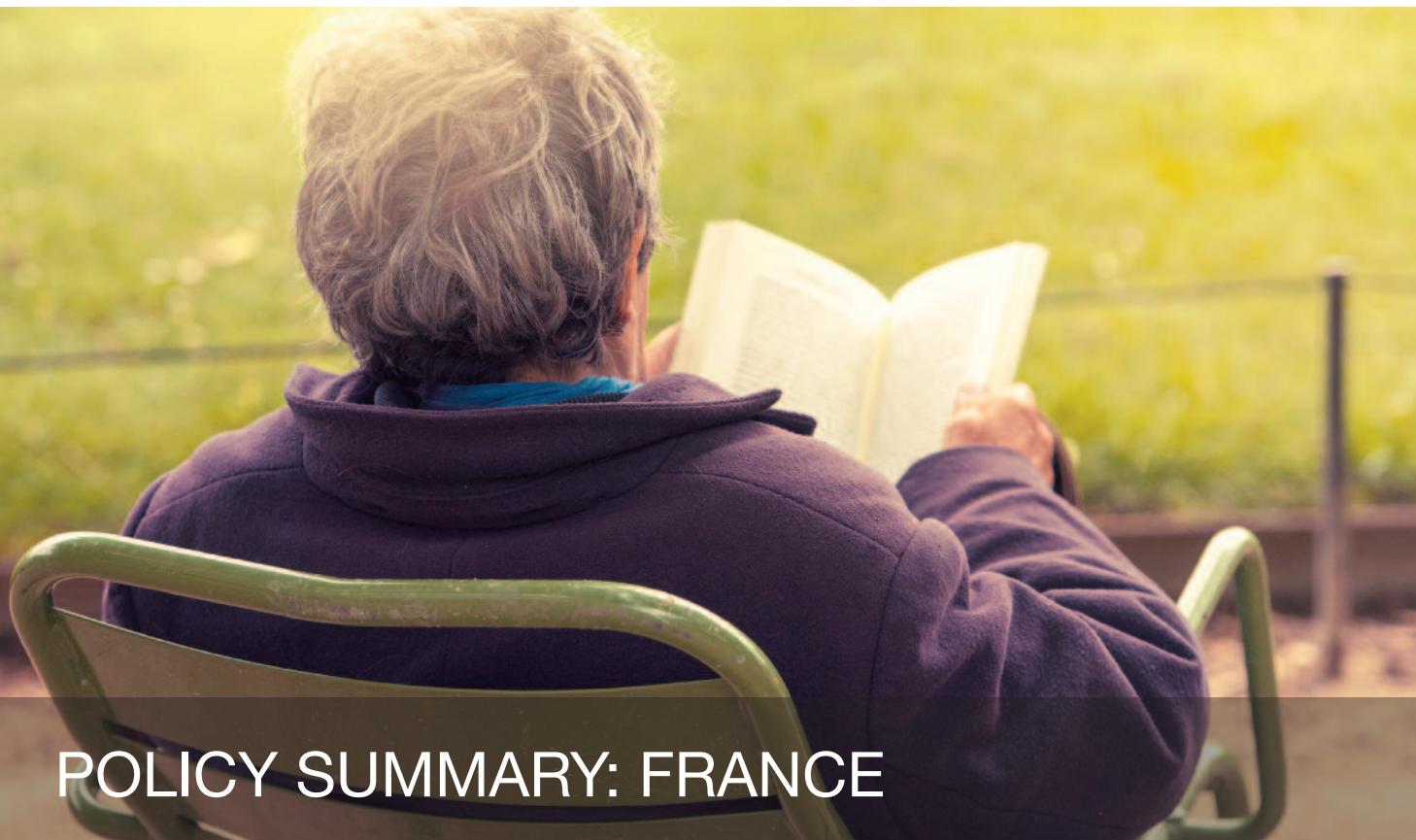


Quality and cost-effectiveness in long-term care and dependency prevention



POLICY SUMMARY: FRANCE

The MAIA scheme

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Policy theme	Strategies to maximise coordination in care provision
Design and implementation level	Designed at the national level as part of the Third Alzheimer's Plan (2008–2012). Implemented locally by the regional health agencies.
Policy objective	Integration of health and social care services for elderly people
Start date – End date	First pilots in 2009–2011, the scheme is currently being extended to the whole French territory.

Aims

The scheme is based on three integration mechanisms and tools.

Integration mechanisms

1. A consultation process with two interdependent levels:

- a strategic meeting (table stratégique) at institutional level with all decision-making and financing actors in the territory of the MAIA scheme;
- a tactical meeting (table tactique) at organizational level with managers representative of all health, social and medico-social organizations dealing with elderly people in the territory.

Their objective is to create a collaborative and decisional space where institutional and professional actors work to break down barriers between sectors and to develop a common and shared integrative project.

2. Integrated entry point ('guichet intégré'):

Implies that any professional in contact with the old person is able to propose a harmonized and adapted response to the users' needs in order to limit both the number of potential contacts and potential through the system. The existence of such an integrated entry point supposes the participation of all the pre-existing

information and orientation points within the territory and is closely linked to the work performed in the tactical meetings.

3. Intensive case management for complex cases ('gestionnaire de cas'):

Provides an intensive follow-up to elderly people with complex health and social needs. The intensive case managers become the professionals to whom all the family and professional actors involved in the care arrangement of the elderly person can refer. By identifying failures at the clinical level, they contribute to the improvement of the organization of health and social care in the territory.

Integration tools

These aim to support clinical-level integration performed by case managers:

1. Multidimensional analysis form for all the professionals participating to the integrated entry point and a multidimensional evaluation tool (the Resident Assessment Instrument-Home Care – RAI-HC) for the case managers;

2. Individualized service plan including all health and social interventions to deal with the complex situation;

3. Shared information system.

Implementation

The scheme was first tested in 17 localities as a pilot and then extended to the whole territory with 352 existing schemes in December 2016.

According to a national evaluation report produced by the CNSA, 85% of the territory is covered by the scheme in June 2016.

Eligibility criteria	<p>The inclusion criteria for complex case management were initially defined at the tactical meetings of each MAIA scheme by the professionals involved.</p> <p>Since 2014, national criteria have been defined in the National Plan of Neurodegenerative Diseases (2014–2019) as follows:</p> <ul style="list-style-type: none"> • situations where maintaining the elderly person in their home is compromised 	<p>because all of the following are present: functional autonomy problems, health problems and decisional autonomy;</p> <ul style="list-style-type: none"> • existing health and social care services are insufficient or inappropriate for the elderly person's needs; • there is no available relative to design an adequate health and social care response to the elderly person's needs and to coordinate it intensively in the long term.
Resources	<p>Funding:</p> <p>The scheme is funded by the CNSA's budget dedicated to elderly people (section 1–2) through the solidarity contribution for autonomy. The CNSA delegates, via the Regional intervention fund (FIR), the credits corresponding to each MAIA scheme to the regional health agencies in charge of the operational implementation of the scheme. These credits include: €100,000 per year for the recruiting the 'pilot' – the initial manager – and all the operating costs; and €60,000 per year and per intensive case manager.</p> <p>In 2017, this represents €98.6 million (CNSA 2017).</p>	<p>Staff involved:</p> <p>For each project selected, a dedicated professional – the MAIA pilot – is recruited to foster the integration dynamics across the scheme's territory, alongside between two and five case managers, who are in charge of up to 40 complex cases each.</p> <p>In 2017, this represents 352 MAIA schemes with almost 300 recruited pilots and more than 1,000 case managers (CNSA 2017).</p>
Performance assessment and monitoring	<p>The implementation of the MAIA scheme has benefited from regular assessment by a team of researchers in its experimentation phase. Various reports have been produced: Balard et al. 2010; Carrier et al. 2008; de Stampa et Somme 2011; de Stampa et Somme 2012; Trouvé et Somme 2012.</p>	<p>The Foundation Médéric Alzheimer carried out a national survey in 2016 of the intensive case managers from the MAIA scheme: Fondation Médéric Alzheimer 2016.</p>

Evidence of success (outcomes, quality, satisfaction, awareness)

A national evaluation was completed in 2016, five years after the beginning of the extension of the scheme throughout the national territory (CNSA 2017).

It underlines the evidence of the effects of the MAIA scheme on:

- Shared governance and harmonized policies aiming to improve the user's care pathway, through the participation of the MAIA pilots in the development of the shared information system;
- Adapting local health and social care services to the population's needs, through the transformation of temporary residential beds into emergency beds.
- Local actors' involvement in the construction of the integrated entry point and concrete coordination practices. Whereas one of the main reasons for a situation to become complex is the elderly person's refusal to accept services and care they are eligible for, the CNSA points out that within a year of intensive case

management, the proportion of elderly people refusing help goes from 30% to 7%. The mean number of contacts for an elderly person before they find an adequate response also decreases: 3.2 contacts on territories where no MAIA scheme is present against 1.3 in territories where the integration method has been implemented.

Finally, the CNSA report underlines that the efficiency of the MAIA method is not measurable for two main reasons: its progressive implementation over five years (and still in progress) and the absence of impact indicators (CNSA 2017, p. 21). The analysis within the CNSA's evaluation report was made by taking into account the scheme's perceived efficiency by the different actors participating to the evaluation and the interdependency of the different mechanisms contributing to this perceived efficiency.

A keyword search within the report for the term 'coût' (cost) showed no occurrences.

Transferability/ uniqueness

The French MAIA scheme was inspired by the Canadian Prisma programme. The conditions for the transferability of the Prisma model to the French context have been investigated in the literature: Somme et al. 2014b; Couturier et al. 2009; Couturier et al. 2011; Etheridge et al. 2009.

The political decision to extend the scheme to the whole French territory was taken after

a pilot period and its roll-out is almost complete.

Nevertheless, all the evaluation and monitoring reports, as well as academic literature, put the accent on the necessity to adapt the scheme as described in the national specifications to the local specificities and pre-existing coordination practices.

Is this an emergent practice?

Degree of innovation

Coordination policies in France have a longstanding history.

With the MAIA scheme, the coordination objective was reaffirmed with a new dedicated term – that of integration – introduced in the official discourse, marking a break with earlier attempts at coordination that had been found wanting (Somme et al. 2014a).

Its local implementation is closely linked to the creation of the regional health agencies in 2009. These new agencies are new institutional actors representative of the state on the regional level. Their field of intervention was extended from the traditional health-only intervention of the previous regional hospitalization agencies to

the medico-social care sector. This was supposed to legitimise the scheme's capacity to extend its action to all three – health, social and medico-social – sectors concerned with elderly care.

Recent evaluations show that even if the MAIAs' objective of integration of all three sectors is very strong, in practice the scheme remains more oriented to the medico-social and social sectors (IGAS 2014). This is due to different factors, such as the absence of medical doctors within the MAIA team and also partly to the fact that they are carried out in a majority of cases by the départements (35%) or medico-social structures such as CLIC (28%) or MDPH (1%) (CNSA 2017).

Sustainability

The extension of the scheme and its inclusion in the main pieces of legislation is an expression of the political will to install the scheme on a permanent basis.

Its possible extension to the disability sector is developing in some territories.

Critical assessment

See country report.

Academic literature on this action

MAIA scheme:
De Stampa et al. 2013; Pimouguet et al. 2013; Somme and de Stampa 2011; Somme 2014
Intensive case management:
Balard et al. 2013; Corvol et al. 2012; de Stampa et al. 2014; Ennuyer 2012; Somme et al. 2015.

Documents

The CNSA's website (in French): www.cnsa.fr/parcours-de-vie/maia