ISRCTN94081440 https://doi.org/10.1186/ISRCTN94081440

Modelling expectations of users and health professionals - how to build congruence between users and health professionals for unscheduled care

Submission date 23/09/2021	**Recruitment status** No longer recruiting	[X] Prospectively registered ☐ Protocol ☐ Statistical analysis plan [X] Results ☐ Individual participant data
Registration date 29/09/2021	**Overall study status** Completed	
Last Edited 25/06/2024	**Condition category** Other	

Plain English summary of protocol

Background and study aims

Unscheduled care is defined as care that must respond to a perceived emergency, but which does not medically fall under the heading of an emergency and does not require treatment by hospital emergency services.

The Territorial Professional Health Communities (CPTS) are working on local (multi-professional) care organisation solutions, thanks to universal health insurance (CPAM) funding via the inter-professional agreement (ACI). Access to a general practitioner and to unscheduled care is one of the core missions of the CPTS.

A national survey of emergency departments conducted in 2013 shows that only 46% of requests for care in hospital emergency departments - 42% in Île-de-France - actually required emergency care. There may be a mismatch between primary care supply and demand. Some of this demand for unscheduled care comes from consultations with primary care professionals and organisations. However, there has been an uninterrupted increase in the number of visits to hospital emergency departments over the past 20 years, from 10 million in 1996 to over 20 million in 2016. Various solutions focusing on the adaptation of the emergency care offer have been proposed without any notable effect. Medical on-call centres in France and abroad, devices such as single call numbers like NHS 111 and 'walking clinics' in England, have not limited the continuous increase in patients' use of emergency departments.

The use of hospital emergency departments for unscheduled care seems to be largely determined by users' choices. Thus, in the 2013 survey, 62% of patients decided to go to the emergency department by themselves. At present, no population-based data makes it possible to anticipate the demands, needs and behaviour of users seeking unscheduled care before they go to the emergency department. The literature shows that the reasons why healthcare users seek care are mainly sought in places dedicated to urgent care and most often based on an assessment of the need for medical urgency. However, proposals for responding to unscheduled care are not limited to emergencies: more than 8 out of 10 general practitioners organise themselves on a daily basis to deal with unscheduled care. The demand for unscheduled care does not seem to be sufficiently analysed from the point of view of users in the general

population and does not meet the solutions proposed by health professionals.
Reorganisation at the level of the doctor or the emergency room seems useful, but insufficient on its own. Medical assistants, advanced practice nurse (APN), telemedicine and dedicated regulation are some of the solutions proposed, but these national recommendations are difficult to put into practice and adapt locally. The intermediate scale, which would be that of the territory, seems the most relevant.
By choosing to emphasise access to care in the ACI, the law recognises that the intermediate level - that of the territory - seems the most relevant for improving the match between users' need for access to care and the responses of the care system. The stakeholders required to devise these territorial solutions are varied and must integrate the demands and expectations of users, which has never been done before. These two characteristics make CPTSs, which are funded by the health insurance system to improve access to care, including unscheduled care, and to a general practitioner, the tools of choice for rapid adaptation, taking into account the needs and expectations of users, and for improving the resilience of the population and the health system in crisis situations.
The responses and the importance of adapting the territorial organisation of care appear to be well confirmed by the COVID-19 pandemic. In Île-de-France, the organisation of primary care was based on the creation of consultation centres dedicated to COVID within the framework of existing projects or CPTSs. The territorial action framework constituted by the CPTS thus seems relevant for working on analysing the demand for care and developing appropriate solutions to improve access to care.

Who can participate?
Users and professionals from the four selected territories (Pantin, Paris 10e, Ermont, and Marnes et Gondoires)

What does the study involve?
The study involves interviewing professionals and users from four territories corresponding to the CPTS of Pantin, Paris 10e, Ermont, and Marnes et Gondoires.

What are the possible benefits and risks of participating?
There is no direct benefit to the participant. The long-term benefit is to better address the demands for unscheduled care in these four territories. The collected data will be anonymised before analysis, so the risks of participating are limited.

Where is the study run from?
Girci Idf (France)

When is the study starting and how long is it expected to run for?
November 2020 to December 2023

Who is funding the study?
Girci Idf (France)

Who is the main contact?
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Contact information

Type(s)

Scientific

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Additional identifiers

EudraCT/CTIS number
Nil known

IRAS number

ClinicalTrials.gov number
Nil known

Secondary identifying numbers
Nil known

Study information

Scientific Title
Perception, representations and postures on unscheduled care of users and health professionals in four territories through semi-directed interviews

Acronym
MATCH

Study objectives
The number of consultations in the emergency room is continuously increasing. Faced with this, some professionals consider that there is a misuse of emergency structures. However, it has been shown that users are rational in their choices. It seems necessary to explore the user's point of view to allow a better use of the emergency care system.

This work is anchored on the territory of four Territorial Professional Health Communities (CPTS) (territorial association of actors involved in care), which have the vocation to manage and regulate urgent and unscheduled care. The results of this work will make it possible to produce recommendations for the CPTS in order to better manage the problem of urgent or unscheduled care. The results of this work will be made available to those who participated.

Ethics approval required
Old ethics approval format

Ethics approval(s)
Approved 28/07/2021, the CNGE Ethics Committee (155 rue de Charonne 75011, Paris, France; +33 (0)1 75 62 22 90; comite-ethique@cnge.fr), ref: AVIS 010721289

Study design
Qualitative research with semi-directed interviews

Primary study design
Observational

Secondary study design
Qualitative research with semi-directed interviews

Study setting(s)
GP practice

Study type(s)
Other

Participant information sheet
Not available in web format, please use the contact details to request a participant information sheet

Health condition(s) or problem(s) studied
Unscheduled care

Interventions
General considerations
This project is built on four methodological components to achieve the proposed objectives. The first part will explore the demand for NPS from the point of view of users in territories with different characteristics in the Île-de-France region. A second part will explore the response of the actors in the system. These first two parts use a qualitative method. The field survey will be carried out in territories with different profiles in Île-de-France. A third part will describe the local organizations. It will use a quantitative method by questionnaire. The last and fourth part will progressively put the proposed solutions together with the evaluation tools suggested by the different participants.

Qualitative study
Methodological approach
The methodological approach of the qualitative component of this study is based on grounded theory (GT). The objective of GT is to describe a system from the point of view of its various actors and to arrive at an explanatory system. The aim of this method is to describe social interactions as well as possible, to precisely describe the processes underlying the different stages and to produce a model (Glaser and Strauss, 1967).

A deconstruction of the researchers' preconceptions will be carried out, in order to get out of the opinions and representations on the subject and to adopt a posture of distance, called "phenomenological reduction", allowing an inductive and not deductive analysis of the material to be treated (participants' discourse).

Sampling strategies

Sampling diversities will be carried out on two levels. The first level will be that of the organizations, i.e. the CPTS. We are deliberately looking for territories that are varied in terms of population and organization of care. The second level will be that of the actors.

For the first level, the territories chosen will vary in terms of the following elements: territorial profile (rural/urban), population density, transport, service offers, in quantity and in terms of modalities (emergency services, hospitals, medical centres on call). This diversity will allow for a wealth of responses and data. It will make it possible to propose solutions for organizing the response to NPS in each type of CPTS.

Four territories for action by the CPTS in Île-de-France have been selected: Paris 10th arrondissement (75), Pantin in Seine-Saint-Denis (93), Ermont in Val-d'Oise (95), Marne et Gondoire in Seine-et-Marne (77).

These areas have an urban fabric of varying density: dense urban in Pantin and Paris 10e, multipolar urban in Ermont, and sparser urban in Marne et Gondoire. The profile of the inhabitants of the northern suburbs (Pantin, Marnes et Gondoires, Ermont) is generally younger than the population of Ile de France (Paris 10). The profile of families with children is therefore more represented there. In Pantin there is a higher proportion of single-parent families. The over 75s are less represented in Pantin, while the 60-74 age group is more represented in Marne et Gondoire. The socio-demographic profile is more unfavorable in Pantin than in the other sites. The CMU rate varies from 6% in Marne et Gondoire to 13% in Pantin. In terms of health care supply, there are sites with municipal health centers and a multidisciplinary health center (MSP), MSPs with a health center (CDS) in nearby municipalities, or only private practitioners. Access to emergency services is also heterogeneous (CHU in Paris, public and private emergency rooms in Ermont Marne and Gondoires). The age of general practitioners varies, with a higher proportion of young female doctors in Ermont, unlike the other sites, which have mainly male doctors over 60 years old. In summary, the community of communes of Marne et Gondoire is less densely populated than Paris 10th and Pantin. Marne et Gondoire is more favored than Pantin, with the commune of Ermont in between. Each territory has its own specificities in terms of health care supply.

The second level of sampling will concern the population of patients and care providers. It will follow the rules of the GT. It will seek the widest possible diversity by including actors from close by. In fact, in GT, the sampling is said to be "theoretical", because it is not possible to describe the exact number of patients at the beginning of the study. The number of interviews needed will be deduced from the sufficiency of the data, and therefore from the analysis of the words of the different actors. At this stage, a minimum number of 20 interviews per CPTS seems necessary. We are not looking for statistical representativeness at this level, but for a diversity of respondents.

The diversity criteria for the patients will be the following: age, gender, family composition, social environment (and in general the data used by the EPICES score), users of the SAMU social, patients with psychological disorders. Patient associations (e.g. UNAF) and people with disabilities will be solicited. Individuals who do not use health services spontaneously will be sought out where they live and circulate (transport, supermarkets, etc.) to find out how they understand and try to solve their health problems in these areas.

The diversity criteria for caregivers will be: the profession practiced (pharmacists, SOS doctors, general practitioners, nurses, osteopaths, emergency physicians, associations, etc) the type of structure (group practice, MSP, CDS, professional commitment).

In the rules of GT, theoretical sampling allows the characteristics of the population to be varied after analysing several interviews and constructing intermediate hypotheses; characteristics not determined a priori in this way could emerge and allow targeted sampling on these characteristics.

Data collection techniques

Data will be collected through semi-structured interviews with each person, after a phone call, email, or oral exchange to agree on the best date and time. Some interviews will be conducted by associate researchers, recruited locally in the territory or by a sociologist. The recruitment method will be opportunistic, from close to home, based on the analysis and suggestions of the participants, and the elements described in the sampling strategy.

The researchers will seek maximum variation from these criteria and interviews will be continued until sufficient data are available. A critical process of internal validation by feedback to the interviewees is planned.

Intervention Type
Other

Primary outcome measure
Access to unscheduled care (methods of access, knowledge of accessible resources, resources for accessing them, difficulties in accessing them, experience of last access to unscheduled care, the impact of COVID-19 on use of unscheduled care, and opinion on indicators for evaluating the use of unscheduled care) assessed using interviews with users and professionals at a single timepoint

Secondary outcome measures
There are no secondary outcome measures

Overall study start date
17/11/2020

Completion date
01/12/2023

Eligibility

Key inclusion criteria
User or health professional present in one of the study areas

Participant type(s)
Mixed

Age group
Adult

Sex
Both

Target number of participants
The number of interviews will depend on data saturation. The researchers estimate the number of interviews to be carried out as 40

Key exclusion criteria
1. Patient's opposition to participating in the study
2. Incapacity to consent to the research

Date of first enrolment
15/10/2021

Date of final enrolment
01/03/2022

Locations

Countries of recruitment
France

Study participating centre
CPTS Paris 10e
France
75010

Study participating centre
CPTS Ermont
France
95120

Study participating centre
CPTS Lagny Marne et Gondoire
France
77400

Study participating centre

CPTS Pantin
France
93500

Sponsor information

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Sponsor type
Research organisation

Website
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Funder(s)

Funder type
Research organisation

Funder Name
GIRCI Idf

Results and Publications

Publication and dissemination plan
Feedback will be given to the four territories involved, then a publication in a high-impact peer-reviewed journal is planned.

Intention to publish date
01/09/2022

Individual participant data (IPD) sharing plan

The datasets generated and/or analysed during the current study during this study will be included in the subsequent results publication. The researchers will provide anonymised verbatims as an appendix to the scientific articles if the editor allows it. This data will therefore be public and accessible at the same time as the article.

IPD sharing plan summary

Other

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Funder report results			25/06/2024	No	No