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Mots clés : Indicateur de précarité ; Score EPICES ; MPR

Introduction.– Le score EPICES est un indicateur de précarité utilisable en hospitalisation de MPR.

Objectif.– Comparer le niveau de précarité des patients en hospitalisation complète (HC) et en hôpital de jour (HDJ) de MPR par le score EPICES en 2011 et 2012.

Méthode.– Analyse par une coupe annuelle un jour donné de l'indicateur EPICES.

Résultats.– Les 38 patients présents le jour de l'enquête en mars 2011 et février 2012 ont reçu le questionnaire pour autoadministration. En 2011, 55 % des sujets pris en charge étaient précaires, et 66 % des patients en HC et 41 % en HDJ. En 2012, les résultats sont proches : 58 % des sujets pris en charge, 60 % en HC et 55 % en HDJ.

Les sujets précaires ont un âge moyen identique à l'ensemble de la population. La répartition est proche selon le type de pathologies (appareil locomoteur ou pathologie du système nerveux).

Discussion–Conclusion.– La comparaison entre 2011 et 2012 montre des résultats similaires : plus de 55 % des patients en situation de précarité. Il s'agit du reflet du territoire de santé du CH de Gonesse.

Les patients précaires sont plus nombreux en hospitalisation complète. Il n'existe pas de lien entre la précarité et le type de pathologie ou l'âge.

L'analyse de l'impact sur la durée moyenne de séjour serait utile sur un nombre de patients suffisant pour des pathologies comparables. L'enregistrement de l'indicateur EPICES à l'entrée pourrait être utilisé pour cibler précocement la préparation de la sortie.

Pour en savoir plus

Le score EPICES. L'indicateur de précarité des Centres d'examen de santé financés par l'Assurance Maladie Précarité et Inégalités de santé. Octobre 2005.

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Programme d'autorééducation en séries fatigantes de contractions maximales dans la parésie faciale périphérique chronique

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Mots clés : Autorééducation ; Parésie faciale périphérique ; Contractions maximales ; Fatigue ; Plasticité du système nerveux

Introduction.– Il n'existe à ce jour aucune méthode validée permettant la récupération d'une parésie faciale périphérique (PFP) installée sur la chronicité, i.e. au-delà d'un an après le début des troubles. Cette étude rapporte l'effet d'un programme d'autorééducation conçu pour mettre en jeu de façon optimale les phénomènes de plasticité synaptique.

Observation.– Onze patients (8 F ; âge 45 ± 7 ans) atteints de PFP chronique stabilisée d'étiologies diverses ont consécutivement suivi pendant au moins 2 mois un programme d'autorééducation comprenant une séance quotidienne de travail en séries de contractions musculaires bilatérales d'intensité maximale, menées jusqu'à la fatigue, visant 3 groupes musculaires faciaux essentiels : peaucier du front, orbiculaire des paupières et zygomatiques. Chaque contraction devait être réalisée durant au moins 3 secondes avec une pause de 1 seconde au maximum avant la contraction suivante. À chaque visite le patient devait remettre au thérapeute un registre écrit du travail effectué dans l'intervalle. L'évaluation en simple aveugle avant et après entraînement s'est basée sur l'Échelle de Créteil (EC) cotant 12 groupes musculaires de 0 à 3 (score EC maximal 36) sur des enregistrements vidéo des examens moteurs faciaux.

Discussion.– Les PFP étaient d'origine idiopathique, tumorale, iatrogène, traumatique et congénitale. Un patient avait une PFP bilatérale (12 hémifaces rééduquées). Le délai moyen de prise en charge depuis la date de la lésion était de 13 ± 12 ans et la durée moyenne d'application du programme de rééducation était de 4 ± 2 mois. Le score EC moyen est passé de $17,3 \pm 3,2$ points à $19,3 \pm 3,4$ ($p < 0,001$). Neuf patients ont rapporté avoir effectué le travail mais seuls 2 ont remis un registre écrit.

Conclusion.– Les patients atteints de PFP chronique ont amélioré leur motricité faciale en seulement 4 mois de traitement, et ce quel que soit le délai de prise en charge, moyennant un travail d'autorééducation impliquant intensité maximale des efforts et fatigue induite par les séries de contractions. Avec la répétition en grand nombre des efforts, il s'agit là des 3 conditions essentielles pour l'implication optimale des phénomènes de plasticité du système nerveux.

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English version

CO29-001-e

“Trajectory” a rehabilitation referral software for acute care patients: A comparative study

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Introduction.– The aim of this study was to compare referral efficiency from acute care wards to rehabilitation units, before and after implementation of the “Trajectory” software.

Method.– We analyzed the number of patients in acute care wards, the number of referral requests for each patient, the number of admissions to rehabilitation units, patient efficiency rate, waiting time before referral, and unwarranted lengths of stay in acute care wards.

Two 5-month periods were compared: before (2009) and after (2010) implementation of the “Trajectory” software in the Mulhouse hospital.

Results.– After implementation of “Trajectory”, we observed:

- an increased number of referral requests (+39.10%);
- an increased number of admissions in rehabilitation units (+36%);
- a reduction in waiting time before referral (5 days vs 9 days);
- a reduction in unwarranted lengths of stay in acute care wards (2550 days in 5 months).

Discussion.– Benefits, drawbacks and limits of “Trajectory” are discussed.

Conclusion.– “Trajectory” appears to be a means of improving collaboration between acute care and rehabilitation units.

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CO29-002-e

Analysis of 8 years activity of the mobile rehabilitation team in the Besançon University Hospital

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Keywords: Mobile rehabilitation team; Neurologic diseases; Stroke

Objectives.– Referral practices and management of disabled patients needed to be organized in Besançon university hospital. The aim of this study is to evaluate this type of organization.

Methods.– A mobile rehabilitation team (EMH) was developed in 2004. Initially composed by a physician, the team now consists of a physician, two residents and an occupational therapist.

The EMH was solicited by different hospital units to evaluate disabled patients and to offer the best response in terms of referral practices and management.

Results.– EMH examined 339 patients (1 consultation per patient) in 2004 and 622 in 2011 (855 consultations, 1.4 per patient). Admission to a rehabilitation

unit was proposed to 65% of patients (mean age 54 years) in 2004 and to 31% of patients (mean age 55 years) in 2011. Fourteen percent and 48% of patients respectively returned home.

The mean age of patients was 51 years [1–92] in 2004 and 58 years [2–91] in 2011. The proportions of children were respectively 9.3% and 4.3%.

Neurologic diseases represented 60% of patients examined in 2004 (36% of stroke) and 69% (34% of stroke) in 2011.

Discussion.— Early assessment of hospitalized patients by the EMH can improve patient referral practices and better respond to patient needs and to the requests of hospital departments. Between 2004 and 2011 we noticed an increase of requests. Initial EMH activity was mainly to organize referral practices. Now, EMH activity evolves toward the management of patients (increase of number of consultations per patient and number of patients who return home directly from hospital).

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Instrumental functional assessment

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Keywords: Instrumental functional assessment; Health insurance; Repayment; Isokinetic

Instrumental Functional Assessment (IFA) is an essential domain of practice in Physical and Rehabilitation Medicine. However, in France, the General Nomenclature of Professional Acts does not list any IFA. The specialty did successfully promote the introduction of seven new IFA procedures on the Common Classification of Medical Acts (CCAM) list, but none of them are eligible for reimbursement by the national healthcare fund. It was not until 2007 when three procedures for posture, movement and gait analysis were accepted for refund status. And only very recently, in March 2012, was the isokinetic procedure added to the list. All these medical procedures are subject to significant application restrictions. This is especially true for the isokinetic procedure that must be included in a specific programme of care.

The objective of this presentation is to review the various IFA procedures currently taken into account by the CCAM and to explain the prerequisites for acceptance by the national healthcare insurance fund as well as measures necessary to avoid litigation with the healthcare insurance fund.

The second objective of this presentation is to present IFA procedures that are not yet registered as refundable and to suggest a strategy to have them included on the CCAM list.

Further reading

Calmels P, Ribinik P, Barrois B, Le Moine F, Yelnik AP. Parcours de soins en médecine physique et de réadaptation (MPR) : « le patient après ligamentoplastie de genou ». *Ann Phys Rehabil Med* 2011;54(8):501–5.

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Linking the 400-point hand function test to the International Classification of Functioning, Disability and Health (ICF). A consensus between two physiotherapy teams

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Keywords: 400 points hand function test; ICF; Hand; Functional evaluation
Objective.— The 400 points hand function test (HFT) is an assessment tool validated in French with four parts (mobility, force, single hand prehension and moving objects, bi-manual activities). The International Classification of Functioning, Disability and Health (ICF) is a recognized gold standard in rehabilitation. Our aim was to link the items of the 400-point HFT with the different dimensions of the ICF (body structures and function, activities, participation).

Material and methods.— Two teams with occupational therapist and physical medicine physicians, working in two different countries, linked all items of the 400-point HFT to ICF items. A consensus meeting was then made between the two teams according to ICF linking rules [1].

Results.— First and second parts of the HFT are linked to body functions and particularly to neuromusculoskeletal and movement-related functions, more precisely to mobility and stability of joints, muscle power functions and control of voluntary movement functions (5 items). The third and fourth parts linked to activities and participation from different domains: learning and applying knowledge, mobility, self-care and everyday life (9 items). The third and fourth parts were also linked with the same body functions as first and second parts but in a participation situation. The consensus between the two teams was difficult to obtain for the third and fourth parts.

Discussion.— HFT is used for hand disorders and is well linked with ICF items for upper limb functions. The four parts evaluated some these items with a special interest for the third and fourth parts which are centered on activities of daily living. Even though HFT did not link all ICF items, this tool measures hand function well. In a rehabilitation perspective, it is important to know the dimensions captured by an evaluation tool, in order to use, if necessary other tools covering other dimensions important for the patient for a more complete evaluation.

Reference

[1] Cieza, et al. *J Rehabil Med* 2005.

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Pooling competencies to provide a home care rehabilitation service

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Keywords: Hospital at home; Rehabilitation; Stroke

In 2011, a new service for coordinated home rehabilitation care was made available in the greater Paris by a working partnership created between the Saint-Maurice Hospital (SMH) and the Paris Hospitals–Public Assistance Group (AP–HP). The regional health agency delivered an authorization after a Healthcare Cooperation Group (HCG) was created associating the AP–HP polyvalent home care logistics and the SMH competence in physical medicine and rehabilitation. In this new HCG, physiotherapists, occupational therapists, and speech therapists from the SMH and AP–HP staff members (nurses, nurse's aides, psychologists, dietitians, social/educational assistants) work together in the patients' homes. Complementary benevolent assistance can also be integrated into the HCG. Care is coordinated by coordinating practitioners from both institutions, with medical follow-up by a general practitioner or hospital clinician. Patients reside in a geographic area within 30 minutes of the SMH. Rehabilitation home care, 5–10 sessions per week, is provided for children and adults suffering from neurological or orthopaedic disorders. Necessary equipment is supplied by the AP–HP home care facility.

After 9 months of activity (first with 5 beds, then 10 beds since September 2011) home care has been provided for 37 patients, including 8 children accounting