



## **EDITORIAL**

In 2020, ATIH's work was obviously disrupted by the Covid-19 pandemic. Participating in the management of the health crisis in France became a priority for the Agency.

To support the government's crisis unit, as well as the regional health agencies (ARS) and healthcare institutions, the Agency set up a variety of measures to document the Covid-19 pathology, describe it and codify it. The data relating to the institutions' activities were collected, transmitted and disseminated to healthcare players, in particular researchers.

To ensure a revenue level regardless of the institutions' activity, a guaranteed funding mechanism was devised at the request of the Ministry of Health.

The Agency delved into new domains by providing access to its information systems to enhance the testing and vaccination campaign and to manage stocks of vaccines and personal protective equipment.

Our initially scheduled work was carried out, as we adapted to the constraints of remote working arrangements for the Agency's employees and those of our partners.

The timetable of some of the work had to be adjusted. The work on the funding of A&E was thus completed to allow the gradual implementation of reforms starting in 2021.

For post-acute care and rehabilitation (SSR), the technical work including that concerning classification was completed. However, the reform was deferred to 2022 to give the institutions enough time to get used to the changes.





Concerning the reform regarding the portion of the fees remaining to be paid by patients, the technical work was completed but the implementation was deferred.

Certain projects were deferred, such as the simplification of data collection, and the unified and integrated healthcare institution data reporting mechanism (DRUIDES).

The state of health emergency is still in force. The Agency is continuing to adapt its mode of operation and is permanently transforming its work methods to perform its missions.

In view of the current context, the Agency's organisation is set to evolve. Whenever possible, remote work will coexist with on-site work, and we will blend physical presence, connection to the office network and teleworking. These measures will be combined with the greatest flexibility while ensuring that the teams have the best working conditions.

Housseyni Holla, ATIH Managing Director



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Founded in 2000, ATIH (Agence Technique de l'Information sur l'Hospitalisation – France's Technical Agency for Information on Hospital Care) is a public administrative body coming under the authority of the Health and Social Security Ministers. The Agency is headquartered in Lyon and has a branch in Paris.

Its strategic policies are defined by a Board of Directors, a Steering Committee and a Scientific Committee.

The Chairman of the Board of Directors is appointed by the Ministers in charge of health, social affairs and social security.

#### ATIH is tasked with:

- the collection, hosting and output of data on the medico-economic activity of healthcare institutions
- the technical management of the institutions' funding mechanisms
- studies on the costs of medico-social and healthcare institutions
- defining and maintaining healthcare nomenclatures
- conducting analyses, studies and research on health data.

#### PUBLIC SERVICES OF THE FRENCH STATE

General Directorate of Healthcare Services (DGOS), General Directorate of Social Cohesion (DGCS), General Directorate of Public Finance (DGfip), Directorate of Social Security (DSS), Directorate for Research, Studies, Evaluation and Statistics (DREES), General Inspectorate of Social Affairs (IGAS), General Secretariat of the Ministries in charge of Social Affairs, etc.

**AUDITOR GENERAL** 

**HEALTH INSURANCE** 

REGIONAL HEALTH AGENCIES (ARS)

**HOSPITAL FEDERATIONS** 

# **AUDIENCES**

#### **HEALTHCARE INSTITUTIONS**

#### **NATIONAL AGENCIES**

Biomedicine Agency (ABM),
National Support Agency
for the Performance
of Healthcare Institutions (ANAP),
National Management Centre (CNG),
National Solidarity Fund for Autonomy (CNSA),
Haute autorité de santé – French Health
Authority (HAS),
National Cancer Institute (INCA), etc.

#### TEACHERS/ RESEARCHERS

#### **COMPANIES**

Study and consulting firms, media, etc.

#### **MANAGEMENT**

- External communication
- Partnerships mission

#### **GENERAL SECRETARIAT**

- Quality
- Legal affairs and contracts
- Budget, accounting and financial management
- Management of human resources and internal communication
- Secretariat

#### NATIONAL COST STUDIES

- Healthcare: MCO, HAD, SSR, Psychiatry
- Medico-social: EHPAD, PH, SSIAD/SPASAD

#### INTERNAL ORGANISATION OF THE AGENCY

#### ITARCHITECTURE AND PRODUCTION

- Web-based information system
- Medical data collection systems
- Software for healthcare institutions
- System and network

#### CLASSIFICATIONS, MEDICAL INFORMATION AND FUNDING MODELS

- Medical information
- Classification and funding of medical activities

#### FUNDING AND ECONOMIC ANALYSIS

- Analysis of activities and the quality of care
- Analysis of the costs of healthcare institutions and medico-social facilities
- Analysis of the financial situation and National Objective for Healthcare Spending (ONDAM)
- Mechanisms for the funding of healthcare institutions: management and reforms

#### DATA REQUESTS, ACCESS, PROCESSING AND DATABASE ANALYSES

- Compilation and provision of hospital data
- Output of information for healthcare players
- Management of data access

## **TEAMS**

As at 31 December 2020, the Agency's staff comprised 121 people, including employees under public contracts and civil servants working on a secondment basis.



#### THE AGENCY'S 2020 BUDGET

ATIH's expenses amounted to €38,197,000 while its revenue totalled €38,185,000.

#### BREAKDOWN OF EXPENSES

## 23% Personnel 30% Operating Support grants for healthcare institutions

#### BREAKDOWN OF REVENUE

4%	Other income
6%	Own resources
19%	National Solidarity Fund for Autonomy (CNSA)
26%	Health insurance
45%	Fund for the modernisation of public and private healthcare organisations (FMESPP)



#### **2020 KEY FIGURES** ON HOSPITAL CARE

Data derived from the 2020 PMSI, rounded off to the nearest thousand.

11.6M patients treated

272,000 **Covid patients** 



-9.9% compared to 2019



390,000 deaths in hospital

13% deaths of Covid patients



+7.6% compared to 2019



69 years average age of patients with Covid

51 years average age of patients

#### Medicine, surgery, obstetrics (MCO)

11.1M patients treated









50 years average age of patients MCO

2.2M nights in intensive care

314,000 deaths















69.2M days of hospitalisation (stays excl. sessions)



67 years

average age

of patients with Covid





**-9.8**%

compared to 2019

Between 17 March and 11 May 2020, Covid stays accounted for:

**7%** of patients in MCO 14% of hospital days in MCO 31% of deaths in MCO **53%** of nights in intensive care

## Post-acute care and rehabilitation (SSR)

872,000 patients treated



**-14.8%** compared to 2019

**37,000** deaths

11 % deaths of Covid patients **+6.1%** compared to 2019









79 years average age of Covid patients **69 years** average age of patients

695,000 patients treated on a full-time basis



**-13.4%** compared to 2019



29.6M days of treatment on a full-time basis **-9.6%** compared to 2019



215,000 patients treated on a part-time basis





3.1M days of treatment on a part-time basis **-32.7%** compared to 2019



## Hospitalisation at home (HAD)

153,000 patients treated



**+20.2%** compared to 2019

38,000 deaths 10 % deaths of Covid patients

+38.8% compared to 2019









83 years average age of Covid patients 68 years average age of patients

6.6M days of treatment on a full-time basis



#### **Psychiatry**

389,000 patients treated





**-7%** compared to 2019



43 years average age of patients

302,000 patients treated on a full-time basis



basis

compared to 2019

-8.4%





Without the adaptation of the funding system, healthcare institutions would have encountered difficulties due to the loss of a significant portion of their revenue.

#### **ADAPTING** coding procedures

ATIH provided specific coding rules to identify activities induced by Covid-19:

- specific coding procedures for stays arising from a SARS-CoV-2 infection, with the creation of new extensions for ICD-10 codes based on infection codes provided by the WHO. More recently, new codes have been established, in particular concerning prior COVID-19 infections
- specific coding rules were produced for outpatient care in SSR and psychiatry due to the changes introduced in the provision of treatment in these areas during the health crisis
- an adaptation of coding rules was put in place for SSR facilities handling MCO patients
- special instructions were provided for resuscitation, intensive care and continuous monitoring.

These coding rules were defined during meetings with the Ministry, and then disseminated to the relevant players in the form of detailed

#### **ENSURING**

#### the funding of healthcare institutions

ATIH took part in the designing and technical implementation of the funding guarantee for the institutions.

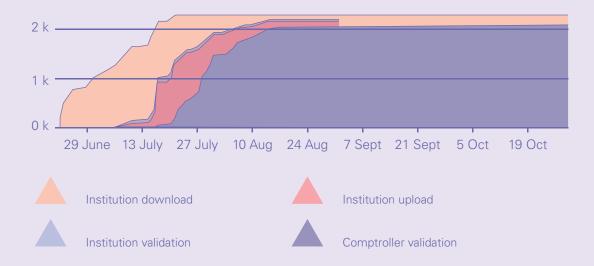
The lockdown started on 17 March 2020. During this lockdown, hospitals had to cancel all of their planned surgical activities to cope with the influx of patients.

The health crisis had two major impacts: firstly on the transmission of revenue-related data (invoices and medical data), and secondly through the cancelling of interventions. Without the adaptation of the funding system, healthcare institutions would have encountered difficulties due to the loss of a significant portion of their revenue. The Ministry of Health thus introduced a funding guarantee mechanism to ensure a revenue level regardless of the institutions' activity.

ATIH participated in the set-up of this mechanism. In coordination with regional health agencies (ARS), it provided the required information for the calibration of funding guarantees. With the CNAM, the formats of the notification orders were established. ATIH also integrated the new mechanism in the e-PMSI by creating specific OVALIDE tables. Other tables were adapted to automatically supply the data required for the adjustments planned by the Order.

#### Flash budget survey

on daily activity



#### COLLECTING budget impact data

ATIH participated in the work groups steered by the DGOS to define the methods for collecting data on additional costs. The Agency thus developed and put on line a data collection platform.

The impacts of the crisis on financial balances were substantiated through a survey. This survey took stock of the major impacts in terms of expenses and losses of revenue in order to appraise the distortion of the institutions' budget structures. It provided a first estimate of the magnitude of the impacts, which varied depending on the situations encountered by the hospitals and clinics during the crisis. It also made it possible to analyse consequences and reflect on the compensation mechanisms that could be implemented during the second half of 2020.

Participation in the survey was not mandatory. It covered all healthcare institutions operating in the fields of MCO, PSY, SSR, HAD.

Out of around 3,300 institutions, 2,212 transmitted their data.

The data collection platform opened on 22 June and the data was mainly transmitted in July.

The objective was to: track and anticipate changes in the Covid-19 epidemic; prevent, diagnose and treat the disease in the most efficient way; and adapt the organisation of the healthcare system to combat the epidemic and mitigate its impacts.

## **CREATING**a Fast-Track PMSI data transmission system

The national crisis unit asked ATIH to design a simplified, fast-track system for the transmission of PMSI MCO data to enable researchers to conduct specific research programmes within the Health Data Hub (HDH). The objective was to track and anticipate changes in the Covid epidemic in order to prevent, diagnose and treat the disease in the most efficient way, and adapt the organisation of the healthcare system to combat the epidemic and mitigate its impacts.

The weekly transmission of data on Covid stays started in the week of 27 April 2020. Requests initially focused on stays for SARS-CoV-2, and then spread to all PMSI MCO data. The data transmission was first done on a weekly basis, and then became bimonthly.

Numerous discussions took place with the crisis unit, the DGOS, the CNAM and DIM physicians for the creation of the system and its adaptation to the constraints it introduced. A new version of the IT tools had to be produced for the transmission of data between healthcare institutions and ATIH. The institutions were asked to codify Covid stays as a priority, followed by stays relating to four target activities (abortions, cardiovascular activities, cancer and neurovascular activities), as part of the monitoring of deferred activities due to the epidemic.

The data from the Fast-Track PMSI-MCO system were transmitted to the CNAM for their link-up with private-practice data in the National Health Data System (SNDS) and for their integration in

the HDH for specific projects. These data were also input into the ATIH hospital data platform. This information is available to healthcare facilities, hospital federations, regional health agencies (ARS), institutional bodies (DGOS, DREES, etc.) and national organisations (HAS, SPF, INCA, etc.). The state of emergency ended on 10 July 2020, along with the Fast-Track PMSI system. These data transmissions, conducted in parallel with the usual PMSI data transmissions, were based on a specific calendar and specific transmission tools. A new fast-track PMSI data transmission system was subsequently authorised by the Order of 21 July 2020 - amending the Order of 23 December 2016 on the PMSI-MCO - and put in place. ATIH is now allowed to access the facilities' data sent via the monthly channel and transmit it to the CNAM, for the pairing of the data in the SNDS, without waiting for ARS approval. Like in the initial Fast-Track PMSI system, these data are only used for health monitoring and vigilance purposes, as well as research. The PMSI's general provisions have been modified, without any impact on healthcare institutions. With this modification, the monthly data available on the ATIH platform and within the SNDS will be available fifteen days to one month earlier than usual.

## 2020 ATIH ANNUAL REPORT

#### **PRODUCING**

## indicators and monitoring activity during the crisis

To tackle the health crisis, the DGOS asked ATIH to analyse the impact of Covid-19 on hospital activity. In response to this request, indicators and infra-annual notes were produced on a regular basis to analyse hospital activity. They concerned the treatment of patients with Covid-19 as well as non-Covid activities, in particular those for which the postponement of treatment was liable to reduce the patient's chances of cure.

#### Analysis of hospital activity relating to the treatment of patients with Covid-19

The Agency produced a note analysing the treatment of patients with Covid-19. This analysis notably identifies the patients' different characteristics, such as their demographic characteristics, stay characteristics, and the different diagnoses coded during the stay. The places of treatment are also covered.

#### Overall analysis of hospital activity in 2020

Concerning overall hospital activity in 2020, ATIH produced infra-annual notes analysing 2020 hospital activity in order to estimate the disruption in the activity structure. They involved observing the drop in activity during the first wave, the resumption of activity, and measuring the change in patients' characteristics during the different periods (before/during/after the lockdown). These notes were produced for the fields of MCO and HAD.

#### Analysis of hospital activity in target pathologies

At the request of the DGOS, work was undertaken in coordination with DIM physicians, hospital federations and regional health agencies (ARS) to target pathologies for which the postponement of treatment in the field of MCO was liable to reduce the patients' chances of cure. Four activities were thus targeted (abortions, cancer treatments, cardiovascular activities and neurovascular activities). Specific indicators were developed using the PMSI MCO system for their monitoring. These indicators were analysed within the framework of specific notes, backed by dashboards, made available to the DGOS. The analyses concerned the comparison of activities in 2020 and 2019, in terms of volume and annual trends.

## The data on Covid-related hospitalisations are updated monthly based on the institutions' fast-track data transmissions.

## **OUTPUT OF**data from the fast-track data transmission system

The rapidly obtained hospital stay data stemming from the Fast-Track PMSI, and then from the healthcare institutions' fast-track systems, have been published online on the hospital data platform developed by ATIH since 18 May, with frequent updates. This mechanism, which was initially limited to Covid-related stays, was subsequently extended to all MCO stays, with the bi-monthly, and then monthly publication of hospital data on the platform.

A dashboard, in Excel format, summarising the data was disseminated by ATIH. With monthly updates, this dashboard was developed and adapted to meet the requirements of the various players. In parallel, specific OVALIDE tables on the healthcare institutions' Covid-related activities are produced for the institutions.

Moreover, an interactive data output tool developed in R Shiny was produced in October, covering the main indicators of the initial dashboard that it replaced, for its dissemination to all players (healthcare institutions, hospital federations, ARS, DGOS, and DREES). The data on COVID-19 hospitalisations are updated monthly based on the institutions' fast-track data transmissions.

## **COMPILING**data on positive Covid tests

A Fichsup compilation of the services involved in the diagnosis of SARS-CoV-2 through RT-PCR tests was established for institutions in former DG sectors for all fields. It serves as a basis for the funding of these services. It was put in place in several stages starting in March 2020, and in a time-delayed manner in certain regions.

A second Fichsup compilation was introduced in December 2020 to collect information relative to the services involved in SARS-CoV-2 rapid diagnosis tests.

## **CREATING**a platform to track stocks of medicinal products and

medical devices

At the supervisory authorities' request, ATIH developed a platform called "e-Dispostock", as a replacement for a pre-existing fee-paying solution, to keep track of the healthcare institutions' stocks of medicinal products. This application is intended for pharmacists in hospital pharmacies, who input data one or twice a week concerning the stocks of certain strategic medicinal products. The fee-paying application used at the beginning of the year was replaced in October 2020. The e-Dispostock application was rolled out gradually starting in November, on a region-by-region basis. At the Ministry's request, its scope was extended to include EHPADs with in-house pharmacies.

A first upgrade was requested, to add to the list of medicinal products the monitoring of flu vaccines in EHPADs with in-house pharmacies. This upgrade was rolled out on 16 December.

A second upgrade concerns the tracking of stocks and needs of EHPADs with in-house pharmacies, in relation to the Covid vaccination. This module is set to be finalised by early 2021.

## **OFFERING**authentication tools to access a personal protective equipment ordering platform

At the supervisory authorities' requests, ATIH offered its authentication tool (PASREL/PLAGE) to the Distrilog platform, managed by a consortium (La Poste, UniHA and RESAH) and used for the ordering of personal protective equipment (PPE). This request required the extension of the scope of PASREL/PLAGE to certain categories of social institutions not included in the dashboard of medico-social institutions and services (ESMS). The PASREL/PLAGE system is also used for the EPI-Stock platform developed by the DREES to monitor PPE stocks.

## COMMUNICATING with the playxers in a different way

In order to maintain ties with users and transmit a variety of information, the Agency organised several large video conferences.

In early November, the Agency organised an information session on the new features of the 2021 PMSI. The goal was to present the new developments in all activity fields (MCO, HAD, SSR, and Psychiatry), ahead of the publication of the technical data sheet, in order to enable institutions to anticipate their implementation.

A total of 1,140 people participated in the event online.

In mid-November and early December, the new features of the SSR classification were also presented online via a conference entitled "Premiers pas pour la comprendre" (The First Steps to Understanding it). Two sessions brought together a total of 1,172 participants.

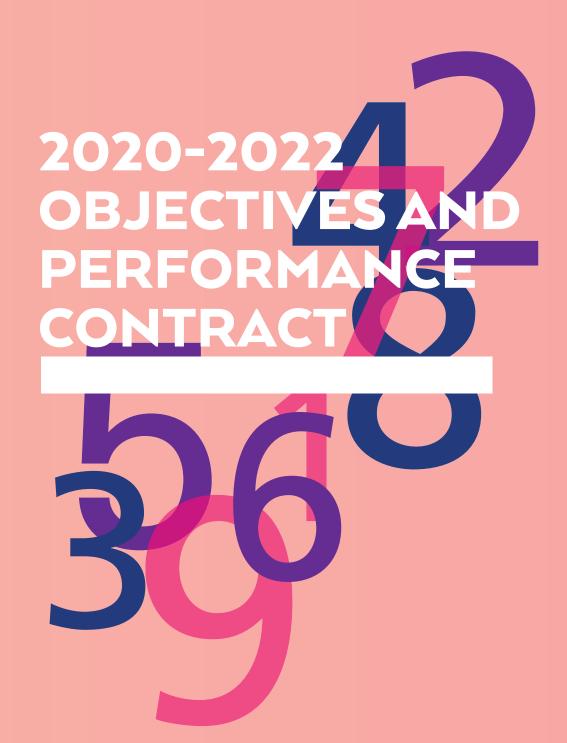
The audience was mainly composed of doctors, medical information technicians, comptrollers, IT personnel, admission desk staff, administrative staff and healthcare managers. Members of hospital federations, ARS representatives and Health Ministry representatives were also present.

The participants were generally satisfied with the online conferences. They particularly appreciated the ongoing contact with the Agency. This new format is convenient and flexible. Through the chat feature, participants can ask questions and get answers which are shared with everyone.

The video format has the advantage of bringing together more people, without any limitation as to their number. Several people from the same facility can thus attend. It also avoids travel.

Despite a few connection problems and bandwidth issues, the webinars work well. However, in-person interaction between speakers and participants is a missing element.

Eventually, the two formats could co-exist according to the types of meetings, the choice of participants, and the needs of the Agency's staff.



## 2020 ATIH ANNUAL REPORT

## TECHNICAL CONDITIONS REGARDING FUNDING

#### 1. Participating in the design and implementation of the funding reform

The work performed by ATIH on the funding reform is carried out in line with the recommendations of the Ségur healthcare agreement – in particular concerning the fields of psychiatry, A&E, medicine and critical care – as well as the co-payment recommendations. Other initiatives which started several years ago are to be fast-tracked: funding reforms concerning the SSR and HAD sectors, as well as activities associated with chronic diseases and the factoring-in of quality in the funding of care activities.

## Contributing to the development of combined payments

#### Flat rates for the follow-up of patients (chronic diseases)

ATIH continued its work concerning a flat rate for the treatment of "chronic kidney disease". Uploads of information were regularly monitored in 2019. Reminders were sent to institutions to prompt them to transmit their information within the time limits set by the Ministry, but postponed several times due to the difficulties encountered by the institutions, particularly because of the health crisis. In late summer, the Agency provided the institutions with a new data collection tool, pending the production of a more efficient tool by software publishers, based on specifications to be laid down by the Agency upon completion of a service managed in early 2021. The funding arrangements planned for 2020 could be

reviewed due to certain field implementation difficulties. ATIH will participate in the technical work to develop quality-based funding in the years to come (development of quality indicators based on data collection variables, and adjustment of the flat rate according to the result of these indicators).

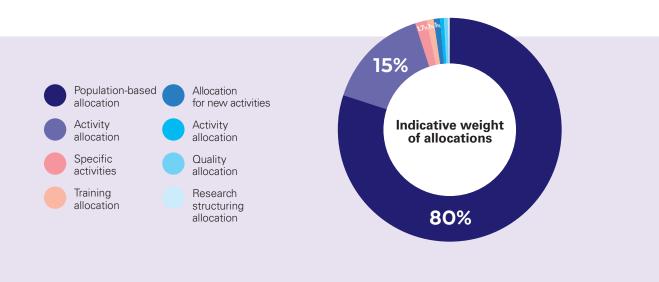
#### Quality-based funding (IFAQ)

In view of the health situation, the allotted IFAQ budget (€400m) was not allocated according to the indicator update. Thus, €200m corresponded to the 2019 allocation, while the additional €200m was broken down according to the each institution's economic activity volume.

#### A new funding model for psychiatry

In 2020, ATIH conducted technical work on the new funding model for psychiatry, in anticipation of its planned implementation by the Health Ministry in 2022.

The funding of psychiatry would revolve around various allocations.



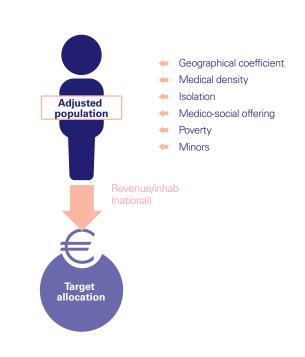
#### The Agency particularly worked on the modelling of the population-based allocation and the active file.

- Population-based allocation

This allocation rests on the assigning of a national average revenue per capita to the region's population, adjusted according to population-based criteria. The criteria were laid down following discussions with the work groups coordinated by the funding task force. They consist of: medical density, remoteness, the medico-social offering, poverty, and the proportion of minors in the region's population.

- Allocation per activity or active file

The weighted active file will be used as an allocation distribution key. The weighting factors – set by government Order – are specific to each type of care (full time, part-time, or outpatient).



For the outpatient model, the Agency put forward principles for the construction of a first type of care, based on the frequency of contacts with professionals, and including intensity and the care provided outside the institution's care facilities.

The Agency also provided its support for the development of psychiatric care quality indicators derived from the medico-economic databases and coding quality indicators, which form other compartments of the reform.

#### New funding model for A&E

To define the new flat rates, ATIH conducted analyses on the factors behind the duration of A&E care (based on A&E care records), and on care consumption markers based on PMSI invoicing data.

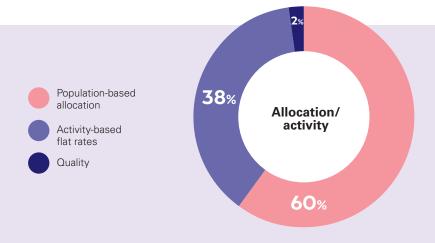
The Agency also contributed to an upgrade in the financing arrangements for the amount remaining to be paid by the patient via the creation of a single flat rate.

ATIH also monitored the work under way on the population-based allocation.

The funding model for emergencies is based on a combined allocation/activity principle.

The population-based allocation is based on a catch-up model which aims to converge regional funding into an allocation modelled and based on an A&E care rate determined for each department according to population criteria and regional characteristics.

Activity-based flat rates will depend on patient characteristics, such as age, and will be adjusted at a later stage.



#### Continuing the technical work on funding models

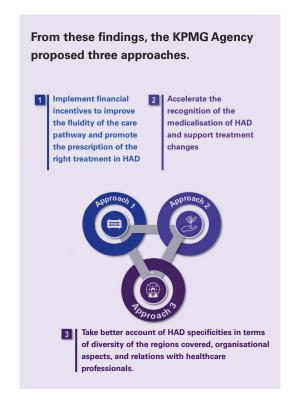
#### SSR activity funding reform

Following an interruption during the first wave of the health crisis, the work related to the funding reform for SSR healthcare institutions resumed in June. It involved the set-up, by the DGOS, of a pilot committee with the hospital federations. In early autumn, progress had been made on the funding model and the conditions for the implementation of the reform as from 2021, including, for that year, a revenue guarantee mechanism for institutions, before the attainment of the target model in 2022. With the 2nd wave of the health crisis, the Ministry decided to defer certain reforms in progress, including the SSR reform. The postponement of the implementation of this reform to 2022 raises questions as to the tools to be prioritised in 2021, in particular the medical activity description tool (GME classification). A decision was finally made to maintain, in 2021, the same classification version as in 2020, while testing the new classification version on an experimental basis according to methods yet to be defined. This decision also involves the preservation of the parameters of the model, including the activity-based allocation (DMA), maintained at 10%.

#### **HAD** funding reform

A study had been initiated on the changes in the funding model for HAD institutions. Due to the health crisis, it only resumed in September 2020.

The service provider thus supplemented the first diagnostic phase conducted in early 2020 with the teachings of the crisis. The results of this diagnostic phase, based on interviews with players in the home hospitalisation sector as well as studies of foreign specificities and experiences, were presented to the pilot committee in October 2020.



For each of the approaches, objectives were set and recommendations were made. The study is now in the phase of co-construction with the players involved. Each of the recommendations will be discussed via workshops in order to stabilise the rational objectives (expected results) and their actual implementation (who, where, when and how). These workshops will make it possible to outline a draft architecture of the model based on the recommendations for the funding model.

### Contributing to the reform of the portion of the fee to be paid by the patient

ATIH conducted technical work for the reform of the portion of the fee to be paid by the patient in the MCO sector. This work included the finalising of an initial version of a national fee scale for daily services.

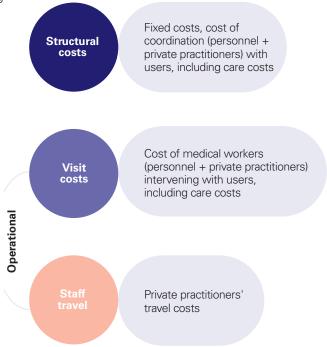
The Agency also conducted impact studies on the implementation of these national fees. This work should resume with the players concerned in 2021, in order to finalise the principles of the scale (integration or not of a medicalised component) and the conditions for its implementation starting in 2022.

### Contributing to the funding reform in the medico-social sector

ATIH processed the cost data collected in the disability sector and nursing home services (SSIAD) sector. For the disability sector, this work provided input for the discussions conducted by SERAFIN-PH with the players. For SSIAD, the processing work should identify a first list of factors behind the variability of costs.

In preparation for the 2021 collection of data on user characteristics across all voluntary SSIADs and SPASADs to continue the exploratory work on the development of a new funding model, ATIH undertook preliminary work in 2020 including filing for a CNIL authorisation, defining the data to be collected and building data collection tools. This work was conducted within the framework of the inter-administration working group formed by ATIH, DGCS, CNSA and CNAM. In parallel, work was conducted to study the variables responsible for the variability of costs.

#### These analyses concerned the three cost components



Concerning visits, the study demonstrated the capacity to find statistically correct models and enhanced the data to be collected. The modelling of structure costs is more complex. Analyses are to continue concerning transport.

The major principles of the funding model will be defined in 2021. They will then be tested, based on the data collected in the first half-year.

#### Integration of new work topics, within the framework of the Ségur de la Santé healthcare agreement

Initial exploratory work was conducted, in accordance with the supervisory authorities' approaches on:

- the funding model for medicine activities: setup of an allocation in 2021 under an option right, and work on the experimentation of a populationbased allocation for the target funding model for this activity
- the funding model for critical care: first methodological reflections.

## 2020 ATIH ANNUAL REPORT

#### 2. Implementing the innovative funding mechanisms

#### Continuing the work conducted on the experimentation of payment per care episode (EDS) in surgical interventions

The Covid-19 health crisis disrupted the original time frame for the experimentation of funding per care episode. The learning phase was extended for the three types of surgery – hip replacement, knee replacement and colectomy due to cancer. Thus, the model adjustment work initially planned for after the analysis of the feedback and the integration of quality in the funding model were deferred to 2021.

However, ATIH still conducted a certain amount of work on the adjustment of the funding model: refining of the "improved post-surgery recovery" modulator, factoring-in of the geographical coefficient, and the possibility of extending the scope of the experimentation concerning colectomy due to cancer to rectal resection (GHM root 06C03 - Rectal resection). This work was presented to the players concerned. In addition, in collaboration with the DIM experts of the institutions participating in the project, ATIH revised and validated the intervention/diagnostic code lists used in the care pathway prediction model and for funding. Moreover, discussions continued on the development of quality indicators for the monitoring of the experimentation and the funding model.

#### Supporting the work done on the experimentation of a shared care incentive (IPEP) and payment per team of healthcare professionals (PEPS)

The work on the adjustment of quality indicators and their inclusion in the IPEP and PEPS models continued in 2020. Adjustments were made and a methodology was defined to determine the targets. An update was done based on 2019 activity data.

## Conducting the technical work required for the various experiments conducted pursuant to Article 51

The work initiated on radiotherapy (DGOS presentation of the flat rates calculated by ATIH in January 2020) was interrupted due to the health crisis. ATIH will resume its work according to the approach adopted by the supervisory authorities, which are expected to defer the implementation until 2022.

The Article 51 experimentation also concerns anticancer drugs. For the 5 participating institutions, a FICHCOMP file is put in place for declarations of intra-GHS anticancer pharmaceutical products, as well as a DATEXP file containing information on the treatment and its follow-up.

## **3.** Adapting the technical tools concerning funding, management and knowledge of the hospital and medico-social sector

#### Measuring hospital and medico-social costs

ATIH continued its studies and surveys based on the measurement of costs in the hospital and medico-social sectors by refining its methodology: clarification of the definition and scope of work units, continuation of the experimentation on the measurement of the intensity of the care (SIIPS), revision of the analytical tree, etc.

The Agency started to adapt its data collection tools to reduce input time for the entities participating in its work.

It extended the scope of the national cost study (ENC) and accounting adjustment (RTC) to external consultations and care, in order to come into line with the Auditor General's requests and adapt to the changes in the funding models. Through the contribution of voluntary institutions, instructions were laid down and will be completed in 2021.

Due to the current situation, it was not possible to complete all of the work planned on the work units. The surgery work units as well as the rehabilitation work units in MCO were adjusted. Work on other aspects – such as biology, imaging and functional investigations – had to be deferred to 2021.

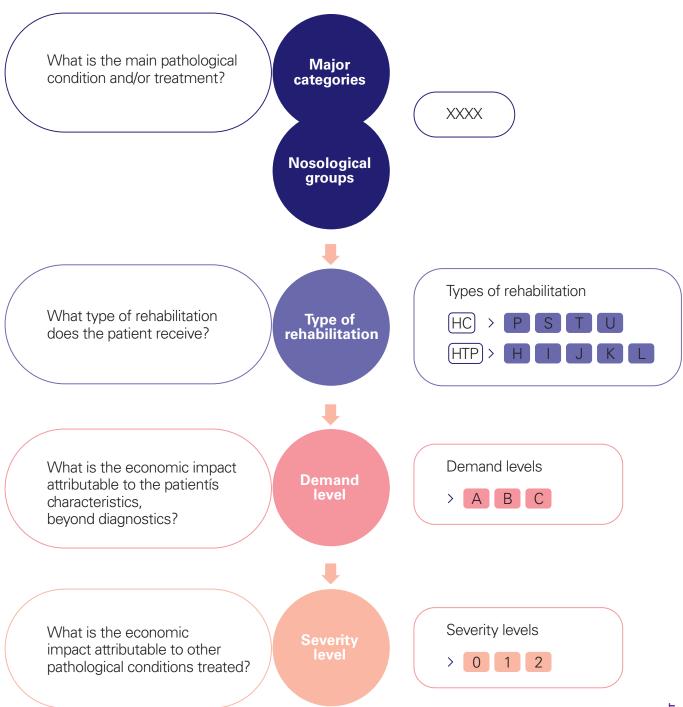
ENC time frames and financial conditions were amended and eased because of the health crisis. Specific methodological instructions were also produced in view of the heath crisis.

Moreover, the Agency launched a project on the writing of a good practice guide for healthcare institutions concerning the use of ENC and RTC data.

#### Classifying medical activity in order to analyse it and fund it

ATIH produced a new version of the SSR classification, distinguishing between rehabilitation intensity, patients with heavy demands and severe conditions. The drafting of this new version had started in 2019, in collaboration with hospital federations, in response to their requests concerning the description of their activities. From the month of March, it became impossible to hold regular meetings with the federations due to the health crisis. However, the work continued and allowed the presentation of a version rolled out across all major classification categories at the end of June. In the summer, the tool was adjusted and bilateral meetings were held with each of the 7 federations concerned, in order to get their opinions on the new tool. Those opinions were summarised at the technical committee meeting in October, giving the DGOS all the elements required to decide on whether or not to use the tool in 2021. While the SSR institution funding reform was deferred to 2022, the classification will be tested in 2021.

#### SSR classification project



The work on the HAD classification was interrupted during the crisis. The work on the "medical" segmentation (using diagnoses) of the nature of the stays resumed in the summer with groups of experts. In parallel, ATIH continues to conduct work on the other levels of segmentation of the classification (heavy demand and severity). Those levels will factor-in diagnoses, age, socioenvironmental aspects and dependencies. Work was conducted on the clarification of the definitions of the types of stays.

Concerning the description of medical activity in psychiatry, given the context, the work focused on care trends, the use of telemedicine and remote outpatient care.

In 2020, the recording of health insurance numbers started in outpatient facilities including medico-psychological centres. This will allow the linking of these facilities' activities with SNDS data.

In 2020, the recording of restraint and seclusion measures was enhanced with new variables to specify the reason, the diagnostic profiles and whether or not the patient was known to the professionals who applied those measures.

To report on the organisational measures used by psychiatric institutions to cope with the health crisis, the collection of medical information in psychiatry (RIM-P) was adapted as a matter of urgency and subsequently improved in a more permanent way. The summary of outpatient activity will thus include a new variable to describe how outpatient procedures are carried out – either in-person or remotely. This change makes it possible to identify telemedicine procedures.

The description of the activities performed on a part-time basis (essentially outpatient activities) by public or private psychiatric institutions was enhanced with a list of services. This list specifies the types of care (individual or group) as well as whether it is carried out in-person or remotely.

ATIH also initiated work to better describe the socio-environmental factors encountered by the patients and liable to have an impact on their care. In the SSR field, this work focuses on the data which is currently missing in the PMSI. The work revealed the possibility of identifying certain socio-environmental factors in the PMSI via ICD-10 codes, and the need to provide clearer

coding instructions in the methodology guide. The work on the description of socio-environmental factors is continuing. It may lead to the revision of the notion of precariousness presented in the methodology guide.

#### Determining rates and the allocation of resources

The 2020 campaign was marked by:

- the introduction of the grading of outpatient care in healthcare institutions
- the broadening of the scope of the support measure to include improved post-surgery rehabilitation (RAAC) practices
- the adjustment of distance-based transport supplements.

Concerning outpatient care, the "Grading" instruction clarifies the invoicing criteria between external activity and hospital outpatient activity. For hospital outpatient activity in the field of medicine, this new corpus characterises the means used for the care of the patient across the number of interventions carried out, while taking account of the patient's fragility or risk factors, as well as the specificities of certain treatments that may require extra supervision time or the use of a specific environment. These changes are particularly reflected in the creation of an intermediate level of care invoiced by a dedicated homogeneous stay group (GHS). The rates associated with these GHSs are grouped into "classes" in order to make the mechanism clearer. As a result, very few different rates need to be set for this type of care.

In 2019, a measure was introduced to support the development of RAAC activity in order to maintain the rate of the stay which corresponds to its severity level, irrespective of its duration. In the 2020 campaign, two GHM (homogeneous patient group) roots were added to the 17 GHM roots concerned by this measure in 2019:

- 04C02 Major interventions in the thorax
- 08C22 Revision joint replacement treatment

The 2020 campaign was also marked by the ongoing implementation of the reform on the funding of transport between institutions (Article 80 of the 2017 Social Security Funding Act (LFSS). As a reminder, Article 80 of the 2017 LFSS entrusted healthcare institutions with sole responsibility for the funding of transport within and between institutions, as from 1 October 2018. This modification resulted in the creation of specific supplements. For the 2020 campaign, the main change concerns the adjustment of these supplements according to the number of kilometres travelled. The value of the supplements thus depends on the type of transfer (definitive or temporary for a particular session) and the distance in kilometres.

Moreover, the price modulation process initiated several years ago continued in order to:

- support the development of outpatient care
- review the prices of certain obstetric GHMs
- pursue the pricing policy geared at encouraging the development of dialysis outside the facilities.

#### Reinforcing the knowledge, monitoring and management of hospital activities and expenses

As part of the monitoring of emerging phenomena, the main focus was on the change in hospital activity due to the health crisis and the monitoring of care in target activities. In November, ATIH participated in the online event of PCSI (*Patient classification system international*). Three topics related to the work conducted by the Agency in connection with the health crisis were examined:

- innovative ways of collecting PMSI data and the Covid-19 coding rules implemented for the monitoring of hospital activity during the Covid-19 pandemic.

Data collect and coding innovation in France at the time of Covid-19 pandemic

- hospital activity analyses conducted in connection with Covid-19.

How to estimate the impact on hospital care of the COVID-19 pandemic in France?

- the healthcare institution funding guarantee implemented in 2020 and the national study conducted to assess the costs incurred by the institutions for the treatment of Covid-19.

How to fund French hospitals during the Covid-19 pandemic? Implementation of a funding guarantee and evaluation of the additional coronavirus costs

The presentations have been published online on the PCSI site.

## DEVELOPMENT OF QUALITY INDICATORS

## • Contributing to extending the measurement of the satisfaction and experience of patients/residents in the hospital and medico-social sector

ATIH continued its work on the maintenance of quality indicators (QUALHAS).

In 2020, ATIH collected data for the pilot phase and then the general rollout phase, as well as the calculation of e-Satis indicators concerning SSR. It also monitored the work on the measurement

of the "patient experience" steered by the DGOS within the framework of national experimentations, pursuant to Article 51 of the LFSS for 2018 (Article L. 162-31-1 of the Social Security Code).

## 2. Developing the use of data to contribute to the development of care quality indicators

In 2020, work was thus conducted:

- in association with HAS, with regard to the quality of care pathways for 4 pathological conditions: obesity, stable coronary heart disease, chronic renal failure, and pulmonary disease
- in association with HAS, concerning a 30-day mortality indicator after myocardial infarction,
- within the framework of the psychiatry funding reform, with the development of 2 indicators: percentage of rehospitalisations in psychiatry after emergency care in MCO; percentage of patients having come out of hospital with an appointment with a healthcare professional within X days of their discharge.
- within the framework of IPEP/PEPS: rate of emergency care not followed by hospitalisation, proportion of direct hospital admissions in medicine, proportion of hospitalisations in medicine and psychiatry with a consultation

(doctor or nurse) during the month following the discharge.

ATIH also contributes to the design, calculation and dissemination of alert indicators concerning professional practices, in association with HAS and the DGOS.

## of quality indicators for funding purposes f interest on this topic was The projects will be monitored on a regular basis

A call for expression of interest on this topic was launched and four research teams were selected by ATIH's Scientific Committee.

Four projects were subsequently retained:

- 1. Development of an IT platform for the recording of PREM/PROM data in French psychiatric institutions: "Patient Experience Data Hub in Psychiatry"
- 2. Creation of an indicator for potentially avoidable serious rehospitalisations (RHPEG)
- 3. Development and validation of an indicator measuring quality of life at work (QLW) in healthcare institutions
- 4. Design and validation of A&E care quality and safety indicators that can be automated and rolled out across all French emergency services.

The projects will be monitored on a regular basis by the Scientific Committee and information will be provided to ATIH's Board of Directors. The maximum duration of the projects is three years

3. Developing studies for the design and construction

Agreements have been signed and the projects have been launched.

#### MANAGEMENT OF TOOLS FOR THE COLLECTION AND OUTPUT OF DATA

#### 1. Modernising and expanding data collection tools

#### Adapting and expanding data collection tools

ATIH has undertaken work to modernise the activity data collection mechanism (DRUIDES: Dispositif de remontée unifié et intégré des données des établissements de santé – Unified and integrated healthcare institution data reporting mechanism). This new mechanism was due to be rolled out in 2020 in the field of MCO. It was deferred to 2021, due to the need for an overhaul following remarks from the CNIL and the results of the tests conducted (rollout difficulties expected in small facilities).

In association with the DREES, ATIH continued the harmonisation work between the SAE (annual statistics of healthcare institutions) and the PMSI in the field of psychiatry. The other fields have already been covered over recent years.

The Agency recorded the social security numbers of patients having received outpatient psychiatric care (medico-psychological centre), in order to link up the various treatments received (hospitalisation/outpatient care).

ATIH improved the e-Satis mechanism for the collection of patient satisfaction data by automating the healthcare institutions' upload of e-mail files, as well as the reminder module and detailed results.

ATIH handled the maintenance of the performance dashboard of medico-social institutions and services (ESMS). It will implement the required

upgrades, in connection with the players involved. It worked with the DGCS, the CNSA and the ANAP to take over the provision of general assistance in this matter, on top of project management duties. Moreover, the Agency assisted the DGOS in the overhaul of the health system observatory (OSIS) to improve its ergonomics, simplify its use and extend its scope to the management of public policy programmes.

The Agency contributed to the knowledge on the purchase and consumption of medicinal products. This annual collection of data, carried out by ATIH since 2015, takes stock of the total volume of medicinal products used by institutions, whether or not they are included on the "additional lists". In 2020, e-Med platform developments enabled healthcare institutions to transmit their files directly on the platform, thereby doing away with the use of the IDEM software. Compared to the previous year, the number of institutions having transmitted their data in this way increased, going from 1,758 to 1,806, just like the percentage of institutions with usable data, which went from 92% to 99% this year.

Data outputs for the year 2019 have been published on the ATIH website in the form of a global analysis of results and ranked by field of activity and by region.

# Putting forward interoperable data collection solutions in keeping with the changes in terms of funding quality and relevance of the care

ATIH has created data collection tools of the record type and from medical data stemming from the healthcare institutions' clinical information systems.

Work was conducted on the follow-up of the administration of CART-Cell gene therapy products. This project was conducted in collaboration with LYSARC, an operational entity performing clinical research on lymphoma. The records maintained by this entity allow the automation of inputs by institutions.

In connection with the records of the nephrology information and epidemiology networks (REIN) and those of the Biomedecine Agency, ATIH has provided a transitional tool to the institutions eligible for the chronic renal disease (CRD) allocation to enable them to collect 2020 activity data.

The Agency contributes to the structuring of patient surveys for patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs). In this concern, in 2020, the DNS (Health-related digital technology delegation) approved ATIH's strategy of implementing the Eval-Santé platform, currently under development and to be completed in the first half of 2021.

This platform will handle surveys sent to patients getting optical or audio equipment, as well as a quality-of-life questionnaire for patients covered by the CRD allocation.

## Maintaining and developing tools to collect data in the field of innovation

ATIH is continuing to improve the PIRAMIG and INNOVARC tools.

Continuing to improve tools for the collection of data on costs, funding, accounting and human resources, in coordination with other data collection systems (DREES, DGFIP, and DNS)

In 2020, the financial data collection platform (ANCRE) was overhauled. This overall required major efforts on the part of users to understand the new data collection framework. Support material was put forward to assist them. As a result, the exhaustiveness of the data is highly satisfactory.

The integration of the basic cost accounting table (TIC) into the ARCAnH cost data collection tool facilities accounting adjustments (RTC) by allowing the import of the institutions' raw accounting data and the viewing of RTC cost accounting rules. The user is guided in a pedagogical way and all modifications can be traced. The data from these preliminary stages are automatically fed into the RTC workbook. By using this tool, the institution builds itself a log that can be downloaded for the next campaign.

The different stages of the TIC tool are presented in an interactive tutorial available on the ATIH website. This tutorial includes a concrete example, testimonials from institutions, and a quiz to better understand the interest of using the TIC tool.

Examining, in association with the DNS, the need to adapt data collections in keeping with the implementation of the digital space dedicated to health (ENS)

In 2020, ATIH made the required modifications to the Agency's platform dedicated to the management of application users (PLAGE tool) to ensure its compatibility with health-related digital technology standards, and thus the digital space dedicated to health. Users identified by PLAGE

will thus be able to use the applications presented in ENS.

The modifications consisted in introducing the possibility of using the standard protocol recommended for health-related digital data (OpenIdConnect), and using multi-factor identification (SMS or email).

Work is under way with the ANS and the DSS

to allow the use of ProSantéConnect. The healthcare professionals identified by PLAGE in the institutions will thus be able to connect to the teleservices available in ENS.

#### 2. Modernising public data output platforms

#### Responding to public demand for hospital and medico-social data, notably through the adaptation of ScanSanté

The ScanSanté website provides hospital data to a broad public with a version accessible without credentials. The data collected by ATH concerning hospital activity, as well as the institutions' financial data, human resource data and quality-of-care data are re-processed by ATIH and displayed in the form of indicators on the ScanSanté website. This information is easily disseminated through the filling of forms.

ScanSanté is frequently updated and enhanced with new features to meet user expectations. Satisfaction surveys are conducted every year to identify needs.

The output of data on medicinal products and medical devices on the "additional lists" has been modernised.

ScanSanté's homepage has also been redesigned for easier navigation. Several data outputs have been improved and provide more detailed information, with data based on the geographical FINESS number.

ATIH is currently working on a tool that will enable users to make custom queries in a more flexible way, while preserving ScanSanté's ease of use.

## Renovating and adapting the output of data on care quality and safety, in line with the work done on ScanSanté

In addition to Scope Santé, which is dedicated to providing quality indicators to the general public, ATIH develops data outputs on quality in ScanSanté, intended for healthcare professionals (2020-2021 project).

In order to add new data outputs in ScanSanté, ATIH initiated exchanges – on the one hand with INCA, and on the other with the research team in charge of the Shewhart study to provide digestive surgery indicators to institutions.

# 2020 ATIH ANNUAL REPORT

### **3.** Participating in the management of healthcare nomenclatures

## Deploying ICD-11 in collaboration with France's WHO Collaborating Centre (WHO CC)

ATIH pushed forward with the translation of ICD-11 headings into French. This work, which is conducted in coordination with the WHO and WHO CC, was slowed down by the health crisis. Closer collaboration is being developed with the ANS (member of the WHO CC) for the implementation of automatic translation, as well as a partnership project with francophone countries (for the production of synonyms). Professional translators may also be called upon in order to meet the deadline set for this translation.

#### Contributing to the validation of the International Classification of Health Interventions (ICHI) in collaboration with the WHO

After having organised the validation tests proposed by the WHO to users of member countries, ATIH engaged in ICHI/CCAM and ICHI/CSARR transcoding work in 2020. This work was conducted at the request of the WHO with the goal of validating this nomenclature in 2021.

## Updating the Specific Catalogue of Rehabilitation Procedures (CSARR)

The CSARR audit planned for 2020 did not take place due to the failure of the tender and the health crisis. The specifications for this audit will be re-examined in line with the tool simplification project stemming from the Ségur de la Santé agreement.

## IMPROVING ACCESS TO HEALTH DATA

## Continuing to develop and enhance the hospital data platform

ATIH is continuing its regular enhancement of the hospital data platform, in particular through outputs of newly collected data. The platform was particularly enhanced with the data collected on the Covid-19 pandemic.

ATIH has started to supplement the hospital data platform with a new offer of "intermediate" data, i.e. between raw data and ScanSanté indicators, in line with the requests of the Agency's data output users. This work will be finalised in 2021 with a view to its implementation in 2022. This project should unify ATIH's data output offering, which now comprises ScanSanté for indicators, and the hospital data platform for raw data. This new offering will thus consist of indicators, raw data and intermediate data.

Moreover, ATIH will continue its technical work concerning processing on the platform, using technologies such as R and Python as alternatives to the SAS software.

An inter-department work group was created, in particular to reflect – in conjunction with a service provider – on the upgrade of data storage arrangements, some of which are used for "big data".

At the end of 2020, ATIH carried out a migration of the SAS system used on all its servers and on the hospital data platform in particular. The new system provides high availability while being resilient to the failure of a machine. It speeds up data processing through optimal

system load management, according to the number of processing operations under way. This environment also offers the possibility of progressive development of the IT infrastructure, as user numbers and data volumes increase, without any service interruption.

## 2. Contributing to health data governance (Health Data Hub, SNDS, etc.)

ATIH is one of the producers of data for the SNDS historic databases and the main databases of the Health Data Hub with the PMSI hospital data. The SNDS allows the link-up of Health Insurance data (SNIIRAM database), hospital data (PMSI) and data on the medical causes of death (INSERM's CépiDC database). From 2021, disability-related data (stemming from departmental facilities

for disabled persons – CNSA data) will also be included.

The Agency holds a seat at the general meeting of the Health Data Hub, in the SNDS data producers' committee, and in the SNDS strategic committee.

## **3.** Supplying health data to enhance data access tools: the ATIH hospital data platform, the Health Data Hub, the SNDS, etc.

ATIH continues to participate in the supply of health data access tools.

This action chiefly concerns data on care quality and safety, chronic diseases (approach similar to that of registers), emergency care records, and the data stemming form patient referral software linked with the PMSI.

## 4. Ensuring the security of the pseudonymisation process in the collection and output of data

ATIH participated in discussions with the CNAM and the DREES to revamp the pseudonymisation process.

Following CNIL's formal demand to the CNAM, an in-depth overhaul of the pseudonymisation process – introduced in 2000 by the CNAM and ATIH – was undertaken by CNAM and will be rolled out in March 2022. This overhaul makes it impossible for ATIH to have a common pseudonym with the SNDS. The Agency has thus started to work on proposals for a specific system.

In early 2020, CNIL issued a formal demand to ATIH concerning the functioning of the Magic

application which handles the first phase of pseudonymisation in institutions. In response, the Agency modified all the data transmission applications of the institutions in the PMSI (some ten applications). The formal demand required the encryption of Magic output data, so that institutions no longer have access to the first pseudonym managed. In April 2020, all applications were updated for the transmission of M3 data.

# 2020-2022 OBJECTIVES AND PERFORMANCE CONTRACT

#### THE AGENCY'S PLACE IN THE HEALTHCARE SYSTEM

## Consolidating the Agency's performance through organisational improvements and the adaptation of skills

In 2020, through its training programme, ATIH ensured that its staff's skills were in keeping with new technologies, organisational changes and environment developments (development of the R software, development of webconferences, etc.).

For several years now, ATIH has been making organisational changes in order to increase its cross-functionality, thus promoting the upskilling of staff and the pooling of resources (in particular in the FAE and CIM MF services). This initiative

aimed at improving efficiency was taken a step further in 2020 with the IT department (API). The recommendations of the audit will be implemented in 2021.

Moreover, the RDE (response to external requests) department underwent a positioning audit. The implementation of the recommendations began in 2020, starting with the change of the department's name to DATA.

> see insert opposite

## 2. Preventing and managing risks through quality assurance and compliance with the General Data Protection Regulation (GDPR)

Concerning risk management, ATIH regularly reassesses its activities' compliance and performance based on standards and indicators. Action plans are implemented, in accordance with the implications and risks involved. The main focuses are the satisfaction of users, the security of the IT system, and the protection of personal data.

#### Security of the IT system and protection of personal data

For the entire IT system, ATIH's actions are mainly underpinned by the IT System Security Policy of the Ministry of Social Affairs (PSSI-MCAS). For the provision of access to PMSI data, the security standards applicable to the SNDS (National Health Data System) are used as a main reference.

#### The RDE department becomes the DATA department

At the end of 2019, the RDE (response to external requests) department was audited in order to position the department as the key interlocutor for access to hospital data. The department's name was thus changed in 2020, to better reflect all of the department's activities and optimise its identification for external players.

The department's name was no longer consistent with its missions, as internal and external processing requests only account for a small part of its activity.

The department's main activities are now the following:

- building and providing access to PMSI databases and RPU (emergency care summary) databases; processing the medication survey
- providing hospital stay data by populating various platforms dedicated to public or private players
- managing agreements and data access; supervising data exports
- populating the SNDS and the Diamant platform
- producing OVALIDE tables to help healthcare institutions and regional health agencies with data collection and control
- facilitating the use of the data through reference guides, nomenclatures and dictionaries.

The department is in permanent contact with all health players: DGOS, DSS, Health Data Hub, DREES, CNAM, HAS, INCA, pharmaceutical laboratories, ARS, etc.

It is also the reference entity for the governance of the Health Data Hub and monitoring of innovation and experimentation initiatives involving Big Data technologies.

Internally, the objective is also to reinforce the department's cross-functional role to turn it into a genuine data centre.

Based on this precept, the name DATA – French acronym for Demandes, Accès, Traitements, Analyses (Requests, Access, Processing, Analyses) – was chosen. The term "Data" is now commonly used in France. Numerous public and private organisations have their own Data departments.

The name DATA Department reflects all the department's missions: everything that concerns data, from their processing to their output, including the creation of databases and the management of data access.

In 2020, the approval for the Agency's system to provide access to PMSI data was renewed for a period of 3 years, following an audit conducted by an IT security audit firm.

ATIH also ensures that it complies with the General Data Protection Regulation (GDPR) and the French Data Protection Act. In particular, the processing of personal health data is the subject of data protection impact analyses (AIPD) by the Agency and its parters in order to ensure the compliance of processing operations and the

management of the risk of illegitimate access to the data.

This process also concerns the quality of accounting and budgeting operations, the staff's health and occupational well-being, as well as compliance of the Agency's practices with the European Statistics Code of Practice.



To measure and improve its performance, ATIH notably relies on a satisfaction barometer. The Agency regularly queries its users to learn about their overall and detailed level of satisfaction according to certain key criteria.

The questionnaires, usually short and online, enable the audience to help improve a service/product in a quick and easy way through a few questions. Individuals can also leave their contact details for additional contributions if the Agency wishes a more in-depth study of a particular subject.

#### The Agency uses this barometer to:

- obtain relevant and regular feedback on its activities
- adapt by undertaking actions targeting the chief expectations of users
- evaluate its efforts by observing the effects on satisfaction.

In particular, this barometer covers each data collection campaign (such as PMSI, ENC, financial accounts, etc.), each database distributed (such as PMSI, RTC, etc.), the Agency's website, on-demand data processing and ScanSanté restitutions.

Participants in ENCs on healthcare fields

92%

of respondents state that they are satisfied or highly satisfied with the process

Participants in the EHPAD ENC

96%

of respondents state that they are satisfied or highly satisfied with the process

Participants in the collection and transmission of RTC data

88%

of respondents state that they are satisfied or highly satisfied with the process Participants in the SERAFIN-PH cost study

86%

of respondents state that they are satisfied or highly satisfied with the process

Users of PMSI databases on the hospital data platform

in 2019

95%

of respondents state that they are satisfied or highly satisfied with the PMSI databases and their access system Participants in the collection and transmission of data from the social assessment

89%

of respondents state that they are satisfied or highly satisfied with the process

> Participants in the collection and transmission of financial data\*\*

**59%** 

of respondents state that they are satisfied or highly satisfied with the process

\*\* The lowest satisfaction rate relates to the collection and transmission of financial data, which were completely overhauled in 2020. This overhaul requires a certain amount of time for the ATIH to stabilise its technical tools and for users in healthcare institutions to become familiar with the new processes.

in 2019 \*

**PMSI** data

Participants in

transmission of

the collection and

of respondents state that they are satisfied or highly satisfied with the process

\*Surveys not conducted in 2020

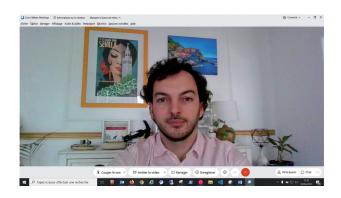




## GENERAL ROLL-OUT OF TELEWORKING

#### **Thomas Ricou**

Computer Engineer, Systems and Networks Division



#### In concrete terms, how did you manage to get all Agency staff to work from home from one day to the next?

After the surprise phase, our Systems & Networks team made emergency arrangements to enable all employees to work from home. We had no choice. However, we were lucky to have the required infrastructure for remote work, i.e. Virtual Private Network (VPN) servers to connect to the Agency's internal network from outside. All we had to do was configure all the laptops.

With respect to computers, not all staff members had laptops. We took stock of those we had in our reserves and then decided on how to allocate them. Numerous employees kindly agreed to take their desktop computers (screen and tower) home. Some employees offered to use their own personal computers in the meantime.

#### How did you get organised to cope with this emergency?

The entire team moved into action! The tasks were distributed amongst all of us.

As for me, I configured the server part. Brice Sauvajon and Damien Mure installed the VPN on the PCs. Xavier Malin and Boumédien Mammad managed the distribution of the PCs and provided quick-start instructions to the staff. Marie-José

Ben Naceur, assisted by Myriam Martin, handled the distributions logistics, i.e. which computer for whom

The whole process was finalised in two days!

#### What difficulties did you encounter?

The main difficulty was dealing with the shortage of laptops.

Subsequently, after the lockdown, we were able to order new ones and provide them to those who didn't have any.

#### And in terms of security?

We got everyone to work from home without any compromise on security, which was never bypassed in favour of functionality.

Several security levels are in place, such as the security token required to turn on one's PC, encrypted hard drives on all computers, and access to the VPN reserved for ATIH through the deployment of enterprise certificates.

#### Once everyone was at home, was everything finished?

Not quite, we had to provide ongoing assistance, especially in the first days when we were in high demand. When uses change completely, it is sometimes difficult to diagnose the problems:

ATIH server? personal connection?

Once the initial technical problems had stabilised, usages adapted. Each person more or less learned on their own to determine when to call the help line.

Certain persons work well remotely and help us view their screens. For others, things are more complicated, but the situation incited them to improve their skills.

We got used to guiding people over the phone, sharing their screen or remotely taking control of their computers, in particular via collaborative tools such as Webex or Jabber.

These tools have been installed for a long time but now, out of necessity, their use became commonplace. When you guide someone to help them solve their problem, they understand what they are doing and remember it.

The situation forced us to be patient and imagine the likely or unlikely situations.

Everyone managed to work from home, with ups and downs of course!

#### Did this period hold pleasant surprises?

The fact of having a generalised VPN infrastructure was a real advantage for us. This project had required 6 months' work in 2019.

Concerning external IT service providers: before, they used to come into the Agency's premises, now most of them work remotely with a VPN access. We built a dedicated entry structure. We thus have better control over what they access and what they need.

#### Is teleworking now working perfectly?

On the whole, yes!

We are still working on providing all employees with a "work" laptop (with no connection to a desktop computer in the office) instead of just a "connection" laptop (which needs to connect to the desktop computer in the office), to eventually do away with all desktop computers.

But going back to the office from time to time is still useful to keep in touch with close colleagues and discuss different matters.

# 2020 ATIH ANNUAL REPORT

## TELEWORKING AT THE AGENCY

#### Fabienne Pecoraro

Deputy Head of Department National cost studies



#### Miora Piffret Comptroller



#### For you, how did the switch to "teleworking only" go in mid-March?

Fabienne Pecoraro: Everything changed at once, from one day to the next. Before, I used to work from home now and then, but I had never tested it on a full-time basis. It took me a whole week to adapt to the situation, accept it, and get into new work habits.

**Miora Piffret:** It was brutal! I had to find an office to share, with the constraint of being at home with my husband and children every day.

The Agency's IT teams were very efficient in rapidly providing us all with a laptop and a remote connection to our servers.

#### Concerning team work, did things work out well?

**FP:** All our service meetings were maintained and informal "web cafés" were organised to enable us to keep in touch.

Before the meetings, we also spent a little time "nattering". We needed to talk, get back together, especially at the start of the first lockdown.

**MP:** Amongst colleagues, we used to phone one another regularly to progress in our work, but also to have breaks and catch up on each others' news.

#### With the healthcare institutions, did you manage to work as usual?

**FP:** Technical committee meetings, meetings with the various players, information sessions and training sessions all took place remotely. On the whole, there was a larger number of participants, as people were freed from time constraints and transport costs.

**MP:** For example, we took part in 6 workshops on pharmacies' work units with ANAP. For each of these workshops, some twenty pharmacists from all over France logged on for 2 hours. When

such meetings were held in-person, we generally had a much smaller number of participants.

Concerning visits to institutions – conducted when an institution joins the national cost study – it was more difficult to grasp the reality on the ground without going on site.

The description of all of an institution's services (analytical breakdown) is not so easy at a distance. On site, we think of certain questions to ask, and we can go and see the different services.

As an alternative, we organised online conferences with the Management Committee, the Information Systems Department, the Pharmacy, the Audit Department and the Administration. These video conferences were very effective, but they lacked the conviviality and enriching nature of face-to-face discussions.

#### What relationships did you have with your usual interlocutors?

**MP:** Some of our interlocutors in institutions were requisitioned for other tasks, like in the postponement of interventions or even the laundry room, in order to strengthen the teams. In regional health agencies, our contacts were often mobilised within crisis units.

We were prudent in our communication with them. In agreement with the supervisory authorities, in particularly the DGOS, we tried to limit our requests.

#### What did you retain from this period?

**FP:** We had a heavy workload, especially when we launched the survey on additional costs due to Covid-19 (FlashBudg), which required high levels of involvement and availability. This effort was offset by the feeling of being at the heart of current events. Without being a healthcare worker, I did my bit during this crisis, which gave even more meaning to my everyday commitment.

**MP:** In terms of tools, Webex (video conferences) was very helpful to us and facilitated our discussions. We discovered a large number of functionalities that had been little used before. This really helped us to lead interactive information sessions using the chat facilities, online questionnaires, direct surveys, etc. A trail was even kept through the recording function.

#### What do you miss the most?

**FP and MP:** Our colleagues! Being behind closed doors with the family is starting to weigh us down. We miss our social interactions at the Agency, in particular "informal" moments when a lot of information circulates. We didn't realise it before!

#### **GLOSSARY**

#### **ANAP**

Agence nationale d'appui à la perfromance – National support agency for the performance of healthcare institutions

#### **ANS**

Agence du numérique en santé – Health-related digital technology agency

#### **ARS**

Agence régionale de santé – Regional Health Agency

#### **CCAM**

Classification commune des actes médicaux – Joint Classification of Medical Procedures

#### **CEPIDC**

Centre d'épidémiologie sur les causes médicales de décès – Centre of epidemiology on the medical causes of death

#### **CNAM**

Caisse nationale d'assurance maladie – National Health Insurance Fund

#### **CNIL**

Commission nationale de l'informatique et des libertés – French Data Protection Authority

#### **CNSA**

Caisse nationale de solidarité pour l'autonomie – National Solidarity Fund for Autonomy

#### **COP**

Contrat d'objectifs et de performance – Objectives and performance contract

#### **CSARR**

Catalogue spécifique des actes de rééducation et réadaptation – Specific catalogue of rehabilitation procedures

#### **DAF**

Direction des affaires financières – Financial Affairs Department

#### DG

Dotation globale – Total allocation

#### **DGCS**

Direction générale de la cohésion sociale – General Directorate of Social Cohesion

#### **DGFIP**

Direction générale des finances publiques – General Directorate of Public Finance

#### **DGOS**

Direction générale de l'offre de soin – General Directorate of Healthcare Services

#### CRD

Chronic Renal Disease

#### DIM

Département d'information médicale – Department of Medical Information

#### **DMA**

Dotation modulée à l'activité – Activity-based allocation

#### **DNS**

Délégation du numérique en santé – Healthrelated digital technology delegation

#### **DREES**

Direction de la recherche, des études, de l'évaluation et des statistiques – Directorate of Research, Studies, Evaluation and Statistics

#### **DRUIDES**

Dispositif de remontée unifié et intégré des données des établissements de santé – Unified and integrated healthcare institution data reporting mechanism

#### **DSS**

Direction de la sécurité sociale – Directorate of Social Security

#### **EDS**

Épisode de soins – Care episode

#### **EHPAD**

Établissement d'hébergement pour personnes âgées dépendantes – Residential care institutions for dependent elderly people

#### **ENC**

Étude nationale de coûts

– National cost study

#### **PPE**

Personal protective equipment

#### **ESMS**

Établissements et services médicosociaux – Medico-social institutions and services

#### **GDPR**

General Data Protection Regulation

#### **GHS**

Groupe homogène de séjours – Homogeneous stay group

#### **GME**

Groupe médicoéconomique – Medicoeconomic group

#### HAD

Hospitalisation à domicile - Hospitalisation at home

#### ЦΛС

Haute autorité de santé – French Health Authority

#### **HDE**

Health Data Hub

#### **ICD**

International Classification of Diseases

#### **IFAQ**

Incitation financière pour l'amélioration de la qualité – Financial incentive to improve quality

#### **IMD**

Implantable medical devices

#### **INCA**

Institut national de lutte contre le cancer – National Cancer Institute Inserm - Institut national de la santé et de la recherche médicale – National institute for health and medical research

#### **IPEP**

Incitation à la prise en charge partagée – Shared care incentive

#### **LFSS**

Loi de financement de la sécurité sociale – French Social Security Funding Law

#### **MCO**

Médecine, chirurgie, obstétrique et odontologie – Medicine, surgery, obstetrics and dentistry

#### WHO

World Health Organisation

#### **ONDAM**

Objectif national des dépenses d'assurance maladie – National objective for healthcare spending

#### OQN

Objectif quantifié national – National quantified objective

#### **PEPS**

Paiement forfaitaire en équipe de professionnels de santé en ville – Flatrate payment per team of non-hospital healthcare professionals

#### PH

Personnes handicapées – People with disabilities

#### **PMSI**

Programme de médicalisation des systèmes d'information – Programme for Medicalisation of Information Systems

#### **QUALHAS**

Plateforme de recueil des indicators de la qualité de la HAS – HAS platform for the compilation of quality indicators

#### **RAAC**

Réhabilitation améliorée après chirurgie – Improved post-surgery rehabilitation

#### RIM-P

Recueil des informations médicales en psychiatrie – Collection of medical information in psychiatry

#### **RPU**

Résumé des passages aux urgences – A&E care summary

#### **RTC**

Retraitement comptable – Accounting adjustment

#### SAE

Statistique annuelle des établissements de santé – Annual statistics of healthcare institutions

#### **SERAFIN-PH**

Services et établissements : réforme pour une adéquation des financements aux parcours des personnes handicapées – Services and institutions: reform to adapt funding to the pathways of people with disabilities

#### **SIIPS**

Soins infirmiers individualisés à la personne soignée – Nursing care tailored to the person receiving care

#### **SNDS**

Système national des données de santé – National Health Data System

#### **SPASAD**

Service polyvalent d'aide et de soins à domicile – Multidisciplinary home aid and care services

#### SPF

Santé publique France – French Public Health

#### **SSIAD**

Service de soins infirmiers à domicile – Home nursing services

#### **SSR**

Soins de suite et de rehabilitation – Post-acute care and rehabilitation

#### UO

Unité d'œuvre – Work unit



