per case”. It does not reflect the different processes of care, but the categories of the 2008 decrees. Foreign models have in common the reference to ICF model, a clear definition of the concept of rehabilitation, a classification whose the first level is the medical purpose of care, and whose classes of patients are based on their needs, identified by a combination of disease and comorbidities, robust indicators of functional limitations, personal and environmental factors. The Australian system includes outpatient. The payment unit seeks a balance between payment per diem weighted by activity, payment per case, and fixed block grant.

Discussion—Conclusion.— The first level of a coherent medico-economic classification in post-acute sector must match the major goals of medical management. Their description as care programs help to formalize clinical objectives for target populations by linking treatment modalities, predictable resources and evidence. A reform of PMSI-SSR must precede the fair valuation of rehabilitation activities. Their specification is complementary to better integrated care pathways.

Further reading

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Respective contribution of chronic conditions to disability in France: Results from the national disability-health survey
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Keywords: Disability; Health; Social inequality; Health inequalities; France

Objectives.— The French National Health Institute has been collecting since 2003 information on chronic conditions and their consequences on a large sample of the French population. This study aims to analyse the respective role of chronic conditions in the development of disability in France.

Methods.— The French National Health Institute asked a large sample of the French population, between 19 and 80 years old, about their health status and all chronic conditions that they had ever had, and about the consequences of these chronic conditions on their activities of daily living. The disability status of respondents has been classified into 5 levels: from “no disability” to “total disability”. The “global” disability status of respondents has been constructed from their 4 activities of daily living. Disability has been defined as the self-reported inability to perform the actions of the activities of daily living.

Results.— The chronic conditions that the French population has suffered since 1995 are expressed in the result of a multivariate logistic regression analysis: the chronic conditions that are associated with disability are the duration of time since the diagnosis for each condition, the number of co-morbidities, and the number of chronic conditions. The chronic conditions that are the most strongly associated with disability are those that have the longest duration since diagnosis and that are associated with the highest number of co-morbidities and chronic conditions.

Discussion.— The results show that the chronic conditions that are the most strongly associated with disability are those that are the most severe. The chronic conditions that are the most strongly associated with disability are those that have the longest duration since diagnosis and that are associated with the highest number of co-morbidities and chronic conditions.

Further reading

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