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## Experiencing the Impact of a Specific Funding Scheme for Primary Care Teams on Professional Dynamics and Inter-Professional Teamwork in France: A Qualitative Assessment

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This qualitative research examines professional dynamics in primary care teams<sup>1</sup> and more specifically, the effect of a prospective and supplementary budget (called NMR) allocated to the practice, specifically to foster new forms of inter-professional teamwork. Our analysis of this pilot program called "Experiments with New Mechanisms of Remuneration" (ENMR) is based on a sample of four primary care teams purposively selected among 114 participating primary care teams but only those with self-employed professionals<sup>2</sup>.

This paper gives a summary of the main results of an in-depth analysis (Fournier *et al.*, 2014) and is the third Issues in Health Economics in a series. The first paper presents the aims and methods of the forthcoming quantitative evaluation developed by IRDES over the last four years 2009-2013 (Afrite *et al.*, 2013). Based on this assessment, the second paper analyses the geographical distribution of the participating primary care teams and their impact on the density of general practitioners (Chevallard *et al.*, 2013 a and b).

This exploratory research has three aims: to study the conditions under which inter-professional teamwork emerges and the numerous forms it exhibits within the selected sample; to generate hypotheses on the main factors that favour or hinder the development of inter-professional team work and more particularly the role played by the new funding scheme (NMR); finally, to contribute to the public debate about what factors ought to be taken into consideration so that this experiment can be scaled up and implemented successfully.

This experimental program (ENMR) set out in Article 44 of law n° 2007-1786 relating to social security financing constitutes an innovative funding mechanism: Access to the new funding is based on the prerequisite that the primary care team develop a health project<sup>3</sup>. Once this plan is approved by the regional health authority (*Agence régionale de santé*, ARS), the budget is allocated. This research closely interfaces with the quantitative evaluation mentioned above of ENMR to test hypotheses concerning the relationship between pri-

mary care teams and performance using a deductive and explanatory approach (Afrite *et al.*, 2013). The approach developed here is inductive and aims to be comprehensive. The term "inductive" refers to the premise that the complex object 'primary care team/new "funding scheme"' to be analysed will to some extent be constructed a posteriori by the investigative work, according to factors revealed by the "field agents" themselves. The term "comprehensive" refers to the fact that our main goal is to understand the meaning that agents attach to their actions, without

<sup>1</sup> Teams which contain different types of health professional, at least GPs and doctors.

<sup>2</sup> Primary care team can be split into three categories: multidisciplinary group practices where all professionals work in the same location/setting. They are called in France "*maison de santé*" and correspond to patient-centered medical home in the US. The second category are Primary Health care networks (called in France "*pôle de santé*" with at least two different settings but with large variation in the latter number and distances). In both cases, health professional are self-employed. This is not the case of the third category of primary care team called "*health care centre*" where health professionals are salaried.

<sup>3</sup> A health project is a proposal setting the principles and scope of team working in various domains such as long term diseases, screening and prevention, patient and health education.

making any normative judgment regarding their behaviours based on our own a priori opinion. So the two approaches are complementary as one is more focused on the process leading to team work and the other on the outcome of the new patterns of skill mixing that result from the team's new dynamic. Throughout this exploratory research, we successively study the conditions under which inter-professional work emerges within the framework of primary care teams and the numerous forms it takes within our sample; the nature of the main factors influencing the set-up of team work and, when possible, the specific influence of the new funding scheme; finally the conditions that would appear necessary and also caveats in view of scaling up and implementing the experiment.

### Conditions for the emergence of inter-professional teamwork and the numerous forms it takes based on the study of four primary care teams within the experimental framework

The general practitioners in our sample currently perceive an absence of competition within their profession. This situation and the desire not only of physicians but also of all non-physician health professionals involved (nurses, physiotherapist, dietician, podiatrist, psychologist, midwives, etc.) to work together but first in "peer group practices", appears to facilitate the subsequent creation of primary care teams but also cooperation within the latter. It favours also cooperation with other professionals working in other health or social care structures. From this observation and others coming from the literature (Crabtree; Dobson) we can induce that the time period for multi-professional teamwork to emerge and establish on a regular basis will need an average period of 3 to 5 years.

A greater proximity between professionals is a major factor favouring cooperative work in teams (Huard, 2011). The concept of proximity can be broken down into different dimensions (cognitive, physical, professional, organisational, cultural) that are all closely related (Boschma, 2005). Among them, cognitive proximity appears to be the most determinant. It is characterised by a

high level of reciprocal knowledge between different types of health professionals in terms of skills, expertise, practical experiences and type of works. It favours the development of trust between health professionals and in parallel a weakening of the "symbolic hierarchy" between the medical and non-medical professions. Information sharing on the way patients are followed and treated from which cooperative work will be developed is thus facilitated. In this regard, "physical proximity" in shared premises can contribute to reduce cognitive distances. But this type of proximity may not be enough. In this case the elaboration of the health project (sometimes in close relation with the architectural project) is a powerful and complementary tool as it helps to shape a common understanding and appreciation of the difficulties of teamwork (Juillard *et al.*, 2010). Its impact is twofold: first, through a selection mechanism, by attracting certain professionals who see its advantages for their practice. Second, by favouring the emergence of cognitive, organisational and physical proximity through frequently held meetings involving different types of health professionals; notably between those with few previous links or those practicing in distant settings ("*pôles de santé*" as opposed to "*maisons de santé*" where the premises are shared). Subsequently, formalising inter-professional interventions and training a team in the elaboration and implementation of a Patient Education Program (PEP) have been considered also as favouring cognitive proximity and thus team work.

Active participation in teamwork constitutes for non-physician health professionals a strong challenge. Our investigations have shown that despite all the difficulties they encounter, many of them want to be involved. This explains why the way by which the health project has been elaborated can influence the development of cooperative work: in particular, "shared leadership" combined with "participative management" or collegial governance favours the development of work: each of these three elements, independently but also jointly, increases the probability of involving non-physician health professionals as they enable them to better find their place and gain new legitimacy within the overall project through the recognition of their specific skills and expertise that are needed for setting up inter-professional team work.

The methodology used for the survey piloted by the Institute for Research and Information in Health Economics (IRDES) was defined in collaboration with the team responsible for the quantitative evaluation and a consultant specialised in primary care teams in the public health domain (Durand, 2012).

**The sample** made up of four self-employed primary care team involved in the pilot experiment was purposively selected from two French regions. Among these structures, two are established in disadvantaged urban areas and two in non-disadvantaged semi-rural areas. Two of the selected sites are MSP while in the two remaining are "*pôles de santé*": one with a more developed setting and two smaller at very close distances; one with 9 settings but separated by a distance of less than 8km. Among the selected practices, team working dates back to over thirty years, for another to six years, whereas the last one is only beginning as it established only two years ago. The number of health professionals varies (10, 12, 15 and 28), with 3 to 8 different health professions being represented. Two to 3 medical clerks worked in all practices, and one had a project coordinator.

The funds are divided in two different grants: Two of the practices benefit from the "Coordination grant" dedicated for managing and paying for inter-professional programs (team work) while the other two practices benefit also from a grant for paying for "New Services for Patients" which in this context consists in setting up and delivering a program of patient education in groups. Volume grants are calculated separately and are principally based on team size at full-time equivalents (FTE), the number of patients registered on the "preferred doctor" scheme for the first one; the number of patients included in the patient education program for the second.

**Data collection** covers the period from April to September 2013 and consists of three levels. At national level, individual interviews were conducted with the ENMR project Director at the Directorate of Social Security (*Direction de la Sécurité sociale*, DSS) and his assistant, with the IRDES economist responsible for the quantitative evaluation and the consultant. Interviews conducted at regional level concerned members within the Regional Health Agencies (*Agence régionale de santé*, ARS) in charge of the experiment. Within the practices, observations and interviews (individual and collective) concerned health and non-health professionals. They were conducted during site visits that lasted between 2 to 3 days by the authors and reached 62 out of the 77 professionals working on the four sites (general practitioners, nurses, physiotherapists, podiatrists, speech therapists, nutritionists, chemists, psychologists, midwives, angiologist, project managers).

**The different dimensions and themes** structuring the interview guidelines were: factors relating to peer and primary care teams; type and content of inter-professional programs and their formalisation; national, regional and local political and professional dynamics in relation to the experiment and specifically the perceived impact of the new budget; finally the tools used to supervise and support the practices involved in the experiment and the way they were used.

**The analysis** was based on 32 interviews, observation notes, and documents collected on each site. A monograph of each selected practice followed by a coding of predefined and emerging themes was carried out within the framework of a global analysis. The data collected from professionals belonging in the practices were confronted with data collected from institutional representatives and support staff. The results were discussed with the consultant, members of the assessment steering committee, and compared to national and international literature.

T1

### Access to the budget produces or amplifies a cultural shock that is framed through an institutionalisation process

Access to this experimental program either provokes or amplifies a "cultural shock"<sup>4</sup>. All professionals involved are faced with the challenge of sustaining their core private and individual practice, regulated within the traditional regulative framework with the National Health Sickness fund (CNAM), while trying to develop new inter-professional teams based on a contractual agreement with the State regional representative body (ARS) [Table 1]. Even if working as a team represents a small portion of their clinical work, it generates a significant amount of efforts and is time consuming. However interviews showed that the coexistence of these two types of work was acceptable for most of the professionals concerned: even if, in their opinion, the new budget amount does not fairly compensate for their efforts, it is precisely the limited revenue it brings relative to the one generated by the fee-for-service schedule (FFS) coming as a supplement to the latter, that guarantees their professional autonomy as it does not threaten the dominance of the FFS schedule<sup>5</sup>. We found the same ambiguous standpoint among both the physician and non-physician health professionals when considering the optimal arbitrage to be set between the levels of these two forms of remuneration. The type of management put in place in the investigated sample appears in this regard as key in how to set the best balance between the traditional culture of individual professional autonomy and the new "teamwork based" culture.

In the four sites, the process by which professionals set up their specific organisation for teamwork with their group becoming "institutionalized" remains flexible and evolutionary. This transformation effectively requires the acquisition of new skills and knowledge in the field of management, accounting, law, strategic planning, political bargaining, as well as institutional representation that is

<sup>4</sup> Similar to that experimented in certain city networks that have developed multi-professional actions.

<sup>5</sup> In this respect, it is probably no coincidence that none of the professionals interviewed (apart from one), considered the fee-for-service scheme as an obstacle to setting up multi-professional actions.

### Two cultures to link together in the ENMR

	Individual culture	Group culture
	Mono-professional (Peer) Contractual (general agreement with the Health sickness fund)	Multi-professional in addition to mono-professional Based on Contractual agreement with Regional Health Authority supervised at national level
<b>Underlying Dimensions</b>		
Followed population	A patientele	Patienteles and/or population of a territory
Remuneration/basis	Ex post Individual	Ex ante collective (practice group health project related)
Remuneration/type	<ul style="list-style-type: none"> <li>• Fee for service</li> <li>• Individual P4P only for physician (Rosp)</li> <li>• Flat rate capitation (long-term illness scheme (ALD), preferred doctor scheme...)</li> </ul>	Global and closed envelope to set up interprofessionnal actions
Entrepreneurial role	Independent, autonomous	Collective through bargaining/negotiation
Implication in team working	Self-decision	Negotiated within the context of belonging to a team
Peer professional relationship	Implicit competition	Explicit interprofessionnal cooperation
Inter-professional relationships	Variable on a case-by-case basis	Framed by the content of interprofessionnal cooperation
Type of decision process	Individual (care) collegial (means/resources)but only for members of the health professional association(SCM)	Collective, involving all type of professional belonging to the Inter-professional Ambulatory Care Organisation (SISA) which enables to redistribute money to all involved professionals while preserving the self-employed status of the health care professionals
External supervision of professional work	National public sickness: individual evaluation and performance measurement (ROSP)	Self-evaluation by the team on a voluntary basis steering by Regional Health Authority (ARS) and National comparative evaluation (IRDES)
Judgement regarding the quality of professional practice/activity	Mono-professional by chosen peer (no data, local reputation)	Peer and inter-professional assessment, by externally selected health/medical-social partners
Type of contracting and practice regulation	Primarily self-regulated, with weak external regulation according to the content of the general contractual agreement with the national sickness fund (little constraint and perceived more implicit than explicit)	Local Contractual agreement with ARS on the basis of the health project (erceived with contradictory feeling: weekly coercive but also explicit recognition of their work)
Type of professional dependency/interdependence	Informal network made of chosen professional with arrangement discussed on a case by case basis	Always negotiated in the context of IP actions mostly informal but with shared responsibility +formalisation for some individuals
Type of professional responsibility	Individual	Individual and collective
Control of revenue	Individual by type of professional based on volume and type of clinical activity	Collective control of a global budget with negotiated redistribution to individual
Institutional representatives	Trade unions, orders, national Sickness fund and complementary for profit and not for profit health insurance	RHA (ARS), local political levels (county, town) regional and national professional unions ( URPS), regional and local boards of Medical homes and at national level the "French Federation of 'maisons' and '-pôles de santé' (FFMPS)
Training and Continuing education	Formal education and training based on global individual practice or through peer profession networks	<i>Idem</i> + specific training in the context of IP team working financed through (NMR) focusing on: patient education, population screening and follow-up...)

T2

## Indicative list of multi-professional services set up on the sites analysed

	Type of action
<b>Organisation of primary care and operational management of the structure</b>	
Primary care structuring	<ul style="list-style-type: none"> <li>Incentives to take up primary care team on the health area</li> <li>Development of specific skills (ex. : gynaecology, sports medicine...) within each "maison de santé"</li> <li>Sharing of certain multi-professional actions between MSP in a same area</li> <li>Positioning the MSP as privileged interlocutor (having become visible) for partners and/or professionals seeking to set-up</li> </ul>
Architectural project	New architectural project or existing project extension
Methodological work	Written methodological guidelines to develop health prevention actions (project supported by the Federation of "maisons" and "pôles de santé" (FMPS), with several MSP)
Training-Research Accompanying and supporting projects or structures	<ul style="list-style-type: none"> <li>Welcoming students (doctors and paramedical professionals)</li> <li>Primary care research development (MSP actions are the subject of numerous theses in general medicine)</li> <li>Welcoming numerous visitors interested in the projects being developed (notably professionals wishing to set up an MSP)</li> <li>Support missions carried out in other MSP by certain professionals</li> </ul>
Information technology project	Shared medical file: development of new functions (e.g. screening a population with regard to a risk factor or monitoring)
<b>Coordination of patient or population care (health project)</b>	
Prevention	<ul style="list-style-type: none"> <li>Awareness of the importance of language in the pre-natal period : interventions in maternity</li> <li>Contraception: behaviour to adopt in the event of forgetting to take the pill (interventions in secondary schools; development of an Internet site)</li> <li>Vaccination: file updates; vaccination of target populations by nurses; duty transfer protocol (prescription) toward nurses</li> </ul>
Screening	<ul style="list-style-type: none"> <li>Screening for aortic aneurysm</li> <li>Screening against the risk of cardiovascular disease</li> <li>Home-based memory impairment screening project by nurses Cancer screening</li> </ul>
Patient Education Programme (PEP)	<ul style="list-style-type: none"> <li>Training carried out or planned on the four sites for all or part of the team (in one MSP, training carried out with social workers)</li> <li>In one MSP: a "diabetes" PEP project</li> <li>In another MSP: link with the "diabetes" network until a specific training project has been developed</li> </ul>
Chronic disease monitoring	<p>Open sores:</p> <ul style="list-style-type: none"> <li>Joint work between the nurse and the angiologist or between the nurse and the GP, on the point of being formalised in one MSP (aim to create a resource centre)</li> <li>In the other MSP: more informal GP/nurse protocol</li> </ul> <p>Anti-vitamin K (AVK):</p> <ul style="list-style-type: none"> <li>Joint work between GP/nurse, usually informal</li> <li>Key role played by secretaries in decision-making information reporting (INR)</li> <li>Protocol on trial</li> </ul> <p>Hemochromatosis:</p> <ul style="list-style-type: none"> <li>Protocol almost completed in one MSP on treatment provision</li> </ul> <p>Diabetes:</p> <ul style="list-style-type: none"> <li>Informal nurse/GP interventions to adapt insulin doses, sometimes based on protocols (diabetes network; hospital) used by the nurse</li> <li>Informal work on diabetic foot : GP/podiatrist or nurse/podiatrist</li> <li>HbA1c dosage monitoring by secretaries or nurses</li> </ul> <p>Static disorder:</p> <ul style="list-style-type: none"> <li>Multi-professional staff for complex cases</li> <li>Screening, orientation and treatment of pregnant women suffering from lumbago</li> <li>Joint osteopathy/physiotherapy/podiatry consultations</li> </ul> <p>Home care:</p> <ul style="list-style-type: none"> <li>Training / fall prevention</li> <li>Home file</li> <li>Nursing diagnosis in the home</li> </ul> <p>Alzheimer:</p> <ul style="list-style-type: none"> <li>Preparation of memory consultations at the University Hospital (CHU): health check by a GP, a speech therapist and a psychologist</li> </ul> <p>Organisation :</p> <ul style="list-style-type: none"> <li>Juxtaposition of appointments with the physiotherapist and speech therapist (to avoid patients' need to visit twice)</li> </ul>



built up through the project's development process and management of needed changes. In this regard different types of coordination are needed at different levels: for the routine monitoring of each inter-professional action, whether internal or external, and for the provision of coordinated care to insure care continuity for each patient. But also regarding the coordination of the overall project; in our sample, coordination involved from 1 to 3 professionals according to MSP with always one or several doctors and with different types of task division: in 3 out of 4 cases one dietician /speech therapist/nurse belonged to the management staff. In one case there also existed a dedicated non-health project manager (called coordinator). Furthermore, in addition to the regional health authority, the practices were able to call on the services of an external consultant with an expertise in specific domains in order to help the practice set out the collective health and social needs of the population in the geographical area to which it belonged or to finalize their health project, for financial simulations, legal advice, etc. Sometimes they also asked for advice on specific regional structures such as the Regional Union of health professions (*Union régionale des professions de santé*, URPS), the Regional Agency for Health Education and Promotion (*Instance régionale d'éducation et de promotion de la santé* (IREPS), etc.).

### Entry into the experiment favours the development of inter-professional team work regarding volume and scope

Despite its limited amount averaging 50,000 €/practice group, corresponding to a 2 to 5% increase in revenue for each type of professional, the new funding scheme appears to favour the development of great creativity in the process of inter-professional teamwork. In the visited sites, all inter-professional actions that existed exclusively informally before they entered the experiment have at least been maintained as the allocated budget has been first used to recognise and better remunerate what existed before, and remobilise professionals involved. But it has also been used to support their motivation in order to formalize inter-professional actions and/or develop new ones that would have been impossible without the new funds.

As a large amount of operational freedom was given to the professionals regarding

the choice of actions, the inter-professional work essentially developed not only according to identified local needs but also to the skills and expectations of the involved professionals. We thus observed that educational and preventive services but also clinical and follow-up programs developed to a greater extent than before, the range of new services for patients being relatively extensive (see Table 2). If these programs always involved professionals belonging to the practice, some also engaged other local health and social professionals and/or settings. Finally, if inter-professional work primarily concerned physician-registered patients, it also affected patients of health professionals working in the group practice but whose registered physician may not have belonged to it.

### Towards a redefinition of professionals' roles and the mobilisation of new expertise: Changing the skill-mix distribution

Dealing with how to set up inter-professional programs may entail some important modifications of professional boundaries and the power structure between health professionals in order to build a new skill mix distribution. Frequently, it leads doctors to refocus their activities on their core clinical work while non-physician professionals extend their field of activity and sometime autonomy. However, and simultaneously, for the medical and physicians and non-physicians involved in non-clinical tasks, their "activity framework" extended to management and political or professional representation (Table 2). Also, in some of the study practices, medical clerks (which is an improper term to describe their extended scope of work<sup>6</sup>) played an important role in the circulation of information between health professionals facilitating both project management and the continuity of patient care pathways. Finally, all investigated settings were more or less considering hiring non-medical project coordinators, debating about their professional knowledge base and training and how to mutualise their funding.

These internal transformations generated different effects. Firstly, within each practice, specific skills are redistributed: whether between physicians (gynaecology, eye fundus, palliative care, gerontology, sports medicine) or between physio-

therapists focusing on specific techniques or domain. This type of specialization may concern also two practices located at close to one another with one focusing on a patient education program, for example, while the other focuses on developing primary care research. For two practices, we observed this emergence of inter-professional programs involving a population/territorial-based approach. All these innovations are "context dependent" as their focus and types of cooperation depend strongly on the distribution of the local health care resources and the type of relationships established with medical and social institutions as well as with local government representatives. This sort of "primary care structuring process" has also had the effect of turning such group practice into a visible new stakeholder for potential health or social partners such as the regional health authority (ARS), local government representatives or health professionals wanting to set up in the concerned area.

### Formalisation of multi-professional work program: a complex and creative process

Informal cooperation remains the preferred mode of work relationship among multi-professional teams. Formalised cooperation is rare although its volume varies from one site to another. Health professionals, and especially physicians, have very different conceptions regarding the process of formalising their work when considering its impact in terms of quality of care and/or benefit to patients. But they also diverge regarding the nature of activities to be formalised and the populations that ought to benefit from. Their conceptions also vary regarding the content of an inter-professional protocol: it goes from a simple and weakly formalised agreement to a highly detailed and specified group of actions validated by the High Authority for Health (*Haute autorité de santé*, HAS) [a national agency responsible among other missions for setting evidence-based clinical and organisational guidelines]. Formalisation indeed is a complex process where clinical practice guidelines based on evidence-based knowledge are integrated with another type of collective and empirical knowledge, grounded on the clinical experience of each

<sup>6</sup> For example, checking that patients have performed their planned tests (Fournier et al., 2014)

professional (Shuval *et al.*, 2010; Gabayand Lemay, 2004). This process generates controversies in that it calls into question the boundaries of specialisation domain and the clinical but also legal responsibilities of each professional involved. Thus, even if an agreement between the professional team, which is responsible for formalising a specific program, is reached, its further application by other professionals belonging to the practice is never guaranteed. But formalising multi-professional work nevertheless has a significant impact: beyond giving professionals a greater legitimacy in the eyes of decision makers, it strongly contributes to reinforce interdisciplinary and professional dynamics. And even if the end result is not usually a written protocol, more importantly, the process can lead to the emergence of a greater vigilance and responsibility regarding events (access to and discharge from hospital, treatment modification...), recognised by all professionals as a source of rupture/discontinuity in patients' care pathways. When this type of consensus is reached, it means that a professional will be less reluctant to warn his colleagues regarding a patient clinical or social situation he considers threatening, even if it does not belong to his specific professional jurisdiction, thus enhancing the responsiveness of the team.

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### Various uses and redistribution of the new practice's budget

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#### Negotiated use of the allocated funds contributes to the team's dynamics

The use of the new funds whose modes of redistribution are subject to almost no constraints, (except that they must focus only on multi-professional programs) appear to be specific to each site and to vary according to the existence of complementary sources of funding. However, we observe common traits because within each MSP the process of building multi-professional actions requires common choices to be made regarding the budget redistribution: paying for the building up/ the realisation/ the coordination /operational costs, of a specific inter-professional program, and finally for each one, how to redistribute money between the different types of professionals involved. These choices play an

important role in structuring and motivating the team's dynamic.

#### Different approaches for the redistribution process but with a constant concern for equality and equity

On the four sites, the choices made are different and may evolve depending on the stage of teamwork development and the nature of the chosen actions. Some MSPs put aside a fixed amount to be allocated to each professional plus a flexible amount allocated according to the time spent in performing inter-professional actions, while others only take into account the time spent. In all the MSPs, but with varying degrees, we observe attempts to remunerate non-physician health professionals in such a way as to reduce relative income inequalities with doctors. Furthermore, in one site, the budget is used to reduce these income inequalities coming from a P4P program (and called ROSP). The latter benefits the doctors only whereas achievement targets partially rely on specific task performed by other professionals such as nurses or clerks as they remind patients to perform certain medical examinations, the frequency of which affects these targets. The use of this budget *also* enables paying unlisted<sup>7</sup> nutritionists and psychologists for their contribution to specific multi-professional programs. They also enable nurses to be paid for their evaluation of certain complex situations in the practice. Finally, professionals involved in coordination tasks are remunerated differently in different sites, either on a flat rate basis or on the time spent. The remuneration changes from one year to the next, notably according to whether new inter-professional actions have been implemented.

#### Problems relating to the formula used for calculating the budget amount

As previously quoted (methodology) the overall budget is, by design, divided into two pieces: one for paying for coordinating, managing, and delivering inter-professional programs as a team; the other for paying specific inter-professional programs called "New Services to Patients" and applying specifically to patient education. The determining factor of the first piece's budget formula is the total volume of the physician's patients in the practice. The adjust-

ments that aim to take into consideration the participation of other health professionals seemed insufficient and play against health care networks called "*pôles de santé*" as non-physician professionals are usually more numerous in the latter. All the formulae used for the second piece happened to cover the costs incurred in organising the patient education program but not entirely for delivering it such that the teams used the first grant to supplement the second, thus limiting other inter-professional programs.

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### Obstacles and incentives to setting up inter-professional teamwork

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The emergence and development of inter-professional teamwork have been favoured by several factors: cognitive and geographical proximity, the ability to create a health project, work on protocols, types of management, etc., but such teamwork is also faced with numerous obstacles. First, setting up inter-professional actions elaborated as part of the health project is all the more delicate in that for all the health professionals interviewed, their priority remains responding to their patients' care needs and being reimbursed through a fee-for-service (FFS) scheme. It is a case of maintaining their income levels as the newly allowed budget (NMR) is perceived as limited but not permanent. Yet the participation of paramedical professionals in multi-professional team actions renders the organisation of their routine activities more complex. It assumes work time adaptability, which is not the case as their activity is essentially based on repetitive and fixed appointments. Secondly, doctors do not always perceive the psychological blockage effect that results from the way they influence the process of inter-professional work: in certain cases, they have difficulty delegating responsibilities to paramedical professionals; in other cases, the blockage comes from physicians' difficulties in setting and sharing new professional boundaries, notably by formalising them through protocols.

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<sup>7</sup> Services delivered by these health professionals do not benefit from reimbursement by National Health Sickness fund (CNAM) and thus are to be paid out-of-pocket.

Other barriers to set up multi-professional teamwork come from the hermetic initial training of all health professionals, generator of significant cognitive distances more particularly in the primary care context, together with the relatively poor post-university programs that allow for training them in common group. Furthermore, despite their willingness to participate, non-physician health professionals currently have fewer professional references (such as Evidence-Based Medicine, EBM) available to them than doctors. Providing them with training and appropriate tools, which are not always available despite the significant amount of work carried out by institutions overseeing the setting-up of inter-professional team work, would be of great benefit to them. Finally, they have more limited financial resources to compensate for the time spent in preparing team actions. Among them, nurses face specifically numerous obstacles that can hinder their investment in inter-professional teamwork. One obstacle comes from their revenue structure (Juillard, 2010): home visits generating the majority of their revenues explain the relatively short time they spend physically in the practice setting and thus this limits their possibilities to interact frequently with the other professionals. To this should be added an important gap between their officially domain of recognized skills/competencies and the limited tasks/services for which they are paid through their specific FFS schedule. Paradoxically they also have greater difficulty to negotiate within a multi-professional context their new roles and responsibilities as autonomous professionals than nutritionists or podiatrists (Fournier *et al.*, 2014). Finally, they are poorly acculturated in the use of information technology, maybe because their activity-based billing is essentially managed through paper work (1hr 30 on average per working day) rather than through remote electronic transmissions.

Extending the field and the scope of services of non-physician professionals and especially nurses is key for the development of inter-professional teamwork. In France, doctors have the monopoly of all health services to be delivered to a patient; thus, each specific non physician professional jurisdiction is defined as an exception to this monopoly. So any extension of this jurisdiction is largely based on the rules set up in a specific law (article 51) which authorizes the

delegation to non-physician professionals of specific tasks as a national derogation to what prevails normally while making it also possible to pay for it. This creates strong obstacles to inter-professional teamwork development especially regarding specific programs promoted by nurses. The way this "article 51" has been written is a major source of incomprehension (Genisson and Millon, 2014) leading to the credo that the only inter-professional actions that can be paid (for example by using the new budget) must necessarily relate to it. This was the case in one region where a nurse consultation was proposed. It did not belong to services included in nurse's fee schedule. This program should not be considered as relevant for the application of the derogation clause. The regional health authority thus could have used its legal ability to give a regional authorization to this program letting the nurses be paid for by the new budget. Instead inadequately it decided to ask for the application of the article 51. The result was that the nurses were forced to engage themselves in the well-known cumbersome administrative procedure to apply for it, which finally led nurses to give up.

Regarding the information system, the medical component of the shared multi-professional file is currently almost exclusively used by doctors and medical clerks who value it while its non-physician and inter-professional communication components are unanimously criticized by both non-physician health professionals and the physician responsible for managing inside the practice of this "electronic shared record" but usually not trained for it. This has not, however, had a major impact on the development of inter-professional actions. Having remained essentially informal, they have led to alternative information flows, often through medical clerks, which maintained existing information routines thus minimizing the use of the so called shared record. Interview analyses showed that non-physician professionals, who currently use their own business-specific software enabling them to monitor their patients and manage their accounting, are not willing to duplicate data entry to complete the common shared medical file. They only use the read access to the files, and when they encounter any difficulties they call on the medical clerks. Other defects are found in some software, with shortcomings in sorting efficiently specific records, resulting in projects

founded on a population-based approach to be postponed. The observed gaps are in part the result of the inefficient accreditation process of the numerous commercial software of the Agency for Shared Health Information (*Agence des systèmes d'information partagés de santé*, ASIP) that was supposed to guarantee their effective use in a multi-professional context. But also because doctors working in these group practices were satisfied with their mono-professional use of the medical part of the common record software and barely aware of the problems it poses for the paramedical staff, this could explain the weak response of their institutional representatives in trying to articulate the needs of the different professions concerned.

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### Conclusion: taking as a serious concern inter-professional team work in group practices

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The new funding scheme has been tested within a 4-year lasting experimental context that is not yet stabilised. Our study shows that, as in other countries, new ways of inter-professional teamwork coupled with new mechanisms of paying for it (Bitton *et al.*, 2012; Finlayson *et al.*, 2011), can act as an effective incentive to reorganise jointly physicians' work with non-physician health professionals (Ladden *et al.*, 2013; Lombraïl, 2014) through a more effective skill mix distribution.

Initially, it is the desire to work inside a peer group that prevails. The progressive transition toward inter-professional teamwork takes from three to five years. But as soon as the process has been initiated, inter-professional work is perceived by professionals themselves as a factor improving the quality of their work. Specific factors that favour this transition have been identified: the elaboration of a "health project" related or not to an "architectural project"; collegial governance, participative management and shared leadership; the effort to formalize inter-professional work, training the whole group in patient education; their ability in project building and change management skills. This teamwork sometimes embeds external local health and social professionals/settings and occasionally local authorities. This makes these practices legitimate

stakeholders as participants in local regulation of primary care (Fournier, 2014)

On our studied practices, negotiations regarding the redistribution of NMR between different professional categories constitute an important driving factor in the innovation process generated by building inter-professional team work. Thus, the objective to try to achieve equal payment levels for equivalent tasks between different types of health professionals, associated with the attempt to close the gap in revenue between physicians and non-physicians when relating to IP actions, can be considered as a strong signal of the aim to integrate the latter as equal partners in the team.

The time-consuming building process of inter-professional teamwork is confronted with constraints related to structural barriers but also with current limitations of the new budget design. Specific training

and structured support to manage change, both at clinical and organisational levels, are necessary in order to overcome the cultural resistance to multi-professional work. Certain legal and technical barriers could easily be lifted by simplifying the redaction of article 51, which would also clarify the possibility of building inter-professional programs that cannot be considered as a delegation. Also helpful would be inciting software developers to answer to the specific needs of paramedical professionals working in primary care teams and by developing remote transmission for their activities.

The process of redistribution of the collective budget is a powerful tool in work innovation and dynamics: searching for the best balance between the respective levels of global remuneration (capitation) and "individual remuneration" (FFS, P4P) can help in extending inter-professional work. In this regard, the formula for calculating the new budget should take better account

of the number of and time invested by non-physician professionals. The geographical/population dimensions of some components of inter-professional team work would also justify the formula for calculating the budget taking into consideration not only the number of registered patients of physicians working in the group practice but also patients of all health professionals working in the practice.

The necessary cultural transformations (Mac Donald *et al.*, 2013; Marshall *et al.*, 2003) expected within a public policy framework promoting primary care team needs to be sustainable within a stable political protective framework for the agents involved (Crabtree *et al.*, 2011; Dobson *et al.*, 2002). This framework would facilitate its development, consolidate achievements and capitalise knowledge of the effectiveness and efficiency of primary care teams in the perspective of a general evolution of the organisation of care. ♦

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