Journal of the National Institute of Public Health 2012 Vol.61 No.2 p.148－154

Topic：Issues and international trends towards the community-based integrated care system in Japan

＜Review＞

Hospital care at home in France: an alternative to conventional hospitalization with the same obligations towards quality and administration

Olivier TERRADE[1)], Takako TSUTSUI[2)], Alexis COTTENCIN[3)]

[1)] Director of In-home Healthcare, Care and Home Hospitalization Structure.
[2)] Research Managing Director, National institute of Public Health.
[3)] Guest Researcher, National institute of Public Health.

Abstract

The system of Hospital Care at Home in France (hereafter HAD[1]) was recognized legally in France in 1970 and has been reformed and adjusted many times since the first HAD facility was established.

These changes can be difficult to process, especially from the users' point of view: earning the understanding of users with regard to new ways of working can be difficult when it concerns health, or more precisely, the treatment of a health condition.

Nevertheless, the FEDOSAD association ventured into home care with the support of local partners, health professionals, and various public institutions at the national, regional, and departmental level. In this paper, we will present the stages of its implementation, the difficulties encountered, the "providential events," the professionals involved, the partnership established, the text defining professional practices, and the limits of the system as experienced by an HAD FEDOSAD 21 facility established in Dijon.

The role that HAD plays in geriatric care, the evolution of HAD, and the relationships with retirement homes will also be discussed throughout the paper.

keywords: Hospital Care at Home (*Hospitalisation à domicile*), establishment, structure

(accepted for publication, 11th April 2012)

Ⅰ. Integrated-care in France and HAD

As England has implemented HCH (Hospital Care at Home) and Australia HITH (Hospital In The Home), France also has its own system of in-home healthcare service delivery: l'Hospitalisation A Domicile (HAD). Even though these systems show significant differences, they have gathered interest and have been implemented or further developed in recent years. In France, the patient's home is seen as an extension of the hospital, and HAD facilities are considered as full healthcare facilities.

In 1973, a federation of HAD facilities (FNEHAD), was established in France to ensure the delivery of high quality care in the comfort of the user's home. Since the notification of 2000 from the Ministry of Health and Solidarity, HAD has been considered as a form of hospitalization in the home of the patient and prescribed by hospitals or primary care physicians. HAD provides seamless coordinated medical and paramedic care in the patient's home for a given period of time (subject to changes depending on the evolution of the patient's health condition).

The Director of the In-home Healthcare, Care and Home Hospitalization Structure of the FEDOSAD [2] association, M. Terrade Olivier, wrote the following paper. The FEDOSAD association provides various in-home care services in the French city of Dijon and includes a HAD facility. This paper gives an insight into the HAD system, the difficulties encountered by the FEDOSAD association,

Takako TSUTSUI
2-3-6 Minami, Wako, Saitama, 351-0197, Japan.
Tel: 048-458-6111
Fax: 048-458-6715
E-mail: tsutsui@niph.go.jp

and the future of in-home care services in France.

Studying this system would certainly benefit Japan in its attempt to implement a community-based care system that integrates medical and long-term care.

Ⅱ. History of HAD

Dr. E.M. Bluestone, from Montefiore Hospital in New York, started a home healthcare program that can be considered as the first American experience with HAD.

In 1950, the possibility of taking care of patients in their home started to be examined in France, especially for patients with cancer.

In 1957, the Public Hospital System of Paris[3] established the first HAD facility.

In December 1970, HAD was legally recognized in France through the Hospital Act (December 30, 1970). The National Federation of Hospital Care at Home (FNEHAD [4]) was then created to fix the terms of HAD.

In 1974, the National Healthcare Fund defined the functioning rules of HAD.

In 1985, 28 facilities (36 in 1990) providing HAD services had already been created.

The law of July 31, 1991, positioned HAD as a full alternative to conventional hospitalization.

On October 2, 1992, decree 92-1101 related to alternative structures of hospitalization as well as decree 92-1102 related to the functioning terms of HAD were adopted.

The notification and the complementary notification of May 30, 2000, defined the types of care provided by HAD facilities. Every HAD facility in France is following these notifications.

In 2000, the number of facilities providing HAD services reached 78.

An order for the simplification of the organization and management of the healthcare system went into effect on September 30, 2003. This order terminated the pre-existing change rate in which two hospital beds had to be cut before one HAD bed was created.

The Ministry of Health defined conditions for accessing HAD services through a February 4, 2004, notification.

A December 1, 2006, notification expressed once again the general and comprehensive nature of HAD. This notification also clarifies the conditions for accessing HAD services as well as the obligations and roles of the various persons involved in HAD. The need to further develop HAD is also stressed throughout this notification.

In 2007, the number of facilities providing HAD reached 207.

The HSPT [5] Law of July 21, 2009, also considers HAD facilities as full healthcare facilities.

Ⅲ. Creation of HAD facility in Dijon

FEDOSAD is an association specializing in the care of dependent or sick elderly persons. This association, which had been delivering in-home social and nursing care, became interested in the HAD system and started to investigate the local needs of elderly persons in the city of Dijon.

The FEDOSAD association had been providing in-home nursing care services since 1987 and thus had expertise in answering the care needs of users in a home setting.

Furthermore, the association had already been recognized as an innovative structure as it had implemented an Apartment with Coordinated Therapeutic Care. This apartment was created as a part of the City-Hospital Network that supports the care of patients with HIV. This experimental project was made possible because of the recognition of HIV patients as a target for in-home nursing care services (SSIAD [6]) and thanks to the collaboration of a teaching hospital in Dijon, which allocated one physician of the infectious disease department and a social worker to the project.

These are the reasons FEDOSAD chose to experiment with HAD in Dijon in partnership with the teaching hospital and the Hospital Regional Agency (ARH [7]), which later became the Healthcare Regional Agency (ARS [8]). This experimentation was made possible by using staff from the in-home nursing care services (SSIAD) and from the teaching hospital (one care assistant and 0.25 coordinating nurses for every three beds in HAD).

In September 2002, the ARH started a debate on “How to improve care in the Dijon area,” which eventually led to the creation of a HAD facility in that city.

During the next six months, many meetings, studies, and discussions with healthcare professionals and private hospital personnel were conducted. This led to the creation of a HAD facility that could provide care for 35 patients (10 of the 35 beds are for the exclusive use of the geriatric department of Dijon’s hospital).

In August 2003, the documents required for the creation of the facility were sent to the relevant authorities. Finally, the CROSMS [9] and the COMEX [10] authorized the creation of this facility at the beginning of 2004.

The HAD venture in Dijon started at this moment, involving recruitment of personnel, creation of job descriptions, intern planning, and communication with other health professionals.

The facility finally opened in November 2004.

Ⅳ. Administration of HAD

Once the authorization was granted, it was necessary to organize the internal structure of the facility and to recruit staff members.

Meetings were held with independent physicians, members of the Independent Nurses Association, and pharmacists and chemists, in collaboration with the teaching hospital, private hospitals, networks, the Local Center of Information and Coordination (CLIC [11]), and other services (in-home nursing care services, home help providers). After these meetings, agreement contracts were signed, and the teaching hospital decided to allocate a coordinating physician [12] in charge of medical decisions.

As HAD facilities provide services 24 hours a day, 7 days a week, it was necessary to bring the facilities up to code, keep a stock of supplies, and build a place to handle medical waste.

Vehicles were also purchased to enable staff members to make home visits.

Ⅴ. Legal framework, concise procedures, and specific regulations

Until 2009, the French health care code had considered HAD facilities as an alternative to hospitalization. However, in July 2009, they became recognized as full healthcare facilities and as a full healthcare system.

HAD facilities are healthcare facilities that provide coordinated medical and non-medical care in the patient's home for a given period of time (subject to changes depending on the evolution of the patient' s health condition). This care differs from that provided by other at-home care services with regard to the complexity and frequency of the care provided.

It is important to remember that HAD is a type of hospitalization. This means that without HAD services, the user would have been placed in a conventional hospital. The user's personal physician can directly prescribe HAD services even if there was no previous stay at a conventional hospital. The primary care physician is frequently consulted regarding the situation at home. He has to agree with the use of HAD, and it is recommended that he pay a weekly visit to the patient.

Thus, HAD facilities are considered as hospital facilities where patients do not come or stay. As such, these facilities have to follow the same rules and regulations as public or private hospitals, including those pertaining to continuity and constancy in care delivery, safety and quality, certification from the French Authority for Health [13], measures against nosocomial infections, pain management, drug use, and medical waste.

Ⅵ. What type of care for what type of patient?

Care provided by HAD facilities is regularly adjusted and normalized in a care protocol, which determines the goal, the follow-up, and the fee for services. This protocol is thus a clinical, psychosocial, and therapeutic care plan contracted by a primary care physician and a coordinating physician.

Three main types of care are provided: palliative and supportive care provided continuously to patients who will not recover (this care may be provided until the end of the patient's life), rehabilitative care for patients who may make a full recovery or whose condition may improve, and one-time care provided for a short period of time that requires special skills to administer it.

The strength of the Dijon HAD facility (hereafter the HAD FEDOSAD 21 facility) is the giving of care in a comprehensive manner, which includes psychosocial care. The care services involve the family and others close to the patient because they are often the key to providing successful care. To ensure such care is provided, the facility includes a psychologist and a social worker to make allowances for the needs and expectations of not only the patient but also of other caregivers.

Ⅶ. HAD facilities: providing users with HAD while improving decision-making on healthcare issues

The HAD FEDOSAD 21 facility does whatever it can to respect the choices of users. However, the limits of in-home care sometimes go against what the user or the multidisciplinary team would want.

This is because HAD is just one step in a larger care process and serves as a stepping-stone to other independent professionals or in-home nursing care providers who will take care of the patient once his or her condition is stabilized. On the other hand, if the patient's condition gets to the point where HAD is no longer a suitable option, then the patient will be transferred to a conventional hospital. Nevertheless, as the HAD FEDOSAD 21 facility has various internal resources (skilled staff) and as the department of ambulatory palliative care of the teaching hospital signed a contract with the facility, it is possible to properly support patients in their own home until the end.

Ⅷ. Ensuring high quality care to gain recognition from everyone

Every healthcare facility, private or public, has to be certified. This certification applies to healthcare facilities in a legal meaning and concerns the activities conducted by the staff of the facility involved with providing care to patients.

The certification process has been established to ensure high quality care and safety for the patient and to promote continuous assessments and improvements. Another goal is to gain the public's trust by making the results of audits available to them.

In order to be certified by the French Authority for Health, the HAD FEDOSAD 21 facility established six work groups focusing on different issues (management, logistics, quality management, risk management, information technology, patient processing).

Three of the work groups, comprising mainly field staff (staff from the facility and independent healthcare professionals), started working on how to assess professional practice regarding items such as in-home transfusion, drug channels, and end-of-life care at home.

The facility supported multiplicity in practices and viewpoints, internal or external, by including a plurality of professionals in its steering committees. For example, many professionals from outside the facility (teaching hospital staff, pharmacists, primary care physicians, etc.) participated actively in the steering committees and contributed to follow-up on quality procedures. In June 2009, the HAD FEDOSAD 21 facility was certified by the French Authority for Health (HAS). This accreditation is renewed through various audits conducted every two years.

Ⅸ. Reinforced and specialized partnership

There is no standardized model of organization for HAD.

Commensurate with its status, a HAD facility may include a variable number of independent staff members working in partnership with it.

These partnerships are based on agreements between the facility and the independent professionals to define the legal framework. The professionals must follow the practices established within the facility concerning items such as continuity of care, information-sharing, and care files and must take part in care quality assessments.

In October 2007, a notification authorized HAD facilities to take care of patients staying in retirement homes, whether or not such homes provided care. The notification followed the passing of a convention between the two types of facilities. This eventually led to a new type of cooperation between healthcare facilities and medical-social facilities.

For an HAD facility to intervene when the retirement home is one that already provides care (i.e., is a care center for dependent elderly persons [14]), the patient's condition must require highly qualified care that the care center cannot provide. This qualified care does not replace the nursing and social care that the care center staff members may already provide.

The remuneration provided for HAD services delivered in a care center is lower than that provided when the services are delivered in the patient's home. In this case also, the HAD facility intervenes in order to prevent a conventional hospitalization.

Both the HAD facility and the care center must agree on the decision to intervene. The request for the intervention is made by the primary care physician of the patient or by a care center physician. However, both physicians must give their opinions on the matter since it is a form of medical prescription. The care center physician must also explain why the care center cannot by itself fully cover the needs of the patient.

The HAD FEDOSAD 21 facility has at times intervened in this manner, and the interventions have reinforced inter-facility cooperation and led to better standardization and better sharing of practices between the facilities.

Ⅹ. Partnership with general practitioners

At the beginning of HAD, the lack of knowledge among general practitioners about the HAD system led to some difficulties.

However, through media communication and information sharing, FNEHAD improved this situation. In 2008, two-thirds of general practitioners said they had used HAD services at least once during the year.

This partnership still needs to be reinforced because general practitioners are frequently consulted regarding the patient's situation at home and must consent to the use of HAD services before they can be delivered. Moreover, general practitioners work together with coordinating physicians to consolidate the patient's care plan because they already have valuable information on the patient, the patient's family, and the patient's home.

Ⅺ. The role of HAD in geriatric care

HAD is a strong link in the geriatric care system, but it still needs to be developed and reinforced, especially in the countryside. The delivery of HAD services may prevent disorientation and adaptability issues from arising by

avoiding sudden changes of environment. However, HAD services would not be possible without a reliable and efficient family or social environment. Most of the time, the use of home help services is also necessary. The HAD FEDOSAD 21 facility used to directly employ home-helpers for the delivery of HAD services. However, due to the lack of funding from the national health insurance towards these services, this method of employment is no longer sustainable given the current financial situation.

HAD has now found its place in the healthcare system. The system's economic qualities and the clear improvement in the quality of life it provides to users are now well established. However, HAD facilities require personnel with a high level of medical skills, considering the frequency of palliative care provided and the complexity of the users' health conditions. Thus, HAD facilities can only work if good collaboration is established between the coordinating team, the primary care physician, and the other persons involved.

If this collaboration is achieved, HAD facilities can play a major role in establishing an efficient gerontology network.

XII. Specific payment model

Since 2005, HAD has been entirely funded by the French national health insurance system through a fee-for-services model called T2A. The model is similar to the one used in private and public hospitals. All care delivered through the HAD system is thus covered by the insurance.

The payment for services delivered by HAD facilities is based on a special payment system: fee categories (called GHT [15]) were established for the types of care delivered, and each day HAD facilities receive fees commensurate with the type of care they provide. Each day of care provided to a patient is classified into one fee category through a computer program called "fonction groupage," with the categories based on four RPSS [16] variables. These variables are the main care type, the associated care type (if there is one), the Karnofsky index (which measures the functional impairment of the user), and the length of care delivered overall. These daily fee categories include all costs that the HAD facility may have to cover, such as payment for physicians and non-medical professionals, drugs, use of medical equipment, and transportation for medical reasons [17].

Every HAD facility also uses a computer program for transferring medical information (PMSI) to the Technical Information Agency on Hospitalization (ATIH [18]). Every year, HAD facilities must submit their own statistics (SAE [19]) to the Directorate of Hospitalization and Care Management (DHOS [20]) in order to determine the ICALIN [21] score of the facility.

XIII. Organization of HAD FEDOSAD 21 Facility

The organization of the HAD FEDOSAD 21 facility has closely followed the terms stipulated for the originally authorized project. It involved taking various steps such as recruiting staff members, establishing procedures, finalizing an admission system, and setting up a teleprocessing system for employees to record their entry and exit times from the patient's home.

The coordinating physician quickly became accustomed to this new way of providing care and, from the outset, an important and necessary spirit of cooperation was established between the physician and the coordinating nurses. To ensure medical care could be provided 24 hours a day, 7 days a week, a shift system was designed. Time was also secured for exchanging necessary information regarding the evolution of the patient's situation at home and the patient's needs, as well as for continuously readjusting the care provided.

From the start, the HAD FEDOSAD 21 facility included both facility members and independent professionals on its steering committee to ensure it could immediately meet the medical requirements of its patients. These professionals shared their experiences and worked together to pursue, develop, implement, and improve medical strategies. The FEDOSAD association also created various entities within the HAD FEDOSAD 21 facility such as a Nosocomial Infections Control Department, a Medical Facility Committee, a Committee for Pain Management, a Committee on Hygiene and Work Safety, and a committee in charge of facility-user relationships and care quality.

The FEDOSAD association already included many home care services, which eventually led to better responsiveness and mutual cooperation. For example, a client using FEDOSAD home-help services may have access to various other services such as transportation to medical appointments and, if his or her condition becomes worse, have direct access to in-home nursing care services or even to HAD services. Moreover, as the FEDOSAD association is also managing care centers for dependent elderly persons (EHPAD) and day care centers, it can easily offer respite care services, which are beneficial for both the patients and the various caregivers.

XIV. Experiences with and feedback on HAD FEDOSAD 21 Facility

It did not take long for someone like Jean to decide to use

HAD services. He certainly has a long medical history: ten years ago, he was diagnosed with an extremely rare orphan disease with symptoms similar to those of multiple sclerosis. He was told the only way to stabilize the disease would be for him to receive an intravenous injection of a very expensive drug over a four-day period every two or three months.

In the quietness of his hospital room, he thought about the burden the treatment would impose on him and how expensive would be the hospital and drugs without which his condition could not be stabilized. "I thought about how the money could be better spent on kids. I refused care but the doctors got angry!" In the end, he accepted the treatment, and from this point his tour of hospitals started. At first, he went to a hospital close to his home but then had to change to another one because the treatment was too expensive. He then switched hospitals once more, this time for one in Dijon city. In each case, he was forced to endure a long waiting time because his treatment was of a lower priority than other emergency cases. Even though the injections caused him headaches, most of the time he had to share a room with other patients. Thus, he was often forced to hear the sounds of other patients' TV sets or family visits. He sometimes had to stay in the hallway because of the lack of available rooms and also experienced the lack of sufficient staff members. "At first, I could deal with the situation, but after a year or two, I started getting progressively weaker and getting tired more and more quickly. Finally I decided, 'I'm not coming anymore…'"

But the day he made this decision, he met the department chief in the hallway. The chief, who was at first reluctant to the idea of using HAD services, finally asked him if he would prefer to be treated at home.

When we spoke to Jean about this, he told us, "When I have cards in my hand, I play them." He then added, as if wishing to apologize for the money that his treatment cost, "My treatment still costs less to society. It does not cut jobs, it creates new ones!" Jean also frequently expresses his satisfaction with the time he has spent with the in-home care providers, their warmth, and their availability.

XV. Strengths of HAD FEDOSAD 21 Facility

One goal of the HAD FEDOSAD 21 facility has always been to constantly improve the satisfaction of both patients and employees. This is why the facility chose a mixed organization involving independent nurses and a coordinating kinesitherapist to promote collaboration among employees and more flexible adjustment of professional practices. To ensure safety and optimization of the drug channel, a coordinating pharmacist was recruited to check procedures (creating a chart for the beneficial use of drugs, checking the content of prescriptions). A psychologist and a social worker were employed to support patients and to meet possible needs of other employees. A pediatric nurse was recruited for the future development of pediatric care in collaboration with the teaching hospital.

Since its inception, the facility has had a high occupancy rate. In 2011, it received 228 admission requests. During that year, the facility was taking care of 50 persons a month on average, for a total of 12,585 days of services provided. Of the 59 patients who died in 2011, the end-of-life occurred at home for 47 of them. In 2011, the use of HAD services lasted on average 17.25 days per patient.

XVI. Difficulties encountered by HAD FEDOSAD 21 Facility

Many issues still remain to be addressed before a long-lasting expansion of HAD can be secured. One of these is that the payment model (T2A) has not been adjusted during the last few years. Another is that funding for palliative care has apparently been insufficient.

Moreover, HAD is still not well known by many healthcare professionals regardless of whether they are working in the community, in private or public hospitals, or providing ambulatory care. Many physicians that may prescribe HAD services, especially those working in hospitals, still have some difficulties in understanding how HAD works. Another issue concerns the lack of availability of in-home nursing care services (SSIAD) to take care of patients after their use of HAD services.

The lack of care providers is also a major issue, as many professionals would rather work in an inpatient facility to avoid the discomfort of going from one patient's home to another. This is an issue that in-home care providers will surely have to face. Since going from home to home is energy-sapping and time-consuming, in-home care providers are more likely to get tired than those who work in hospitals. This may eventually lead to a lack of human resources.

XVII. For the future

It is necessary to give physicians a better understanding of the HAD system and the utility of HAD services by improving their knowledge about the admission criteria and about the types of care that can be delivered. Furthermore, HAD should increase their opportunities to work in care centers for dependent elderly persons (EHPAD) and should establish more partnerships with new

services to enable them to specialize in new types of in-home care (pediatrics, chemotherapy). It is vital for a HAD facility to be specialized in certain types of healthcare to avoid being overwhelmed by having to provide too broad a range of care services.

The goal of HAD is to become a sort of in-home hospital facility. This goal can be reached, but it is our responsibility to expand the system and general knowledge of it so that patients will have more choices about the way they receive care. Nevertheless, the HAD system is already providing relief for overcrowded hospitals and clinics, and thus should be supported to help persons secure access to care and to establish a fair care system for everyone.

Reference

[1] "HAD, Hospitalisation A Domicile" (In French)
[2] "FEDOSAD, Fédération Dijonnaise des Oeuvres de Soutien A Domicile" (In French)
[3] "AP-HP, Assistance Publique Hopitaux de Paris" (In French)
[4] "FNEHAD, Fédération Nationale des Etablissements d'Hospitalisation A Domicile" (In French)
[5] "HSPT, Hôpital Santé Patient Territoire" (In French)
[6] "SSIAD, Services de Soins Infirmiers A Domicile" (In French)
[7] "ARH, Agence Régionale d'hospitalisation" (In French)
[8] "ARH, Agence Régionale de Santé" (In French)
[9] "CROSS, Comité Régional d'Organisation Sanitaire et Sociale" (In French)
[10] "COMEX, Commission Executive de l'ARH" (In French)
[11] "CLIC, Centre Local d' Information et de Coordination" (In French)
[12] One characteristic of the French HAD system is to include the position of a coordinating physician. In theory, this physician is in charge of coordinating services and does not provide care directly (except in emergency cases), despite being responsible for medical care provided to the patient and for authorizing the use of HAD services.
[13] "HAS, Haute Autorité de Santé" (In French)
[14] "EHPAD, Etablissements Hospitaliers pour Personnes Agées Dépendantes" (In French)
[15] "GHT, Groupe Homogène de Tarif" (In French)
[16] "RPSS, Résumé Par Sous-Séquences" (In French)
[17] More precisely, remuneration for a HAD facility includes the costs of primary care physicians, HAD staff members, inspection fees, medical imaging, independent professionals (nurses, kinesitherapists, speech therapists), ambulance transportation (only when the ambulance is called by HAD members), medical equipment (transfusion equipment, syringe pumps, ventilators), special medical equipment (care beds, lifting aids, chairs), medical supplies, and disposable equipment (used by HAD only). From the patient's point of view, all HAD services are completely covered by insurance. However, this concerns HAD services only and not other services that may be used at the same time.
[18] "ATIH, Agence Technique de l'Information sur l'Hospitalisation" (In French)
[19] "SAE, Statistiques Annuelles des Etablissements" (In French)
[20] "DHOS, Direction de l'Hospitalisation et de l'Organisation des Soins" (In French)
[21] "ICALIN, Indicateur Composite des Activités de Lutte contre les Infections Nosocomiales" (In French)

抄録

本稿は，これまで，日本で紹介されることがなかった，実際にこのHADを運営してきたディジョンのFEDOSADという組織における地域での取り組みを紹介したものである．

フランスのHAD（l'Hospitalisation A Domicile）と呼ばれる在宅における入院制度は，1970年に法律が制定されてから，これまで何度もの改革を経てきた．

とりわけ患者の視点から見れば，その変化を受けいれることは容易ではない．利用者の健康，或は利用者の健康状態への治療に関わるサービスに対しては，新しい提供体制を導入する度に利用者の理解を得ることが複雑な問題となる．

ここで紹介するDijon市で創設されたFEDOSADは，地域の専門家と国，地方，県レベルの機関からの支援を受け，在宅ケアという，いわばベンチャー産業に挑んだ組織体である．

本稿では，このHAD FEDOSAD 21事業体の創設当時から，これまで直面してきた問題点，幸運な出来事，関係のある様々な専門家，プラクティスを定義する文書や，フランスにおけるこれらの制度の限界を紹介する．

さらに，日本への示唆として，フランスの高齢者医療制度におけるHADの位置づけとHADの開発および老人ホームとの関係について言及した．