

We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

4,800

Open access books available

122,000

International authors and editors

135M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.

For more information visit www.intechopen.com



The PRISMA France study: Is there a way to measure the implementation of integration in different countries?

Trouvé Hélène¹, Veil Anne², Hébert Réjean³ and Somme Dominique⁴

¹*National Foundation of Gerontology, University of Paris Pantheon Sorbonne
France*

²*Research Centre on Aging, Health and Social Services Centre - Sherbrooke Geriatric
University Institute
Canada*

³*School of Medicine, University of Sherbrooke; Research Centre on Aging, Sherbrooke
Geriatric University Institute
Canada*

⁴*Assistance Publique Hôpitaux de Paris, University of Paris Descartes
France*

1. Introduction

In France, as in many Western countries (Vaarama & Pieper, 2006), home care services for frail older adults are fragmented and compartmentalized with services organized sectorally and vertically under different jurisdictions. In the French system, some services are associated exclusively with the social work sector and are the responsibility of the Ministry of Labour, Social Relations, the Family, Solidarity and Municipalities, Others are affiliated with the public health sector and come under the Ministry of Health and Sports. This sectoral and non-population approach, perpetuates the compartmentalization of services, which can be seen at four levels: between the health, social and welfare sectors, between municipal and hospital workers, between the public, private-for-profit and private-non-profit sectors, and between home and institutional environments (Somme & Trouvé, 2009; Couturier et al., 2009). This makes it difficult to coordinate home care services for frail older adults, especially when home care clients receive care or services from three workers on average, and 25% of the most frail receive help from six or more (Bressé, 2004).

Various attempts have been made to improve coordination in the past twenty years. The introduction of structures such as Local Information and Coordination Centers and gerontology care networks has resulted in significant advances in the coordination of services for frail older adults (Colvez et al., 2002). However, their areas of intervention are still compartmentalized, i.e. primarily social in the first case, mainly health in the second, and both operate independently of the welfare sector, which is responsible for the Personalized Autonomy Benefit (Ennuyer, 2006).

Building on international pilot projects (Hébert 2008b; Hofmarcher et al., 2007; Johri et al., 2003; Leutz, 1999; Varrama & Pieper, 2006), the French authorities decided to test the implementation of an integrated service delivery system for older adults in so-called 'complex' situations: PRISMA-France, the French version of PRISMA (Program of Research on Integration of Services for Maintenance of Autonomy). Integrated care is defined as "a discrete set of techniques and organizational models designed to create connectivity, alignment and collaboration within and between the cure and care sectors at the funding, administrative and/or provider level" (Kodner & Kyriacou, 2000: 3). Thus integration is conceptualized as the result of a series of modelable, flexible mechanisms designed to improve continuity in managing the evolving and complex needs of frail populations (Pieper, 2006). At its core is the case manager, who is responsible for intensive management. The WHO (2000) and OECD (2007) have both made this a quality of care goal.

Today integration programs around the world vary widely. What are their objectives? What mechanisms do they employ? Who are the case managers and what do they do? For which population? How big is their caseload? How often do they intervene? With whom? With what needs assessment and service planning tools? What successes have they had? How have they failed? And why? By developing a project methodology backed by an research-action framework, the PRISMA-France pilot project provides precise answers to these different questions. A particular feature of this research-action framework is continuous feedback from a synthetic tool that defines the action plans and provides progress reports. This tool is a grid for evaluating the implementation of the components of the PRISMA integration model. It was constructed during pilot projects in Quebec, Canada, and adapted for the French pilot project. We believe that this tool, and this type of method in general, could meet a need identified in the literature, namely the need for valid tools to evaluate service integration that are transferable to different national contexts (Strandberg-Larsen & Krasnik, 2009).

This article describes the implementation and evaluation of the PRISMA integration model in France. First we describe the model as it was conceptualized, piloted and evaluated in Quebec. Second we describe the French implementation study, with a particular focus on the evaluation tool. Third we discuss the use of this methodology within an action-research framework designed to support decision-making and the move towards service integration. Finally we discuss the difficulty of deploying this action-research framework.

2. PRISMA: a model conceptualized and evaluated in Quebec, Canada

2.1 Conceptual framework: six tools and mechanisms for the integration of services for older people

According to the PRISMA model piloted in Quebec, Canada, integration is achieved when six mechanisms and tools are all brought into play (Hébert et al., 2003):

- 1) Coordination is the core function in constructing an integrated network for frail older adults. Because of the large number of players involved and their different professional and institutional affiliations, this coordination between partners at all levels (national, regional/departmental, local and practitioners) is a precondition of integration. The model calls for the use of regular coordination meetings in which all players involved are continuously represented depending on their level of strategic responsibilities (governance), tactical responsibilities (management) and clinical responsibilities. These meetings result in decisions leading to changes in the institutional and professional practices of the players in the network.

- 2) Case management here is a generic 'intensive home care' function. With local support, the case managers work with a limited number of older adults (40 cases per full-time case manager). This intensive case-management is supported by the use of specific intervention tools (assessment, planning and coordination) chosen based on the objectives for living at home, as defined by the older person and his/her family with the help of professionals; Case management is a new role performed by professionals (nurses, social workers, occupational therapists, even psychologists) who are trained to be complementary, are employed by local players in the existing network, and are assigned to this function in accordance with local needs and the human and financial resources that can be brought to bear.
- 3) The aim of the single entry point is to improve equity and access to services. To achieve these goals, liaison and interaction between the professionals must be facilitated. Increasing the centralization of information for older people, their families and the health, social and welfare workers also improves access to services. The use of dedicated tools makes it easier to identify the population at risk of functional decline and to implement a preventive policy to monitor and manage this population.
- 4) Using the standardized needs assessment reduces redundant assessments and interventions and thus intrusions in clients' lives. However, getting a wide variety of professionals to use the same tool requires changes in professional practices. Application of the same tools by all partners to the entire population in case management is an important integration element because these tools share clinical information and use a common language, which is necessary to guide the professionals in their work and foster mutual recognition.
- 5) The individualized service plan is developed after functional decline is assessed and the situation is summarized by the case manager. The case manager develops the plan with the individual concerned and in partnership with the other workers and the attending physician. The aim of this plan is to create a cross-structure coordination mechanism to organize the different client-centered interventions. Every person with a case manager must have an individualized service plan listing that person's needs and the services delivered, as well as the services required to meet unmet needs. To be a coordinated intervention planning tool, the plan must be shared with all the partners and communications between professionals must refer to this plan.
- 6) The primary function of the information sharing system is to provide the professionals with standardized procedures for sharing information about older people in case management, if the clients consent to the sharing of this information with the professionals working with them. The workers must define the type of information that can be shared and the sharing procedures for everyone involved. This information sharing system must be accessible to and used by all. All the players involved must have agreed on a common definition of the specifications for such a system and its implementation.

How the functions of these six integration components are operationalized is determined by a development process that is both horizontal (co-construction at national, regional and local committee levels) and vertical (two-way channel between the committees to ensure the tools and procedures are relevant and legal). In principle, with this approach it should be possible

to implement an integrated network in different service contexts, as we will now see (Somme et al., 2008b).

2.2 Results of the Quebec pilot projects

This approach was tested over nine years in Quebec in two phases, first in the Bois-Francs region, then modeled and evaluated using a quasi-experimental design combining an implementation study and a population impact study.

In the first pilot project, two cohorts of subjects in the study and comparison areas were followed for three years. The results showed a reduction in institutionalization, caregiver burden and caregivers' desire to have the care recipient institutionalized (Tourigny et al., 2004). The evaluation found small changes in how services were used: fewer trips to emergency, increased use of social services and greater use of GPs, but no significant impact on the use of hospital services or readmissions.

Based on this pilot project and after modeling the components tested, the Quebec PRISMA group organized a replication and impact study in three regions of the Eastern Townships. To measure the implementation, qualitative methods with data triangulation were used. These data were summarized and operationalized in the form of a score with a pre-determined number of points assigned to each of the six components (Hébert & Veil, 2004). Since the total was out of 100, the score represented the model's implementation rate. It was shown that the model is reproducible when the implementation rate reaches over 70% (Hébert et al., 2008a). The impact was measured by a controlled cohort study (Hébert et al., 2008b; Hébert et al., 2010). The primary end point was a combination of functional decline, death or institutionalization (Hébert et al., 2008b). The analyses showed a 7% reduction in functional decline in the experimental group with a threshold effect of about 70% of model implementation (Hébert et al., 2010). Other results did not have a threshold effect: individual autonomy increased in the experimental areas; use of emergency services and hospitalizations remained stable in the experimental areas while increasing significantly over time in the control areas; individuals in the experimental areas reported a significant increase in their satisfaction with services (Hébert et al., 2010). This integration system, which received a positive evaluation in terms of public health, was adopted across Quebec in a modified form.

3. The French experiment: implementation study and evaluation tool

Based on the evidence from the PRISMA model in Quebec, French authorities with national gerontology responsibilities decided to initiate a pilot project in France (Somme et al., 2008a; Somme et al., 2008c). This project was directed by an independent multidisciplinary team of professionals (organizational engineers, geriatrists and consultants) supported by a multidisciplinary team of researchers (physicians, sociologists and economists). The researchers continuously monitored the project in an implementation study whose results were given to all the stakeholders, regardless of their level of involvement. The strategy used in this pilot project was based on a 'Help it happen' change management approach (Greenalgh et al., 2004). We describe this French pilot project with a particular focus on the methodology used.

3.1 Implementation study methodology

The pilot project was conducted at three sites, corresponding to the main French sociodemographic territorial configurations. They were a rural area (South of Etampes), an urban area (Mulhouse and its Nord-Est periphery) and a metropolitan area (20th district of Paris). The specific demarcation of the experimental areas corresponded to a zone covered by an existing coordination structure on which the project was based (Somme et al., 2008b). Thus the implementation study methodology was a multiple case study, which allowed for both a comparative (by site) and overall (in relation to the French system) analysis. The aim was to be able to identify and analyze the institutional, organizational and contextual factors affecting the implementation. Each case study involved the collection and processing of so-called 'multimodal' data:

- Political/institutional watch (legislation and regulations, territorial planning and programming);
- Direct observations of coordination meetings at the national, regional/departmental and local levels;
- Semi-directed interviews with participants at the national, regional/departmental and local levels;
- Interviews with case managers and with medical, welfare and social workers working with the case managers;
- Direct observations of the single entry point and case management mechanisms;
- Analysis of de-identified case management files.

3.2 A dedicated tool: implementation evaluation grid

Based on the data collected, the implementation study monitored the implementation of the tools and mechanisms using a process evaluation method (Somme & Trouvé, 2009). This evaluation was based primarily on a synthetic indicator, namely the implementation rate of the integrated system in the territory.

This synthetic indicator is the total number from an evaluation grid that measures the density and quality of the implementation. This grid was constructed from the grid developed in the PRISMA implementation study (Hébert et al., 2008a), whose relevance had been validated by a Quebec impact study (Hébert et al., 2008b; Hébert et al., 2010). Based on a context analysis, the French configuration was modified by the multidisciplinary team in collaboration with the PRISMA team in Quebec.

The 'density' and 'quality' end points cover both the actual implementation of the six tools and mechanisms as outlined below, and also their horizontal and vertical co-construction processes in the coordination committees, taking into account the legal and administrative timeframes and thresholds attained.

More specifically, the methodological assumption was functional, i.e., the evaluation was based on the function of each component (called 'strategic variable'). These variables were then broken down into 'functional criteria', which refer to an observable and measurable purpose, behaviour or event with an attainment timeframe. Each of these phenomena is evaluated by 'indicators' measuring the presence, partial presence or absence of the function. Points are assigned to each component, variable, criterion and indicator out of a total of 100, which gives the implementation rate.

The following table shows the grid used to evaluate the implementation of the PRISMA integration model.

1. Component coordination			
Strategic variables	Functional criteria	Unit basis	Indicators
1.1 Presence of a coordination structure	Is there a coordination mechanism?	3 points	Unit basis breakdown: <ul style="list-style-type: none"> - 1 point for existence (Binary scoring system: Yes = 1 / No = 0) - 1 point for frequency (Relative scoring system: 0.25 - 0.5 - 0.75 - 1) - 1 point for organizational independence (Binary scoring system: Yes = 1 / No = 0)
1.2 Representation of the players concerned	Do the members represent all the groups of players involved in integrated service networks?	3 points	Number of groups of players represented versus the total number of groups of players concerned (Percentage scoring system)
1.3 Continuity of representation	Do the players concerned all have stable representatives?	3 points	Number of designated representatives of a group of players versus the total number of groups of players (Percentage scoring system)
1.4 Regular participation	Do the representatives participate in meetings regularly?	3 points	Stability of the representation of each group of players versus the total number of groups of players (Percentage scoring system)
1.5 Players informed of changes in services	Do the players in the strategic partnership committees and tactical partnership committees share information on the changes in services for the target groups?	4 points	Unit basis breakdown: <ul style="list-style-type: none"> - 2 points for respect for the agenda: acceptance versus rejection (Relative scoring system: 0.5 - 1 - 1.5 - 2) - 2 points based on judgement concerning the content of the discussion: model implementation phases and tools versus related general problems (Relative scoring system: 0.5 - 1 - 1.5 - 2)
1.6 Players involved in the shared regulation of the service continuum	Do the players play a role in regulating the service continuum?	4 points	The shared regulation correspond to the levels of commitment, illustrated by the types of decisions (Scoring system: items are mutually exclusive) <ul style="list-style-type: none"> - 1 point for collaborative model (players involved in supply activities meeting the needs of the target populations) - 2 points for mobilization model (players involved in a 'common cause' with partners' accountability) - 4 points for social development model (players involved in the change process concerning structure and/or functioning, with commitment of the partners in action)
		20 points	

2. Component case management			
Strategic variables	Functional criteria	Unit basis	Indicators
2.1 Profession of case management	2.1.1 What is the gap between the number of case managers (FTE) in place compared to the objective set by the players?	4 points	Unit basis breakdown: - 2 points for commitment of organizations during implementation (Relative scoring system: 0.5 - 1 - 1.5 - 2) - 2 points for the process of matching the number of case managers / case management needs (analysis of active list/waiting list) (Relative scoring system: 0.5 - 1 - 1.5 - 2 - 2.5 - 3)
	2.1.2 Are case managers able to get quality training?	4 points	Unit basis breakdown: - 2 points for the presence of all case managers in all the training sessions (Percentage scoring system) - 2 points for the perceived quality of the training taken, evaluated by a satisfaction questionnaire (Relative scoring system: 0.5 - 1 - 1.5 - 2)
	2.1.3 Is the number of case managers (FTE) in place consistent with the steering committee's estimate?	2 points	(Relative scoring system: 0.5 - 1 - 1.5 - 2)
2.2 Functions of the case manager	2.2.1 What is the gap between the average and recommended case managers' caseload (40 cases per FTE case manager)?	5 points	(Relative scoring system with threshold: 0%: 0 points 20%: 1 point 40%: 2 points 60%: 3 points 80%: 4 points 100%: 5 points 120%: 4 points 160%: 2 points 180%: 1 point 200%: 0 points)
	2.2.2 In the case management files, are there traces of shared information and information sharing systems?	5 points	Survey of the type and frequency of shared information (Scoring system: unit basis breakdown: - 1 point for contacts with attending physician (Percentage scoring system per file) - 2 points for traceability of coordination between the practitioners (Per file and relevant workers: 0.5 - 1 - 1.5 - 2) - 2 points for all of the case management tools (Standardized Assessment Instrument, Individualized Service Plan, Shared Information System) (Percentage scoring system per file)
		20 points	

3. Component single entry point			
Strategic variables	Functional criteria	Unit basis	Indicators
3.1 Existence of a single entry point to case management	3.1.1 Is the single entry point the only way to access case management?	2 points	Unit basis breakdown: - 1 point for dedicated location and phone number (Binary scoring system: Yes = 1 / No = 0) - 1 point for including development of a method for disseminating conditions for access to case management (Relative scoring system: 0.25 - 0.5 - 0.75 - 1)
	3.1.2 Is the single entry point perceived as a locus of interaction and liaison between the health and social sectors?	2 points	(Relative scoring system: 0.5 - 1 - 1.5 - 2)
3.2 Single entry point as a centralizer of information about the care and services network	3.2.1 Is the single entry point a structure for access to information about the network?	3 points	Unit basis breakdown: - 2 points for information being accessible: o 1 point: to older individuals and their families (Binary scoring system: Yes = 1 / No = 0) o 1 point: to professionals (Binary scoring system: Yes = 1 / No = 0) - 1 point for method of access to information: o 0.5 point: by phone (Binary scoring system: Yes = 0.5 / No = 0) o 0.5 point: on site (Binary scoring system: Yes = 0.5 / No = 0)
	3.2.2 Is the single entry point a structure of credible information about the network?	2 points	Unit basis breakdown: a professional is responsible for defining: - 1 point: an information collection method (Binary scoring system: Yes = 1 / No = 0) - 1 point: an information updating method (Binary scoring system: Yes = 1 / No = 0)
3.3 Identification	Does the single entry point function with a dedicated, common tool to identify individuals at risk of functional decline?	6 points	Unit basis breakdown: - 2 points: defined identification procedure (Binary scoring system: Yes = 2 / No = 0) - 2 points: compliance with identification procedure for access to case management (Percentage scoring system) - 2 points: systematized procedure, including identification tool, applied to the entire older population (Relative scoring system: 0.5 - 1 - 1.5 - 2)
3.4 Triage/Referral function	Does the single entry point make it possible to coordinate access to care and services?	2 points	The professional responsible for referring requests can mobilize sufficient resources (data collection, pre-assessment, etc.). Unit basis breakdown: - 1 point: performance of the function (Relative scoring system: 0 - 0.25 - 0.5 - 0.75 - 1) - 1 point: efficacy of the referral (Relative scoring system: 0 - 0.25 - 0.5 - 0.75 - 1)

3.5 Proactive strategy	Do the entry point professionals use follow-up for prevention of functional decline?	3 points	Unit basis breakdown: <ul style="list-style-type: none"> - 1 point for acceptance by staff of the usefulness of this function (Binary scoring system: Yes = 1 / No = 0) - 1 point for ability to perform this function (human resources in particular available) (Binary scoring system: Yes = 1 / No = 0) - 1 point for effective follow-up preventive practices (Relative scoring system: 0.25 - 0.5 - 0.75 - 1)
		20 points	
4. Component standardized needs assessment			
Strategic variables	Functional criteria	Unit basis	Indicators
4.1 Common, shared assessment tool	4.1.1 Has a common tool been defined and validated by the players?	2 points	(Relative scoring system: 0.25 - 0.5 - 0.75 - 1 for definition 1.25 - 1.5 - 1.75 - 2 for definition and validation)
	4.1.2 Is there a collaborative, multidisciplinary assessment process?	3 points	(Relative scoring system: 0 - 0.5 - 1 - 1.5 - 2 - 2.5 - 3)
4.2 Recognized assessment tool	4.2.1 Is the entire population targeted by case management assessed with this tool?	2 points	(Percentage scoring system)
	4.2.2 Is the assessment done by case managers recognized for access to benefits (acceptance of the RUG)?	4 points	Unit basis breakdown: <ul style="list-style-type: none"> - 2 points for formal recognition by the Personalized Autonomy Benefit Team (Binary scoring system: No = 0 / Yes = 1) - 2 points for form recognition by the National Retirement Fund Team (Binary scoring system: No = 0 / Yes = 1)
	4.2.3 Is the multi-dimensional assessment done by case managers recognized by all the partners?	2 points	(Relative scoring system: 0.5 - 1 - 1.5 - 2)
4.3 Older adult profile classification tool	4.3 Are the individual profiles systematically classified after the evaluation?	2 points	(Percentage scoring system)
		15 points	

5. Component individualized service plan			
Strategic variables	Functional criteria	Unit basis	Indicators
5.1 Individualized service plan (ISP)	Is there an ISP in the case managers' files?	3 points	Number of ISPs versus the number of case management' files (Percentage scoring system)
5.2 Explicit consent	Do the files contain a procedure for the clients' consent to the ISP objectives?	2 points	Number of clients' consents versus the number of case management files (Relative scoring system: 0.5 - 1 - 1.5 - 2)
5.3 Standardization of ISP content and updating procedures	5.3.1 Do the ISPs list the services delivered and the services needed?	3 points	Unit basis breakdown: <ul style="list-style-type: none"> - 1 point for the number of ISPs containing a list of services delivered (Percentage scoring system) - 1 point for the number of ISPs containing a list of needs not met by the services delivered (Percentage scoring system) - 1 point for the number of ISPs containing a summary (comparative analysis delivered/needed) (Relative scoring system: 0.25 - 0.5 - 0.75 - 1)
	5.3.2 Are there mechanisms to follow up and update the ISPs?	2 points	Unit basis breakdown: <ul style="list-style-type: none"> - 1 point for the definition of an ISP updating procedure (Binary scoring system: No = 0 / Yes = 1) - 1 point for the application of an ISP updating procedure (Percentage scoring system)
5.4 Formalization and effectiveness of procedures for sharing ISPs	Are the ISPs shared by all the partners?	3 points	Unit basis breakdown: <ul style="list-style-type: none"> - 1 point for the formalization of a procedure for case managers to share their ISPs with other practitioners (Binary scoring system: No = 0 / Yes = 1) - 1 point for the formalization of a procedure for other practitioners to access case managers' ISPs (Binary scoring system: No = 0 / Yes = 1) - 1 point for the effectiveness of the sharing and access procedures (Percentage scoring system)
5.5 Communication of the workers re: the ISP	Do case managers communicate with the other workers re: the ISP?	2 points	Unit basis breakdown: <ul style="list-style-type: none"> - 1 point for case managers communicating with the other practitioners based on the information and objectives in the ISP (Relative scoring system: 0.25 - 0.5 - 0.75 - 1) - 1 point for other workers asking the case managers for information and objectives in the ISP (Relative scoring system: 0.25 - 0.5 - 0.75 - 1)
		15 points	

6. Component information sharing system			
Strategic variables	Functional criteria	Unit basis	Indicators
6.1 Definition of standardized information sharing procedures	6.1.1 Have the players defined the type of information that can be shared with practitioners?	3 points	Definition of the information that can be shared with all those working with the individual (Relative scoring system: 0.5 - 1 - 1.5 - 2 - 2.5 - 3)
	6.1.2 Have the players defined case management professional ethics procedures for the sharing of clinical informations?	3 points	Unit basis breakdown: - 1 point for the definition of a method for the individual's consent to the sharing of information about him/her (Binary scoring system: Yes = 1 / No = 0) - 1 point for the definition of measures to protect the security and confidentiality of personal information (Relative scoring system: 0.25 - 0.5 - 0.75 - 1) - 1 point for a single common procedure (Relative scoring system: 0.25 - 0.5 - 0.75 - 1)
6.2 Deployment of the tool	6.2.1 Have the players been informed of the procedures for the sharing of common information with all the practitioners?	2 points	Unit basis breakdown: - 1 point for the method of informing workers of the existence of these procedures (Relative scoring system: 0.25 - 0.5 - 0.75 - 1) - 1 point for the practitioners knowing about the existence of these procedures (Relative scoring system: 0.25 - 0.5 - 0.75 - 1)
	6.2.2 Is the information sharing system accessible to and used by all?	2 points	Unit basis breakdown: - 1 point for access to the information sharing system (Relative scoring system with threshold: ≤ 60%: 0.25 points ≤ 80%: 0.5 points ≥ 80%: 0.75 points 100%: 1 point) - 1 point for use of the information sharing system (Relative scoring system with threshold: ≤ 60%: 0.25 points ≤ 80%: 0.5 points ≥ 80%: 0.75 points 100%: 1 point)
		10 points	

Table 1. Grid for evaluating the implementation of the PRISMA-France organizational model

This evaluation using a 'quantified measure' is validated internally. First the data are triangulated and then scored by the research team. A first rater scores the implementation rate. A second rater scores from the source documents, blinded to the first rater's results. If there is a significant difference in the score (more than 1 point for each functional criterion), a third rater is consulted to decide in favor of one or other of the scores.

3.3 Application and results of the implementation evaluation tool

In each experimental site, the process evaluation measures the reliability, pace and stability of implementation of the integration system. To compare the processes, they are monitored over an equivalent period at each experimental site;

- T0: Pre-implementation phase from start-up (initial situation) to the training of the case managers (1 measure every 6 months);
- T1: Implementation process over 18 months including setting up the case management caseload (5 new cases/month) and testing the tools and processes (3 measures: 1 every 6 months);
- T2: Case management process functioning (2 measures 6 months apart).

In the first 18 months of the implementation study, the evaluation showed similar progress at all three sites. According to the grid, the implementation rate was between 5% and 20%. After this pre-implementation phase, the start of the case management process accelerated the implementation of the tools and mechanisms. At 36 months, the implementation rates were between 50% and 55%. This result can be viewed as the 'glass half empty' or the 'glass half full'. The perception of the level achieved depends mainly on the adoption of and familiarity with the evaluation and change support methods.

From a research perspective, to our knowledge this is the only experiment involving the transfer from one national context to another of the three components of a pilot project for integrating gerontology services: the content of the organizational system targeted by the implementation, the method of supporting the implementation, and the tool used to measure the implementation. Although it required some adaptations for use in France, it is based on the same integration conceptual framework and same components and many of the items are identical (Hébert et al., 2008a). Using a similar adaptation process, its adaptation to other contexts seems feasible and could be the basis for one of the first international methods for measuring the implementation of integration (Strandberg-Larsen & Krasnik, 2009).

4. Action-research framework with an evaluation tool to support decision-making

Developed by the research team, this grid and the rate it indicates are designed to help with action on the ground. This is why the implementation levels are included and discussed in the PRISMA-France methodology.

The integration implementation evaluation grid can be used in the territories to estimate the gap between planned and actual implementation and to identify and analyze the factors that explain local adaptations, successes and failures, which in turn can be used to modify the action plans and help in decision-making.

Because of the intrinsic characteristics of the organizational system involved, the functional evaluation grid can be useful from two perspectives. First, from the perspective of leading to

change, the aim of discussing this grid is to support and provide benchmarks for cross-sectoral and interorganizational co-construction efforts. It is a matter of creating a preparatory and proactive, i.e. participatory dynamic. Given the diversity of the socioprofessional cultures, this grid can be used to point up the negotiated compromises (Somme et al., 2008b). Also, the specific attributes of the organizational system add to the complexity because the integration calls for sharing competencies and jurisdictions. Presenting and discussing the grid helps to point up contradictions, inconsistencies or simply practical problems, even indications that certain actions are not possible.

From a public policy management perspective, in the development phase the national authorities adopted a 'Help it happen' approach, which lies between the 'Let it happen' and 'Make it happen' strategies (Greenhalgh et al., 2004). They wanted to implement an integrated system based on case management. They chose an organizational system that defines functions to be achieved and not tools and practical methods to apply. In each territory, it is the players involved in the strategic and operational coordination who define the integration tools and mechanisms with the aim of achieving the desired functions. Knowing exactly what is implemented in the territories and the factors that explain the adjustments made is thus a task they entrusted to experts outside their departments and territorial networks. The project team provides information about the modifications required to adapt the six integration components to the environment in which they are introduced, without distorting the structural principles of the integration. From the analysis of these data, the research team provides continuous, aggregate and comprehensive information regarding the quality and density of the territorial integration (Somme et al., 2008c).

The implementation evaluation grid is a tool designed to support decision-making at different organizational and institutional levels.

5. Difficulty of deploying the action-research framework

We observed that there was only partial adoption of the research-action framework in which the evaluation grid and implementation rate are tools for defining the action plans and benchmarks to support decision-making. Two main types of factors contributed to the partial adoption of this approach (Etheridge et al., 2009).

First were factors related to the organizational contexts. The overall idea of the integration model was not completely accepted. The players saw the value of taking advantage of their participation in the trial to learn from each other and develop interorganizational relationships. Two dimensions influenced their ability to consider the change process in its entirety: 1) differences in the degree of commitment to the project insofar as their own interests were represented, and 2) previous experiences with partnerships in the gerontology field. Therefore, the players had very different reasons for participating, which translated into differences in emphasis on one or more of the project components and not on the pilot project as a whole.

Second were factors related to differences in the change management approach used in the PRISMA pilot project. The 'Help it happen' approach seems to have generated two different dynamics, partly contradictory. The use of a personalized management approach tailored to the capacities of the organizational participants, designed to encourage organizations to get involved, may have fostered the adaptation of the PRISMA model to the territorial contexts

and the continuation of the project. At the same time, it may also have given the organizational participants an excuse to adopt a 'wait-and-see' posture for explicit instructions regarding the tools and mechanisms to develop. Adapting a pilot project to the particular context is crucial for the success of a change process (Greenhalgh et al., 2004), but a management approach that was too 'hands off' may have encouraged inertia and a lack of interest.

These two factors seem to explain the development of a 'strategic' attitude taken by both the organizational and institutional players towards the research-action team, who they viewed in part as directly responsible for the implementation results. This is evidenced by incomplete acceptance of the research-action framework developed in the pilot project. The detailed and comprehensive nature of the implementation evaluation method used in this pilot project may be a factor that inhibited the adoption of the overall method in which the evaluation tool was designed to be an action planning tool for the stakeholders.

These results indicate the need for and will help to define more user-friendly tools to evaluate and support the process of integrating gerontology care and services in France.

For example, in a larger pilot project launched in 2008 as part of the National Plan for Alzheimer and Associated Diseases" (2008-2012)¹ called the Homes for Autonomy and Integration of Alzheimer Patients, a more concise tool was designed to monitor the integration construction projects conducted in 17 French territories. This tool is presented below:

COORDINATION			Yes =
A strategic coordination committee meets	Yes	No	1
IF YES			
Meeting frequency is identified	Yes	No	1
IF YES			
Decisions are made at the meetings	Yes	No	1
SINGLE ENTRY POINT			
No new entry point is created during the period	Yes	No	1
An organizational analysis is done so that the local resource locations can be listed	Yes	No	1
IF YES			
A common channel for requests has been defined between the local resource locations	Yes	No	1
AND			
A standardized request processing tool has been defined	Yes	No	1
IF AT LEAST ONE YES			
A reduction in the number of entry points has been documented	Yes	No	1
AND			
The single entry point has a function for observing the population's needs	Yes	No	1
AND			
The hospital is included in the channels	Yes	No	1

¹ Downloadable at <http://www.plan-alzheimer.gouv.fr/medias/m/cms/article/alzheimer/0/9/9/9/90/plan-alzheimer-2008-2012.pdf>

CASE MANAGEMENT			
An organizational analysis has been done mentioning potential existing case managers	Yes	No	1
A target population for case management has been defined	Yes	No	1
IF YES to BOTH			
If there are case managers, they are supported by a strategic coordination committee already in place (question 1)*	Yes	No	1
If there are no case managers, the number of case managers needed can be estimated (needs analysis)*	Yes	No	1
IF YES			
Anticipated caseload for case managers <60	Yes	No	1
IF YES			
Physicians in private practice are involved in the process to allow for collaboration between case manager and physician	Yes	No	1
Hospital physicians are involved in the process to ensure the hospital admission/discharge interfaces	Yes	No	1
STANDARDIZED MULTIDIMENSIONAL ASSESSMENT TOOL			
An assessment tool has been defined and validated by the strategic coordination committee	Yes	No	1
IF YES			
None of the following dimensions are missing from the tool: care, functional autonomy, social environment, living conditions, mental/cognitive dimension, financial situation	Yes	No	1
IF YES			
Specific training on use of the tool has been given	Yes	No	1
INDIVIDUALIZED SERVICE PLAN			
The service plan can only exist as a function of the validation of the assessment tool	Yes	No	1
IF YES			
None of the following dimensions are missing from the tool: care, functional autonomy, social environment, living conditions, mental/cognitive dimension, financial situation	Yes	No	1
IF YES			
Unmet needs can be mentioned in the plan	Yes	No	1
INFORMATION SYSTEM			
No dedicated computerized tool has been developed without the advice of the national team	Yes	No	1
Specifications indicating the shareable information and access and network authorization have been defined	Yes	No	1
TOTAL			24

Table 2. Synthetic tool supporting change management

* These items are mutually exclusive (which explains why the maximum score is 24 and not 25).

The complex governance of gerontology policies in France means that appropriate tools are needed to measure the change towards system integration. The detailed and comprehensive

methodology employed in the PRISMA-France pilot project may be used as a paradigm for developing simpler tools, which appear to be needed for more general adoption of the structure and objectives of the integration of gerontology services.

In addition, according to some of the decision-makers involved in developing and piloting public gerontology policies, there is a “virtuous spiral” which builds on the pilot projects conducted and the knowledge generated. The PRISMA integration implementation evaluation grid was validated by an impact study in Quebec (public health outcomes included greater autonomy and satisfaction with neutral costs). The adaptation of this evaluation grid to France showed the need to construct more synthetic tools to measure the integration of gerontology services. These implementation evaluation tools may in turn undergo an impact study of the objectives and quality of care for frail older adults.

6. Conclusion

At a time when many countries are working on programs to integrate services for frail older adults, methods need to be developed to determine the exact content of these programs. Our work proposes an approach to measuring integration that can help public authorities develop, implement and evaluate a public policy for service integration.

In addition, the possibility of transferring this approach to other countries and other target populations (disabled persons, troubled adolescents, for example) could provide opportunities for comparative analyses.

7. Acknowledgments

The authors are members of an interdisciplinary international research team with Y Couturier, PhD (Canada), D Gagnon PhD(c) (Canada), F Etheridge PhD(c) (Canada), F Balard, PhD (France), S Carrier PhD(c) (Canada), O Saint-Jean PhD(c) (France). All authors would like to thank Catherine Perisset, Laurence Leneveut, Sylvie Lemonnier and Virginie Taprest-Raes and the clinical research unit of the Hôpital Européen Georges Pompidou for their work, collaboration and support. The study was funded by French Ministry of Health, the National Solidarity Fund for Autonomy, and the Independent Workers Social Protection Organization.

8. References

- Bressé, S. (2004). Les bénéficiaires des services d'aide aux personnes à domicile en 2000. *D.R.E.E.S., Études et Résultats*, N°297 (March 2004) 1-7, ISSN 1146-9129
- Colvez, A.; Gay, M.; Blanchard, N. & Fages, D. (2002). Coordination Gériatrique. Pour qui, pourquoi, comment? *Gérontologie et Société*, No. 100 (March 2002) 25-33 ISSN 0151-0193
- Couturier, Y.; Trouvé, H.; Gagnon, D.; Etheridge, F.; Carrier, S. & Somme, D. (2009). Réceptivité d'un modèle québécois d'intégration des services aux personnes âgées en perte d'autonomie en France. *Revue Lien social et Politique*, No. 62 (Fall 2009) 163-174, ISBN 978-2-89035-457-9
- Ennuyer, B. (2006). *Repenser le maintien à domicile; enjeux, acteurs, organisations*. Dunod, ISBN 2 10 050094 5, Paris

- Etheridge, F.; Couturier, Y.; Trouvé, H.; Saint-Jean, O. & Somme, D. (2009). Is the PRISMA-France glass half-full or half-empty? The emergence and management of polarized views regarding an integrative change process. *International Journal of Integrated Care*, Vol. 9 (December 2009) e01-e011, ISSN 1568-4156
- Greenhalgh, T.; Robert, G.; Macfarlane, F.; Bate, P. & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quarterly*, Vol. 82, No. 2 (December 2004) 581-629, ISSN 0887-378X
- Hébert, R.; Raiche, M.; Dubois, M.F.; Gueye, N.R.; Dubuc, N. & Tousignant, M. (2010). Impact of PRISMA, a coordination-type integrated service delivery system for frail older people in Quebec (Canada): A quasi-experimental study. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, Vol. 65B, No. 1 (January 2010) 107-118, Print ISSN 1079-5014
- Hébert, R.; Veil, A.; Raiche, M.; Dubois, M.F.; Dubuc, N. & Tousignant, M. (2008a). Evaluation of the implementation of PRISMA, a coordination-type integrated service delivery system for frail older people in Quebec. *Journal of Integrated Care*; Vol. 16, No. 6 (December 2008) 4-14. ISSN: 1476-9018
- Hébert, R.; Dubois, M.F.; Raiche, M. & Dubuc, N. (2008b). The effectiveness of the PRISMA integrated service delivery network: preliminary report on methods and baseline data. *International Journal of Integrated Care*, Vol. 8 (February 2008) e01-e015, ISSN 568-4156
- Hébert, R. & Veil, A. (2004). Monitoring the degree of implementation of an integrated delivery system. *International Journal of Integrated Care*, Vol. 4 (September 2004) e01-e07, ISSN 568-4156
- Hébert, R.; Durand, P.J.; Dubuc, N. & Tourigny, A. (2003). PRISMA: a new model of integrated service delivery for the frail older people in Canada. *International Journal of Integrated Care*, Vol. 3 (March 2003) e01-e08, ISSN 568-4156
- Johri, M.; Beland, F. & Bergman, H (2003). International experiments in integrated care for the elderly: a synthesis of the evidence. *International Journal of Geriatric Psychiatry* Vol. 18, No. 3 (March 2003) 222-235, ISSN 0885-6230
- Kodner, D-L. & Kyriacou, C.K. (2000). Fully integrated care for frail elderly: Two American models. *International Journal of Integrated Care*, Vol. 1 (November 2000) e01-e019, ISSN 568-4156
- Leutz WN (1999). Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. *Milbank Quarterly* , Vol. 7, No. 1 (March 1999) 77-110, ISSN 0887-378X
- OECD Hofmarcher M, Oxley H & Rusticelli E. Improved health system performance through better care coordination. Paris: OECD; 2007 [online]: <http://www.oecd.org/dataoecd/22/9/39791610.pdf>
- Pieper, R. (2006); Integrated care: concepts and theoretical approaches. In *Managing Integrated Care for Older Persons. European Perspectives and Good Practices*, Vaarama, M. & Pieper, R. (Eds.), 26-53, STAKES, ISBN 951-33-1584-3, Helsinki
- Somme, D. & Trouvé, H. (2009). Implanter et évaluer une politique d'intégration des services aux personnes âgées : l'expérimentation PRISMA France. In *L'évaluation des politiques publiques en Europe. Cultures et Futurs*, Fouquet, A. & Méasson, L. (Eds.), 385-395, L'Harmattan, ISBN 978-2-296-09069-9, Paris

- Somme, D.; Trouvé, H.; Couturier, C.; Carrier, S.; Gagnon, D.; Lavallart, B.; Créatin, C.; Hébert, R. & Saint-Jean, O. (2008a). PRISMA France: Programme d'implantation d'une innovation du système de soins et de services aux personnes en perte d'autonomie. Adaptation d'un modèle d'intégration basé sur la gestion de cas. *La Revue d'Épidémiologie et de Santé Publique*, Vol. 56, No. 1 (February 2008) 54-62, ISSN 0398-7620
- Somme, D.; Trouvé, H.; Périsset, C.; Leneveut, L.; Lavallart, B.; Kieffer, A.; Lemonnier, S. & Saint-Jean, O. (2008b), Implanter c'est aussi innover : PRISMA France et la recherche-action. Les Réseaux, *Revue Gériatrie et Société*, No. 124 (September 2008) 95-107, ISSN 0151-0193
- Somme, D.; Trouvé, H.; Couturier, C.; Carrier, S.; Gagnon, D.; Lavallart, B.; Créatin, C. & Saint-Jean, O. (2008c). PRISMA France: Adapting the PRISMA integration model to the French health and social services system. In: *Integration of Services for Disabled People: Research Leading to Action*, Hébert, R.; Tourigny, A. & Raïche, M. (Eds.) 511-526, EDISEM, ISBN 978-2-89130-215-9, Québec
- Strandberg-Larsen, M. & Krasnik, A. (2009). Measurement of integrated healthcare delivery: a systematic review of methods and future research directions. In: *International Journal of Integrated Care*, Vol. 9 (February 2009) e01-e10, ISSN 1568-4156
- Tourigny A., Durand P-J., Bonin L., Hébert R. & Rochette L. (2004). Quasi-experimental study of the effectiveness of an integrated service delivery network for the frail elderly. *Canadian Journal of Aging*, Vol. 23, No. 3 (Fall 2004) 231-46. ISSN 0714-9808
- Vaarama, M. & Pieper R. (Eds.) (2006). *Managing integrated care for older people*. STAKES, ISBN 951-33-1584-3, Helsinki
- WHO The World Health Report 2000 – Health systems: improving performance. Geneva: World Health Organization; 2000. [en ligne]: <http://www.who.int/whr/2000/en/index.html>

IntechOpen



Health Management

Edited by Krzysztof Smigorski

ISBN 978-953-307-120-6

Hard cover, 112 pages

Publisher Sciyo

Published online 27, September, 2010

Published in print edition September, 2010

Possibilities of medical intervention have thrived over the last decades. Our knowledge about mechanisms of the development of diseases and factors influencing it has increased. Effective treatment requires a holistic approach that takes into consideration aspects at first sight not related to a course of a specific disorder. This book contains a few chapters focusing on issues related to health management. The chapters are arranged in an order reflecting multidimensionality of issues constituting this theoretical and practical area - starting from the studies focusing on a general, administrative level, to considerations related to situations of individuals suffering from a specific illness. The discussed problems concern different age groups - children, adults and the elderly. We hope that readers professionally engaged in healthcare - both theoretically and clinically - will find it interesting, useful and inspiring.

How to reference

In order to correctly reference this scholarly work, feel free to copy and paste the following:

Trouve H., Veil A., Hebert R. and Somme D. (2010). The PRISMA France Study: Is There a Way to Measure Implementation of Integration in Different Countries?, Health Management, Krzysztof Smigorski (Ed.), ISBN: 978-953-307-120-6, InTech, Available from: <http://www.intechopen.com/books/health-management/the-prisma-france-study-is-there-a-way-to-measure-implementation-of-integration-in-different-countries>

INTECH
open science | open minds

InTech Europe

University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
Fax: +385 (51) 686 166
www.intechopen.com

InTech China

Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

© 2010 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the [Creative Commons Attribution-NonCommercial-ShareAlike-3.0 License](#), which permits use, distribution and reproduction for non-commercial purposes, provided the original is properly cited and derivative works building on this content are distributed under the same license.

IntechOpen

IntechOpen