Master of Public Health

Master de Santé Publique

EHESP

Constructing Integrated and Coordinated Care: A Qualitative Analysis of the Barriers and Facilitators in the Development of Local Healthcare Networks "Communautés Professionnelles Territoriales de Santé" (CPTS) in Ile-de-France

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MPH 2, 2023-2024

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Acknowledgements

First and foremost, I would like to express my deepest gratitude to the Almighty for His unwavering guidance, strength, and countless blessings throughout this journey. His grace has been the foundation upon which all of this has been possible.

To my husband, Adama Ibrahima Daou, my heartfelt thanks for your steadfast support, encouragement, and unshakeable belief in me. Your love and patience have been my pillars of strength, sustaining me through the challenges and joys of this rewarding journey.

I am deeply grateful to my family and friends for their constant encouragement, support, understanding, and love. I especially wish to honor my mother, Nana Ouattara, whose wisdom and care have always illuminated my path. To my late father, Abdoulaye Sylla, my greatest supporter—your memory lives on in every step I take, and I dedicate this achievement to you. Your unwavering belief in me has been a continual source of strength and inspiration.

I extend my sincere thanks to the EHESP staff, my professors, and colleagues for their guidance, knowledge, and support throughout my academic journey. Your contributions have been invaluable, and I am deeply appreciative.

I am also profoundly grateful to the members of CPTS Villejuif and my professional advisor for their insights, collaboration, and mentorship. Your support has greatly enriched my research and professional growth. Additionally, a special thanks to all the study participants, whose willingness to share their experiences made this research possible.

Lastly, to my little bundle of joy growing inside me—I cannot wait to meet you. You have already filled my life with immense happiness and inspiration, and I dedicate this work to the beautiful future we will share together.

Table of Contents

Abstract

Background: The French healthcare system faces significant challenges, including rising chronic diseases, increasing healthcare costs, and inequalities in care access. These issues are compounded by an aging population and the presence of "medical deserts," where primary care is scarce. To address these problems, the French government introduced the Communautés Professionnelles Territoriales de Santé (CPTS) initiative, aimed at improving integrated and coordinated care nationwide. However, its implementation has fallen short, particularly in Île-de-France, the country's most populous region. This study examines the barriers and facilitators encountered by healthcare professionals in developing CPTS in this region.

Methods: This qualitative study employed semi-structured interviews with healthcare professionals involved in the creation or development of a CPTS in Île-de-France. Participants were recruited through purposive and snowball sampling until data saturation was reached. Interviews were recorded, transcribed, and analyzed using both deductive and inductive coding to identify themes related to barriers and facilitators of CPTS development.

Results: Ten interviews were conducted with professionals from six different CPTS in Île-de-France. Key barriers identified included scheduling and coordination challenges, increased workloads, unclear regulatory guidance, and interpersonal conflicts. Initial resistance to digital tools was noted but diminished post-COVID-19. Facilitators included strong government support, effective leadership, financial incentives, flexible objectives, and established professional networks. Younger professionals' involvement, characterized by enthusiasm and collaboration, was also a significant positive factor.

Conclusion: This study highlights critical factors affecting CPTS development in Île-de-France, offering insights for future interventions. Successful CPTS implementation may require addressing organizational and interpersonal challenges, with an emphasis on leadership and professional networks. These findings can inform future policies to enhance integrated care in the region.

Keywords: Integrated care, coordinated care, organizational integration, interprofessional collaboration, CPTS, healthcare reform.

List of Acronyms

CPTS - *Communautés Professionnelles Territoriales de Santé* (Local Health Networks)

ACI - *Accord Conventionnel Interprofessionnel* (Interprofessional Agreement)

ARS - *Agence Régionale de Santé* (Regional Health Agency**)**

EHPAD - *Établissement d'Hébergement pour Personnes Âgées Dépendantes* (Residential Care Establishment for Dependent Elderly Persons)

Ondam - *Objectif National des Dépenses d'Assurance Maladie* (National Objective for Health Insurance Spending)

CMS - *Centres Municipaux de Santé* (Municipal Health Centers)

MSP - *Maisons de Santé Pluriprofessionnelles* (Multi-professional Health Centers)

IPC - Interprofessional Collaboration

BCF - Better Care Fund (UK)

FHT - Family Health Teams (Canada)

AHS - Alberta Health Services (Canada)

WHO - World Health Organization

OECD - Organisation for Economic Co-operation and Development

1. Introduction

1.1. Structural Changes and Challenges in the French Healthcare System

The emphasis on primary care reforms in health policies, observed in many developed nations including France, stems from a series of significant structural changes in the healthcare landscape that have been unfolding since the 1950s [1].

One of the major changes is the rise in chronic diseases, driven by an aging population and epidemiological transitions, marked by a change in mortality causes from acute, rapidly fatal diseases to the predominance of chronic, often debilitating conditions [2,3,4]. These shifts have been fueled by medical advancements, improved healthcare techniques, and recent lifestyle changes such as increased sedentary behavior and poor dietary habits [5]. In 2022, 24.4 million people reported having at least one chronic or long-term illness [6]. About 80% of deaths were attributed to chronic diseases such as cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, psychiatric diseases, neurological or degenerative diseases, inflammatory or rare diseases or HIV/AIDS and liver or pancreatic diseases [6]. This situation has created a growing demand for individuals to stay in their homes for as long as possible, whether in traditional residences or supportive living arrangements like service residences, autonomous residences, or specific nursing homes (EHPAD). Consequently, it raises critical issues regarding the care of aging, often multi-morbid populations, requiring complex or palliative care managed by healthcare and social professionals working closely with caregivers. Effective coordination between the ambulatory sector, hospital sector (notably with support from home hospitalization), and social sector is essential [7].

Another challenge is the significant social and territorial health inequalities in France, which are slightly more pronounced than in the rest of Europe [8]. Less skilled workers and qualified manual laborers are in poorer health compared to the rest of the population [8]. These disparities, which have been increasing in recent years, are driven by several socio-economic factors, such as individual care and access to healthcare, education, housing conditions, and working conditions [8]. Furthermore, residents of certain regions suffer from the unequal distribution of healthcare services across the country, mainly due to the aging population of general practitioners, unregulated practice locations, evolving expectations of newly trained doctors, and changing practices [9]. These factors have led to the

emergence of "medical deserts" in France, areas underserved by healthcare professionals. According to a Senate information report published in 2020, between 9 and 12% of the French population, or between 6 and 8 million people, lived in medical deserts and it affected 1/3 of the communes in France [10]. About 6.7 million French citizens did not have a primary care physician in 2023, representing 11% of the population, including 714,000 patients with long-term conditions [11].

Compounding to these are challenges faced by the hospitals in France, particularly with rising costs and overcrowding of emergency departments, trends observed for several years [12]. The objective of rebalancing care between ambulatory and hospital settings—referred to as the "virage ambulatoire" or "ambulatory shift" in France—addresses broader issues related to organizing care between urban and hospital settings and managing unscheduled ambulatory care [13]. This is especially crucial for vulnerable populations amidst a rising demand for immediate care. The increasing fragmentation of healthcare services necessitates a reorganization of primary care to not only strengthen ambulatory care but also to improve care coordination for cost efficiency, quality, and patient comfort. The inefficiencies inherent in this fragmented system contribute to higher healthcare expenses and strain on public resources.

Moreover, France's healthcare spending as a share of GDP has consistently exceeded the EU average over the past two decades. In 2021, France allocated a substantial portion of its GDP to healthcare, with expenditures reaching 12.3%, ranking it second in Europe behind Germany [14]. Additionally, per capita health expenditure in France in 2021 was the fifth highest, surpassing the averages of both the EU and the WHO European Region [14,15]. Healthcare expenditures are growing at approximately 4% per year, while the national health insurance expenditure target (Ondam) is set at around 2% per year, threatening the country's social protection model. This discrepancy necessitates moderating the growth of expenditures by about four billion euros annually [16].

These challenges underscore the urgent need for integrated and coordinated care, which has become a focal point in recent health policy reforms by the French government. This comprehensive approach includes establishing new coordinated care structures, such as multi-professional health centers, and implementing advanced coordination tools like shared medical records and disease management programs. Additionally, redefining professional roles through task delegation, advanced practices, and new competencies for

paramedical staff is crucial. Moreover, there is a renewed emphasis on prevention over curative care. Primary care structures are now pivotal in deploying prevention strategies such as vaccination, screening, and therapeutic education. These efforts are supported by incentive tools, including new payment models like pay-for-performance, and public health objectives that align with a population health approach [17].

1.2. A Much-Needed Reform: Communautés Professionnelles Territoriales de Santé (CPTS) or Local Health Networks in the French Healthcare System

The concept of Local Healthcare Networks (CPTS), introduced as part of the Health System Modernization Law of 2016, represents one of these significant reforms in the French healthcare system [18]. This pivotal reform aims to help in improving the management of chronic diseases, facilitating preventive care, and ensuring a swift response to emergency care needs, thereby addressing critical inefficiencies in the healthcare system [19]. Developed by primary and secondary care health professionals, in collaboration with social and medico-social actors, these networks, under the form of Associations, are funded based on the population size they serve, as specified in the interprofessional agreement (ACI) signed on June 20, 2019, and the funding is contingent upon meeting core objectives such as providing access to unscheduled care, organizing care pathways for chronic diseases, and implementing prevention and health promotion initiatives [20]. The CPTS also strive to improve the practice environment for urban health professionals, including doctors, nurses, pharmacists, physiotherapists, dentists, speech therapists, podiatrists, midwives, and orthoptists, regardless of their employment status [21].

1.2.1. Their role in the community:

The CPTS are assigned six public service missions by law, which are [22]:

1. Facilitating access to care, particularly to a healthcare professional for patients in the area without a primary care physician, improving the management of unscheduled care in the community.

2. Implementing and organizing care pathways that address the needs of the territories to enhance the management and follow-up of patients, prevent care disruptions, and promote home care for complex, disabled, and elderly patients.

3. Initiating territorial actions for prevention, screening, and health promotion based on the needs of the area.

4. Contributing to the development of care quality and relevance to promote the exchange of good medical and nursing practices.

5. Supporting healthcare professionals in their territory, for example, by facilitating the reception of interns.

6. Participating in responding to health crises with an adapted action plan.

1.2.2. How they are created (also illustrated in Figure 1)

The creation of a CPTS involves several key stages which are [23]:

- *Initial Leadership Formation*: A group of committed healthcare professionals must come together to lead the project.

- *Territorial Diagnosis*: The team assesses the health needs of the population and available resources within the designated area.

- *Setting Strategic Objectives (inspired by the missions outlined by the law)*

- *Formalizing Goals*: These goals are formalized in a health project, detailing the action plan, steps, and timeline.

- *Determining Governance Structure:* The governance structure, typically a non-profit association, is determined at this stage.

This process can typically take 2 to 3 years and involves [24]:

- *Initial Phase:* Outlining a preliminary project in a letter of intent to the ARS and CPAM.

- *Validation and Support*: Once the letter is validated, project leaders receive operational and financial support to develop a detailed project.

- *Signing the Interprofessional Agreement (ACI):* An ACI is then signed between the CPTS, ARS, and CPAM, providing funding for five years to implement the project.

CPTS Creation Steps

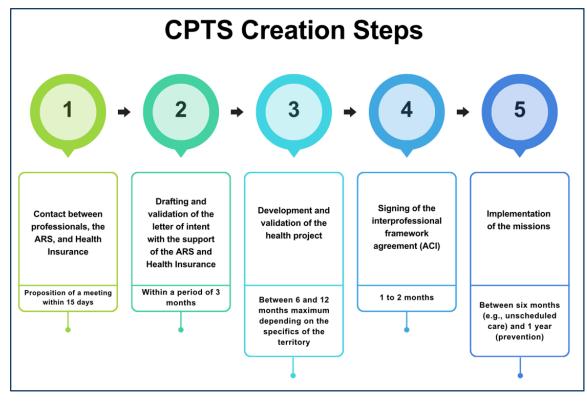| 1	2	3	4	5
Contact between professionals, the ARS, and Health Insurance	Drafting and validation of the letter of intent with the support of the ARS and Health Insurance	Development and validation of the health project	Signing of the interprofessional framework agreement (ACI)	Implementation of the missions
Proposition of a meeting within 15 days	Within a period of 3 months	Between 6 and 12 months maximum depending on the specifics of the territory	1 to 2 months	Between six months (e.g., unscheduled care) and 1 year (prevention)

Figure 1: The five steps involved in the creation of a CPTS and the average time it takes for each step (Ministère des Solidarités et de la Santé [Janvier 2022])

Despite ambitious governmental targets set for the establishment of 1,000 CPTS by 2022, recent data as of June 14th, 2024, indicates that the actual implementation has fallen short of expectations [25,26]. According to the latest updates, only a total of 835 CPTS are currently operational or in various stages of development across the nation. Of these:

- 91 are in the pre-project phase (step 1 and 2 of Figure 1),
- 138 are actively developing their health project with a validated letter of intent (step 3 of Figure 1),
- and 43 are in negotiations for their Integrated Care Agreement (ACI) with a validated health project (step 4 of Figure 1).
- 567 CPTS have successfully signed the ACI-CPTS contracts, marking them as fully operational under the current framework (step 5 of Figure 1).

The Île-de-France region, which is the wealthiest and most populous region in France, currently has 87 operational CPTS, covering approximately 9,373,141 inhabitants, which represents 76% of the region's population [27,28]. In total, 125 projects are listed in the region, aiming to cover 98% of the population [28]. However, only 60% of these projects are fully operational, raising the question of what factors hinder or facilitate the development of a

CPTS. This prompts an investigation into the barriers and levers influencing the establishment and functionality of integrated care organizations such as a CPTS.

1.3. Barriers and Facilitators in Implementing Integrated Care Systems such as a CPTS

Research has shown that integrated care organizations, which are heavily reliant on organizational integration and interprofessional collaboration (IPC), can be difficult to implement [29,30].

Organizational integration involves coordinating services in a connected manner, and fostering inter-organizational relationships can enhance quality, market share, and efficiency by leveraging the combined skills and expertise of different organizations [29,30,31,32]. Healthcare organizations such as Municipal Health Centers (CMS), Multi-Professional Health Centers (MSP), and medical-social organizations are key players in the development of a CPTS. Each brings different cultures, professional roles, responsibilities, and clinical or service approaches [33]. These differences, along with varying bureaucratic structures, levels of expertise, funding mechanisms, and regulations, can complicate organizational integration [34].

IPC in primary care refers to the collaborative effort of various healthcare professionals, combining their complementary skills and competencies to optimize resource utilization [35]. Multiple studies were done to investigate the barriers and facilitators to IPC. The most frequently reported barriers included financial issues such as insufficient long-term funding and inadequate reimbursement policies, followed by a lack of leadership at the national or political level and insufficient legal support for expanding roles [36,37,38]. Organizationally, limitations in human resources, including a shortage of time and skilled professionals, led to increased workloads [36,39,40]. At the inter-individual level, structural hierarchies, particularly between physicians and other professionals, created power imbalances [36,39,40,41]. Unclear roles and scopes of practice, fear of losing professional identity, undervaluing others' contributions, and poor communication further hindered collaboration [37,38,39,41]. Conversely, facilitators at the organizational and inter-individual levels were frequently cited. Organizationally, enhancing human resources with equitable professional involvement and re-organizing practice to include formalized partnerships and coordination rules were beneficial [36,37,38,39,40]. Tools for improving care processes, regular meetings, clear communication routines, and supportive institutions with dedicated team leaders also facilitated IPC [36,37,38,39,40,41]. At the inter-individual level, effective knowledge sharing,

informal discussions, valuing each other's work, trust and respect among professionals, shared goals, and team cohesion through team-building activities were crucial facilitators [36,37,38,39,40,41].

1.4. Research Problem

The shortfall in meeting the initial targets for the CPTS and the variability in their developmental stages across different areas of Île-de-France highlight the need to understand the barriers and facilitators that influence the rollout of such integrated care systems in this specific region. Since the concept of CPTS is relatively new in France, there is limited research analyzing the levers and barriers to their development and implementation. Understanding these factors in Île-de-France will provide valuable insights that can be applied to other regions, making it easier to address similar challenges elsewhere. While CPTS hold significant promise for enhancing healthcare delivery, the practical challenges in their implementation are substantial. These challenges, as per literature, range from organizational and cultural resistance to financial and logistical constraints, making it crucial to investigate these factors in the context of Île-de-France.

1.5. Objective

This thesis aims to identify and analyze the barriers and facilitators involved in the creation of a CPTS in Île-de-France, drawing on the experiences of the different professionals engaged in their development. The insights gained will be instrumental in guiding future policy decisions and practical implementations of integrated care systems within Île-de-France and similar healthcare contexts globally.

2. Methods

2.1. Research Design and Participants

This study employed a qualitative research design using semi-structured interviews to gather in-depth insights from healthcare professionals involved in the creation and implementation of CPTS in Ile-de-France. Participants were recruited using purposive and snowball sampling methods. Initial participants were identified through the researcher's internship with the Villejuif CPTS in Val de Marne. These participants were then asked to recommend other professionals who met the study criteria, ensuring a broad range of experiences and roles were represented. Research has demonstrated that purposive sampling is more effective than random sampling for obtaining information from small

samples [42, 43]. Therefore, interviews were conducted with a select group of key informants. This method has been shown to enhance the chances of reaching data saturation [44]. Evidence suggests that data saturation can be achieved with relatively small samples in qualitative studies that have specific aims, target informants with specialized knowledge, and utilize interviews that are sufficiently lengthy and of high quality [45]. To be included in the study, participants had to be healthcare professionals, social or medico-social actors, allied health professionals, public health professionals, or policy makers involved in the creation and implementation of a CPTS in Ile-de-France. The interview guide (**Annex 1**) was developed based on insights from previous literature on the barriers and facilitators to organizational integration and interprofessional collaboration, as outlined in the introduction. This guide was subsequently translated into French (**Annex 2**) to facilitate the interviews in the participants' native language.

2.2. Data Collection

A total of 10 semi-structured interviews were conducted in French by the researcher, involving participants from CPTS Villejuif, CPTS Champigny-sur-Marne, CPTS de la Bièvre, CPTS Octav, CPTS Vitry-sur-Seine, and CPTS Sud 77 Seine-et-Marne. Participants were recruited via email, and interviews were scheduled throughout late June and July 2024. Conducted via Zoom, the interviews lasted between 30 and 50 minutes. Each session was recorded with an audio device and later transcribed verbatim using Microsoft Word.

2.3. Ethical Considerations

Participants were assured of the confidentiality of their discussions and their anonymity in any reports or publications resulting from the study. Consent was obtained to record the interviews for accurate transcription and analysis, with the recordings being used solely for research purposes and deleted once transcribed. Participation was entirely voluntary, and participants had the right to withdraw at any time or choose not to answer specific questions. Before the start of each interview, participants were asked for their consent to proceed, ensuring they understood the terms and had the opportunity to ask any questions.

2.4. Data Analysis

The data analysis for this thesis was conducted using a systematic approach that combined both deductive and inductive coding strategies, facilitated by the use of Microsoft Word and Excel.

The primary reason for using deductive analysis was to systematically identify and categorize the barriers and facilitators related to the research question. Deductive, or a priori coding, involves creating and applying pre-established codes to the data, organizing it based on predefined categories from literature or theoretical frameworks [46,47]. These codes help organize data by type.

Following the initial deductive analysis, inductive analysis was used to determine the specific types of barriers and facilitators described in the data. Inductive coding, also known as open or initial coding, involves identifying and naming essential concepts and patterns as they emerge from the data [48,49]. This method allowed for a detailed understanding of the various barriers and facilitators identified, helping to develop themes and explain findings.

Step 1: Data Preparation

The data analysis began with the transcription of the semi-structured interviews. Each interview was transcribed verbatim and saved as a separate Word document. The transcripts were labeled with unique identifiers corresponding to each participant (e.g., P1, P2, P3…) to facilitate organization and referencing during the analysis process.

Step 2: Familiarization with the Data

Once the transcripts were prepared, an initial reading was conducted to familiarize the researcher with the data. This step involved thoroughly reading each transcript to gain an overall understanding of the participants' experiences and perspectives. During this process, preliminary notes were taken, and key sections of text that seemed relevant to the research questions were highlighted. This initial familiarization provided a foundation for the subsequent coding phases.

Step 3: Deductive Coding

The next step in the analysis involved deductive coding, where predefined codes based on the research questions and existing literature were applied to the transcripts. A coding framework was developed that included expected barriers and facilitators to CPTS creation, such as "Scheduling and Coordination," "Financial Incentives," and "Strong Government Support."

Each transcript was reviewed again in Word, with relevant sections of text being highlighted and labeled according to the predefined codes. The "Highlight" tool in Word was used to mark these sections, with different colors representing different themes (e.g., red for barriers, yellow for facilitators, green for roles, pink for reflections and recommendations). The "Comment" feature in Word was employed to label each highlighted section with its corresponding code, ensuring that the coded data was clearly organized and easy to reference.

Step 4: Inductive Coding and Identification of Emerging Themes

After completing the deductive coding, the transcripts were revisited to identify any new or emerging themes that were not captured by the initial coding framework. This inductive coding process allowed the researcher to identify patterns and insights that arose directly from the data.

For example, while reviewing the transcripts, new themes such as "Generational Differences" and "Community Engagement" emerged, reflecting nuances in the experiences and perspectives of the participants that were not anticipated in the initial coding framework. These emerging themes were added to the coding structure and were highlighted and labeled in the same manner as the predefined codes. The complete coding structure, including both predefined and emerging themes, is detailed in **Annex 3**.

Step 5: Transferring Coded Data to Excel

Once all relevant sections of the transcripts had been coded, the next step involved transferring the coded data from Word to Excel. During this stage, the quotes were were translated into English to ensure consistency with the language of this thesis. A new Excel workbook was created, with separate worksheets set up for each main category, such as "Barriers," "Facilitators," and "Emerging Themes". In each worksheet, columns were created for: **Participant ID**, **Code Name**, **Quote**, **Comments.**

The highlighted text from Word was then copied and pasted into the corresponding Excel worksheet. For each entry, the appropriate code name was recorded, and the associated quote or excerpt from the transcript was included. This systematic organization of the data in Excel allowed for easy sorting and filtering, facilitating deeper analysis of the coded data.

Step 6: Analyzing the Data in Excel

With the coded data organized in Excel, the researcher used Excel's sorting and filtering tools to group similar codes together. This process enabled the identification of patterns and themes within and across different codes. For example, filtering the data by "Coordination and Scheduling Challenges" allowed the researcher to review all related excerpts and assess the common challenges participants faced in this area.

Step 7: Synthesis and Interpretation of Results

In the final phase of the data analysis, the coded data was synthesized and interpreted to identify overarching themes that encapsulated the key barriers and facilitators in CPTS creation. Related codes were grouped together to form broader themes, such as "Organizational Barriers" or "Regulatory Barriers"

Emerging themes identified during the inductive coding process were integrated into the overall analysis, providing new perspectives on the data. For instance, the theme of "Generational Attitudes" offered a more detailed understanding of "Professional Resistance", highlighting how differing attitudes between older and younger professionals impacted collaboration.

3. Results

This section presents the key findings from the semi-structured interviews conducted with healthcare professionals involved in the creation and implementation of a CPTS in Île-de-France. The interviews reveal that the teams operate by dividing tasks and forming specialized working groups, each focusing on a specific aspect of CPTS development, such as budgeting, constitution, territorial health diagnostics, communication, and mission planning. These groups convene with varying frequencies, some meeting weekly and others monthly. The analysis highlights a range of barriers and facilitators identified by participants, offering valuable insights into the challenges and enabling factors in the development of these local healthcare networks.

Table 1: Demographics of Participants			
Participant ID	**Profession**	**Number of years of professional experience (Range) ***	**CPTS****
P1	Public Health Specialist	(5 – 10)	CPTS Villejuif, CPTS Champigny-sur-Marne, CPTS de la Bièvre, CPTS Octav, CPTS Vitry-sur-Seine, and CPTS Sud 77 Seine-et-Marne
P2	Director of a Medico-Social Organization	(15 – 20)	
P3	Nurse Practitioner	(20 – 25)	
P4	Program Coordinator	(5 – 10)	
P5	Medical Doctor	(0 – 5)	
P6	Healthcare Director	(15 – 20)	
P7	Healthcare Director	(25 – 30)	
P8	Pharmacist	(5 – 10)	
P9	Nurse	(5 – 10)	
P10	Pharmacist	(15 – 20)	

Table 1: Participant Demographics. To ensure participant anonymity, the number of years of working experience is presented in ranges*, and it is not specified which participant is associated with which CPTS**. The Octav, Bièvre, Champigny-sur-Marne, and Sud 77 Seine-et-Marne CPTS are operational and have already signed the ACI. Octav signed the ACI in 2023 after four years of development, Champigny-sur-Marne in 2020 after two years of development, Bièvre in 2021 after three years of development, and CPTS Sud 77 in 2021 after two years of development. The Villejuif and Vitry CPTS have signed the letter of intent and are currently in the development phase.

3.1. Barriers to Creating a CPTS

Organizational Barriers: Scheduling and Coordination Challenges, and Increased Workload

One of the primary barriers identified by all the participants was the difficulty in coordinating schedules and arranging meetings among diverse healthcare professionals. Participants frequently cited the challenge of aligning their commitments, leading to delays in project activities. This indicates that the need for flexibility and the varied availability of professionals made consistent collaboration difficult.

"Finding time to meet was challenging, especially during school vacations. We had to rely on hybrid, physical, and virtual meetings. There were days I couldn't attend meetings due to other commitments like training sessions or other work meetings…or personal commitments" (P1).

P6 pointed out the complexity of scheduling, due to the logistical difficulties of aligning different working hours and responsibilities among the team members, saying:

"The first difficulty was the time, which we had to allocate and impose in our already busy schedules. It's very difficult to coordinate with everyone since not all professionals have the same habits or modes of operation" (P6).

The additional workloads and substantial responsibilities that came with creating a CPTS was seen as a significant barrier, impacting motivation and participation:

"Many colleagues saw the CPTS as additional work without immediate financial compensation, which was a deterrent. They were already overburdened with their regular duties" (P5)

"Many professionals were interested in the CPTS, but few were willing to take on leadership roles due to the extra workload…so it was hard to find someone who would take on the role of president, vice-president, or treasurer…" (P4)

"The second challenge is how to allocate time for the CPTS work in addition to our personal work. This is a major issue" (P3)

The absence of some critical members, usually those who have had a previous experience in creating a CPTS, during some meetings, hindered progress.

"We tried to have regular meetings, but often, key members couldn't attend due to their clinical duties, which slowed down our progress a bit because some of us had no idea what the next steps were" (P10).

Regulatory Barriers: Unclear Guidance from Regulatory Bodies such as the ARS

Regulatory uncertainties slowed down progress. Several participants highlighted the confusion and administrative challenges that arose due to insufficient direction from the ARS.

"There was confusion about what the ARS expected from us. We knew we needed to engage with the system, but it wasn't clear what we needed to do, who was responsible, or how to proceed" (P2).

This indicates a lack of clear guidance and communication from regulatory bodies. P4 noted the complexities involved in understanding and complying with regulations:

"We had to get legal advice to ensure our statutes were in line with regulations. It was a significant challenge because the structure was new, and the regulatory framework wasn't fully clear" (P4).

The need for external legal support underscores the complexity and uncertainty of the regulatory environment.

"The regulatory landscape is very complex, and as independent practitioners, we found it difficult to navigate without clear guidance…we are from the scientific world, I'm a pharmacist, chemistry is my thing… then we were thrown into a world of statutes and all other legal terminologies. It took very long hours of discussion for sure" (P8).

The ambiguity and complexity of legal requirements added to the administrative load of the professionals involved.

"The legal requirements for forming and running a CPTS were not always straightforward, creating additional administrative burdens for us…there was a lot of back and forth between the ARS and our team, just trying to get everything in order" (P9).

Cultural and Professional Resistance: Interpersonal and Historical Conflicts

Historical conflicts and interpersonal issues were identified as significant barriers. Past disagreements and long-standing tensions resurfaced during the CPTS creation process, hindering effective teamwork or participation. One participant emphasized the importance of considering past relationships and conflicts that could impede project progress:

"It's essential to consider past issues because they can impact relationships and slow down the project" (P1).

"There were instances where past conflicts between professionals resurfaced, causing delays and disruptions in meetings and decision-making processes" (P4).

"Some professionals were very resistant, fearing that the CPTS would compromise their independence" (P7).

Some highlighted ego conflicts and power struggles, which can significantly impede collective efforts:

"The major pitfall in organizing human groups is ego battles and power struggles. In (mentioned name of CPTS), development has stalled for six months due to these issues…the leaders said it was either their way or no other way" (P2).

"Personal egos and historical disputes often overshadowed the common goal, making it difficult to maintain a cohesive team" (P8).

The persistence of personal conflicts, hierarchical issues, made teamwork challenging and affected overall cohesion, and the morale, of some teams.

"I have witnessed instances where hierarchy came into play…where some people's contributions were looked down upon because hierarchy wise, they were below the person in lead. It is important that everyone is treated the same…just for the sake of morale of the group you know?" (P9)

Technological Barriers

Initial technological barriers have lessened over time, with improvements in the acceptance and use of digital tools. The pandemic accelerated the adoption of digital tools such as WhatsApp, Zoom, and Google Drive, improving collaboration. However, despite the overall progress, disparities in technological proficiency still exist within the teams. While many have adapted, there are still challenges for those less familiar with advanced digital tools, which can impact overall team efficiency.

"Some of my colleagues are quite comfortable with tools such as AI and other digital platforms, which helps them work more efficiently. However, my work takes longer because I don't have the same ease with these tools" (P3)

3.2. Facilitators to Creating a CPTS

Government Support and Encouragement

Government support and encouragement were significant facilitators for the creation of CPTS. High-level political support motivated local efforts and facilitated stakeholder engagement. Participants emphasized that without the backing of the government, including clear mandates and financial incentives, the CPTS would have struggled to take off.

"The government encourages this kind of initiative. This support acts as a lever" (P1).

"The financial incentives and clear objectives provided by the government were crucial in motivating healthcare professionals to get involved" (P2).

Some stakeholders joined the movement only after observing how encouraging the government was, especially for the first CPTS in the region:

"I had approached some medical groups about starting a CPTS six months before the President's speech in September 2018, but they were reticent about the idea. However, after the President advocated for the creation of 1000 CPTS in France by 2022, I received a call from these same groups just three days later, wanting to discuss starting the CPTS" (P5).

"*Government support provided a framework and legitimacy to our efforts, making it easier to gather support from various stakeholders*" (P9).

Leadership and Collaboration

Effective leadership and the natural emergence of leaders within the group facilitated progress. Natural leaders helped manage tasks efficiently, maintain project momentum, and overcome challenges.

"Leaders emerged naturally within the group, and this natural leadership helped manage tasks effectively" (P1).

"The challenge was to work together in a coordinated manner. We successfully managed to keep the project on track through collective efforts…with everyone taking turns leading" (P4).

"Having a clear leadership structure, even if informal, helped in maintaining momentum and direction for the CPTS" (P2).

"The emergence of dedicated leaders who were passionate about the project helped us… overcome many hurdles" (P10).

Financial Incentives and Flexibility

The flexibility to define their own objectives were crucial motivators for participants. Equitable financial treatment was seen as a positive, and being compensated for work was rewarding. Financial support and goal-setting flexibility were key motivators.

"They [health professionals] could now choose their own health project, objectives, and indicators. This flexibility was rare and highly valued" (P2).

"We insisted on financial equality, ensuring the same hourly rate for everyone regardless of their status" (P3).

"The financial support provided by the ARS and the flexibility to set our own goals were significant motivators for our team" (P4).

"The ability to tailor our goals and receive financial support based on achieving them was highly motivating" (P8).

Existing Professional Networks

Existing professional networks and community bonds among healthcare professionals facilitated the creation of CPTS. Established networks provided a foundation to build off on.

"All motivated professionals in a territory know each other. These networks provided a foundation for the CPTS" (P2).

"The existing relationships and trust among professionals in the area made it easier to form a cohesive team for the CPTS" (P5).

"Our strong professional networks allowed us to quickly mobilize support and resources for the CPTS" (P9).

For some, being part of a network helped navigate through challenges such as medical deserts, in territories where there weren't many physicians:

"The medical faculty network helped find, unite, and bring general practitioners on board with the project…it [the CPTS] could not have gone forward without general practitioners" (P4).

In addition to these networks, the presence of existing CPTS initiatives served as a valuable reference point for the newer CPTS. These established CPTS provided a roadmap for new projects, offering insights into best practices and helping to navigate common challenges.

"The existing CPTS in other territories have shown us what works and what doesn't. By looking at their experiences, we were able to avoid some of the mistakes they made and adopt practices that have already been successful. This was incredibly helpful in getting our project off the ground….and they are very open in sharing their experiences…everyone wants to brag about their baby (project)" (P2).

A New Generation of Young Professionals and Motivation

The involvement of young professionals was identified as a key facilitator due to their enthusiasm and motivation.

"You'll notice….it is this younger generation of healthcare professionals that are very enthusiastic about the CPTS. We bring fresh ideas and energy to the project. This motivation and eagerness to work collaboratively is really encouraging…" (P1).

"Young professionals like myself are particularly motivated by the opportunity for collaborative work and innovation….We see the CPTS as a chance to make a significant impact in our communities and are very open to new ways of working, especially together….We are the ones who will bring change and drive these new initiatives forward because we are eager to see improvements and are willing to adapt to new methods" (P2).

3.3. Emerging Themes

During the analysis, several themes emerged that were not initially anticipated but provided additional insights into the dynamics of CPTS development.

Generational differences in professional approaches

A notable emerging theme was the generational differences in attitudes and approaches to healthcare delivery. Younger professionals were generally more open to collaboration while older professionals were more resistant to these changes because they have seen many failed initiatives in the past.

"The younger generation is very open to new ways of working and collaboration. It's different from professionals who are close to retirement, they are used to working solo…as they have been doing for many years…so they are not very open to joining the initiative" (P9).

"….can we blame them (older professionals)?....I mean there have been many initiatives that did not really take off in the past….I can understand the reluctance in joining a CPTS project, they probably think it will fail in the long run" (P10)

Community Engagement as a Facilitator

Another emerging theme was the importance of community engagement in facilitating CPTS development. Participants highlighted that strong involvement from the local community and grassroots movements significantly supported the creation of CPTS. This engagement helped in gaining broader acceptance and participation from local healthcare providers and leaders.

"The initiative is highly encouraged by our local politicians. Historically, our territory has followed the principles of communism…. these still exist today and can be observed with the local policies and political movements. The support of our community has made things move faster." (P7).

"The community was very supportive, and their involvement made a huge difference in how quickly we were able to get things up and running." (P10)

Post-COVID Digital Integration: Pandemic-Driven Technological Adoption

The COVID-19 pandemic acted as a catalyst for the adoption of digital tools and remote communication methods within CPTS. This shift not only overcame initial resistance but also led to more efficient communication and collaboration among professionals.

"Since Covid, there have been significant improvements in the use of digital tools. At the beginning, all meetings were physical…which was not easy…but now tools like WhatsApp and Zoom are widely accepted" (P2).

The gradual acceptance of digital platforms improved team communication and collaboration.

"We initially faced resistance to using digital platforms, but over time, everyone adapted. Now, tools like Google Docs and WhatsApp are integral to our communication and collaboration"
(P6).

"The initial resistance to new technology was a barrier…we could go a month or two without everyone meeting face to face. But the pandemic forced us to embrace technology in ways we hadn't before. It was not easy at first but with dedication and persistence, most members adapted well, and it ended up being a positive change for our work " (P9).

4. Discussion

The objective of this study was to explore and evaluate the barriers and levers influencing the creation and development of the CPTS in Île-de-France. The findings uncovered several critical challenges, such as the complexity of scheduling and coordinating meetings among healthcare professionals, the burden of increased workloads, ambiguity in regulatory guidance, interpersonal and historical conflicts, and initial resistance to adopting technological tools. On the other hand, the study identified key facilitators that contributed to the progress of CPTS development, including robust government support, strong and effective leadership, the provision of financial incentives and operational flexibility, well-established professional networks, and the enthusiastic engagement of younger healthcare professionals. Additionally, emerging themes such as generational differences in professional approaches, the importance of community engagement, and the impact of post-COVID digital integration further influenced the development process, either complicating or facilitating it.

Some of these findings align closely with those detailed in the "*Rapport 'Tour de France des CPTS' - Bilan et propositions pour le déploiement et le développement des communautés professionnelles territoriales de santé*," commissioned by the Ministry of Territorial Organization and Health Professions and authored by Dr. Marie-Hélène Certain, Albert Lautman, and Hugo Gilardi [50]. Their report, based on visits to 19 CPTS across France, similarly identified human resource management challenges, difficulties in expanding participation, and confusion regarding the role of CPTS as significant barriers. The report also identified key facilitators, including the importance of adapting projects to local characteristics, strong leadership, and sustained support from authorities [50]. Both this study and the 2023 report underscore the critical role of solid governance, clear role definitions, and fostering cooperation among CPTS to enhance healthcare coordination and coverage throughout the country.

A surprising finding in this study was the emergence of generational differences among healthcare professionals, particularly in their attitudes towards collaboration and innovation within the CPTS framework. Although age was not a primary focus of the research, many participants identified themselves as younger professionals who were more enthusiastic and open to new methods of working together. In contrast, they described older colleagues as exhibiting a degree of reluctance, likely shaped by their experiences with previous, often unsuccessful, healthcare initiatives. This generational divide suggests that while the CPTS model is gaining traction, its long-term success may hinge on bridging these attitudinal gaps through targeted interventions, such as inclusive leadership strategies and continuous professional development tailored to different age groups. Furthermore, the impact of post-COVID digital integration emerged as a significant facilitator, accelerating the adoption of digital tools like Zoom and WhatsApp for coordination and communication. The pandemic acted as a catalyst for overcoming initial resistance to these technologies, which have since become essential for the efficient operation of CPTS. These findings highlight that while CPTS implementation in Île-de-France is progressing, addressing generational dynamics and ensuring the continued integration of digital tools will be vital for future success.

Comparative Analysis with Other Integrated Care Models

While the challenges faced in Île-de-France are significant, they are not unique. Across different nations and regions, integrated care systems face similar hurdles such as scheduling difficulties, increased workloads, and resistance to change [51].

In the UK, for instance, the Better Care Fund (BCF), an integrated care model, has encountered significant obstacles due to organizational and financial complexities, including difficulties in managing pooled budgets, misaligned geographical boundaries, entrenched cultural differences between health and social care sectors, and established hierarchies of power and status [52,53]. These issues have often hindered progress, despite the BCF's goal of improving collaboration and reducing hospital admissions. Although there is limited literature on the subject, healthcare providers within the UK's Primary Care Networks—a similar integrative care initiative—have expressed concerns through opinion pieces about the additional workload it creates. They argue that this increased burden detracts from their ability to focus on their core responsibilities [54,55]. This underscores the need for better support and clearer operational frameworks to facilitate successful integration, as emphasized by the participants in this study.

Similarly, Canada's integrated care system, particularly within Family Health Teams (FHTs) in Ontario and Alberta Health Services (AHS), faces its own set of significant challenges that mirror some those observed in this study. A major issue is the lack of clarity and uncertainty in roles and responsibilities among healthcare providers, which complicates the transition from traditional, individual practices to effective team-based care [56]. Additionally, ineffective management and leadership can significantly impede the development and cohesion of these teams, further challenging the integration process. Physical and logistical constraints, such as the geographical separation of team members, exacerbate communication difficulties and hinder collaborative efforts [57]. The early-stage development of the integrated care initiatives also struggled with defining roles, recruiting qualified professionals, and implementing interprofessional initiatives, undermining the effectiveness of these integrated care models [56,57].

Building on the challenges observed in the UK and Canada, both Italy and Germany have also faced significant obstacles in implementing their integrated care models, each reflecting the unique complexities of their healthcare systems. In Italy, the development of the *Casa della Salute* (Health Homes) model has been hindered by substantial technological barriers, such as the inconsistent digital infrastructure across regions, compounded by resistance from healthcare professionals who struggle with adopting new technologies and engaging in interdisciplinary collaboration [58]. Additionally, regional disparities in funding and infrastructure have led to uneven implementation, with some areas achieving greater success than others. In Germany, the *Integrierte Versorgung* (Integrated Care) model has encountered difficulties due to the fragmented nature of the healthcare system and resistance from healthcare providers to new collaborative practices. Research indicates that while integration has enhanced relationships within the same service, cooperation with external organizations remains less satisfactory, slowing progress [59,60].

<u>Mitigating Barriers and Enhancing Sustainability in Integrated Care: Key Mechanisms for Success</u>

The barriers identified—such as coordination difficulties, increased workloads, and resistance to change—are common across different healthcare systems. However, the facilitators highlighted in this study, including strong governmental support, effective leadership, and the establishment of robust professional networks, offer valuable insights into how these challenges can be mitigated. Research on 17 case studies from 8 European countries, has shown that ten key mechanisms contribute to the successful implementation of integrated care models, particularly for individuals with multi-morbidity [61]. These include gradually managing complexity

through an incremental growth model, maintaining a balance between flexibility and formal structures to ensure sustainability, and fostering collaborative governance that actively involves all stakeholders in decision-making processes [62]. Effective leadership is particularly crucial when it is distributed across multiple levels of the health system, enhancing the multidisciplinary culture that is vital for mutual recognition of roles among healthcare professionals [62]. Additionally, the development of new roles and competencies supports the integration process, while securing long-term funding and innovative payment models further incentivize collaboration. The use of information and communication technology (ICT) systems plays a pivotal role in facilitating communication and collaboration, supported by feedback loops and continuous monitoring to drive ongoing improvements [62]. Ultimately, the alignment of all components and levels within the health and social care system is essential to ensure these mechanisms work in harmony, leading to more effective and sustainable care models [62].

5. Strengths and Limitations

This study exhibits several notable strengths. Primarily, its qualitative design provides in-depth insights into the experiences and perspectives of healthcare professionals involved in the creation of a CPTS. The use of semi-structured interviews enabled the collection of rich, detailed data, capturing the complexities and nuances of the barriers and facilitators in the development of a CPTS. Additionally, the diverse participant sample, which included individuals from various CPTS projects within Île-de-France, ensures a broad representation of experiences and roles, enhancing the generalizability of the findings within the region. The study's focus on real-world relevance is another strength, as the findings are grounded in the actual experiences of healthcare professionals, making them particularly valuable for informing policy decisions and practical implementations in similar healthcare contexts. Moreover, this study adds to the limited literature on CPTS by exploring the barriers and facilitators in developing integrated care models from the perspective of those directly involved in building them. It provides valuable insights that can inform future research and policy-making. By identifying specific barriers and facilitators across multiple levels—organizational, interpersonal, and technological—the study offers a comprehensive understanding of the factors influencing CPTS development, delivering actionable insights for stakeholders.

However, the study also has several limitations. The small sample size, with only ten participants, may affect the generalizability of the findings to all CPTS projects across France. Additionally, the study's focus on Île-de-France, the wealthiest and most populous region in France, may limit the applicability of the findings to other regions with different socio-economic

and healthcare landscapes. The potential for participant bias is another limitation, as the purposive and snowball sampling methods used may have introduced selection bias, with those agreeing to participate potentially having specific experiences or perspectives that differ from non-participants. Furthermore, the self-reported nature of the data collected through interviews may be subject to recall bias or social desirability bias. The study also lacks a longitudinal perspective, providing only a snapshot of the barriers and facilitators at a specific point in time. A longitudinal approach could offer deeper insights into how these factors evolve and impact the long-term success of CPTS projects.

6. Conclusion

In conclusion, this study has provided valuable insights into the barriers and facilitators influencing the creation and development of CPTS' in Île-de-France. While the CPTS model shows great promise in enhancing healthcare coordination and delivery, several challenges, such as scheduling difficulties, increased workloads, and regulatory ambiguities, pose significant obstacles to its successful implementation. Conversely, strong governmental support, effective leadership, financial incentives, and the enthusiasm of younger healthcare professionals have emerged as crucial facilitators driving progress. Additionally, unexpected findings, such as the generational differences in professional attitudes and the positive impact of post-COVID digital integration, show the complexity of implementing integrated care models in a dynamic healthcare landscape.

These findings suggest that for the CPTS initiative to achieve its full potential, it will be essential to address both the identified barriers and the emerging challenges. This includes fostering inclusive leadership, providing tailored professional development, and ensuring the sustained integration of digital tools. Moreover, the study highlights the importance of adapting strategies to the specific needs of different professional groups and leveraging the momentum gained from recent technological advancements.

Implications for Future Policy

To improve the development and effectiveness of CPTS and similar integrated care models, future policy should focus on providing clearer guidance and support to healthcare professionals involved in these initiatives. This could include standardized training programs, better communication of regulatory requirements, and more robust frameworks for leadership and collaboration. Additionally, policies such as establishing CPTS-specific coordinator roles to

address workload concerns, along with offering tailored financial incentives to meet the specific needs of healthcare professionals, could significantly enhance participation and commitment.

Implications for Future Research

Future research should explore the long-term impacts of these integrated care models on healthcare outcomes and cost efficiency. Longitudinal studies could provide insights into the evolution of barriers and facilitators over time, allowing for more dynamic and responsive policy adjustments. Furthermore, expanding the scope of research to include patient perspectives would offer a more comprehensive understanding of the effectiveness of these care models. Finally, comparative studies across different regions or countries could help identify universal strategies for successful integrated care implementation, contributing to global healthcare improvements.

By addressing these areas, both policy and research can play a crucial role in refining the implementation of integrated care systems, ultimately leading to more cohesive and efficient healthcare delivery.

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Annex 1: Interview Guide and Research Questions

Study Aims:

- **Identify Barriers**: To systematically identify and analyze the barriers that health professionals face during the creation and development phases of a CPTS. This includes organizational, financial, regulatory, and cultural challenges.

- **Understand Facilitators**: To explore the factors that facilitate the successful implementation of CPTS, such as strong leadership, effective communication strategies, robust IT infrastructure, and aligned incentive structures.

- **Document Experiences**: To capture and document the real-world experiences, perspectives, and insights of healthcare professionals directly involved in a CPTS. This aims to provide a detailed understanding of the practical challenges and successes encountered.

- **Inform Policy and Practice**: To generate knowledge that can inform policy decisions and practical implementations of integrated care systems, both within France and in similar healthcare contexts globally.

Population (Inclusion Criteria):

Healthcare professionals who have been involved in the creation and implementation of a CPTS in Ile de France. This includes:

- **Physicians**: General practitioners and specialists who are part of the CPTS initiative and contribute to the collaborative networks.

- **Nurses**: Registered nurses who play a significant role in care coordination and patient management within CPTS.

- **Administrators**: Individuals responsible for the management and operational aspects of CPTS, including project managers and coordinators.

- **Policy Makers**: Local health authority representatives or governmental officials involved in the regulatory and funding aspects of CPTS.

- **Allied Health Professionals**: Other healthcare providers such as physiotherapists, pharmacists, and mental health professionals, who participate in the multidisciplinary teams of CPTS.

Recruitment Strategy:

In order to gather rich and relevant data for my thesis, I will employ purposive and snowball sampling methods to recruit participants. This approach will begin with purposive sampling, targeting healthcare professionals who are directly involved in the creation and operational management of CPTS. I will identify potential participants through my current internship with the Villejuif CPTS in Val de Marne, ensuring a diverse range of roles and experiences are represented. Once initial participants are interviewed, I will utilize the snowball sampling to extend the recruitment reach. This will involve asking initial participants to recommend colleagues who also meet the study criteria and could provide additional valuable insights. This two-pronged recruitment strategy is designed to ensure a comprehensive understanding of the varied experiences and perspectives on the barriers and facilitators affecting CPTS development, thus providing a robust foundation for the research conclusions and recommendations.

Research Questions and Interview Guide

Introduction

Hello, my name is Nana Sylla, and I am a second-year Master of Public Health student at EHESP. The purpose of this study is to explore the barriers and facilitators involved in the creation and operationalization of the Communautés Professionnelles Territoriales de Santé (CPTS) in Ile-de-France. Your participation in this interview is critical as it will help us identify key challenges from the perspective of professionals directly involved in the process.

This interview is a vital part of my thesis research and aims to contribute to improving the implementation strategies of integrated healthcare systems like the CPTS. The insights you provide will not only enhance academic understanding but may also inform future policy and practical recommendations in healthcare management.

Confidentiality and Consent

Before we proceed, I would like to assure you of the confidentiality of this discussion. The interview will be recorded to ensure that no details are lost and to facilitate accurate transcription and analysis of the data. However, this recording will only be used for research purposes, and

your identity will remain anonymous in any reports or publications that result from this study. The recording will be deleted as soon as the interview is transcribed.

Your participation is entirely voluntary, and you have the right to withdraw at any time or choose not to answer any specific questions. Before we begin, I will need your consent to record this conversation and to use the data as described.

Do you agree to these terms, and do you have any questions before we start?

Do I have your consent to proceed with the interview?

Research Question 1: What are their Roles and Experiences?

1. **Can you please introduce yourself briefly?**
   - o **Probes:**
     - What is your job title?
     - What is your level of education?
     - Did you undergo any specific training for your current role?
2. **How long have you been involved in the creation or management of a CPTS?**
   - o **Probes:**
     - What motivated you to take on this role?
     - What are your primary responsibilities within the CPTS?
3. **Can you describe a typical day in your role related to CPTS?**
   - o **Probes:**
     - What are your daily tasks?
     - How do you interact with other healthcare professionals?
     - Can you share any significant experiences or challenges from your daily tasks?
4. **Have you taken on any additional responsibilities beyond your traditional role due to the CPTS?**
   - o **Probes:**
     - Can you provide examples of these additional responsibilities?

Research Question 2: What are the Barriers in the creation of a CPTS?

1. **Can you describe any significant challenges faced during the creation of the CPTS?**

- o **Probes:**
    - Did you encounter any organizational obstacles?
    - Were there any financial or resource-related constraints?
    - How were you able to manage your time?

2. **What were the major regulatory or legal challenges you faced?**
   - o **Probes:**
       - How did these challenges impact the CPTS development?

3. **Did you experience any cultural or professional resistance from other healthcare providers?**
   - o **Probes:**
       - What were the main points of resistance?
       - How did you address these issues?

4. **Can you discuss any technological barriers, particularly related to IT systems and data sharing?**
   - o **Probes:**
       - How did these technological issues affect the project?
       -

Research Question 3: What are the Facilitators in the creation of a CPTS?

1. **What factors or strategies have been most effective in overcoming barriers to CPTS creation?**
   - o **Probes:**
       - Can you give examples of strong leadership or effective communication?
       - How did these factors contribute to overcoming challenges?

2. **What resources or tools significantly supported the CPTS implementation?**
   - o **Probes:**
       - How did IT infrastructure facilitate the process?
       - Were there any financial incentives that were particularly helpful?

3. **How did collaboration among healthcare providers enhance the CPTS development?**
   - o **Probes:**
       - Can you describe successful collaborative practices?
       - What strategies were effective in promoting teamwork?

Research Question 4: Have there been any impacts, and can the participants provide any reflections on their experiences? (some of these would depend on the current status of the creation of the CPTS)

1. **How has the establishment of the CPTS impacted healthcare delivery in your area?**
   - **Probes:**
     - Can you provide specific examples of improvements?
     - What challenges remain?
2. **What lessons have you learned from the CPTS development process?**
   - **Probes:**
     - What would you do differently in future CPTS projects?
     - Are there any best practices you would recommend?
3. **What recommendations would you make for future CPTS developments?**
   - **Probes:**
     - How can policymakers better support CPTS implementation?
     - What additional resources or support would be beneficial?

Closing Comments

- Do you have any further comments or questions?

Thank you again for taking the time to meet. I appreciate you sharing your experiences with me today.

Annex 2 : Guide d'Entretien Semi-Directif

Introduction

Bonjour, je m'appelle Nana Sylla et je suis étudiante en deuxième année de Master en Santé Publique à l'EHESP. Le but de cette étude est d'explorer les freins et les leviers impliqués dans la création et l'opérationnalisation des Communautés Professionnelles Territoriales de Santé (CPTS) en Île-de-France. Votre participation à cet entretien est essentielle car elle nous aidera à identifier les principaux défis du point de vue des professionnels directement impliqués dans le processus.

Cet entretien est une partie vitale de ma recherche de mémoire et vise à contribuer à l'amélioration des stratégies de mise en œuvre des systèmes de soins intégrés comme les CPTS. Il durera de 45 min à 1 heure. Les informations que vous fournirez ne renforceront pas seulement la compréhension académique, mais pourront également informer les futures recommandations politiques et pratiques en gestion des soins de santé.

Confidentialité et consentement

Avant de commencer, je voudrais vous assurer de la confidentialité de cette discussion. L'entretien sera enregistré pour s'assurer qu'aucun détail ne soit perdu et pour faciliter la transcription et l'analyse précises des données. Cependant, cet enregistrement ne sera utilisé qu'à des fins de recherche et votre identité restera anonyme dans les rapports ou publications résultant de cette étude. L'enregistrement sera supprimé dès que l'entretien sera transcrit.

Votre participation est entièrement volontaire et vous avez le droit de vous retirer à tout moment ou de choisir de ne pas répondre à certaines questions. Avant de commencer, j'aurai besoin de votre consentement pour enregistrer cette conversation et utiliser les données comme décrit.

Êtes-vous d'accord avec ces termes et avez-vous des questions avant de commencer ?

Ai-je votre consentement pour procéder avec l'entretien ?

Thème 1 : Compréhension des rôles et des expériences

1. **Pouvez-vous vous présenter brièvement ?**
   - Quelle est votre fonction ?
   - Quel est votre niveau d'éducation ?
   - Avez-vous suivi une formation spécifique pour votre rôle actuel ?

2. **Depuis combien de temps êtes-vous impliqué dans la création ou la gestion d'une CPTS ?**
   - Qu'est-ce qui vous a motivé à prendre ce rôle ?
   - Quelles sont vos principales responsabilités au sein de la CPTS ?
3. **Pouvez-vous décrire une journée typique dans votre rôle lié au projet CPTS ?**
   - Quelles sont vos tâches quotidiennes ?
   - Comment interagissez-vous avec les autres professionnels de la santé ?
   - Pouvez-vous partager des expériences ou des défis significatifs de vos tâches quotidiennes ?

4. **Avez-vous assumé des responsabilités supplémentaires au-delà de votre rôle traditionnel en raison du projet CPTS ?**
   - Pouvez-vous fournir des exemples de ces responsabilités supplémentaires ?

Thème 2 : Obstacles à la création des CPTS

1. **Pouvez-vous décrire les défis significatifs rencontrés lors de la création de la CPTS ?**
   - Avez-vous rencontré des obstacles organisationnels ?
   - Y a-t-il eu des contraintes financières ou liées aux ressources ?
   - Comment avez-vous pu gérer votre temps ?
2. **Quels ont été les principaux défis réglementaires ou juridiques que vous avez rencontrés ?**
   - Comment ces défis ont-ils impacté le développement de la CPTS ?
3. **Avez-vous rencontré une résistance culturelle ou professionnelle de la part d'autres prestataires de soins/professionnels de santé ?**
   - Quels étaient les principaux points de résistance ?
   - Comment avez-vous abordé ces problèmes ?
4. **Pouvez-vous discuter des barrières technologiques, notamment en ce qui concerne les systèmes informatiques et le partage des données ?**
   - Comment ces problèmes technologiques ont-ils affecté le projet ?

Thème 3 : Leviers facilitant la création de la CPTS

1. **Quels facteurs ou stratégies ont été les plus efficaces pour surmonter les obstacles à la création de la CPTS ?**
   - Pouvez-vous donner des exemples de leadership ou de communication efficace ?
   - Comment ces facteurs ont-ils contribué à surmonter les défis ?
2. **Quelles ressources ou outils ont soutenu de manière significative la mise en œuvre de la CPTS ?**
   - Comment l'infrastructure informatique a-t-elle facilité le processus ?
   - Y a-t-il eu des incitations financières particulièrement utiles ?
3. **Comment la collaboration entre les prestataires de soins/professionnels de santé a-t-elle amélioré le développement de la CPTS ?**
   - Pouvez-vous décrire des pratiques collaboratives réussies ?
   - Quelles stratégies ont été efficaces pour promouvoir le travail d'équipe ?

Thème 4 : Impact et réflexions (certaines de ces questions dépendraient de l'état actuel de la création de la CPTS)

1. **Quel impact la création de la CPTS a-t-elle eu sur la prestation des soins de santé dans votre territoire ?**
   - Pouvez-vous fournir des exemples spécifiques d'améliorations ?
   - Quels défis subsistent ?
2. **Quelles leçons avez-vous tirées du processus de développement de la CPTS ?**
   - Que feriez-vous différemment dans de futurs projets de CPTS ?
   - Y a-t-il des bonnes pratiques que vous recommanderiez ?
3. **Quelles recommandations feriez-vous pour les futurs développements de la CPTS ?**

- Comment les décideurs politiques peuvent-ils mieux soutenir la mise en œuvre des CPTS ?
- Quelles ressources ou soutiens supplémentaires seraient bénéfiques ?

Commentaires de clôture

- Avez-vous d'autres commentaires ou questions ?

Merci encore d'avoir pris le temps de me rencontrer. J'apprécie que vous ayez partagé vos expériences avec moi aujourd'hui.

Annex 3: Coding Structure Table with Emerging Themes

Main Category	Sub-Category	Code	Synonyms/Alternative Phrasings
Understanding Roles and Experiences	Professional Background	Role and Responsibilities	Job Duties, Core Functions, Primary Tasks, Key Responsibilities
		Motivation for Involvement	Reasons for Participation, Driving Factors, Incentives for Engagement, Underlying Motivations
		Interactions with Professionals	Collaboration with Peers, Professional Interactions, Coordination with Colleagues, Networking Efforts
		Additional Responsibilities	Expanded Duties, Extra Tasks, Increased Responsibilities, Supplemental Roles
		Significant Experiences	Key Challenges, Notable Experiences, Critical Incidents, Major Events
Barriers	Organizational	Scheduling and Coordination	Time Management Conflicts, Meeting Logistics, Synchronizing Schedules, Coordination Issues
		Increased Workload	Task Overload, Additional Workload, Excessive Duties, Extra Work Burden
	Regulatory	Unclear Guidance from ARS	Regulatory Ambiguity, Confusing Regulations, Lack of Regulatory Clarity
	Cultural/Professional Resistance	Historical Conflicts	Past Disputes, Pre-existing Frictions, Historical Disagreements
		Professional Resistance	Resistance, Reluctance to Change, Opposition from Colleagues
	Technological	Technological Resistance and Adaptation	Tech Adoption Challenges, Resistance to Digital Tools,
Facilitators	Leadership and Collaboration	Strong Government Support	Political Backing, Governmental Endorsement, State Support, Public Authority Encouragement
		Effective Leadership	Strategic Leadership, Capable Management, Proactive Leadership, Leadership Emergence
	Resources and Tools	Financial Incentives	Monetary Motivation, Economic Benefits, Financial Rewards
		Existing Professional Networks	Established Relationships, Pre-existing Connections, Professional Bonds, Community Ties

		Enthusiasm of Young Professionals	Youthful Motivation, Dynamic Participation, Fresh Energy, Younger Professionals' Engagement
Impact and Reflections		Ongoing Challenges	Continued Difficulties, Persistent Issues, Unresolved Challenges, Lingering Obstacles
	Lessons Learned	Lessons from CPTS Development	Key Takeaways, Insights Gained, Developmental Lessons, Learning Points
	Recommendations	Best Practices	Effective Strategies
		Policy Support Suggestions	Support Proposals, Strategic Suggestions for Policymakers
Emerging Themes		Generational Differences	Age-Related Perspectives
		Community Engagement	Local Involvement, Grassroots Participation, Community-Driven Initiatives, Public Engagement
	Technological	Post-COVID Digital Integration	Pandemic-Driven Tech Adoption, COVID-19 Tech Shift, Digital Transformation Post-Pandemic

Abstract in French (Résumé)

Construire des soins intégrés et coordonnés : une analyse qualitative des freins et leviers dans le développement des Communautés Professionnelles Territoriales de Santé (CPTS) en Île-de-France

Contexte : Le système de santé français fait face à des défis importants, notamment l'augmentation des maladies chroniques, la hausse des coûts de santé et les inégalités d'accès aux soins. Ces problèmes sont aggravés par le vieillissement de la population et la présence de "déserts médicaux", où l'accès aux soins primaires est limité. Pour y remédier, le gouvernement français a lancé l'initiative des Communautés Professionnelles Territoriales de Santé (CPTS), visant à améliorer la coordination et l'intégration des soins à l'échelle nationale. Cependant, sa mise en œuvre n'a pas atteint les objectifs escomptés, en particulier en Île-de-France, la région la plus peuplée du pays. Cette étude examine les obstacles et les facilitateurs rencontrés par les professionnels de santé lors du développement des CPTS dans cette région.

Méthodes : Cette étude qualitative a utilisé des entretiens semi-structurés avec des professionnels de santé impliqués dans la création ou le développement d'une CPTS en Île-de-France. Les participants ont été recrutés par échantillonnage raisonné et en boule de neige jusqu'à atteindre la saturation des données. Les entretiens ont été enregistrés, transcrits et analysés à l'aide de techniques de codage déductif et inductif pour identifier les thèmes liés aux obstacles et facilitateurs du développement des CPTS.

Résultats : Dix entretiens ont été menés avec des professionnels de six CPTS différentes en Île-de-France. Les principaux obstacles identifiés comprenaient des défis de planification et de coordination, une augmentation de la charge de travail, des directives réglementaires floues et des conflits interpersonnels. Une résistance initiale aux outils numériques a été notée, mais elle a diminué après la pandémie de COVID-19. Les facilitateurs comprenaient un fort soutien gouvernemental, un leadership efficace, des incitations financières, des objectifs flexibles et des réseaux professionnels établis. L'implication des jeunes professionnels, caractérisée par l'enthousiasme et la collaboration, a également été un facteur positif significatif.

Conclusion : Cette étude met en évidence des facteurs critiques influençant le développement des CPTS en Île-de-France, offrant des perspectives pour de futures interventions. La mise en œuvre réussie des CPTS pourrait nécessiter de relever des défis organisationnels, et interpersonnels, en mettant l'accent sur le leadership et les réseaux professionnels. Ces résultats peuvent orienter les futures politiques pour améliorer l'efficacité des modèles de soins intégrés dans la région.

Mots-clés : Soins intégrés, coordination des soins, intégration organisationnelle, collaboration interprofessionnelle, CPTS, réforme de la santé.