DESCRIPTION OF THE PRACTICE	
1. Title of the practice	
- 'Autonom@Dom: multidimensional integrated services to support independent living at home for people with chronic conditions' -	
2. Organisation responsible for the practice	
Isère County Council, France	
3. Contact person(s)	
E-mail	policy@esn-eu.org
4. National/regional/local context of the practice	
Healthcare and social care systems are fragmented in France. The counties are responsible for the welfare and care of older people and disabled persons. Health care is organised and financed by national structures. This fragmentation was addressed by the creation of the 'Regional Health Agencies (ARS) in 2009. The ARS have responsibility for several fields: prevention and public health, monitoring and safety, provision of care and long-term care. Medical care is covered by national health insurance. Local authorities are responsible for providing benefits to dependent, older people. The 'Personal Autonomy Allowance (APA)' provides benefits to help older people to meet some of the cost of care that is not covered by health insurance. The APA is a means-tested benefit for people over 60 that is calculated based on a 'help plan' that is done on the basis of a needs assessment. 70 per cent of APA is funded by the 'General Councils, and the remaining 30per cent by the 'National Solidarity Fund for Autonomy (CNSA). The CNSA is a national organisation responsible for providing financial support for services to persons who have lost their independence. The 'Law on the Adaptation of Society to the Ageing of the Population' was adopted in 2014. It sets out a reform agenda in home and residential care that aims to reduce copayments by service users, improve working conditions and staff training, build up respite care, develop prevention and promote the use of home adoptions. The 'Health Law' will be discussed in Parliament in April 2015. It highlights the need for an integrated one-stop shop to address health and social care needs.	

At the local level, new approaches are being implemented to address fragmentation, such as MAIA, interconnected geriatric networks and PAERPA experiments (individualised care plans for people with a loss of autonomy).
5. Summary of the practice

Autonom@Dom is a large-scale demonstration that will take place in Isère County. The ambition is to scale up the practice, which needs a national framework evolution that is already being addressed by a national committee (CNOSA: National Committee on Guidance for Autonom@Dom). Autonom@Dom aims to integrate health care and social care and foster cross-sector cooperation. Therefore, it involves the whole system, from health to social services, from public and private sectors.

Autonom@Dom is based on a call centre and an open software platform for service integration, acting as a one-stop shop for demands and needs for health care and social care from different stakeholders (professionals, older people, families, social workers, carers).

The pilot will be implemented in 2015. It is based on the cooperation between health and social care professionals, the private and the public sector and is enabled by ICT and data sharing and analysis. Besides the inter-professional coordination centred on the personal needs of an individual user, services will be proposed to different cohorts of users:

- retired people: support for personal management and empowerment based on physical activity, cognitive stimulation, nutritional education, and social activities;
- seniors at risk of losing their independence: a prevention programme plus a fall prevention programme and remote surveillance and monitoring of motor and cognitive activity;
- patients suffering from chronic heart failure: the same package for the group above plus integrated care and remote surveillance and monitoring;
- patients suffering from cancer: coordination of health care and social care, scalability of home services, secondary prevention and remote surveillance;
- a one-stop front office for anyone facing health or social difficulties or seeking a home service.

To prepare for the implementation of Autonom@Dom, 6 pilots were implemented in 2013 and evaluated (main results, global strengths and weaknesses, difficulties, and user feedback).

Lessons learnt:

- Initiatives must take account of human resources issues relating to new jobs, which will require new training, induction, and integration into existing workforce systems.
- Training is needed to ensure mutual trust between health and social actors to achieve co-responsibility of the user.

- There is a need to remove legal and structural barriers to relocating human and financial resources to achieve a sustainable business model.
- Strong change management is needed to achieve cross-sector cooperation and behavioural change.
- An international coding system related to social problems or diagnosis is required as in the health sector; some communication tools are needed based on platform functionalities to support virtual work between professionals.
- Evidence of effectiveness is needed to ‘convince’ stakeholders and decision-makers.

6. Staff involved

General Practitioners, doctors in hospitals, nurses, social care home services, physiotherapists, representatives of associations for older people or patients, health network representatives
7. Target group
Older people and others with chronic conditions
8. Aims of the practice
The practice aims to use resources better and improve health for service users and informal carers by integrating health and social care for older people to live longer at home or in-home settings, with a better quality of life, in an economically sustainable model. It also aims to improve coordination and continuity of health and social care, support independence for service users and enhance new forms of working by developing new organisations in health and social care delivery, new forms of work, and better training and ICT.
9. Issues for social services

Service Integration/ Cooperation across services	X	**Service Planning**		**Contracting**	
Technology		**Skills development (of the workforce)**		**Quality of services**	

ANALYSIS OF THE PRACTICE	
10. Status	
Pilot project (ongoing)	X
Pilot project (terminated)	

Project (ongoing)	
Project (terminated)	
Implemented practice (restricted areas)	
Widely spread practice/rolled out	

11. Scope of the practice

Describe the setting of the practice, considering the following criteria:

- *Micro-level practice: a* practice that involves individuals at the local level
- *Meso-level practice: a* practice that involves organisations or communities
- *Macro level practice: a* practice that involves large population groups

Macro level integration

12. Leadership and management of the practice

Describe the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

Collaborative management: This macro-level initiative and consists of a large partnership of central, regional, and local representation from council, industries, academia, insurance, alongside health and social care agencies and service user representatives. The General Council of Isère is the leader with a strong partnership with the regional health agency, the retirement funds and private insurance; cooperation with academics and large industries; inputs and feedback from users via the CCUSDA (Consultative Committee of Users).

13. Engaging stakeholders in the practice

Describe the engagement of stakeholders, considering the following criteria:

- *Individual practice*: individuals have sought practice change
- *Network approach*: one or more organisations develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

Collaborative approach: This macro-level practice describes a large collaboration with relevant stakeholders. Professionals were brought together from health and social care sectors, home services, physiotherapy, associations for older people, and health network: "A consultative body was created for dialogue, expression, information, discussion, and proposals, and to provide feedback to a Project Steering Committee. Members of the consultative body is representatives of patients associations, seniors associations, other associations of 'health users' or informal carers, locally, regionally or nationally organised." The practice aims to build up a shared vision between the agencies participating. This unified collaboration and 'working together' is essential for success, and system transformation is the wider ambition.

Training to support new working: The importance of training for change management is important in this practice. 'Training and change management has been going on for five years at the local level. Local integration of health care and social care already brings professionals from different sectors together and helps to understand each other, especially when building co-responsibility of patients.'

Data sharing: An ICT-based tool to achieve a shared medical and social record is being developed and improved thanks to users' and professionals' inputs. Data sharing (a shared record) is connected with home devices and software to allow prevention, remote surveillance and monitoring (falls, cognitive and motor activity, blood pressure, weight, adherence to treatment) and software to foster adapted physical and cognitive activity.

14. Involvement of service users and their families

Describe the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the practice team*
- *Consultative: a consultative body of users was set up for ongoing dialogue and feedback*
- *Involvement in care: person-centred approaches to care/support*

Consultative: A consultative body of service users was set up, who are part of ongoing dialogue and feedback to help shape the project.

15. Costs and resources needed for implementation

Describe how the practice is financed, considering the following criteria:

- *Within existing resources:* staff time and other resources are provided 'in-house'
- *Staffing costs:* costs for staff investment
- *Joint/Pooled budgets:* two or more agencies pool budgets to fund services
- *Funded project:* external investment

Joint funding scheme: Public and private co-funding through a general council, a regional agency, a retirement fund, and private insurance for the project. This initiative also had external investment: There was a rough budget of 6 million euros for the project. A business model provided sustainability for the new organisation through decentralisation and relocation of funding between health and social care. New management jobs were created to coordinate complex situations, and training was undertaken for formal and informal carers.

16. Evaluation approaches

Describe the evaluation method of the practice, considering the following criteria:

- *Multi-method:* use of both a qualitative and a quantitative approach
- *Single method: a* qualitative or quantitative approach
- *Audit:* looks at data sources such as existing medical records and/or other routinely collected service data.
- *Informal:* refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback
- *No evaluation*
- *An evaluation is planned*

Multi-method evaluation: planned.

17. Measurable effects of the practice and what it has achieved

Service users	To prepare for the implementation of Autonom@Dom, 6 pilots were implemented in 2013 and evaluated. The group with software tools and remote activity monitoring to prevent decline had better adherence and better functional results than the control group.
Formal caregivers	
Informal carers	
Organisations	

18. Anticipated or 'aspirational' effects of the practice and what it has achieved *This category can include outcomes which are not documented, quantified or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.*	
Service users	
Formal caregivers	
Informal carers	
Organisations	

19. How has the practice changed the way the service is provided
Not yet

20. Sustainability of the practice *Describe if the practice is sustainable, considering the following criteria:* • *Potential for sustainability:* practice was newly started or is ongoing/not yet mainstreamed. How could the practice be sustained (in terms of resources)?
• *Organic sustainability:* service users have been empowered to take the practice forward • *Established:* the project has been operational for several years
Potential for sustainability: the initiative is newly started and is not yet mainstreamed, but the pilots already help to put forward ideas for how the initiatives could be sustained. Sustainability could be ensured through a business model that pools and relocates funding, alongside securing private and public co-financing.

21. Transferability of the practice *Describe if the practice has been transferred, considering the following criteria:* • *Transferred:* transfer to other regions, countries, service user groups, etc. • *Potential for transferability:* there is interest from the outside; elements of the practice have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed
Not transferred yet: the demonstrator is about to be implemented in the Isère County. Isère County is part of a regional project ("territoire de santé numérique") that will evaluate this new approach in an area including another county (including parts of the city of Lyon). This demonstration is led from a national deployment perspective, under the responsibility of the Ministry of Health and the regional health agency (ARS).