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on evidence-based policy in long-term care

Session : Health and social care integration

Health and social care policies for people with chronic conditions in France : *How to (re)connect parallel universes?*

Marie-Aline Bloch, PhD, Dean of Research and Educational Innovation
EHESP – French School of Public Health

Léonie Hénaut, PhD, Research Associate Professor
Center for the Sociology of Organizations, CNRS, Sciences Po Paris

Correspondence to: marie-aline.bloch@ehesp.fr

EHESP SciencesPo. CSO CNRS

Origin and Scope of the research

This presentation is based on a 3-year study conducted with **Léonie Hénaut** about the development of care coordination for people with chronic conditions (including the vulnerable elderly) in France.

Three main interests:

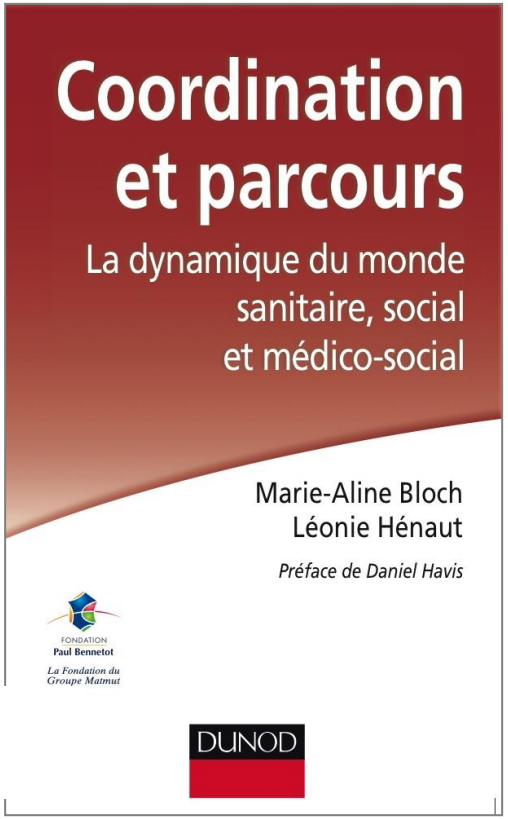
Part 1-Public policies

Part 2-Innovation dynamics

Part 3-New professionals

Elderly & disabled people, mental health, cancer, rare diseases, stroke, brain injury

Book published on January 8th 2014



Study mainly based on :

- Grey literature: official documents, assessment reports…
- Data produced in political sciences, sociology, management studies, public health
- Original case-studies:

Presentation outline

- ✓ Different groups of people with chronic conditions have been targeted by French public policies but they share similar issues in terms of health and social care coordination
- ✓ Public policies have been developed in parallel for care improvement for each category and present specificities due to different main stakeholders
- ✓ Convergence can be identified recently between these public policies
- ✓ All public policies are facing recurrent difficulties

- ✓ We propose general recommendations based on a double loop and transversal learning process

Elderly people (>75 y old) (~5,8 Millions)

Persons with Alzheimer or related disease (ALD : 0, 29 M)

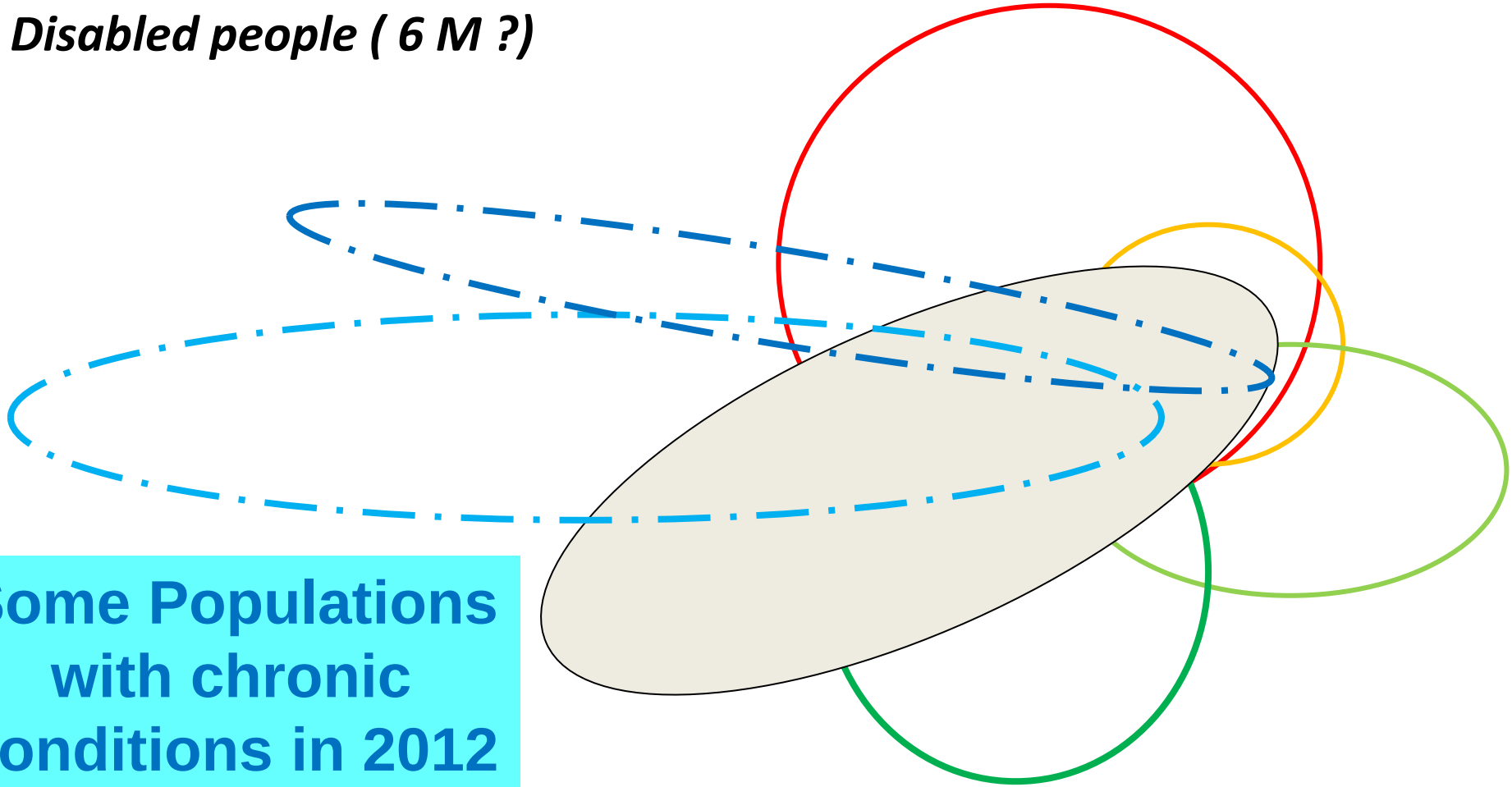
Persons with mental health disorders (ALD : 1, 16 M)

Persons with cancer (ALD : 2 M)

Persons with rare disease > 3 M

Persons with stroke/brain injury 0,3M new persons each year

Disabled people (6 M ?)



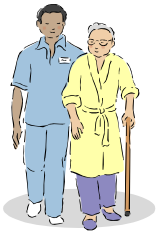
Some Populations with chronic conditions in 2012

What would happen to persons under different regimes/policies ?

Eg : an elderly person having a stroke and a cancer

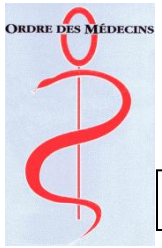
Common issues faced by the persons with chronic conditions with regards to care coordination and integration

Hôpital aigu



SSR

Inf Libéraux



Med Libéraux

Plateforme répit

Accueil de Jour

Services sociaux

CLICs

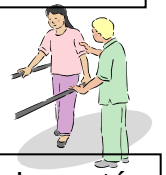
Ressources Alz

Réseaux

Bénévoles

Association malades

Aides à dom



Prof de santé libéraux

HAD

SSIAD

Mairies

MDPH

Similar issues

For persons with chronic conditions and their families *:* access to services, fragmentation, redundancy of assessments, delays

For ***professionals*** *:* difficulties for cooperation, lack of common tools and culture particularly between health and social care

For ***organizations*** *:* funding, competition, flow of information, flexibility

For ***health and social authorities*** *:* regulations, trade-off between large-scale population services and personnalized services

↳Need to ensure continuity and coherence all along the care pathway

↳ Coordination and integration issues at each level and within levels

Care improvement policies
have been developed in parallel for each category

and
present specificities partly due
to different main stakeholders

Major steps of the development of the parallel public policies

	Elderly people	Alzheimer	Mental health	Cancer	Stroke/brain injury	Rare diseases &disability	Disabled persons
<1960				hospital based			
in the 60ies	⇧social policy		sector creation				
in the 70 ies							2 Acts
in the 80 ies	decentralisation						
in the 90 ies	Allowance/ medicalization				a major report for Brain inj.		
2000-2008	2 plans	3 plans	1 plan	3 plans		1 plan (diseases)	a main Act in 2005
>2008	National health strategy : care pathways				1 plan for Stroke	1 plan (disability) 1 plan (diseases)	
nr of reports							

Coordination schemes and strategies

Definition: **Coordination is the process by which actions led by different actors are articulated in order to enhance their efficiency**, both in terms of cost and satisfaction for persons, family and professionals

Various **coordination strategies and schemes** were developed by policy makers and healthcare experts (liaison, coordination, integration, case and care management, network…)

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Many coordination schemes and strategies were developed

	Elderly people	Alzheimer	Mental health	Cancer	Stroke/brain injury	Rare diseases &disability	Disabled persons
<1960				CRLCC			
in the 60ies	local coordination social services		sectors				
in the 70 ies							SESSAD
in the 80 ies	SSIAD SSIAD		CMP				
in the 90 ies	Geriatric care networks APA team		MH care networks		UEROS	resources centers for disability	
2000-2008	CLIC Home-based hospitalization Geriatric line structure Mobile geriatric team	Memory clinics	SAMSAH psy mobile teams CLSM GEM	canceropoles 3C, RCP announcment setting, UCOG	UNV EPR brain injury line str.	reference centers (disease) competence centers (disease)	SAMSAH/SAVS SSIAD MDPH
>2008		MAIA Case managers for complex needs	CreHPsy				
	PAERPA : care pathways						

Specificities of each policy

	Elderly people	Alzheimer	Mental health	Cancer	Stroke/brain injury	Rare diseases &disability	Disabled persons
Governance	Ministry	Project and Foundation	Mission	Institute	Project	Foundation	Ministry
Main stakeholders	Professionals	Professionals and family associations	Family associations	clinicians	Professionals and family associations	Family associations	Family associations
Specificities	taking into account the global needs of the person and facilitating home care	dealing with complex situations	to stabilize status and thus facilitate social participation	to give access to the best therapies	to handle the very acute phase to avoid mortality and heavy disability	to get access to the competences	to facilitate social participation

Consequences of these specificities

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Main results	the development of multiple coordination schemes aiming at coherence between the different services	the implementation of intensive case management	the creation of peers groups	a regional and hospital based coordination descending	the creation of neurovascular units in each region specialized in emergency care	the creation of a network of reference centers	the creation of MDPH for global needs assessment connected to the field of education and of employement

A recent convergence between these public policies

- Since the 2004 Public Health Act :
  - in terms of process :
    - most policies are conducted through large 3 to 5 years national plans
    - Mid-term and final assessment with involvement of the High Council for public health (HCSP) and the National health conference (CNS) including representatives of end-users
  - in terms of content :
    - an increased involvement of general practitioners,
    - the creation of case managers positions,
    - And very recently the notion of care pathway.

However these public policies are still facing recurrent difficulties

- Many reports too superficial with an unsufficient learning process :
  - repeteadly creating coordination schemes (in the field of elderly)
  - Difficulties to address the real issue (mental health) (garbage can model)
- Plans and assessment procedures not considering conditions for success (change management) and a correct timing (political agenda not compatible with implementation agenda)
- Institutional hurdles : lack of resources, regulatory texts not operational, path dependency phenomenae, bureaucratic compartmentalisation
- Weak participation of end-users and of professionals
- Issues linked to the weak coordination between these policies although populations overlaps: for national and local authorities, for professionals (eg GPs), and for persons with chronic conditions

Example : Reports in the field of mental health

Juin 2001	Le Livre Blanc des partenaires de Santé Mentale France, associations d'usagers de la psychiatrie, de soignants et de responsables du social dans la cité	Propositions faites lors des réunions de juin 2001
Juillet 2001	Rapport Piel et Roelandt	De la psychiatrie vers la santé mentale
2003	Rapport Cléry-Melin, Kovess, Pascal	
Mars 2003	Le livre blanc de la psychiatrie de Collectif	
Janvier 2009	Rapport Couty	Missions et organisation de la santé mentale et de la psychiatrie
Avril mai 2009	Rapport OPESP Milon au parlement	RAPPORT sur la prise en charge psychiatrique en France,
Aout 2011	Rapport IGAS d'Amara et al.,	La prise en charge du handicap psychique
Octobre 2011	Rapport HCSP	Évaluation du Plan Psychiatrie et Santé mentale
Déc 2011	Rapport de la cour des comptes	L'organisation des soins psychiatriques : les effets du plan "psychiatrie et santé mentale"(2005-2010)
21 sept 2012	Rapport Terra Nova par Chierici et Pradalié	Quelques repères pour la psychiatrie publique
2012	Le livre blanc 2012 de la psychiatrie française	
Décembre 2012	Rapport Milon au parlement	RAPPORT D´INFORMATION FAIT au nom de la commission des affaires sociales (1) relatif à la prise en charge psychiatrique des personnes atteintes de troubles mentaux,
2013	Rapport Couty	Le pacte de confiance pour l'hôpital

Our general recommendations

- A generic plan should be designed :
  - capitalizing on all policies experiences (take the best of each policy eg for cancer research and clinical competences, for elderly and disabled people using a global assessment process and facilitating social participation and home care)
  - They should be more population based to avoid persons to be the target of different uncoordinated plans/policies
  - including a “conditions for success” section that would be the basis for new plans whatever the target population.
- Local contexts should be taken into account, thus plans should leave more margin to field actors to adapt the plan at their level
- Assessment teams should include more end-users and persons competent in change management
- Innovation coordinators should involved at national and local levels to facilitate the implementation process


Questions and discussion

Complementary slides

I. Background and methodology

A broad study of integrated care in France

The fragmentation process is twofold:

Horizontal fragmentation: between care providers	**Vertical fragmentation:** between policy makers
(1) "*sanitaire*" or cure area (2) "*social*" or social work area (3) "*médico-social*" or home-based and residential care area	(1) local level (2) regional level (3) national level

→ Numerous **integrated care schemes** have been conceived and implemented at various levels by various actors over the past decades: inter-organizational networks, new technologies, multidisciplinary teams, gate-keeping organizations, case management and integration strategies…

	Elderly people	*coordination schemes*	**Alzheimer**	*coordination schemes*
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