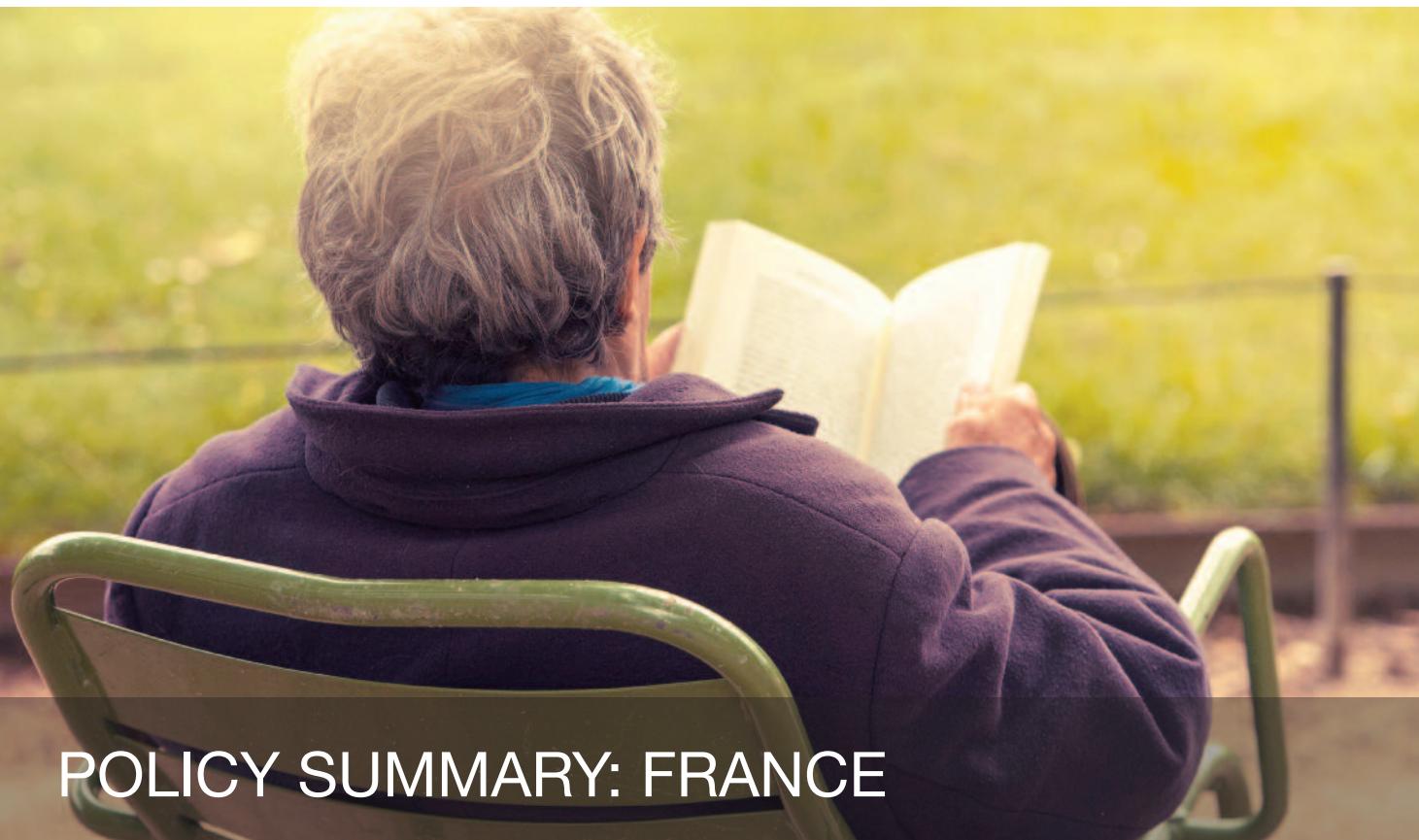


Quality and cost-effectiveness in long-term care and dependency prevention



POLICY SUMMARY: FRANCE

PAERPA (Elderly people at risk of loss of autonomy)

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Policy theme	Strategies to maximise coordination in care provision
Design and implementation level	National design, implemented locally by the regional health agencies
Policy objective	Improve the quality of life of elderly people and their relatives, increase the efficiency of health and social care for elderly people by developing the logic of the health care pathway
Start date – End date	2013/14 – Experimental six-year schemes extended to each French region in 2016

Aims

The scheme has five interdependent objectives corresponding to five different steps in the elderly person's health pathway.

1. Prevent elderly people's loss of autonomy by identifying at early stage risk factors potentially leading to hospitalizations and/or early institutionalizations (such as depression, falls, drugs interactions, undernourishment). To do so, the scheme leans on a cooperation process between frontline professionals called 'close clinical coordination' ('coordination clinique de proximité' or CCP) involving a general practitioner, a nurse and a pharmacist, as well as any other health or social care professional intervening with the elderly person at risk of loss of autonomy. A personalized health care plan is thus jointly devised under the scrutiny of the general practitioner.
2. Improve the coordination of health, social and medico-social interventions and to provide an adequate response by the right professionals at the right health and social care facilities to all elderly people at the lowest cost. It focuses on support to frontline professionals – especially general practitioners – in their coordination functions: the so called 'dedicated territorial coordination' ('coordination territoriale d'appui' or CTA). Its role is to provide information to both professionals and elderly people and their relatives and to orient them to the appropriate health or social care facility for their needs. The dedicated territorial coordination is implemented on the

basis of pre-existing coordination or integration schemes (CLIC, MAIA etc.) and does not imply the creation of a new structure. It can rely on a range of tools, such as a unique telephone number or an information platform.

As in the MAIA scheme, the 'close clinical coordination' and the 'dedicated territorial coordination' are closely linked. They also serve the three other objectives of the scheme:

3. Secure hospital discharges, by providing support to the implementation of new procedures, better anticipation of hospital discharges and better use of intermediate care, temporary residential beds, home care and home health care services.

4. Limit unplanned (avoidable) hospitalizations or unnecessary emergency visits by the use of educational therapies or simplified access to geriatricians, etc.

5. Improve use of medicines and reducing unjustified polymedication and the risks of drug-related iatrogenia by informing the pharmacists and the GP of the elderly person's medical prescriptions after a hospital stay.

The accent is also put on information sharing with the GP, with the help of the dedicated territorial coordination. For the purpose, the scheme relies on different tools in order to facilitate information sharing: mainly standardized information sheets and a secure messaging system common to all three sectors, developed at the national level

Aims (continued)

by competent institutions. In the same perspective, the information flow and sharing between professionals participating in a PAERPA was regulated in a specific piece of legislation (decree of December 2013).

Another decree from January 2014 allows the regional health agencies implementing a PAERPA to access the national information system (SNIIRAM) of the different health insurance regimes.

Implementation

Implemented on an experimental basis starting in 2013 in nine areas in two waves:

- September 2013 in Nord-Est Paris (Île de France), Grand Nancy (Lorraine), Hautes Pyrénées (Midi-Pyrénées), Mayenne (Pays de la Loire), Sud Indre et Loire (Centre);
- January 2014 in Bordeaux (Aquitaine), Sud Corrèze (Limousin), Valenciennois quercitain (Nord Pas de Calais), Nord Nièvre (Bourgogne).

The national coverage of the PAERPA scheme is still very low. Its extension has been announced by the social security department in March 2016 with the objective of having at least one pilot in each region. This is the first step to its full coverage as stated in the decree defining the national specifications of this new generation of PAERPA schemes.

Target group

PAERPA schemes target elderly people aged 75+ at risk of loss of autonomy and are based on interventions aiming at preventing the risk of loss of autonomy.

Nevertheless, in practice, the majority of personal health plans devised by professionals concern elderly people with severe health problems and already experiencing loss of autonomy.

Eligibility criteria

All elderly people 75+ at risk of loss of autonomy.

The personalized health plan (PPS) is reserved for elderly people 75+ in a vulnerable situation and/or suffering from one or several chronic diseases.

Resources

Funding

At the national level: act on financing of social security 2013.

At the regional level, the regional intervention fund (FIR) allocates an annual flat-rate payment to the ARS (agence régionale de santé – regional health agency) responsible for the pilot. These funds cover the actions linked to the support functions (expenditure on governance, dedicated territorial coordination), the frontline professionals'

payments (for the personalized health plans, for instance), the costs incurred by the reorganization of the health and social care facilities and the information sharing (support for the use of secured information system) (decree 2013-1090, 2 December 2013).

The FIR's financing envelope comes in addition to that allocated to other schemes and policies whose aim is to achieve better coherence of the health, social and medico-social sectors, services and professionals within the elderly care field.

Resources (continued)

Staff involved

In each regional health agency, a PAERPA project team is set up with a project leader in charge of the implementation and monitoring of the scheme and an IT engineer. The project leader is the sole interlocutor of all actors involved in the scheme, and works

across the regional health agency structures, in close collaboration with the agency's territorial structures. The presence of an IT engineer is compulsory, ensuring IT assistance for frontline professionals and helps them to adapt to the IS and to integrate it to their practice.

Performance assessment and monitoring

In April 2012, a national committee was formed to produce recommendations for the new PAERPA pilots national specifications. It is composed of all the partners in the PAERPA method: hospitals; health and social care facilities; health, social and medico-social professionals; the general practitioners' professional organization and user representatives. Different agencies are also associated with the project to provide the tools necessary for its implementation, or to carry out evaluation: the national agency for health facility performance (ANAP), research and documentation institute on health economy (IRDES), the high health authority (HAS) and the CNAMTS .

The implementation of the PAERPA pilot includes a continuous evaluation process under the supervision of the DREES and the social security department (SSD). Its cost-effectiveness – in terms of better quality and resource savings – is a main criterion for the roll-out of the scheme.

The evaluation's main hypothesis is that the redefinition of roles, tasks and practices of the different actors and organizations involved in the elderly person's health pathway, would lead to improvements in both the elderly people and their families' quality of life and the use of hospital resources and drugs.

The evaluation is three-fold:

1. Quantitative evaluation of the implementation process through a follow-up of different process indicators: the number of trained professionals, of personalized health

plans or of secured message systems deployed within the scheme's territory.

2. Qualitative evaluation of the implementation process, aiming at identifying the facilitating factors and difficulties affecting the implementation process at both national and territorial levels.

3. Cost-effectiveness evaluation, performed by IRDES, through the follow up of health consumption indicators related to drugs and hospital admissions (frequency, length of stay and number of re-hospitalizations within 30 days) and health impact indicators (quality of life and health status maintenance or improvement, reduction of the loss of autonomy). In order to make sure that the observed impacts are due to the implemented PAERPA scheme, the evaluation focuses on the nine pilots implemented in 2013 and covers the period from 2009 to 2017 [expected end 2017-begging of 2018].

The evaluation process is supervised by a scientific evaluation committee composed of representatives from the other social affairs and health ministry departments; of the regional health agencies (ARS) from the pilot territories; of the national salaried workers health insurance fund (CNAMTS) concerning primary care and frontline facilities health consumption data; the technical agency on hospitalization information (ATIH); the high health authority (HAS); the CNSA; the ANAP; and the Institute for Research and Documentation in the Economics of Health (IRDES) for the economic evaluation.

Evidence of success (outcomes, quality, satisfaction, awareness)	<p>The creation of the PAERPA scheme stems from a report estimating the global cost of loss of autonomy for the health insurance at €9–21 billion. The HCAAM 2011 report utilizes data from the CNAMTS, according to which in 2010, elderly people aged 75+ were prescribed up to seven different drugs at least three times a year, 85% of them have at least one pathology, and 33% have been hospitalized at least once (of which 44% were emergency admissions) for an average length of 12 days. It also analyses the age-related hospitalizations (85+) and the disparities of the hospital lengths of stay across the national territory. The report concludes that these could be reduced by optimizing elderly people's health pathway before and after hospitalization. The gains for health insurance are expected to represent up to €2 billion.</p>	<p>Qualitative evaluation reports:</p> <p>ANAP, 2016, Mettre en place la coordination territoriale d'appui. Retours d'expérience des territoires PAERPA, www.anap.fr/publications-et-outils/publications/detail/actualites/mettre-en-place-la-coordination-territoriale-dappui-retour-dexperiences-des-territoires-paerpa</p> <p>Gand S., Periac E., Bloch M.A., and Hénaut L., 2017, Evaluation qualitative PAERPA, Rapport final, Etudes et recherches n° 135, May 2017, DREES, http://drees.santé.gouv.fr/etudes-et-statistiques/publications/documents-de-travail/serie-etudes-et-recherche/article/evaluation-qualitative-paerpa-rapport-final</p> <p>The cost-effectiveness evaluation carried out by IRDES is expected end 2017-beginning of 2018.</p>
Transferability/uniqueness	<p>The scheme was created and specified at the national level in order to be implemented locally in different local contexts. Gand et al. (2017) underline the necessity to have a well-</p>	<p>defined and coherent national framework and piloting while ensuring its adaptability to all local specificities and pre-existent local dynamics.</p>
Is this an emergent practice? Degree of innovation	<p>The PAERPA scheme is one of the coordination and integration schemes that goes furthest in affirming the cost-effectiveness objective of the policy, and in</p>	<p>providing support from legislation and national administrations for IS and other tools to develop.</p>
Sustainability	<p>The three-fold process of evaluation will determine whether the scheme is maintained after the pilot period. Nevertheless, a first step to its full roll-out was made in 2016 with</p>	<p>the decision to extend the experimental scheme to each region (see figure 2) before the results of the first evaluations.</p>
Critical assessment	<p>See Country Report, theme 5.</p>	

Academic literature on this action

Garabige, Alexandra, et Loïc Trabut (2017) 'L'approche globale dans le champ de la dépendance. De l'impulsion nationale à la réappropriation locale d'une réforme en France', *Revue européenne des sciences sociales*, vol. 55-1, no. 1, pp. 149–168.

Documents

Cour des comptes, 2016, *La maintien à domicile des personnes âgées en perte d'autonomie. Une organisation à améliorer, des aides à mieux cibler*, Rapport public thématique, juillet 2016, p. 198.

HCAAM, 2011, *Assurance maladie et perte d'autonomie. Contribution du HCAAM au débat sur la dépendance des personnes âgées*, Haut conseil pour l'avenir de l'assurance maladie, Rapport adopté à l'unanimité lors de la séance du 23 juin 2011.

IGAS, 2014, *Evaluation de la coordination d'appui aux soins*, Inspection générale des affaires sociales, établi par P. Blanchard, L. Eslous, I. Yeni et P. Louis, Décembre 2014, 2014-010R.

Mounier C. and Waquer C., 2013, *Rapport sur la mise en œuvre des projets pilotes*, Comité national de pilotage sur le parcours de santé des personnes âgées en risque de perte d'autonomie, présidé par D. Libault, Janvier 2013.

IRDES's website dedicated to PAERPA evaluation: www.irdes.fr/recherche/projets/paerpa-evaluation-du-parcours-sante-des-aines/actualites.html

Ministry of Solidarities and Health, PAERPA: <http://social-sante.gouv.fr/systeme-de-sante-et-medico-social/parcours-des-patients-et-des-usagers/le-parcours-sante-des-aines-paerpa/article/le-dispositif-paerpa>
