

ATIH Annual Report

2022



atih

AGENCE TECHNIQUE
DE L'INFORMATION
SUR L'HOSPITALISATION

ATIH Annual Report

2022

contents

Editorial	6
1. A centre with wide-ranging expertise	8
2. A few key figures	18
3. Review of the year 2022	24
Participating in the management of the health crisis	26
Contributing to the funding reforms in the healthcare and medico-social sector	30
Participating in the development of indicators on care quality, safety and relevance	40
Modernising data collection and output tools in keeping with the health-related digital technology policy	46
Securing, enhancing, simplifying and facilitating access to health data	54
Continuing to improve the performance of ATIH	58
IT security at ATIH	60
4. Measuring the satisfaction of users	62
5. A word from the teams	66
Glossary	72

editorial

After 2 years of disruption due to the pandemic, ATIH's work has accelerated.

To simplify data collection, work started on the overhaul of the e-PMSI, the deployment of the new DRUIDES data collection software, and the collection of new activity data in healthcare institutions. This last project will totally modernise ATIH's data collection process in order to reduce the medical staff's data collection workload, rationalise information requests to institutions, and optimise the ways in which the institutions provide access to the data to be collected.

In the medico-social sector, the Agency collected data on SSIAD/SPASAD facilities, in particular to simulate the effects of the funding reform. Within the framework of the funding reform project targeting facilities caring for disabled persons (SERAFIN-PH), it collected data from 1,200 facilities for the construction of the future funding model. Moreover, the Agency is conducting preliminary work on a performance dashboard for medico-social institutions and services in order to extend the scope of the data to real estate and broaden the scope of the facilities to home aid and care services (SAAD).

On ScanSanté, several data output processes have been modernised to simplify access to the platform. Flexible query processes have been developed, thus facilitating access to data aimed at a wider public.

In 2022, work continued on the collection of data and construction of indicators on care quality and safety, in collaboration with HAS.

The first version of the EvalSanté tool – dedicated to the structuring of patient surveys for patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) – was finalised.

Housseyni Holla

/ ATIH Managing Director



Concerning the institution funding reforms, technical work was conducted for A&E, Psychiatry, SSIAD and SSR.

In 2023, the Agency will participate in the technical work of the IGAS support mission relating to the funding reform for MCO activities.

In 2022, preliminary work started on the new 2023-2027 COP (Objectives and Performance Contract), notably with an IGAS mission focused on conducting an assessment of the previous COP and providing input for the next one.

For greater efficiency, the Agency's cross-functional organisational structure was consolidated, thus improving our responses to supervisory authorities and facilitating the execution of our missions.



**A centre with
wide-ranging
expertise**



1

mission

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, Social Affairs 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 creation of a repository, the processing of data and access to data from the performance dashboard of the medico-social sector.



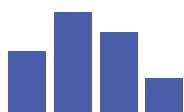
The technical management of funding mechanisms applicable to medico-social and healthcare institutions.



Conducting studies on the costs of medico-social and healthcare institutions.



Defining and maintaining healthcare nomenclatures.



Conducting analyses, studies and research on health data.



The collection, analysis and dissemination of data to assess care quality and patient satisfaction.



Participating in the management of health alerts.

audiences

State services

General Directorate of Health Services (DGOS), General Directorate of Social Cohesion (DGCS), General Directorate of Public Finance (DGFIP), Health-related digital technology delegation (DNS), 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 and medico-social federations

Healthcare institutions

Medico-social institutions and services (ESMS)

National organisations

Biomedicine Agency (ABM), National support agency for the performance of healthcare institutions (ANAP), Health-related digital technology agency (ANS), 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.

organisation

Management	External communication
	Partnerships mission
	Quality-of-care mission
General Secretariat	Quality
	Legal affairs and contracts
	Budget, accounting and financial management
	Management of human resources and internal communication
	Secretariat
IT architecture and production (API)	Management of IT system demand and development
	Quality assurance and support
	Infrastructures
Classifications, medical information and funding models (CIM-MF)	Medical information
	Classification and funding of medical activities
Collection of management information (COLLIGE)	Collection of cost information: national studies, surveys and accounting adjustments
	Funding campaigns
	Performance dashboard of medico-social institutions and services (ESMSs)
	National data collection in ESMSs within the framework of funding reforms
Funding and economic analysis (FAE)	Analysis of activities and 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)
	Healthcare institutions funding mechanism: management and reforms
Data requests, access, processing and analyses (DATA)	Compiling and providing access to PMSI databases
	Output of hospital data

teams

129

**people
employed by
the Agency at 31
December 2022.**

BREAKDOWN OF EMPLOYEES

Employees under public contracts and civil servants working on a secondment basis.

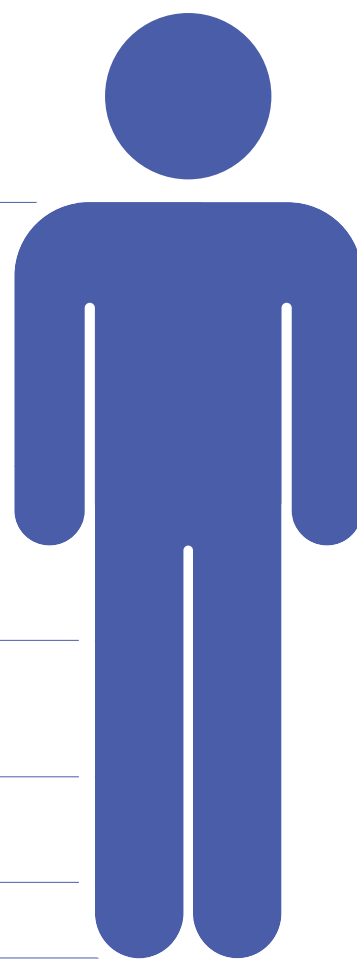
35% Statisticians

23% IT specialists

18% Support & Management staff

14% Doctors

10% Comptrollers & financial analysts



budget

€36,433k

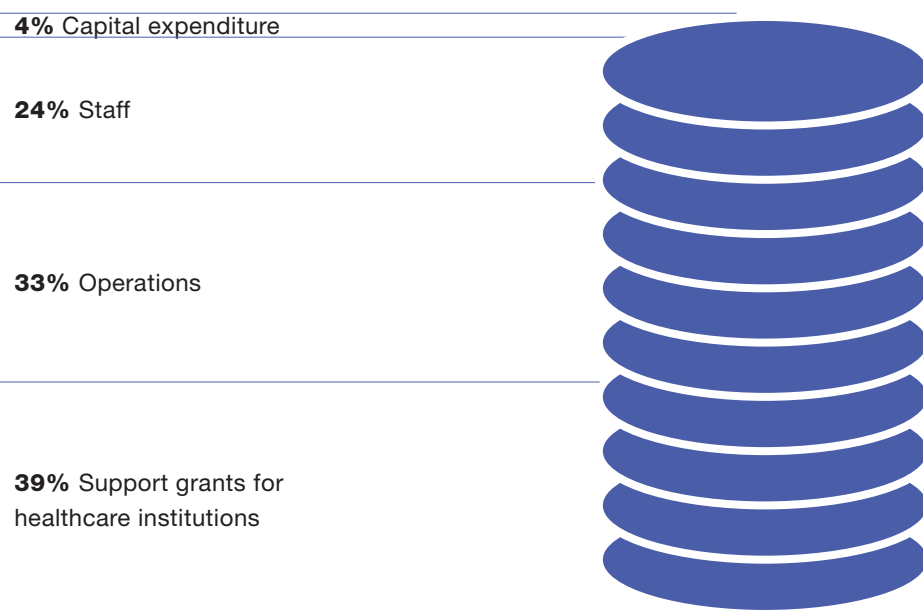
in expenses

(excluding capital expenditure)

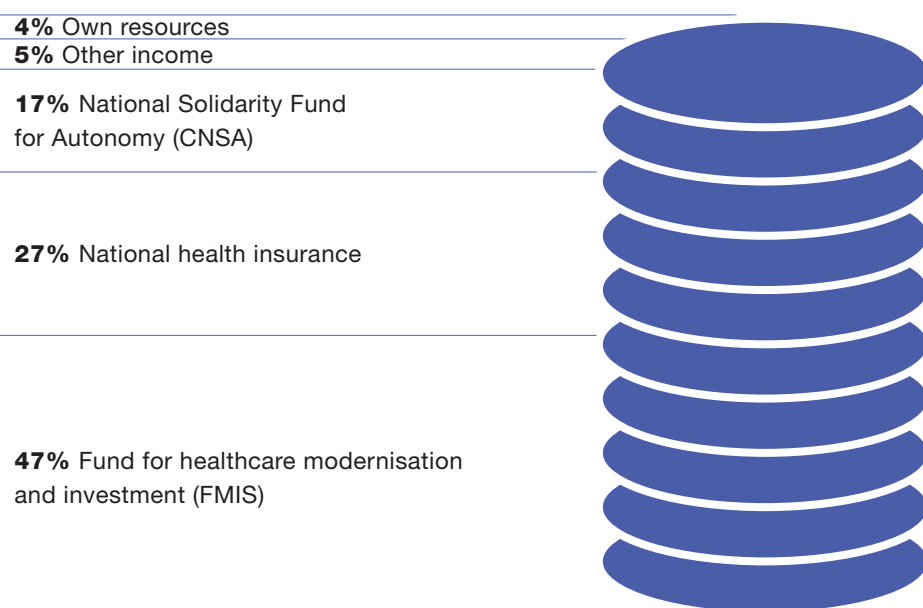
€36,680k

in revenue

BREAKDOWN OF EXPENSES



BREAKDOWN OF REVENUE





**A few
key figures**



2

figures

Hospitalisation

PATIENTS TREATED

Total

12.8m

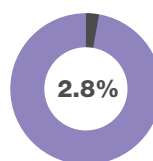
average age **51 years**



Covid-19

358,000

average age **68 years**



-0.3%

compared to 2019



+1.6%

compared to 2021

PATIENTS DECEASED

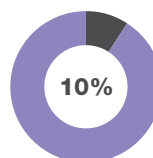
Total

393,000



Covid-19

40,200



+8.4%

compared to 2019



-0.7%

compared to 2021

These indicators were derived from non-sealed PMSI data.

A symptomatic Covid stay is coded with at least one ICD-10 diagnosis out of the following: 'U071', 'U0710', 'U0711', 'U0714', 'U0715'.

The 2020 key figures are not displayed, since the health crisis severely disrupted hospital activity for that year.

MCO Medicine, surgery, obstetrics

PATIENTS TREATED

Total

12.4m

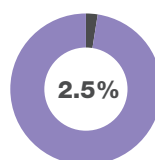
average age **50 years**



Covid-19
symptomatic

311,000

average age **66 years**



of which 1.5% under
full hospitalisation for
Covid-19



-0.1%
compared to 2019



+1.5%
compared to 2021

PATIENTS DECEASED

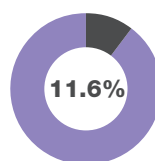
Total

318,000



Covid-19

36,900



+6.3%
compared to 2019



-1.1%
compared to 2021

HOSPITAL DAYS (stays excl. sessions)

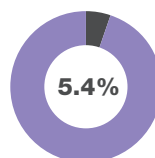
Total

71.8m



Covid-19

3.9m



-6.4%
compared to 2019



0%
compared to 2021

NIGHTS IN INTENSIVE CARE

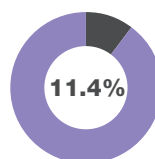
Total

2m



Covid-19

231,000



+3.3%
compared to 2019



-13.7%
compared to 2021

SSR Post-acute care and rehabilitation

PATIENTS TREATED

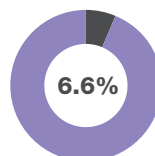
Total

916,000

average age **68 years**

Covid-19

61,000

average age **77 years**

-10.5% compared to 2019



+2.4% compared to 2021

PATIENTS DECEASED

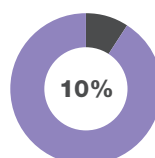
Total

31,000



Covid-19

3,200



-10.4% compared to 2019



-3.9% compared to 2021

TREATED ON A FULL-TIME BASIS

Total

680,000

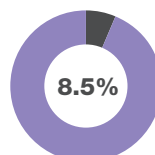
patients



Covid-19

57,800

patients



-15.3% compared to 2019



-0.6% compared to 2021

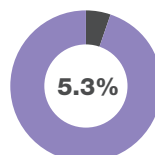
28.8m

days



1.5m

days



-11.9% compared to 2019



+1.3% compared to 2021

TREATED ON A PART-TIME BASIS

Total

289,000

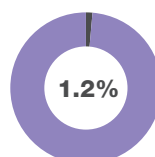
patients



Covid-19

3,400

patients



+5% compared to 2019



+11.5% compared to 2021

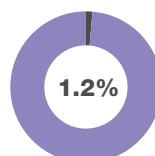
4.9m

days



58,400

days



+6.3% compared to 2019



+12% compared to 2021

HAD Hospitalisation at home

PATIENTS TREATED

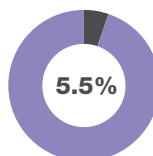
Total

159,000

average age **68 years**

Covid-19

8,700

average age **78 years**

+24.4% compared to 2019



+1.2% compared to 2021

PATIENTS DECEASED

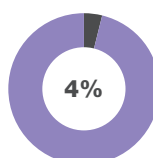
Total

43,000



Covid-19

1,700



+54.8% compared to 2019



+4.7% compared to 2021

HAD DAYS

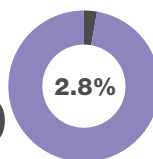
Total

6.8m



Covid-19

193,000



+14.2% compared to 2019



+0.3% compared to 2021

Psychiatry

PATIENTS TREATED

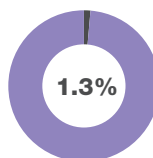
Total

399,000

average age **42 years**

Covid-19

5,000

average age **42 years**

-4.7% compared to 2019



+0.3% compared to 2021

TREATED ON A FULL-TIME BASIS

307,000

patients



-7% compared to 2019



-1% compared to 2021

16.7m

days



-9.6% compared to 2019



-3.9% compared to 2021

A hand in a blue surgical glove holds a scalpel, poised to cut a blue bar chart. The chart has three bars of increasing height, colored blue, orange, and green. The background is a blurred image of a person's face.

Review of the year 2022



2022 was the last year of implementation of the 2021-2022 COP (Objectives and Performance Contract).

Covid-19

Participating in the management of the health crisis

Adaptation of funding arrangements according to the pandemic

The funding guarantee was put in place in 2020, in view of the health crisis and significant loss of activity in the institutions. The purpose of this mechanism is to guarantee a minimum level of resources irrespective of activity level. The funding guarantee was renewed in 2021 and again in 2022. The technical tools and methods used for the payment of the funds to healthcare institutions had to be adjusted in order to make it automatic.

In 2022, the Agency ensured the technical consistency of the healthcare institutions mechanism throughout the year.

At the end of 2022, ATIH provided input for the IGAS IGF mission, requested by the Ministry, to support the pull-out of the funding guarantee.

Data outputs and analyses on the impact of Covid-19

ScanCovid – a tool created in 2021 – provides better knowledge of the epidemic in hospitals. Indicators are compiled using the activity data of institutions in the fields of medicine, surgery and obstetrics (MCO), hospitalisation at home (HAD), post-acute care and rehabilitation (SSR) and Psychiatry. The data are collected via the Programme for Medicalisation of Information Systems (PMSI).

The data are regularly enhanced with the information provided by institutions. They are presented in the form of interactive charts, tables or maps, along with a large selection of available indicators. In 2022, ATIH continued the regular update of the ScanCovid tool.

Hospital activity analyses notably made it possible to study the impact of the pandemic on hospital activity (activity recovery, etc.). These analyses were conducted for the central administration using infra-annual 2022 data on a monthly or quarterly basis. Analyses of 2021 hospital activity aimed at the general public were also conducted across the four fields (MCO, HAD, SSR and Psychiatry) and resulted in the production of key figures and annual summaries of hospital activity. Critical care was the subject of a specific study.

Fast-Track PMSI data transmission system

For MCO, the fast-track transmission of PMSI data between institutions, ATIH and CNAM, launched in July 2020, continued throughout 2021 and 2022.

Tool for the collection of data from the Covid-19 tests performed by hospital laboratories

The funding of the services involved in RT-PCR tests for the diagnosis of Covid-19 was established in March 2020 in several stages depending on the regions. Tests for the detection of Covid-19 antigens, or "antigen tests", were distributed to institutions in September 2020, along with the sequencing of Covid-19 variants (possible in certain institutions). For the valuation of this activity, the collection of data from these various tests was initiated in 2020 via the Fichsup files made available to the institutions.

In 2022, the collection and valuation process was continued. As requested by the Ministry, the institutions were informed of the adjustments made to valuation methods, (e.g. new funding period for the tests, end of funding for contact tracing).

Tool for the collection of hospital vaccination data

In France, vaccination against Covid-19 started in December 2020. It could be performed in vaccination centres, whose operation was partly or entirely managed by healthcare institutions. ATIH organised the transmission of data for these vaccination services. This was done through Fichsup files for public and private institutions operating in the fields of MCO, SSR and Psychiatry managing a vaccination centre. Its purpose was the valuation of this activity conducted by the institutions. In 2022, the data collection and funding continued and the rates were updated. Note that the same data collection methods (FICHSUP) were used for the valuation of healthcare institutions and professionals during the Monkeypox vaccination campaign. Data collection guidelines were transmitted through notices published by ATIH, drawn up in consultation with the DGOS and DSS.

Platform to track stocks of medicinal products and medical devices

At the request of the supervisory authorities, ATIH created the "Dispostock" platform in 2020 to replace the pre-existing fee-paying solution to keep track of stocks of medicinal products and medical devices in healthcare institutions and medico-social facilities. In 2022, ATIH continued to implement the changes requested by the supervisory authorities: import of data on vaccine stocks (in addition to the input already available) for Covid-19, flu and Monkeypox vaccines, tracking of vaccine expiry dates, and technical updates to facilitate the integration of new tracking operations.

Regular collection of data on the activity of institutions authorised to conduct psychiatric activities

Following the public authorities' decision, ATIH produced a platform for the input of psychiatric activity data through bi-monthly reporting. To assist the institutions, the Agency published a technical notice, as well as a platform user guide. On a monthly basis, the Agency populated the hospital data platform with the data stemming from the psychiatric information report.

It also produced a dashboard for the close monitoring of the facilities' activity. At the request of the supervisory authorities, this was continued in 2022. At the same time, a study was conducted on the possibilities of producing a RIM-P (record of medical information in psychiatry) on a monthly basis.

Support provided to regional health agencies (ARS) for the management of the health crisis

In 2021, ATIH was asked to provide to the regional health authorities, on the hospital data platform, the anonymised database of the national population screening system (SIDEPA) for Covid-19 and Covid-19 vaccine data. These data are provided on a daily basis. The Agency was also required to generate an AtlaSanté feed with data stemming from Dispostock and data on vaccination centres and professionals. This process continued in 2022.

focal point 1.

Contributing to the funding reforms in the healthcare and medico-social sector

1.1

Participating in the design and implementation of the funding reform

1.1.1

PARTICIPATING IN THE DESIGN AND IMPLEMENTATION OF COMBINED PAYMENTS

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

In 2022, ATIH continued to focus on quality indicators and how they are taken into account in terms of valuation, as well as the populating of the Eval Santé platform.

Quality-based funding (IFAQ)

In 2020, in view of the health situation, the allotted IFAQ budget of €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 economic activity volume.

The following indicators were taken into account in the 2021 mechanism:

- E-Satis
- indicators on the measurement of thromboembolic events and surgical site infections following total hip replacement – excluding fracture – or knee replacement
- digital indicators (HOPEN)
- certification.

Only the level achieved was taken into account. However, in order to take account of the impact of the health crisis on institutions, the breakdown of the allotted budget was based on a lighter process in comparison to the results of the quality indicators recorded in 2021.

The breakdown of the 2021 budget was based on 3 compartments:

- 1 • €200m based on the 2019 allocation
- 2 • €100m based on economic activity volume
- 3 • €150m based on indicators.

In 2022, the indicators were those used in 2021, along with certain patient record indicators. Another change in the model, in relation to 2021, was the implementation of the grading of remunerations based on the level achieved and the factoring-in of progression. The year 2022 was also marked by the integration of the Psychiatry field, with a care improvement indicator developed by ATIH: "Measurement of long-term full-time hospitalisation on a voluntary basis".

Like in previous campaigns, the allotted budget is compartmentalised: €400m based on indicators and €300m based on economic activity volume, for a total of €700m in 2022.

Change in the district hospital funding model

The work done in 2022 focused on the review of the lists of eligible institutions, the adaptation of the mechanism to funding based on geographical entity, and the posting of the new payment confirmation online.

New funding model for A&E

As the implementation of the new A&E funding model was deferred to 1 January 2022, ATIH helped to finalise the legal framework and calculate activity-based flat rates based on SNDS data. All parameters, including activity-based parameters (flat rates based on age, imaging, biology, participation in A&E activities, etc.) were stabilised.

In 2022, ATIH calculated the population-based allocation in respect of the DGOS/R1/2022/110 circular of 15 April 2022 relative to the healthcare institutions' first 2022 pricing and budget campaign.

Moreover, work was conducted on:

- the refining of paediatric flat rates based on an age criterion and diagnostic category
- the simulation of the impacts of the reform on the geographical institution.

The work resulted in the proposal of funding arrangements better suited to the different types of paediatric care and their intensity.

1.1.2

CONTINUING OUR TECHNICAL WORK AND THE SUPPORT PROVIDED TO THE DGOS ON FUNDING MODELS

Reform of SSR activity funding

At the end of 2021, ATIH – in coordination with the supervisory authorities – finalised the different compartments of the funding model and defined the parameters for the valuation of activities in 2022. It also carried out simulations covering the entire model.

In 2022, the parameters for the calculation of the allocation based on 2022 activity took account of the new classification and new activity valuation rules. ATIH implemented all the technical upgrades required by the reform. It will implement the measures defined by the Ministry of Health, i.e. ex-post application of the reform in the second half of 2023.

A new funding model for psychiatry

At the end of 2021, the Agency finalised the compartments and carried out comprehensive simulations on the whole of the model coming into effect on 1 January 2022. The regional health authorities transmitted the results to the institutions concerned. In 2022, ATIH built the blank model and the mechanism to ensure the safety of institutions. It took part in the required legal work (adjustment of the decree, orders, etc.). Calculations of the theoretical amounts of the allocations under the new model will be conducted in the first quarter of 2023 and will make it possible to adjust provisional 2022 allocations while taking account of the safety mechanism.

A&E rebuilding agreement

This action, introduced by Amendment No. 1 to the Agency's 2020-2022 Objectives and Performance Contract, provides for changes to the direct hospital admission pathway for elderly people.

In 2021, work was conducted with healthcare institutions to identify pathways for informing and providing care to persons over the age of 75 admitted directly into a hospital ward. Following a consultation with the medical information departments (DIMs), a new activity record was integrated in the PMSI to track this care pathway. ATIH took part in the reflection process to define indicators allowing the funding of this Ségur measure. In 2022, following the creation of this activity record, ATIH took part in the defining of indicators and allotment of the dedicated funds.

1.1.3 CONTRIBUTING TO THE REFORM OF THE PORTION OF THE FEE TO BE PAID BY THE PATIENT

In 2021, ATIH completed the work initiated in 2020 for the reform of the portion of the fee to be paid by the patient in 2022. The Agency thus produced national fee tables for daily services in the fields of MCO (formerly DG) and Psychiatry and built transition mechanisms. The reform's legal framework was finalised and the various tools were sent to the regional health authorities to enable them to notify each institution, starting in January 2022, of the national fees for daily services. In 2022, ATIH continued the work in the field of SSR, in preparation for the reform which was initially scheduled to come into effect on 1 January 2023.

1.1.4 CONTRIBUTING TO THE FUNDING REFORM IN THE MEDICO-SOCIAL SECTOR

In 2021, ATIH completed the collection of data from all SSIAD and SPASAD facilities after having designed the data collection tool, provided access to this tool to the players involved, and trained the facilities concerned. The Agency oversaw the collection of data, processed the data and proposed updates of the funding model.

Following the construction of the funding model, to simulate the effects of the reform, a new process was added in 2022 concerning the introduction of a data collection for home nursing services – SI-2SID (T0).

In 2021 and 2022, ATIH participated in discussions with the players involved concerning the funding model, and conducted statistical and cost analyses. This work led to the development of new methods for the calculation of SSIAD fund allocations.

These allocations comprise a flat rate to cover the facilities' overheads and transport costs based on their patient capacity, along with an amount aimed at funding home care based on the number of visits, in accordance with the characteristics of the persons cared for.

In the second half of 2022, ATIH processed the data collected from the facilities in order to stabilise the parameters of the chosen model. This work will continue in 2023.

In the disability sector, ATIH contributed to the work of the SERAFIN-PH Scientific Committee in 2022, by processing ENC data.

In 2023, ATIH will take a more active role in the work on the funding reform.

1.2

Adapting the technical tools concerning funding, management and knowledge of the hospital and medico-social sector, in keeping with STSS requirements

1.2.1

UPDATING AND ENSURING THE ACCURATENESS OF HOSPITAL AND MEDICO-SOCIAL COSTS

ATIH continued its work concerning the measuring of costs in the healthcare and medico-social sectors by:

- refining the measurement of work units (UOs)
- continuing the experimentation on the measurement of the intensity of the care (SIIPS)
- conducting cost studies.

In 2022, ATIH conducted work on the revision of the analytical tree and keys for the breakdown of expenses per work unit across a group of sections. This work included the creation of the "Pharma" work unit in coordination with ANAP and pharmacy specialists.

In 2021, ATIH published a good practice guide for healthcare institutions concerning the use of ENC and RTC data. In 2022, ATIH held a series of webinars to present this guide, for which videos are available on the ATIH website and YouTube channel.

Concerning the extension of the ENC/RTC scope to external care, following the defining and revision of the analytical tree, ATIH adapted the data collection tools during the ENC/RTC campaign applicable to the 2021 financial year, for their use in 2022.

The national cost studies (ENCs) conducted in the medico-social field were based on the guidelines of the DGCS and CNSA. In 2021, ATIH prepared the data collection planned for 2022 within the framework of the Serafin-PH project (CNIL file, methodology, implementation of the tools, recruitment and training of medico-social institutions and services).

The 2022 data collection – which is not a national cost study – comprises 3 samples:

- 1 • The "common core" sample involving 1,200 facilities, with the objective of making blank funding simulations to measure the effects of the new funding model, via the collection of data on the characteristics of the facility and the persons cared for
- 2 • Out of the main sample's 1,200 facilities, a "time" sub-sample of 300 institutions and services will record, in addition to the basic data, the times of the direct services and transport carried out or funded by the facility. This data should consolidate the results of the 2018 and 2019 national cost studies (ENCs).
- 3 • A "pathway" sub-sample of 150 facilities already in an advanced stage of the transformation process. These facilities must record the person's entire pathway, including the support provided by partners of the institution or service.

1.2.2 CLASSIFYING MEDICAL ACTIVITY IN ORDER TO ANALYSE IT AND FUND IT

Concerning the modernising of homogeneous patient groups (GHMs), ATIH completed its exploratory work to simplify the description of severity in medicine.

In 2021, it went from exploratory work to the revisions to be conducted in the fields of MCO and SSR on associated complications and comorbidities (CMAs). This work, which hospital players had long awaited, continued in 2022. It will give rise to new severity levels (e.g. 5 in MCO), as well as the development of modulation methods and multiple CMAs.

The fundamental principles of the CMA methodology have been consolidated through the use of a new statistical algorithm and the revision of diagnostic exclusions. The final CMA production model will be defined in 2023, after the study of different scenarios.

SSR

Following the production in 2020 of a new version of the SSR classification, distinguishing between rehabilitation intensity, patient burden and severity, ATIH released support tools in 2021 to enable players to come to grips with this classification scheduled for March 2022.

In 2022, work was conducted on the revision of CMAs, part-time hospitalisation and rehabilitation in paediatric rehabilitation groups.

HAD

In 2021, ATIH resumed its work on the HAD classification – which had been interrupted by the health crisis – for its effective completion in the first quarter of 2022.

Additional work was carried out in 2022 to address requests from the players involved, in particular to cater for changes in patient care during the same HAD episode. The classification should be finalised in the first quarter of 2023.

Psychiatry

Concerning the description of medical activities in Psychiatry, the work conducted in 2022 concerned the following:

- the projects on the overhaul of authorisations and funding: changes in the recording of full-time activity and specific activities
- ongoing work on the link-up of the activities of medico-psychological centres
- the production of care link-up variables through standardised invoicing summaries for ex-OQN institutions
- the preparation of monthly reporting in Psychiatry (RIM-P) scheduled for 2023.

This monthly reporting brings the field of Psychiatry into line with the reporting model applicable to all hospital activity fields. It stems from discussions with the institutions' representatives within the Technical Committee dedicated to Psychiatry.

1.2.3 DETERMINING RATES AND THE ALLOCATION OF RESOURCES

The actions planned in the 2020 and 2021 Objectives and Performance Contract (COP) have been completed: set-up of distance-based transport supplements and graduated valuation of hospital outpatient activities in the field of medicine.

In 2021 and 2022, ATIH also had to take account of the Ségur de la Santé measures concerning wages and make the required calculations for the equalisation system resulting from the integration of these measures.

These measures are managed using a two-prong approach. Since 2021, they are largely integrated in the funding model's general services. In 2022, certain measures only concern specific personnel and have been incorporated in a targeted way in the price of services (critical care bonus, etc.). In 2020, these measures had been funded according to the healthcare institutions' full-time equivalents (ETPs) rather than only according to the services funded. In 2021 and 2022, part of the funds (10%) was allocated to institutions on the basis of an equalisation method which solely concerned institutions having unfavourable effects between an activity-based allocation and an ETP-based allocation in the field of MCO/HAD.

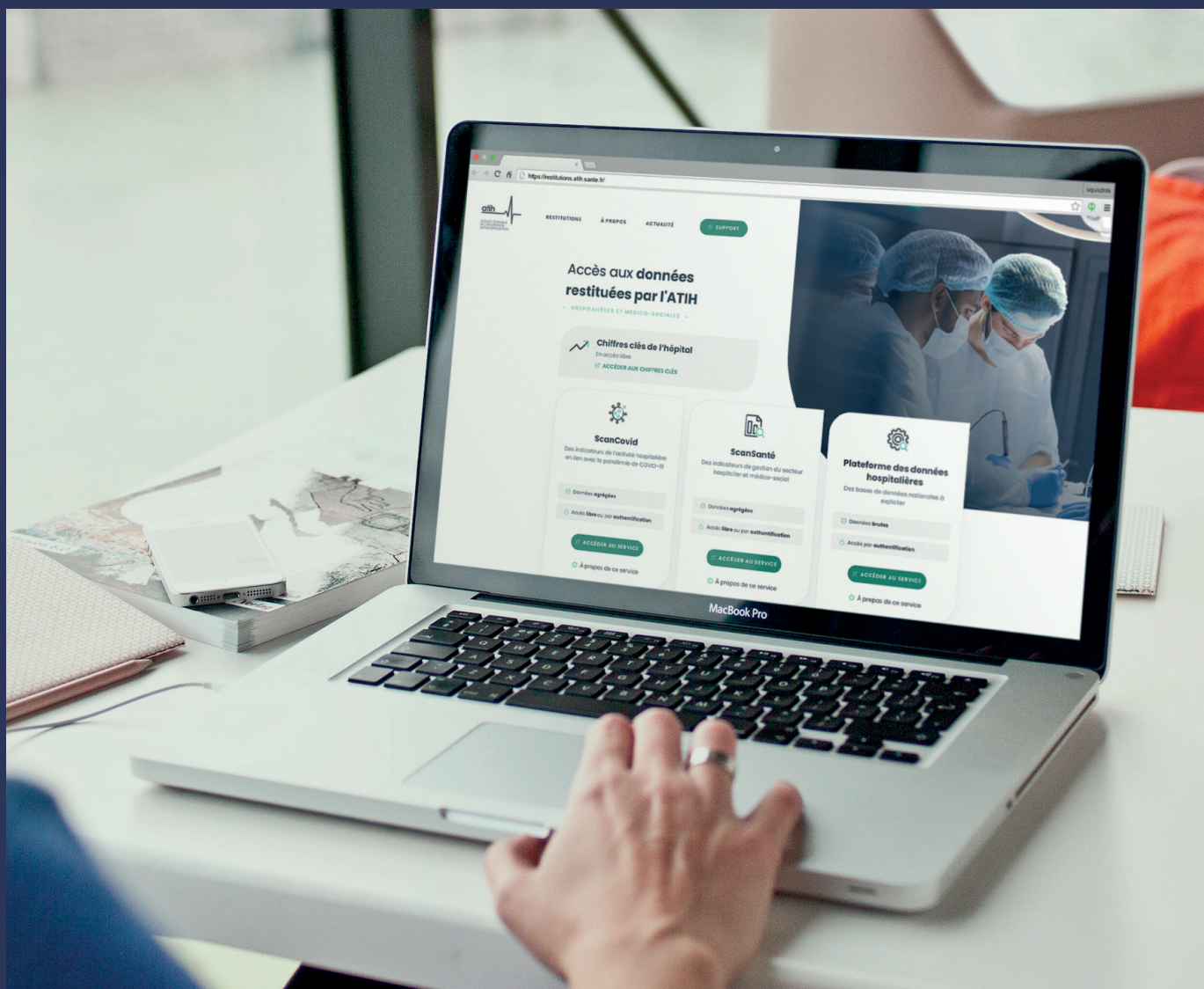
1.2.4 ASSISTING WITH NEW INVOICING PROCESSES

Work was conducted in 2022 in the field of Psychiatry: production of a table taking into account the active file concept used for the allocation per active file.

1.2.5 REINFORCING THE KNOWLEDGE, MONITORING AND MANAGEMENT OF HOSPITAL AND MEDICO-SOCIAL ACTIVITIES AND EXPENSES.

In 2022, the DSS and the DGOS asked ATIH to work within an inter-administration framework on the renovation of the national objective for healthcare spending – ONDAM (multi-year basis, etc.).

zoom in



Single point of access to ATIH data

ATIH is innovating and creating a new single point of access to the health data it produces: key figures on hospital care, ready-to-use indicators, and raw data. This portal provides a clear and concise vision of all data outputs, specifying the types of data (aggregated or raw), the types of access (open or through authentication) and the specificities of each platform. This centralised, target-specific access quickly guides the user according to their needs and profile.

focal point 2

Participating in the development of indicators on care quality, safety and relevance

2.1

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

At the request of HAS, the following work was conducted in 2022:

- the set-up of 2023 surveys for patients hospitalised more than 48 hours in MCO, those undergoing outpatient surgery, and those in post-acute care and rehabilitation (SSR)
- an extension of the experimentation on HAD patients
- experimental work on the measurement of satisfaction in Psychiatry in 2023.

2.2

Developing the use of data to contribute to the development of care improvement indicators

Care pathway quality indicators

Over the duration of the COP, work was 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 chronic obstructive pulmonary disease
- concerning a 30-day mortality indicator after myocardial infarction
- on the quality of post-stroke rehabilitation
- on the recovery of patients after a serious adverse event (PSI 04).

Surgical vigilance indicators

In 2020-2021, ATIH contributed to the defining of vigilance indicators concerning professional practices in the field of surgery, in collaboration with HAS and the DGOS. This work covered all surgical specialities: identification of indicators and the criteria to be used to set warning thresholds. A report was published by HAS in May 2022.

In 2022, ATIH started to draft specifications to produce the selected indicators according to surgical specialities. The first indicator – under development – concerns the hospital mortality rate from all causes, within 30 days following major surgery. It should be finalised in 2023.

2.3

Developing studies for the design and construction of care improvement indicators

Within ATIH

The aim is to increase ATIH's expertise in the design and development of indicators to be used within the compartment framework for the quality-based funding of healthcare institutions.

The work conducted in association with the DGOS concerned:

- the development of indicators based on PMSI data to provide a "financial incentive to improve quality" (IFAQ), including the following:

in MCO: measurement of the development of outpatient activity

in Psychiatry: measurement of long-term full-time hospitalisation on a voluntary basis in Psychiatry and percentage of patients on full-time care with a follow-up by a healthcare professional within 15 days following their discharge.

in SSR and HAD: exploratory work to appraise the possibility of automating calculations based on the PMSI data of HAS indicators computed by referring to the patient record.

Work was also initiated to develop new indicators based on PMSI data in these fields.

For instance, indicators on the rates of change/transfer from SSR/HAD to MCO.

- in parallel, work was conducted in collaboration with the DGOS to develop indicators on the quality of A&E care.
- the defining of quality indicators concerning the care of patients suffering from chronic renal disease (CRD).

Within ATIH's Scientific Committee

The aim is to strengthen ATIH's ties with research teams within the scope of the work carried out by the Agency's Scientific Committee to develop studies for the design and construction of quality-based funding indicators.

In 2020, following the first call for expression of interest on this topic, four projects were selected:

- development of an IT platform for the recording of PREMs/ PROMs in French psychiatric institutions: "Patient Experience Data Hub" for Psychiatry
- development of an indicator for potentially avoidable serious rehospitalisations
- development and validation of an indicator measuring quality of life at work in healthcare institutions
- development and validation of A&E care quality and safety indicators that can be automated and rolled out across all French emergency services.

Another call for expression of interest was launched in 2021. Three projects were selected:

- quality indicators concerning the pathway of patients with chronic coronary syndrome or having suffered a stroke (CHU Bordeaux)
- perinatal care quality and safety indicators (QUALI-N) (Inserm Equipe Epope)
- tele-expertise (AP-HP – Hospinomics).

In 2022, those projects were regularly monitored by the Scientific Committee and provided with technical support from ATIH teams.

zoom in



Key figures on hospital care

Using the data collected in the PMSI, ATIH publishes annual key figures on hospital care. Thanks to summary indicators, these key figures provide a measurement of hospital utilisation. For the 2020 and 2021 editions, a new "data design" model presents all the figures on a comprehensive scale and per activity in the same PDF document, prior to the creation of an online version on the data output platform.

focal point 3

**Modernising
data collection
and output
tools in keeping
with the health-
related digital
technology
policy**

3.1

Modernising and expanding data collection tools

3.1.1

ADAPTING

AND EXPANDING

DATA COLLECTION

TOOLS

Unified and integrated healthcare institution data reporting mechanism (DRUIDES)

ATIH has undertaken work to modernise the activity data collection mechanism under the DRUIDES project. This new mechanism was reviewed in 2020, following remarks from the CNIL and the results of tests conducted in institutions (rollout difficulties expected in small facilities). In 2021 and 2022, further tests were conducted with the institutions and software publishers to ensure the reliability of successive DRUIDES versions.

At the end of 2022, all data collection and transmission software dedicated to MCO activity was integrated in the latest DRUIDES version. The mechanism is now ready to be deployed for the 2023 campaign in the field of MCO.

Performance dashboard for the medico-social sector

In addition to providing general assistance, the Agency managed the creation of the technical system for the collection and output of data from the medico-social performance dashboard, as well as technical and methodological assistance to regional health authorities, and the maintenance of the platform hosting the data.

A total of 21,654 medico-social institutions and services (ESMS) were registered to take part in this data collection in 2022.

Some 90% of ESMSs logged into the platform and around 83% of them – i.e. 17,965 facilities – had their campaigns approved by their pricing and control authorities (ARSs and/or Departmental Councils).

The Agency provided outsourced support on this subject: 754 level-1 tickets were dealt with, as well as 82 level-2 tickets. To enhance the technical support mechanism and limit the use of outsourced technical support, the Agency developed tutorials and made them available to the players.

Record of the social security numbers of patients under outpatient and psychiatric care

In 2020, ATIH made use of the record of social security numbers of patients having received outpatient psychiatric care (CMP), in order to link up the various treatments received (hospitalisation/outpatient care). In 2022, the percentage of link-ups improved for patients exclusively under outpatient care. The percentage of an institution's patients with appropriate link-up went from 38% on average in 2021 to 44% in 2022. The monitoring of the development of the process is ongoing.

Overhaul of the health system observatory (OSIS)

In collaboration with the DGOS, the Agency continued the overhaul of OSIS. In 2022, numerous upgrades of OSIS V2 were requested, in particular the integration of the digital aspect of the Ségur de la Santé healthcare agreement (HOP'EN), as well as the OPSIEES aspect (permanent observatory of the security of the healthcare institutions' IT systems). The Agency also started developments for OSIS V3, extended to social and medico-social facilities, with a first version scheduled for the end of the 1st half of 2023.

Transmission of A&E care summaries (RPU)

In 2021, ATIH made proposals for the revision of the transmission of A&E summaries (RPU), in particular to enable institutions to correct the information transmitted. These proposals follow on from the reform of A&E funding, a portion of which is quality-based.

In 2022, the proposed pathway for RPU was supplemented with a survey questionnaire for field workers (ARS/ORU), in order to establish a panorama of RPU data collection, quality control and transmission procedures. The questionnaire was tested at the end of 2022 and will be disseminated in January 2023.

In addition to the work on the RPU transmission pathway, discussions and proposals took place on the transmission pathway for RPISs (SMUR patient intervention summaries). The discussions are conducted in support of the DGOS project focused on the set-up of a standardised collection mechanism for the activity data of mobile emergency and resuscitation services and the publication of the reference order. They are also conducted to ensure the consistency of RPU and RPIS transmission pathways.

3.1.2

PUTTING IN PLACE INTEROPERABLE DATA COLLECTION SOLUTIONS IN LINE WITH CHANGES IN FUNDING BASED ON CARE QUALITY AND RELEVANCE

ATIH was required to look into the creation of tools to collect record-type data and medical data stemming from the healthcare institutions' clinical information systems. In 2020/2021, work was conducted on Car-T Cells in the treatment of certain lymphomas and acute leukaemias (in collaboration with Lysarc – a European organisation dedicated to lymphoma research) and on the CRD flat rate (REIN record, ABM). In 2022, at Lysarc's request, a new indicator was introduced in the FICHCOMP Car-T file (date of the multi-disciplinary consultation meeting).

Since 2021, this work has been part of a broader project: the design of data collection tools suited to the new activity records (chronic diseases, Article 51, etc.) and the Ségur de la Santé policies aimed at simplifying the collection of information and reducing the workload, especially for clinicians.

At ATIH, in 2021-2022, this "new activity records" project gave rise to an assessment of the data collection system used for the PMSI. All stages of the process for the set-up of new activity records (design, deployment, stabilisation) were analysed.

In addition, international benchmarking (Great Britain, Australia, Denmark) took place to guide ATIH in its thought process. Based on this 2022 assessment, a certain number of options were identified. They were presented to the DGOS, with regard to the standardisation of data and transformation of the hospital data collection system.

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 department) approved ATIH's strategy of rolling out the Eval-Santé platform. V1 of this platform has been finalised.

Pilot projects (100% Santé, MRC, SAS, e-Satis) have been identified, but have not yet been conducted due to the lack of a global legal framework for the platform.

3.1.3

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, DSN)

The financial data collection platform (ANCRE) makes it easier for institutions to report their financial data, in particular following the 2020 overhaul which enables them to import their accounting balances.

In 2022, ATIH increased its support to institutions and regional health authorities by giving them access to new tutorials, webinars and technical data sheets.

Sessions presenting the new features of the 2021 financial accounts were organised to facilitate their production. With this support, the institutions' satisfaction rate is continuing to grow, having reached 85% ("satisfied/highly satisfied") for the 2021 financial accounting campaign.

In the aim of reducing data re-entry, in coordination with the DGFIP, work actively continued on the integration of data stemming from Hélios – the DGFIP's computer application dedicated to the local public sector – in order to automatically populate our data collection tools with the data available within the DGFIP.

To further facilitate the collection of data and ensure its reliability, ATIH completed the merger of ARCAⁿH RTC and ENC software, something that was much awaited by institutions conducting both studies. In 2020 and 2021, the DGOS and ATIH had worked on the convergence of expense scopes and definitions between PIRAMIG and RTC data. This work continued, in preparation for the automatic feeding of PIRAMIG accounting data by the RTC in 2023 (2022 data).

3.2

Modernising data output platforms

The Agency continued its work on the modernisation of its data output applications. This project involved a technological upgrade. The objectives of the project are:

- 1 • increasing the flexibility of query processes
- 2 • making greater use of data visualisation
- 3 • improving the ergonomics of data outputs
- 4 • co-building data outputs with users.

These improvements are already in effect for part of the data outputs and will gradually become the norm.

ATIH continued to develop an offering of “intermediate” data, i.e. between raw data and indicators, in line with the requirements of the Agency’s data output users. In 2021, work was carried out on the needs of ATIH data users. In 2022, technical functionalities were defined to increase the flexibility of data outputs. Webdesign work has already taken place to improve the user experience and provide a single entry point for data access and outputs. A new web-based portal to access ATIH data was completed at the end of 2021.

In 2021, ATIH created a new data output tool called "ScanCovid", in R Shiny, offering new data visualisation possibilities. The development of new data outputs and the overhaul of existing ones (e.g. Casemix MCO) was initiated and continued in 2022 through the use of the latest technologies.

In 2022, ATIH created and provided access to a data output tool called Soins et Territoires (access restricted to health players with a Plage/Pasrel account). This tool makes it possible to explore the population's healthcare needs, compare them with the hospital offering, and measure the contribution of each facility to the care of the population. This work is rooted in the collaboration of a multidisciplinary team stemming from ATIH, ANAP, the Scientific Committee for Health Investment (CSIS), the DGOS and EHESP.

Furthermore, work was conducted in partnership with INCA for the ScanSanté integration of care quality and safety indicators and was finalised in 2022.

3.3

Participating in the management of healthcare nomenclatures

3.3.1

PARTICIPATING IN THE WORK OF THE HAUT CONSEIL DES NOMENCLATURES

Following the publication of the Decree and Order on the composition of the Haut Conseil des Nomenclatures (HCN) in April 2021, ATIH was asked, in particular, to participate in the overhaul of the CCAM. It thus took part in the preparatory work for the establishment of clinical committees composed of clinicians, grouped by specialities, set up in early 2022. The Agency contributed to the production of training documents, and to the reflection on the structuring of the new CCAM. At the end of 2022, the clinical committees' initial feedback was the subject of discussions between HCN, CNAM and ATIH, in order to define how the proposed changes could be taken into account and applied in 2023.

3.3.2

DEPLOYING ICD-11 IN COLLABORATION WITH FRANCE'S WHO COLLABORATING CENTRE (WHO CC)

In 2021, with the help of professional translators, ATIH completed the translation of ICD-11 headings into French. This work was followed by a validation and consolidation phase, managed by ATIH, before the transmission of the translations to the WHO platform. In 2022, ATIH worked on the maintenance of the French headings on the WHO platform and continued its translation of new headings. The expert validation of the translated headings by scientific societies remains to be organised.

In parallel with this nomenclature work, discussions with France's WHO Collaborating Centre (in which ATIH participates), focused on how to organise the deployment of ICD-11 in France. Its effective deployment will only be possible after an analysis of the impact of the shift from ICD-10 to ICD-11, particularly on aspects such as IT systems.

3.3.3

UPDATING THE SPECIFIC CATALOGUE OF REHABILITATION PROCEDURES (CSARR)

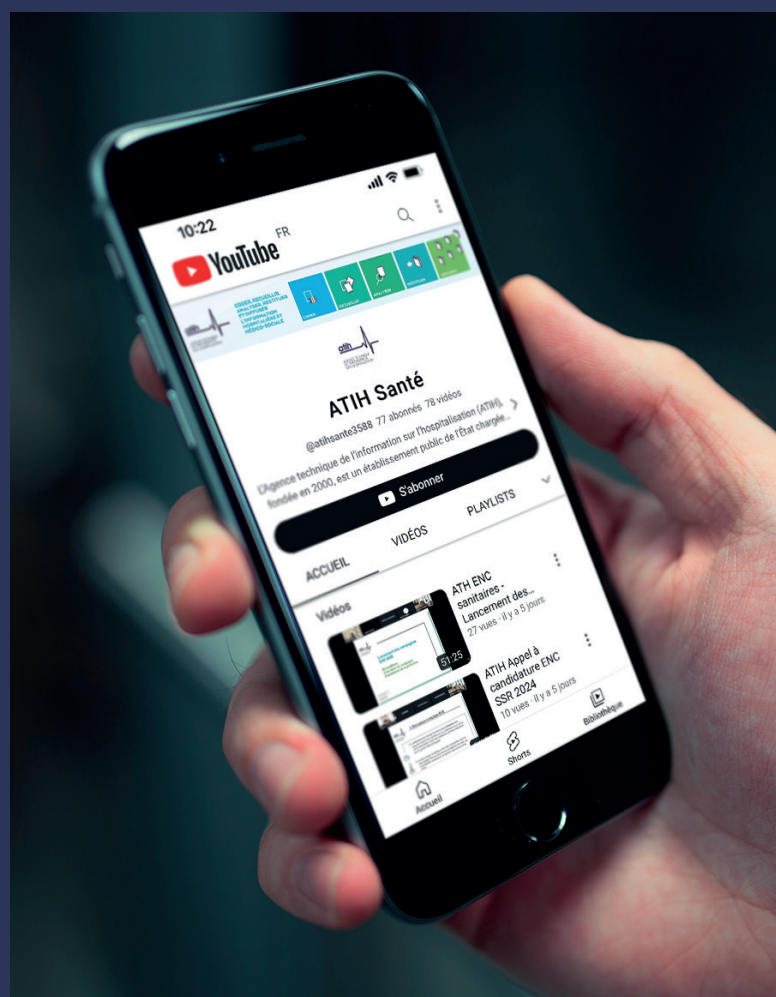
In order to simplify this tool – in compliance with Ségur de la Santé recommendations – ATIH consulted the players involved in order to organise a work group made up of professionals appointed by the federations, as well as members of the CSARR Expert Committee. A total of more than 90 professionals were brought together in 6 work groups, with the aim of completing the simplification process (through the grouping of procedures) in the 2nd half of 2022. The grouping of procedures was completed in late 2022, and should be validated by the players involved (DGOS/ federations/national councils of professionals), in early 2023. An arbitration stage for aspects outside ATIH's remit (clinical validity of certain procedures, authorised professionals, etc.) still needs to be conducted, as well as the redefining of procedure weighting factors.

zoom in

New ATIH YouTube channel

Created in April 2022, the channel offers videos of our information webinars, presentations and demonstrations of new tools, etc.

The different videos are grouped by themes via playlists. Over 70 videos are already available.



focal point 4

**Securing,
enhancing,
simplifying
and facilitating
access to
health data**

4.1

Continuing to develop the hospital data platform

ATIH is progressively continuing to enhance the hospital data platform, in particular by providing data from the new records, in accordance with the needs of healthcare players. In 2020, the platform was particularly enhanced with the data collected on the Covid-19 pandemic. In 2021, data concerning chronic renal disease and treatment with Car-T cells were integrated for certain types of users, after approval by the DGOS. An interactive dictionary of variables has been made available. In 2022, data concerning temporary residential facilities without medical care were added.

Following a CNIL verification, ScanSanté's activity data concerning small teams was masked to allow access to those data.

The Agency is working on the set-up of a secure ScanSanté-specific device for institutional players, and on the adaptation of the security level for access to non-sensitive data. In this connection, in 2021, ATIH made available the "complete" ScanSanté application, i.e. without masking small teams, on a secure server meeting SNDS security standards. Work was conducted in 2022 to allow the installation of a two-factor authentication system for ScanSanté users (with no physical tokens). This new system, due to be rolled out in 2023, may be extended to include access to the non-sensitive data of the hospital data platform (such as financial data).

ATIH is making further progress in its technical work concerning statistical processing on the hospital data platform, using technologies such as R and Python as alternatives to the SAS software.

Major training programmes were offered to staff on the R tool in 2020, 2021 and 2022. An inter-service work group was created for the sharing of knowledge and information on R utilisation and programming.

Work was carried out in 2021 concerning the update of PMSI data storage, in order to facilitate data access from development environments other than SAS. The deployment of the selected solution (Teradata) started in the 2nd half of 2022.

All of these initiatives have resulted in the use of R and Python for data processing developments: ENC medical data outputs, design of an interactive dictionary in R Shiny, etc.

The extension of this data processing in R/Python in 2023 will require the creation of a data science platform for both internal and external users.

4.2

Contributing to the governance and feeding of health data

ATIH contributes to the development of the SNDS through its various governance bodies, the Data Producers' Committee, the Strategic Committee and the Audit Committee.

The PMSI data are routinely fed into the SNDS on a monthly basis.

ATIH participates in the governance meetings of the health data platform, such as the General Meeting of the Health Data Hub.

4.3

Participating in the security of the pseudonymisation process in the collection and output of data

Over the duration of the COP, ATIH conducted work to install a new pseudonymisation system to ensure the secure dissemination of PMSI data. Following the preparation of an architecture proposal and a project macro-plan in 2021, the developments started, with a view to their completion in the first half of 2023. ATIH performs the 1st pseudonymisation process. For the 2nd pseudonymisation, an external partner (Adista) is required for the implementation of the pathway.

Reorganisation procedures (such as: the replacement of former pseudonyms by new ones in the PMSI databases already accessible) were also carried out and will need to be tested in early 2023, before the implementation of the new pathway.

focal point 5

Continuing to improve the performance of ATIH

Skill development

After two years of disruption due to the health crisis, the 2022 training programme was fully implemented.

Over the past 3 years, the switch to technological alternatives to the SAS statistics software required the development of training courses in the use of Python software and, most importantly, R software. To this effect, the training effort continued in 2022.

Training in 2022 also focused on the following topics:
data governance, data science, IT security, the development of tests on IT tools, good teleworking practices, etc.

Major projects impacting the Agency's management, internal control and organisation

Following the DGFIP's abandonment of the "Girafe" pay coding software on 1 January 2023, ATIH had to acquire a new pay transmission module. Its implementation generated 6 months of preparatory work in 2022 and will require increased supervision in 2023.

ATIH was also impacted by the management application project called INFINOÉ (Financial Information of State Organisations) scheduled for 2023. Its aim is to centralise the budgetary and accounting data of State operators in real time. In 2022, this particularly involved work on accounting nomenclatures. This work will continue in 2023.

Moreover, to facilitate project management within the services and across the board, the Agency acquired a dedicated tool (Beesbusy). Its deployment started in 2022. It will be useful for the scheduling of activities per service and across services.

focus

IT security at ATIH

Ensuring secure access to applications published by ATIH

In 2022, to improve the security of accesses to ATIH platforms, the password policy regarding access to our Pasrel/Plage platform was reinforced. All active users in healthcare and medico-social institutions thus had to reset their passwords.

In 2023, we will continue to improve access security. We are planning to set up strong authentication by adding a second authentication factor. At each login attempt, in addition to having to enter a username and password, users will initially also have to enter a one-time password (OTP) sent via a second email address. For this to work, users of our applications will need to have previously entered their second email address in their Plage profile.

Later on during the year, a second authentication, via an application such as Google Authenticator (to be installed on a smartphone), should also be available. This use of strong authentication has been imposed on us by our supervisory authorities and CNIL.

In parallel with the improvement of access security in 2022, other work has been conducted on the Pasrel/Plage platform. In particular, we conducted a static code audit, along with intrusion tests, in order to fix critical security flaws. Unlike the change in the password policy, these fixes were seamless for our users and did not require any change in their practices.

Raising the awareness of ATIH staff

ATIH employees are highly aware of in-house security issues and highly vigilant in terms of their required conduct. An awareness-raising programme concerning cybersecurity issues has been available to employees for a year now, to improve their knowledge on the subject.

Twice a month, Agency employees receive an email inviting them to access online cybersecurity awareness-raising modules. Each of these modules focus on a different topic: phishing, understanding a URL, using mobile terminals, proper teleworking conduct, etc. They present associated risks, as well as the good practices to adopt in order to reduce risks.

This improves protection for the Agency and for all of us. These tips and good practices are of course applicable on both professional and personal levels.



Measuring the satisfaction of users



barometer

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 respondents 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:

01.

Obtain relevant and regular feedback on its activities

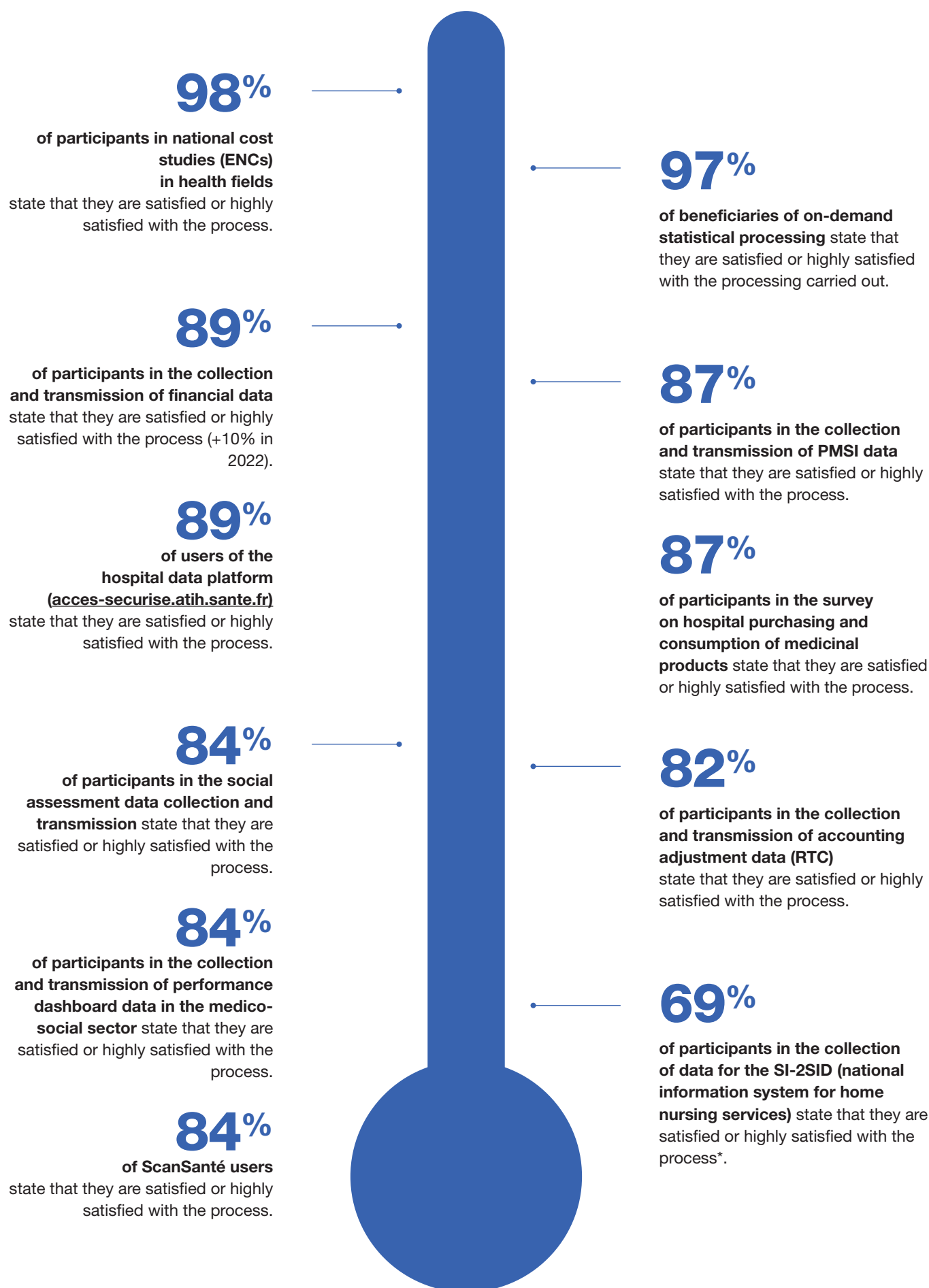
02.

Adapt by undertaking actions targeting the chief expectations of users

03.

Evaluate its efforts by observing the effects on satisfaction.

This barometer covers aspects such as ATIH's data collection activities (PMSI, ENC, financial accounts, ESMS performance dashboard, etc.) and data output activities (ScanSanté hospital data platform, on-demand statistical processing, etc.).



* The lowest satisfaction rate concerns the SI-2SID data collection. For this mandatory data collection conducted for the first time in 2022 with all SSIAD and SPASAD facilities, the main focus was the participation rate, which reached 96.7%. This new type of nation-wide data collection requires a period of adaptation for participating facilities, as well as ATIH (stabilisation of technical tools).



**A word from
the teams
involved**



How do we optimise the collection of data in healthcare institutions?

DR SOPHIE GUÉANT

Head of the Medical Information Department

ETIENNE JOUBERT

Health Economist, Medical Information Department

At present, what data are collected in the institutions?

The scope of the data collected in institutions is extremely wide. It is regularly extended to new data, according to State requirements: care activity, costs, financial data, care quality and organisation, human resources, real estate data, etc.

What are the data used for?

The data are used for funding purposes, the steering of government policies, and the governance of institutions. The need to access data rapidly was particularly important during the 2020 health crisis.

Who asks institutions to collect data?

Mainly the Ministry and its public organisations, such as ATIH. Each entity requests the data it needs from institutions, according to their own missions, without necessarily adopting a collective approach.

The institutions are thus asked to collect a lot of different data, which are sometimes similar. This often involves the copying of data from one software solution to another, something which is time-consuming and leads to errors.

Why are these numerous data collections problematic for hospitals?

In the current context where hospitals are under pressure due to shortages of staff and resources, it is difficult to ask healthcare staff to take the time to collect, transmit and process data. Today, we are faced with a paradox: we are asking institutions to collect an increasing amount of data, while it is increasingly difficult to produce those data due to the workload. It is therefore crucial to improve the entire health data production system to avoid a future logjam.

This concerns all of the institutions' IT systems.

The problem is both economic and technical, i.e. achieving a balance between the quantity of data requested, and the hospitals' capacity to produce it. It is also social and ethical, relating to the meaning given to the balancing of time between care and data production/processing.

Freeing a massive amount of medical time to reallocate it to patient care is a major issue, acknowledged world-wide. WHO and OECD reports emphasise the importance of data management to improve the performance of the health system.

Do institutions use the data collected?

The data is not always accessible to healthcare staff. It is difficult to cross-tabulate the data to give them meaning for care purposes. Concerning the planning of care and the management of care pathways, ATIH's hospital data platform provides access to PMSI data (diagnoses and procedures). Other data included in medical records can also be useful (e.g. consultation data, prevention actions, etc.).

How is ATIH dealing with the question of how to optimise the collection of data?

As a major player in the collection of health data, ATIH has been reflecting for several years on how to improve the efficiency of the data collection process. This reflection needs to go beyond the framework of the PMSI. The entire data collection system must be improved, in view of the numerous purposes of hospital data.

Our principle is for data to have the maximum number of uses, to avoid duplications, and thus reduce production workload for institutions.

In concrete terms, what can be proposed?

Two avenues can be envisaged:

- The first concerns the coordinated management of data, by asking several questions: How can we better organise new hospital data requests? What rules do we set at national level to obtain useful information from field workers while minimising costs?

Achieving the point of equilibrium involves a search for convergences between the demands and needs of the Ministry's different central administrations, its agencies, and health organisations: ANAP, ANS, HAS, DNS, DGOS, Health Data Hub, etc.

We could thus define the data of interest (a minimum data set) and the norms and standards to be complied with (imposed upon publishers) in order to promote the retrieval of this data in the most automatic way possible.

- The second avenue concerns technological innovations, with the installation of data warehouses within the biggest institutions, mainly for research purposes at the moment. This technology could be useful for PMSI data. However, such systems require significant investments within the institutions. We are also examining the automatic retrieval of structured information or the use of artificial intelligence.

These new technologies improve the overall performance of the health data collection system. The grouping of large amounts of digital information in a single place makes it possible to link up such information and thus build original data without the need for manual copying or consolidation in Excel files. Such is the challenge of IT system interoperability within healthcare institutions.

How is ATIH working on that issue?

A small team was brought together with the support of our service and our management. In 2022, an external service provider helped us establish a diagnosis and lay down detailed policies. Some fifteen projects were identified, focusing on the simplification of data collection, the standardisation of the data, and a strategy to deploy data concentrators. We are starting to hold regular discussion meetings with the DGOS and other agencies. Furthermore, our reflection process was enhanced with the experience of other countries – Australia, England and Denmark.

We were particularly impressed by the Danes, who have an extremely efficient health data production system. They rely on their lengthy experience in the production of records, and all of the data are fed into a single IT system. For example, they set up a Covid compendium very rapidly with a significant amount of inputs in a fairly short time. While it is difficult to compare France with Denmark, the model remains a strong source of inspiration for us.

Our work also lies within the framework of reflections on the European Health Data Space.

What have we already started to do at ATIH?

After the assessment, we tested our assumptions and ideas with a number of players (institutions and agencies). All of the persons questioned considered them to be forward-looking and relevant, thus confirming our ideas and pushing us to move forward. Expectations are high!

What are the next steps?

The next steps are to continue to communicate on the subject at a political level and to launch certain technical projects in priority areas:

- The creation of a framework, i.e. a minimum health data set. This common core would help to standardise the collection of essential data.
- Giving further thought to economic aspects (Who pays?), technical aspects (What standards?), legal aspects (What framework?), environmental aspects (What impact?) and organisational aspects in particular.
- Putting into perspective the purposes of the PMSI, and the roles and responsibilities of all professionals contributing to the production and processing of the information.

This is a systemic project, which targets all of the nuts and bolts of hospital IT systems, and which is rooted in discussions with field players. This project also relies on convergence between the medical and technical teams of other agencies, along with political support.

And in your opinion, what will happen if data collection remains unchanged?

If the collection of data doesn't evolve, we risk the blocking of the health system, such as through coding strikes that would prevent the recording of data because doctors no longer have the means to deal with it. But fortunately, we are aware of the risk and the project is moving forward!

Glossary

A

ABM

Agence de la biomédecine – Biomedicine Agency

ANAP

Agence nationale d'appui à la performance des établissements de santé – National Support Agency for the Performance of Healthcare Institutions

ANS

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

AP-HP

Assistance publique hôpitaux de Paris – Public assistance, Paris hospitals

ARS

Agence régionale de santé – Regional Health Agency

C

CAR-T cells

T cells carrying a Chimeric Antigen Receptor

CCAM

Classification commune des actes médicaux – Joint Classification of Medical Procedures

ICD

International Classification of Diseases

CMA

Complication ou morbidité associée – Associated complication or comorbidity

CMD

Catégorie majeure de diagnostic – Major category of diagnosis

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

D

DAF

Direction des affaires financières – Financial Affairs Department

DG

Dotation globale – Total allocation

DGS

Direction générale de la santé – General Directorate of Public Health

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

DIM

Département d'information médicale – Medical Information Department

DNS

Délégation du numérique en santé – Health-related digital technology delegation

DREES

Direction de la recherche, des études, de l'évaluation et des statistiques – Directorate for 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

E**EHESP**

École des hautes études en santé publique – French School of Public Health

EHPAD

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

ENC

Étude nationale de coûts – National cost study

ESMS

Etablissements de santé et médico-sociaux – Healthcare and medico-social institutions

ETP

Equivalent temps plein – Full-time equivalent (FTE)

F**FICHCOMP**

Fichier complémentaire – Complementary file

FICHSUP

Fichier supplémentaire – Supplementary file

G**GHM**

Groupe homogène de malades – Homogeneous patient group

GHS

Groupe homogène de séjours – Homogeneous stay group

GME

Groupe médico-économique – Medico-economic group

H**HAD**

Hospitalisation à domicile – Hospitalisation at home

HAS

Haute autorité de santé – French Health Authority

HOP'EN

Hôpital numérique ouvert sur son environnement – Digital hospital open to its environment

I**IFAQ**

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

IGAS

Inspection générale des affaires sociales – General Inspectorate of Social Affairs

IGF

Inspection générale des finances – General Inspectorate of Finance

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

L**LYSARC**

Lymphoma Academic Research Organisation

LFSS

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

M**MCO**

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

MRC

Maladie rénale chronique – Chronic renal disease (CRD)

O**WHO**

World Health Organization

ONDAM

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

OQN

Objectif quantifié national – National quantified objective

ORU

Observatoire régional des urgences

– Regional A&E observatory

P

PIRAMIG

Pilotage des rapports d'activité sur les missions d'intérêt général
– Management of activity reports on missions of general interest

PMS

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

PREMs

Patient-Reported Experience Measures

PROMs

Patient-Reported Outcome Measures

R

RAAC

Réhabilitation améliorée après chirurgie – Improved post-surgery rehabilitation

REIN

Réseau épidémiologique et information en néphrologie – Nephrology

information and epidemiology network

GDPR

General Data Protection Regulation

RIA

Relevé infra annuel –
Infra-annual statement

RIM-P

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

RPIS

Résumé patient intervention SMUR –
SMUR patient intervention summary

RPU

Résumé des passages aux urgences – A&E care summary

RTC

Retraitement comptable –
Accounting adjustments

RT-PCR

Reverse transcription polymerase chain reaction

S

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

Services polyvalents d'aide et de soins à domicile –
Multidisciplinary home aid and care services

SPF

Santé publique France – French Public Health

SMUR

Structure mobile d'urgence et de réanimation –
Mobile emergency and resuscitation service

STSS

Stratégie de transformation du système de santé –
Health system transformation strategy

SSIAD

Service de soins infirmiers à domicile –
Home nursing services

SSR

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

U

UO

Unité d'œuvre –
Work unit

2022

ATIH Headquarters

117, bd Vivier Merle
69329 Lyon cedex 03
France
Tel. 04 37 91 33 10
Fax: 04 37 91 33 67

ATIH Paris Branch

13, rue Moreau 75012 Paris
Tel. 01 40 02 75 63
Fax: 01 40 02 75 64

www.atih.sante.fr