



**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**

# Meeting Report



**Editor** Health  
Services  
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Division of  
Health  
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## Coordinated/Integrated Health Services Delivery (CIHSD) Kick-off Technical Meeting

**Istanbul, 3-5 February 2014**



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**Meeting Report**  
**Coordinated/Integrated Health Services  
Delivery (CIHSD)**

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**Rapporteur**

**Dr Lourdes Ferrer  
Managing Director  
International Foundation for Integrated Care**

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## BACKGROUND

In line with the vision of the new European Health Policy - Health 2020 - for strengthening health system and pursuing a life-course approach and continuum of care to support universal health coverage, a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) is being developed for the WHO European Region to answer to the health challenges of the 21<sup>st</sup> century, from changing demographics and increases in chronic diseases to the fast evolving technological advances. Strengthening the coordination/integration in the delivery of services is recognised to play a pivotal role in both responding to these needs while overcoming the enduring shortcomings of existing models of care. It is in this context, and in response to the calls of Member States for contextualised, evidence-based policy-options to enable system-wide changes that the development of the Framework for Action towards CIHSD has been shaped. To this purpose, a Roadmap, officially launched by the Regional Director in Tallinn in October 2013<sup>1</sup>, has been defined to guide the development process.

The development of the Framework for Action on Coordinated/Integrated Health Services Delivery (FFA CIHSD), outlined in the above mentioned Roadmap, consists of three pillars leading towards the final Framework: (1) developing of a concept note, (2) gathering of field evidence, and (3) supporting the management of change.

The Roadmap places a strong emphasis on the need for a participatory approach to ensure ownership in the process of its development. This includes input from Member State Technical Focal Points on CIHSD and the Expert Advisory Team throughout the process.

In order to achieve the highest possible engagement, a kick-off technical meeting was called for to capture views from these stakeholders and ensure an appropriate country perspective. This meeting allowed Member States Technical Focal Points, the Expert Advisory Team and the team coordinating the process at the Health Services Delivery Programme of the Division of Health Systems and Public Health-WHO Regional Office for Europe to discuss the progress made to develop the Framework for Action towards CIHSD. It also served to clarify terminology used, the roles of the Member States Technical Focal Points as well as to identify next steps in the process.

The report at hand and the feedback received during this meeting will be used to further develop and refine the Framework for Action, ensuring the highest possible relevance and practicability for Member States.

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<sup>1</sup> For reference, see: WHO Regional Office for Europe. 2013. Strengthening people-centred health systems in the WHO European Region. Copenhagen: WHO Regional Office for Europe.

## MEETING OUTLINE

The sessions were organised with utmost consideration for interactivity and input from the Member State Technical Focal Points and the Expert Advisory Team. After an introduction of the status quo and the milestones achieved so far, the sessions tackled the three pillars outlined in the Roadmap, namely the concept note (pillar 1), the field evidence (pillar 2) and management for change (pillar 3). To visualise what constitutes CIHSD, presentations of the two pilot case studies were complemented by interventions from Member State Technical Focal Points and members of the Expert Advisory Team, to represent the ample knowledge and experience with coordination and integration of care, which has already been gathered in the WHO European Region. These discussions and presentations highlighted important topics, which have to be addressed when moving towards more CIHSD. In order to synthesise these practical examples, a summary was given on the lessons learned from implementation thus far.

Building on these lessons and the findings from the evidence synthesis prepared in the first draft concept note, possible areas for action were identified and discussed. In pillar 3, which corresponds to managing the change process, an overview was given of which topics to consider, when planning and designing a change process towards more coordination and integration of health services delivery.

The kick-off technical meeting gave Member State Technical Focal Points the chance to present their needs and requirements in order to be able to adopt such a Framework for Action, to clarify their roles and to create a common understanding of the process towards a Framework for Action for Coordinated/Integrated Health Services Delivery. The three leading questions for the meeting were defined as:

1. How do we initiate coordinated/integrated health services delivery? What are the drivers for change?
2. How do we design it?
3. How can we scale up? Systematically/Strategically?



## OPENING AND WELCOME

The CIHSD Kick-off Technical Meeting started on Monday 03 February 2014 with a short introduction from the WHO Regional Office for Europe, presenting the importance of strengthening people-centred health systems in the context of the European Policy 'Health2020' and the Tallinn Charter on health system strengthening. The key points for developing the Framework for Action and convening the meeting are understood as the need for the following:

- To examine practical experiences at the system level, 'not small pilot projects';
- To share knowledge by creating a platform for continuous learning and exchange of insights between experts, Member States, and civil society;
- To develop tools to overcome health system barriers towards universal health coverage and equity of access for all citizens in order to provide a basic package of health care;
- To ensure patient-centredness is more than just paid 'lip service' but real engagement of patients, civil society, people, at all stages, from the very beginning.

The main objectives for the meeting were established as:

- Sharing and discussing evidence synthesized in potential areas for action (pillar 1);
- Sharing and discussing experiences across regions, identifying common lessons (pillar 2), and;
- Examining lessons learned on key drivers for change (pillar 3).

In order to put the Framework for Action into context, WHO Headquarters introduced the Global Strategy on High Quality People-Centred and Integrated Health Services. This emergent strategy comes from the need to transform health systems away from vertically-integrated systems with disease management programmes to a new vision.

The main reasons for developing this strategy were described as follows:

- Achieve universal health coverage (UHC), but with a better and more effective service delivery model;
- Create more people-centred primary health care;
- Reach across and influence other sectors, especially social services, to tackle key social determinants of health;
- Manage non-communicable diseases, multi-morbidity, and chronic care.

The draft document proposes 4 preliminary strategic directions: (1) empowering people; (2) strengthening engagement and accountability; (3) settings system priorities; and (4) co-ordinating services. Each strategic direction will include evidence based policies, programmes and interventions, monitoring and evaluation for different levels and different purposes, a selection of indicators, a proposal to work on action cycles for continue quality improvement and highlight lines for future research.

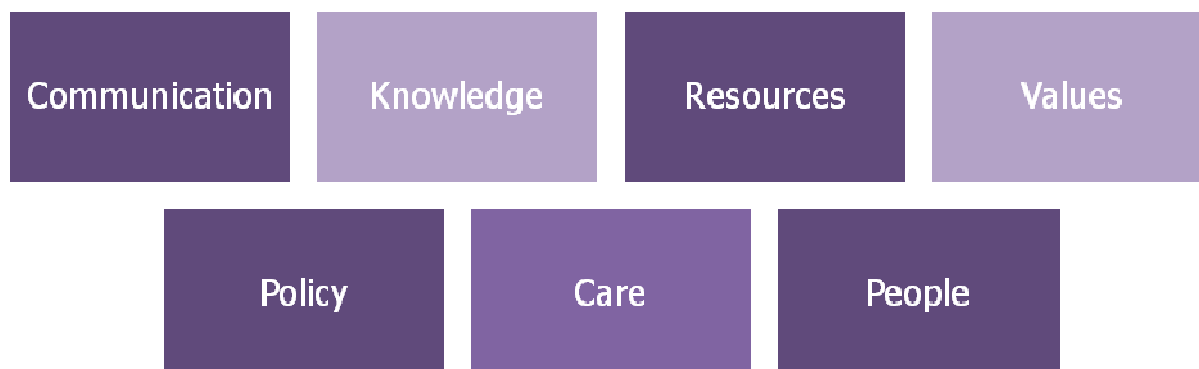


## PILLAR 1. AREAS FOR ACTION

The Framework for Action and the proposed Areas for Action (see Figure 1) were considered both a useful and timely proposition, though there would be need to examine how they might be refined and adjusted to country contexts.

### 1. Discussion on the Areas for Action as a whole

Figure 1. Areas for Action



The participants provided the first general comments on the framework as a whole:

- 'Care', 'Resources' and 'People' were considered at the heart of the framework. It was proposed that some areas should be considered a driving mechanism or core areas, others as supporting mechanisms. For example, the mechanism of quality improvement was suggested to be a 'supportive' mechanism but not a basic component. The point relates to ensuring some degree of prioritisation, which could be made across the action areas to focus key actions and resources in a country context.
- Most participants agreed that there was substantial overlap between the Action Areas 'Communication' and 'Knowledge'. They also agreed that 'Research' is a key element to be added to those areas, especially for conducting a situation analysis and ensuring evidence-informed action. Remarks were made on the complexity of integrated care and the difficulty to put things together and how new elements can fit into the existing health system (legacy and context being important). However participants were quite supportive of the difficulties in establishing 'clean' categories whilst recognising that all the areas will inevitably overlap in many complex ways.
- To prioritise action within so many elements and areas is a key challenge that needs to be addressed. How can WHO support the prioritisation and planning process at a country level? McColl Institute developed the 'chronic care model'<sup>2</sup> based on an evidence-review and so pointed towards key actions and components for change. This CIHSD framework seems more comprehensive and also needs to go several steps further to support prioritisation of major actions according to different building blocks.
- Integrated care as a process should be considered as a means to an end, and by a few participants as an end in itself. It was suggested that this conceptualisation depends on the perspective of the commentator and that on a more basic level integrated care is a design principle when organising care. Everyone agreed that the final targeted outcome of CIHSD is about *people* (to improve the health of the population). 'People' also includes individuals, communities and families.

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<sup>2</sup> Wagner, E. H. 1999. "Care of Older People with Chronic Illness." In E. Calkins, C. Boulton and E. H. Wagner, eds., *New Ways to Care for Older People: Building Systems Based on Evidence*. (39-64) New York: Springer.

- It was agreed that some areas seemed more ‘actionable’ than others. It was suggested that for the framework to be about action, all areas included should have practical applications at different levels. It was discussed that the action area ‘Values’ seemed more about transformative change where actions can lead to rather than being actionable in itself.

## 2. Discussion on the 7 proposed Areas for Action

After the initial discussion, each Area for Action was commented and discussed separately. The guiding questions for each area were:

1. How relevant is this area for CIHSD?
2. Key characteristics? How to evaluate them?
3. What are the main elements/components?
4. What are the main challenges and enablers?

### 2.1 Communication

‘Communication’ was described as being about communication between all stakeholders, of key importance towards CIHSD and patient self-management. It also was noted to include information transfer and the optimization of information technologies.



#### 2.1.1 Relevance

This area was considered essential by all participants and a key supporter of all other areas for action and for the process of change.

#### 2.1.2 Key Characteristics

The main characteristics discussed were:

- There is a need for information and communication on all levels of the system and this implies different challenges. For example, the national level uses this data to make policy; to do research we need the informed consent of the patient.
- It is specific to the users, the objective and what exactly is needed of the information. Data is not an end in itself, but a means to an end.
- Transparency and accountability in the use of information;
- Portability across and between countries and sectors;
- Useful timing especially for budgeting and planning;
- Opportunity costs of collecting data;
- Confidentiality and ethical guidelines to use the information;
- Protection against malfunctioning and dependence on technology;
- Safety and quality.

Delegates described that a difference exists between the need for information and strategies of communication, and that these two topics might usefully be split. *Healthy Ireland* is a good example where all positive information qualities have been enablers for developing their cross-sectoral strategy “right care, right setting, right time, and right people”.

#### 2.1.3 Elements and components

- It was strongly suggested that the conceptual difference and the continuum between information, communication, and knowledge should be made explicit.
- Problems with patient safety are originated from lack of integration and miscommunication. Information and communication have a strong quality component and are key to ensuring patient safety.
- Quality in the exchange of communication can be disturbed by ‘noise’ and by the (lack of) communication skills between professionals. One participant suggested that communication seemed more a supportive factor from the level of the system.

- ‘Research’ should be added as a key component, especially research on implementation and how to link to learning cycles and action.
- Key components vary depending on the context. For example, virtual systems are more demanding if a system has a provider/purchaser split and is contracting out.
- The intensity of the communication varies also depending on the level of decentralisation and autonomy of providers.
- How much face to face, how much virtual communication is necessary/feasible? Role of face to face communication and empathy.
- It was perceived that the more disintegrated a system is, the more micro-management there is.
- How do we bring together personal information with population management? Look at the existing information systems together within and across sectors.

#### *2.1.4 Key enablers and challenges*

As some of the key enablers and challenges in the context of communication and information the following topics were discussed:

- Data ownership and strong protection data law.
- Professionals should remember the fractability of data.
- Patient organisation, between different levels, vertical and horizontal lead to several levels of communication. What technologies are we going to use here?
- General reviews/reports for politicians?
- Level of anonymity?

Country examples:

- Switzerland: each patient has access to their own record and they decide what to share or not. However, providers are hesitant towards data uploaded by other providers, and thus there is the need for guidelines.
- Austria divides access to information between different stakeholders.
- Irish E-Health Strategy: using ICT to deliver high quality care around the patient by providing information and supporting self-management. Patient identifiers are prohibited in Ireland and this makes it very difficult to coordinate, integrate care (piece of legislation introduced). Ireland does not talk about personal health records but sharing person summaries.



## **2.2 Knowledge**

‘Knowledge’ was described as being about education and training to adapt to changing environments. It is important to work in teams, raise health literacy with different strategies for people in different situations. It is also about building management and leadership skills.

### *2.2.1 Relevance*

‘Knowledge’ was considered highly relevant. There is lots of potential in modern communication to foster the will to share knowledge. It might be merged with the action area on ‘Communication’ and information as part of a complex continuum. It was also suggested to rename it into ‘Competencies’. How are these action areas framed towards a common objective of service delivery?

### *2.2.2 Key characteristics*

- The importance of knowledge can be discussed from the patient’s and professional’s perspective.
- ‘Knowledge’ seems to overlap with ‘Care’ for example in shared decision making.

### *2.2.3 Elements and components*

- Introduction of new competencies: inter-professional working, effective communication, disease prevention, use of guidance.
- Components of training can be shared between professionals and patients.
- Evaluation of clinical and practice results: clinical guidelines. Use bottom-up approach or European guidelines to implement them. How to measure implementation of guidelines?
- Health education at all levels where people work and live.

- NCDs are largely preventable and influenced by lifestyle factors.
- Inequities in mortality within developing and developed countries.
- Communication campaigns. Good information about existing medical services.
- Building management and leadership skills especially in professional training. Short of knowledge and management in leading change beyond clinical skills, managerial skills, negotiation.
- Relationship between different leaders.
- Investing in research. Research again needs to be action-oriented to support transformational change.
- Competency in implementation. Goes beyond knowledge to how to apply that knowledge and translate knowledge to action.
- Exchange network and communication network.

#### *2.2.4 Enablers and challenges*

Most of the topics discussed here were identified as being challenges, including:

- Changing contexts in less stable economies.
- Decentralization and capacity building.
- Professional silos.
- Problems of interdependencies for implementation: where and what is most effective?

It was further suggested that all items needed for patient education be described so that Member States can appreciate the complexities. In a simple way, a visualisation of the policy options available should be developed.

### **2.3 Resources**

'Resources' are most often seen as limited. This action area should focus more on how to manage resources (e.g. joint procurement boards, designing incentive systems and avoiding disincentives, new types of contracting) to align organisational processes so that people are incentivised to work together. It is also about human resources, especially professional and family caregivers.

#### *2.3.1 Relevance*

Of course resources are essential. The lack of them is a common reason for failure of CIHSD initiatives. Resources need to be planned up front.

#### *2.3.2 Characteristics*

- Is not only money, but that is always important.
- Change is always uncomfortable.
- Politicians are often more interested in saving money.
- Better use of resources.

#### *2.3.3 Elements and components*

- Within the topic of financial resources, it was stipulated that using a single mode of payment will always lead to disincentives, and that it would be better to use a mixed system of payments.
- What is the right funding model? Answer: there are many options.
- Incentives are handy to move doctors out of their comfort zones. But doctors are also decent health professionals: how to create an environment that helps doctors to promote health especially when knowledge moves so fast. Here infrastructure is useful.
- Human resources and infrastructure

Country example:

- Portugal: PHC reforms included tax-funded investment in primary care. Major achievements due to this. New organisation of teams of family doctors, who get paid for performance. Physicians became proud of their work. Family medicine now earns more than other specialists. But hospitals continue to increase their costs by 50%, even though they reduced beds by 25%. Additionally, reform of medicine costs, but not major reform.



#### *2.3.4 Enablers and challenges*

- Wrong questions: how much does it cost? Will it save money? Need to be differently elaborated. There is always a need to invest at the beginning.
- Right questions: talk about benefits and value to people and society; user and patient satisfaction. Rephrase short-term and long-term gains. Talk more about investment than resources. Healthy population needs less medicines and interventions – leads to health gains and cost-effective use of resources.
- Frontline worker in this area is the patient.
- Management of chronic conditions.
- Problem of separation of social protection system and health system in many countries. Resources of social protection are the citizens.
- Ex. Hepatitis C: prices are unacceptable (works only for 80%), last medicine cures only 40%, only curative.
- How to buy value and not only productivity?
- Lack of resources good for advancing management to integrated care.

## **2.4 Policy**

‘Policy’ is about priority setting, scaling up, and sustainability. It also includes regulatory and governance frameworks (e.g. thinking to new ways to legalise cooperation in the health system). Develop a *health in all policies* approach and create alliances beyond the health system (whole-of-system and whole-of-government approach).

### **2.4.1 Relevance**

‘Policy’ is at the core as a component and needed to assess system transformation. It goes beyond rules and regulations; it is about putting a vision in place. It is important to remember that IC is a means not an end. Vision supports long-term goals and system transformation, but to accept this disruption created through new policies towards CIHSD can cause temporary problems.

### **2.4.2 Characteristics**

The characteristics depend on the context of the care system (e.g. financing, governance, etc.), but policies are important on all levels: macro/meso/micro.

### **2.4.3 Elements and components**

- Vision.
- Important to establish short, medium and long-term goals.
- Willingness to tackle unpopular topics (e.g. closing hospitals, tackling hegemony of care professionals).
- Role of community participation in policy making.
- Key policy making in social security and health. Is it social insurance? Real challenge how to bring these two policy areas together. Social care is based on entitlement, and health on need. Think about aligning these two sectors.
- Meeting the needs of the population in an equitable manner.

### **2.4.4 Enablers and challenges**

- System challenges: how to integrate vertical programs (HIV, TB)?

Country example:

- Latvia: In 2012, 3 priorities were defined. One of them is to strengthen a person’s ability to adapt to changing conditions, especially in the labour market. For health this is related to health at the workplace, healthy lifestyle choices, improved planning and coordination in the health system. For Latvia, it was very important to have this main development document that proposes key strategic goals that then get tailored by each sector. The importance of monitoring the policy implementation and political stability is stressed.

## 2.5 Care

Care is about service delivery, developing and implementing care standards and sharing quality management tools (e.g. NICE guidelines for IC in UK). It is also about putting people at the centre of care (shared-decision making), and defining clear roles and responsibilities. This necessitates a redefinition of the workforce to design it according to CIHSD requirements.

### 2.5.1 Relevance

'Care' is at the core of the concept; it is the reason why we are doing this exercise. But it is important to define what sort of care we are talking about: quality, people-centred, family and community-centred, integrated care along the whole continuum of care, across levels and settings of care, etc. It may be confusing because it's the heart of the framework and overlaps with all other areas.

### 2.5.2 Characteristics

Again, it is mentioned that the context is crucial. But for 'Care', this means that it is important to know what the problems are, which actors have to be involved in the change processes and what is it that we actually want to change as opposed to what is already working well.

CIHSD has also to do with equality and equal access, so target populations should be those with low economic resources. The level of resources affects each planned intervention differently.

A new care model should include core of actions defining roles of different levels, providers, mechanisms, incentives, and changing culture.



### 2.5.3 Elements and components

Many questions revolved around the core elements of coordinated/integrated care, such as:

- How to ensure that there were no functional gaps in the care infrastructure? No barriers for patient flows and no structural barriers?
- Where should technology be placed ideally? Where is it more efficient to have?
- Which is the role of key actors or levels of care? Who coordinates?
- Is care coordination a model or a process?

Some of these questions may be answered by:

- Introducing elements of informational and managerial coordination;
- Introducing appropriate IT;
- Formulating integrated care pathways and introducing integrated clinical guidelines;
- Designing incentives for collaboration.

### 2.5.4 Enablers and challenges

Regarding enablers and challenges for 'Care', different levels need to be addressed:

- **Macro level:**  
It is important that people have access to UHC. Health care is also about entitlements. Enough resources and policies are needed to promote integration of care. In decentralised systems, we often encounter insufficient definitions of competencies and a lack of capacity on the different levels. The example of Romania illustrated this.
- **Meso level:**  
Here it needs good governance, a network of providers, shared goals and strategic plans, organisational culture which supports CIHSD. At the provider level, they often have higher incentives not to coordinate, rather than coordinate, and search for economic profitability.
- **Micro level:**  
Enablers are continuous training in clinical skills, communication, managing change, and team work. Adequate working conditions, especially enough time, is key. Challenges remain the lack of guidelines for co-morbidities and the lack of evaluation studies on adverse effects, or interactions between different medicines in multi-morbid individuals.

## **2.6 Values**

The area for action 'Values' is about adapting values or creating new common values. It is also about changing cultures and attitudes, agreeing on a common language, and inspiring people.

### **2.6.1 Relevance**

The area for action 'Values' is considered highly relevant, but sometimes values are not enough. They are also not always made explicit. The question arose whether an action framework should in fact include values or whether this topic should rather be discussed in a separate chapter since values are also highly personal. It was also asked whether values are a driver for change or an area for action. Shared vision and common understanding of change is required to build social capital for change and enable collective behaviours – but is this about the same values? Potentially, people may have different values, but support a common outcome or strategy.

### **2.6.2 Characteristics**

Values are implicitly embedded in knowledge and in language. It is very difficult to understand values and even more difficult to change them. For example, there is a wide difference in values from the general practitioner or family physician to the politician to the student on what is CIHSD. How are we to change this? Are values an operational tool as others? We need to use values more as a policy tool, but it needs to be operational to include it in the framework. An argument for including values in the framework is that organisations are irrational and instable. This framework introduces some rationality and since it is not structure, management or processes that tie together organisations, but values, they need to be tackled within a framework for action. However the question remains as to how we can tap into those values and use them as a resource. It is difficult to impose values on providers, or patients. Finally, values need to be transversal.

### **2.6.3 Elements and components**

- Self-assessment: what are your values? Is patient-centeredness one of them or not?
- Beyond values there is a series of systems we believe in. Values for doctor: autonomy, politicians come and go but I stay here with my patient. This is a value system that reacts against this.
- Kaiser Permanente uses measurement scores to measure people engagement. However is this a belief system or a value?
- 'Bottom upping': give permission to innovate locally.
- Different value systems for leaders.
- Allow the local level to plan their own micro-system.
- Give a voice to the patient.
- Need to include investing in health in the discourse to create value change.
- Values are related to objectives, you don't miss values if you have objectives.
- Values are needed for the system to perform. Create a history of integrated schemes, and a central narrative to align with the system. This makes teams work better, helps develop a community of interest.
- Create cultural purpose.
- Professionals need to understand that they have two jobs: to be the best professional and to strengthen the system.
- Build social capital and capital for change (transformative changes).

### **2.6.4 Enablers and challenges**

As an example of how a narrative can help to change values, Norway provided a country example:

- In 2012, a reform introduced more coordination, but also aimed to strengthen health promotion and integration. Since the patient was defined as being at the centre of the health system in 1997 already, the focus since has shifted towards patient-centred care and hence facilitated the 2012 reform. This made it easier for providers to understand the need for care coordination. The incentives used were:
  - Shifting power to health professionals. This created a dynamic and movement in the system. But the question of who is at the centre of coordination remained. Problems of access arose, especially because there were not enough doctors. That's why they needed to use other professionals.
- Financial incentives were also useful, as well as legal obligations to establish written agreements of cooperation between the providers.

- Important:
  - Eagerness to do good, to compete
  - Use of data to inform decision making

Further enablers and challenges identified in the discussion were:

- Behaviours
- Organisational culture
- Supportive actions for transformative change

## **2.7 People**

The area for action 'People' is about how we engage people and communities, use public discussions, consultations, support leaders and networks. How do we create stimulating environments and give space to people to try something new?

### *2.7.1 Relevance*

It is a key component, impacts how process and success are measured and where we are going.

### *2.7.2 Characteristics*

- Inform and empower patients
- Adapt to patient perspectives

### *2.7.3 Elements and components*

Important elements and components to be considered within 'People' were:

- Motivation: for provider/payers and patients
- Needs process engineering approaches.
- System problems are bureaucratic, self-serving, make people feel insecure and lost.
- Lack of integration is a safety issue.
- People-centredness in the implementation: importance of patient engagement. Ask patients to prioritise problems, goals and indicators: patients should be included in the design of the system because the things that are relevant to them might not appear relevant to policymakers, providers and professionals.
- Burning platform: more than half of the patients do not take drugs as prescribed.
- Our point of care should be moved to the community.
- Measurement and assessment of implementation. For many the test is the curriculum, the system adapts to pass the test. If we do not measure the patient view this target will not be achieved.
- Each patient could get a balanced score card.

### *2.7.4 Enablers and challenges*

- Simplify the involvement for the patient in the system through use of patient forums.
- What about the voice of those not organised in associations, the vulnerable?
- Risk sharing population stratification?
- Best place are municipalities: bring policy to people.
- Health councils.

With this, the discussion on the areas for action was wrapped up, with the input to be used to further develop the concept and adapt the areas for action accordingly.





## **PILLAR 2. FIELD EVIDENCE**

The next big topic to be tackled was the implementation of CIHSD, for which experiences, drivers and enablers, challenges and lessons learned from case studies and country examples were presented and expert comments invited.

The key questions asked with regard to the field evidence and country experiences presented during the meeting were:

- What was done?
- What were the main drivers for change?
- What were the enablers and challenges?
- What are the main lessons learned during implementation?

### **1. What was done?**

The following subchapter presents a summary of the activities and tools already implemented and practiced in the WHO European Region, according to the different areas for action.

#### ***1.1 Communication***

- Principle of 'high touch': actively go to people, introduce them and yourself by name, talk to them (HIV/TB programme in Ukraine)
- Use of data to compare care settings and influence policy creates incentives for improvement. However, link to outcomes is not necessarily straight forward: problem for example of adherence to TB treatment in Ukraine, or inaccurate post mortem diagnosis in Lithuanian cardio-vascular programme; other examples came from Finland and Bulgaria.
- IT as an enabler: shared ICT systems in Israel, ICT supported cardiology programme in Lithuania

#### ***1.2 Knowledge***

- Inter-disciplinary training in cardio-vascular medicine and team work (Eastern Lithuanian Cardiology Programme). Trainings were also used in Serbia and Israel to strengthen knowledge.
- Management: sharing of power like in Basque country
- Use of data for performance and outcome management

#### ***1.3 Resources***

- Make new funds available: e.g. EU funds, global funds in Lithuania, Serbia. However, beware of the problem of sustainability with these funds, which are usually time-limited.
- Incentives: new diagnostic tools for cardiology program in Lithuania; financial incentives in Germany; pride and satisfaction in Israel; avoiding blame against other regions/country standards in eastern Lithuania.
- Human resources: problem of doctors shortage: too old in Germany, or too new and not motivated in Slovakia; shortages of nurses in Georgia.
- Reinvesting savings due to CIHSD (Denmark, Germany).
- Equipment: expansion of 300 rural medical centres in Uzbekistan.

#### ***1.4 Policy***

- Legal frameworks are important (examples of Serbia, Denmark, Germany), but not sufficient.
- Political (election) cycles and reform cycles are different.
- Negotiations between different levels of governance are needed: national, regional and municipal lead
- Type of payments and contracts count: for how long? Shared accountability? For example 'Gesundes Kinzigal' in Germany.
- UHC mentioned as explicit objective: achieved a year ago in Georgia.
- Coordination councils in Tajikistan.

## 1.5 Care



- Care pathways redesign (Eastern Lithuanian Cardiology Programme); redesign of whole perinatal system in Georgia.
- Case management (in Lithuania for social care and primary health care)
- PHC as a foundation: the importance and pivotal role of strong PHC (Serbia, Ukraine)
- Use of informal providers (NGOs in Ukraine)
- Development of guidelines and protocols

## 1.6 Values

- Value driving change as a potent narrative to move beyond political indifference, use narratives for change (Basque country)
- Quality improvement culture in Israel
- Target populations: start in less healthy population, or disadvantaged rural areas to achieve short-term success and convince people to continue improving (Lithuania, Israel)

## 1.7 People

As a general remark, activities towards people engagement were not mentioned often. One of the questions remaining was whether a framework is strong enough to produce an environment and cultural change conducive to patient involvement?

- Involvement to develop a legal framework in Denmark.
- Improved patient experience in Lithuanian drug abuse program.
- Leadership: can be distributed, orchestrated to all levels and from all directions
- Brave, inclusive and good negotiator, who was happy to leave the success to local level and move on (Basque country and Hungary)
- Community engagement and community resources not very explicit. Only the role of patients as citizens in Denmark.

## 2. What were the main drivers for change?

The main drivers for change discussed during the meeting were identified by the many country examples and the presentations of the pilot case studies.

### 2.1 Communication: differences in outcomes between and within countries

- High variability of quality of care by different providers:  
For example noticeable differences in service provision to patients in the TB and HIV vertical programmes in Ukraine.
- Differing health outcomes between and within countries.  
For example, eastern rural Lithuania decided to tackle cardiovascular diseases and its risk factors after acknowledging that they had higher morbidity and mortality than the urban Lithuania and the rest of Europe.

### 2.2 Knowledge: epidemiological changes

- Increase of NCDs.
- Re-emergence and persistence of communicable diseases.
- Increased problems with multi-morbidity and age-related conditions.

### 2.3 Resources: shortages and new funds

- Shortage of human resources, high mobility, ageing workforce (Germany)
- No possibility of increasing resources to face increasing health demands (Basque Country)
- Decreasing resources in many countries
- Demand for efficiency and better management (Germany)

- Availability of new resources for developing integrated care:
  - Ability to re-invest savings in integrated care in Denmark
  - Bonus payment related to development of new integrated care initiatives in Germany
  - Better Care Fund in England from which to make tenders for new projects and similar funds for stimulating innovation in Denmark



## ***2.4 Policy: new laws and regulations***

- Denmark established a legal mandate for providers to collaborate and involve patients. All providers had to react to this legal demand.
- Increase problems in multi-morbidity and age-related conditions.

## ***2.5 Care: adequate infrastructure and clear roles***

- The care facilities and the necessary resources need to be provided without functional gaps, often not in place in practice.
- What is the role for the PHC level? Are they coordinators? Are they supposed to be coordinating the whole of the health sector? What is the role of the tertiary and specialist sector? There needs to be consensus as to who does what and at what levels.
- The need to define care pathways: requires attention to ensure there are not organizational and structural barriers that could interfere with the patients flow; need to consider what are the most important and relevant mechanism.

## ***2.6 Values: inspiration from new ideas***

- The Eastern Lithuanian Cardiology Programme was influenced by new ideas from the USA about better management of cardiovascular diseases.
- HMOs in Poland were also inspired by models developed in the USA and Switzerland.

## ***2.7 People: enthusiastic leaders***

- Most countries and cases reported enthusiastic and strong leaders who supported the integration and change process, e.g. in Ukraine, Lithuania, Basque country.

# **3. What were the enablers and challenges?**

Most enablers and challenges act as two sides of the same coin. What was found an enabler in some contexts was a challenge in others. Some of these differences are related to the characteristics of the implementation process. The key enablers and challenges discussed are summarised below.

## ***3.1 Communication***

Improving communication and data sharing between professionals and providers was seen as a key enabler:

- In terms of decision-support tools at the point of care;
- In linking information about patients between key partners (as in the Lithuanian example), and;
- For developing shared electronic records, like in Israel.

However, lack of skills in managing data and issues related to confidentiality and ownership of the data can be strong challenges like in Ireland and Ukraine.

## ***3.2 Knowledge***

Access to useful literature and research evidence can be an enabler:

- For example, use of Gröne and Barbero (2001)<sup>3</sup> framework for integrated care.

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<sup>3</sup> Gröne O, Barbero M. Integrated care. A position paper of the WHO European office for integrated health care services. Int J Integr Care 2001; June 1.

- Conceptual paper from Kodner and Spreeuwenberg (2002)<sup>4</sup> to understand components for integrated care in Poland.
- Evidence reviews and knowledge of innovation design help in the development process.

### **3.3 Resources**

- The lack of economic growth and limitations of resources can be a ‘burning platform’ for change which might not be present in some countries and so reform is not seen as an urgent need (e.g. Austria and Germany).
- It is a challenge for all initiatives to ensure sustainability and secure funding (for example in eastern Lithuania when the EU funds were terminated). Many resources for innovations are time-limited grants that do not necessarily stimulate spread and sustainability (e.g. PALKO model in Finland).
- There is a lack of competencies in developing business models towards CIHSD.
- Non-financial incentives for doctors can act as powerful enablers:
  - Doctors for example can have access to more diagnostic instruments and tools for their place of work and better interactions in eastern Lithuania;
  - Doctors felt empowered with data management tools to improve their work in Israel by using benchmarked data on the quality of their performance.

### **3.4 Policy**

- Development of legal frameworks: e.g. in Denmark a new regulation was imposed demanding providers to develop patient involvement mechanisms.
- The mismatch between the short-term political cycle and the long-term goals necessary for innovation to become embedded in the system were cited frequently as a challenge.
- However, new government officials can act as leaders in moving integrated care initiatives if they take them on their agenda.
- Importance of a central narrative for change that drives policy.

### **3.5 Care**

- The role of PHC: to have strong primary care was often an enabler and the lack of it a challenge when developing CIHSD.
- In this regard, it was also discussed that integrated care might not be a priority for all countries, especially the ones without PHC.
- Most initiatives need a redesign in processes or pathways that makes explicit how and when collaboration will be needed (example eastern Lithuania, Hungary).

### **3.6 Values**

- Narratives and culture can act as enablers and challenges.
- For example citizens can vote against laws that support CIHSD when associated with the wrong message for a given culture:
  - In Germany it was perceived as limiting choice of providers.
  - In Switzerland it was associated with lower quality care, because it was sold as cheaper care.
  - In USA managed care movement was disliked by providers and professionals alike on the grounds that it rationed treatment and forced providers into making cost-conscious, rather than quality-led, decisions.
- Israel has a culture of quality improvement and data management that has supported the process of change. Other countries do not have the habit of using data for decision making.
- To convey quality improvement is key, not cost reduction, even if this is an implied strategy.

### **3.7 People**

The role of non-traditional actors was stressed:

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<sup>4</sup> Kodner D, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications – a discussion paper. Int J Integr Care 2002; Nov 14.

- New actors like NGOs were extremely helpful to integrate vertical programs towards a more systematic approach in Ukraine and Belarus.
- The local community could play a part in supporting decision-making or getting involved in the care giving process, for example in the UK.

## **4. What were the main lessons learned from implementation?**

### ***4.1 Success is related to a mix of factors***

There are several factors, which lead to a successful implementation of CIHSD initiatives. However, it is difficult to understand what the key factors are and how they mix in different contexts. How to choose the right mix?



- In Belarus it was a mix of a vision for change, leadership, care process redesign, human resources planning and development and alignment in policies and system goals.
- In Montenegro, key factors for success of their initiative in 2004 to create PHC centres were strengthening PHC with clinical guidelines and protocols, disseminating information about demographic change, introducing structural integration in 8 health care centres, and assessing the capacity needed to provide the care intended.
- Analysis and redesign was needed in the models of care and resources used.

### ***4.2 Scale-up needs to be multidimensional***

- Vertical, horizontal, transversal.
- Lack of robust evidence and specificity of how this can best be mixed makes scaling up difficult.
- Is a small good pilot enough evidence for a good example of CIHSD?

### ***4.3 Roles of health professionals are changing***

- The GP as a coordinator of care is being challenged by other health professions.
- New curriculums and skills need to be developed.
- It is important to highlight how coordinators will manage confidentiality and stigma (eg. problems with GPs and HIV patients in Ukraine).
- Family physicians need to be educated to work with other disciplines and with patients.

### ***4.4 The change process needs management***

- Most initiatives did not develop implementation plans. For example the Odessa region in Ukraine did not have a real plan or design in advance. It was just the initiative of people who were enthusiastic about better management.
- Some degree of forward planning on how to build consensus with key stakeholders was helpful in Belarus.
- Change is not linear or free. There is always a period when processes become less efficient, especially in the early phases (e.g. due to 'double-running' costs or the process of transition) and so needs further time and investment (i.e. a need to understand that a 'maturity model' is operating).
- It is however important to manage the process well in the short terms to keep systems as efficient as possible.

### ***4.5 A proactive communication strategy is needed***

- It is important to not associate the integrated care agenda with cost containment but with an increase in quality of patient care.

### ***4.6 Social determinants can have a major impact***

- For example, TB has existed since the beginning of time but goes up with austerity. It is important that countries work to increase the wellbeing and quality of life of their citizens.

With the discussion on the lessons learned from implementation so far, the session on pillar 2, field evidence, was closed. The activity documented through the country examples, the case studies and the open call were considered as impressive testimony to the increased interest in CIHSD implementation and as a wealth of experience from which we should try to extract more knowledge on what works and what does not.

## **PILLAR 3. CHANGE MANAGEMENT**

The third pillar within the Framework for Action introduces the actual change management necessary to create sustainable CIHSD. The guiding questions throughout this discussion process were:

- How do we make this happen? What is the evidence in change management towards CIHSD?
- Which policies worked?
- Which did not?
- Key messages often forgotten?

### **1. What's the evidence in change management towards CIHSD?**

The synthesis report on the existing evidence concerning change management tools and methods towards CIHSD was conducted as a gap analysis documenting what we know and what we do not know.

#### ***1.1 What we know***



- The health workforce is tired of change but incentives still work.
- There are many tools and support packages to manage change in organizations.
- There is a lot of knowledge about the design principles of many aspects of integrated care, for example to design a curriculum for inter-professional education.
- It is important to articulate the problem you need to achieve: why will you go on such a difficult journey?
- Work from that what sorts of solutions you want to see happen. Something to build on first like PHC, define entry points.
- Design features associated with different levels.
- Integrated care is symbiotic with UHC.
- Emphasis still lies on chronic and long term care.
- Discussion on organisational leadership vs clinical leadership – which leaders do we need?
- Analysing the model of care.
- Implementation science helps to understand how to move forward.
- Planned cycles over time don't happen in reality.
- Freedom and functional autonomy on the ground for autonomy at person/free access (Pim Valentijn, IJIC 2013)
- Difficult to get moving on the system level.
- Need for economic consensus.
- Culture matters: physicians work naturally in network even though there is no law. Germany has a law, but no integrated care.
- Different approaches for different countries, but commonalities remain.
- No healthcare system will have the way forward to face all the problems.
- CIHSD is not a natural solution, it needs to be lead, supported and managed.

#### ***1.2 What we don't know***

- We have the ingredients, but not the recipe: how do I apply the tools effectively to my own context? Implementation science is still needed.

- Pilots often work, but how then to transfer this to the system? How can that intelligence be used to improve the system as a whole? What can the role of pilots be in the future?
- Debate: how much change management strategy do we need? Good examples have achieved CIHSD through learning by doing, or an emerging strategy for change (e.g. Basque Country). How to use incremental change, changing of behaviours, and building relationships? There is consensus that one needs to go through a process of change but the question remains of how to apply change management: iterative or planned?
- We need to understand the how as well as the what.
- We still need guidance on what the necessary skills are? What evaluation methodology to use?
- We also need new research methodologies which work in real time.
- Factors to create conditions to support change practically are still unknown.
- More advocacy capacity needed and capacity to use evidence effectively.
- How to deal with different political parties, with people and positions which will lose power and influence?

## 2. What works?

Aligned with the review of evidence on what we know and what we don't know about CIHSD implementation, there was also an attempt made to capture the evidence and experience in what worked to promote and support CIHSD implementation. The following list provides examples identified during the meeting.

- Developing a 'burning platform'.
- Creating environments which allow people to act, to grow and to make mistakes. It would be expected that also UK, for instance, creates additional opportunity to do so.
- Give enough time for things to evolve, also time to think through key steps.
- Start with definition of the problem: building the case for IC. Link to outcomes. Identify entry point in building the case for change.
- CIHSD is not a goal in itself, it should be linked to equity, UHC.
- Person-centred care coordination should be more than a value-based principle and become a design principle.
- The approach needs to be problem-solving and action-oriented. There needs to be priority settings and a needs assessment in general population. What do we do first?
- Legislative change requires definition of a model of care first.
- Form follows function.
- Priorities for the future: how to get started?
- Start with easy-to-manage pathologies and diseases, before moving to more complex patient groups.
- You need to decide on your tactics/strategise: when we put forward change in Basque region we talked about patients/people at the centre of care.
- It is necessary to realise that CIHSD is not a win-win situation for all stakeholders and this needs to be managed; some will lose their influence, power, jobs, etc.
- Good use of shared electronic health records support change (for example in Montenegro and Israel).
- Link narrative to the chosen strategy and acceptable objectives: pre-conditions for implementation, motivated health workers by geographic levels, health care levels and specialities.
- Technological resources were a key factor for change: integrated health information system; data integration.
- Conceptualise it in the way that makes health data and system move forward.



## 3. What does not work?

On the other hand, all the activities and initiatives in the Region also provide an array of examples what hampers change, for example:

- Lack of appreciation for complexity: it is not a step-wise progression, but needs simultaneous innovation from all levels of the system.

- The wrong narrative: in 2012 in Switzerland, people rejected managed care due to the emphasised placed on “cost containment” which made people suspicious of being delivered cheap, low-quality medicine. But the Swiss Ministry of Health is now changing the narrative to associate managed care with better quality while also explaining why a change in that direction is needed.
- Poland seeks the right balance between bottom-up and top-down to foster innovation.
- What we shouldn't do: mergers without coordination, the coordinating element is the relevant one.

## 4. Going forward

Finally, ways to move forward were suggested.

- Listen to experiences made in other countries. It is not an easy way forward, no common denominator has been identified so far. Learn from Switzerland and Poland: whatever you do, make sure that you have a clear message aligned with your goals and targeted to the people you need to convince.
- We have to explore lessons learned in a more structural way.
- CIHSD is a way of improving quality of services. It is important for everybody: chronic and acute, communicable and non-communicable. We should not only concentrate on NCDs.
- It is important to define where you start, for example in Lithuania it was with the trauma network. Political steps need to be holistic, take baby steps to bring people along the way and not overwhelm them.
- Progress from simple to more complex models.
- CIHSD change should be framed as quality improvement and not as cost reduction tool.

Designing a manual for change:

- In order to support prioritisation, WHO should develop a self-assessment tool for people to be able to understand where they are.
- The framework should then facilitate people to define where they are, where to start, which is the problem they are going to solve and how. And then provide toolkit of how to implement the changes necessary.
- This should then translate into a clear plan of where they are going with an explicit vision, target and indicators.
- Theory of change and change management: process is the burning platform and mapping and identification of higher needs.
- We are measuring at a society perspective; we have to add value for insurance companies and other key stakeholders. Aspects of risk sharing.
- There are good overviews of interventions that can help us to move forward. A good list of essential outcomes and an overview of all potential tools and strategies (a la carte) is needed; also the development of a visualisation for policy options.
- We need to distinguish two types of elements:
  - Tangible: e.g. use of shared care protocols; pay-for-performance; ICT
  - Intangible: e.g. leadership and communication.
- Seek to incorporate different perspectives, and the patient and other views should be taken into account.

For the third pillar, it was concluded that a manual for change with clear prioritisation criteria, visual aides and lists of appropriate tools and instruments is vital for the Framework for Action to be relevant and actionable.



## **OPERATIONAL ISSUES DISCUSSED**

A final session was dedicated to practical issues such as filling in the open-call questionnaire were discussed, as well as the role of the Member State Technical Focal Points. They were asked to act as mediators and multipliers for the ongoing development of the Framework for Action. Their input and feedback will be solicited in following up with the initiatives in the coming months and identifying interesting interview partners.

## **NEXT STEPS**

While the discussions were a very useful reality check for the development process, the input collected will be incorporated into the documents (concept note, field evidence and change management pillars) to ensure relevance for the Member States, actionability and practicability. The feedback and suggestions provided during the meeting will inform the revision of said documents and add to the quality of the material.

A meeting with other stakeholders including delegates of providers (primary health care, hospitals), patients and professional organizations and international partners will be hosted by the Ministry of Health of Belgium in early April 2014.

A meeting of Member States and Expert Advisory Team was convened for the first week of February 2015 in Almaty, Kazakhstan.



## **Annex 1. Scope and Purpose**

### **Background**

In line with the vision of Health 2020 for strengthening health system performance through innovative approaches, a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) is being developed for the WHO European Region, to answer to the health challenges of the 21st century, from changing demographics and increases in chronic diseases to the fast evolving technological advances. Strengthening the coordination/integration in the delivery of services is recognised to play a pivotal role in both responding to these needs while overcoming the enduring shortcomings of existing models of care. It is in this context, and in response to the calls of Member States for contextualised, evidence-based policy-options to enable system-wide changes, that the development of the Framework for Action towards CIHSD has been shaped. To this purpose, a Roadmap has been defined to guide the development process from 2013 until RC66 in 2016, and the process was officially launched by the Regional Director in Tallinn in October 2013.

The development process for the Framework for Action on Coordinated/Integrated Health Services Delivery (FFA CIHSD), outlined in the Roadmap, consists of three pillars leading towards the final Framework: (1) developing of a concept note, (2) gathering of field evidence, and (3) management for change.

### **Rationale**

In the Roadmap for the development of the Framework for Action towards coordinated/integrated health services delivery (CIHSD), a strong emphasis is laid on the participatory approach, which includes input from Member State (MS) technical focal points on CIHSD and the Expert Advisory Team throughout the development process. In order to achieve the highest possible engagement, a Kick-off technical meeting is called for to capture feedback and input from these groups and to incorporate the country perspectives. This meeting will give the MS focal points and Expert Advisory Team the opportunity to discuss the development of the Framework for Action for CIHSD with the WHO HSD/DSP team. It will also serve to clarify terminology used, roles of the Forum of MS focal points and the Expert Advisory Team, as well as any remaining questions on the process of development.

The sessions will be organised with utmost consideration of interactivity and input from MS focal points and the Expert Advisory Team. After an introduction of the status quo and the milestones achieved so far, the sessions will tackle the three pillars outlined in the Roadmap, namely the concept note (pillar 1), the field evidence (pillar 2) and management for change (pillar 3). To visualise what constitutes CIHSD, presentations of the two pilot case studies will be complemented by interventions from MS focal points and members of the Expert Advisory Team, to represent the ample knowledge and experience with coordination and integration of care, which has already been gathered in the WHO European Region. These discussions and presentations will highlight important topics, which have to be addressed when moving towards more CIHSD. In order to synthesise these practice examples, a summary will be given on the lessons learned from implementation so far.

Building on these lessons and the findings from the evidence synthesis prepared in the first draft concept note, possible arenas for action will be identified and discussed. In pillar 3, which corresponds to management for change, an overview will be given of which topics to consider, when planning and designing a change process towards more coordination and integration of health services delivery. This will further be developed into a Manual for Change after the meeting.

The kick-off technical meeting will also give MS focal points the chance to present their needs and requirements in order to be able to adopt such a Framework for Action, to clarify their roles and to create a common understanding of the process towards a Framework for Action for Coordinated/Integrated Health Services Delivery.

### **Objectives**

The meeting aims at presenting and discussing the progress within the 3 pillars of the FFA towards CIHSD. In particular,

1. To present and discuss WHO European Region experiences on CIHSD, including identification and sharing of lessons learned from the implementation.
2. To present and discuss evidence synthesis for potential arenas for action towards CIHSD.
3. To discuss health systems drivers for change management towards CIHSD.

### **Target Audience**

The meeting will be attended by Member State technical focal points on CIHSD, members of the Expert Advisory Team and the HSD/DSP team for CIHSD.

## Annex 2. List of Participants

### Country Focal Points

#### Austria

Dr Herwig Ostermann  
Head of the Department of Health Economics  
Gesundheit Österreich GmbH  
Stubenring 6  
1010 Vienna

Tel: +43 1 515 610  
email: herwig.ostermann@goeg.at

#### Belarus

Dr Elena Leonidovna Bogdan  
Chief of Department of Medical Services Provision  
Ministry of Health  
Myasnikova Str. 39  
220048 Minsk

Tel: +375 17 222 61 75  
email: ebogdan@belcmt.by

#### Bosnia and Hercegovina

Prim. Dr. Drazenka Malicbegovic  
Assistant Minister for Health Sector  
Ministry of Civil Affairs of B&H  
Department of Health  
Trg Bosne i Hercegovine 1  
71000 Sarajevo

Tel: +387 33 492 523  
email:  
drazenka.malicbegovic@mcp.gov.ba

#### Bulgaria

Prof. Petko Salchev, MD, PhD  
Director of Classification Systems  
Directorate National Centre of Public Health and Analyses  
under the Ministry of Health  
15, "Acad. Ivan Geshov" Blvd.  
BG-1341 Sofia

Tel: +359 2 80 56 349  
email:  
p.salchev@ncpha.government.bg

#### Denmark

Ms Helle Schnedlers  
Head of Office  
Ministry of Health  
Holbergsgade 6  
DK-1057 Copenhagen

Tel: +45 7226 9470  
email: hes@sum.dk

#### Estonia

Mr Liis Rooväli  
Head of Department  
Health Information and Analysis  
Ministry of Social Affairs

Tel: +372 6269158  
email: liis.roovali@sm.ee

Gonsiori 29  
15027 Tallinn

### **Finland**

Mr Pasi Mustonen  
Ministerial Adviser, LL.M.  
Department for Social and Health Services  
Ministry of Social Affairs and Health  
P.O. Box 33  
FI-00023 Government

Tel: +358 295 163358  
email: pasi.mustonen@stm.fi

### **Georgia**

Ms Nino Beridze  
Specialist  
Division for Regulation, Department of Health Care  
Ministry of Labour, Health and Social Affairs  
144 Ak. Tsereteli Avenue  
0119 Tbilisi

Tel: +995 32 251 0051  
email: nberidze@moh.gov.ge

### **Hungary**

Dr Ildikó Kissné Horváth  
Head, Health Policy  
Ministry of Human Resources  
Arany Janos u. 6-8.,  
H-1051 Budapest

Tel: +36 1 795-1021  
email: ildiko.horvath@emmi.gov.hu

### **Latvia**

Ms Kristine Klavina  
Head, Division of Strategic Planning  
Ministry of Health  
72 Brivibas street,  
LV-1011 Riga

Tel: +371 6787 6094  
email: kristina.klavina@vm.gov.lv

### **Lithuania**

Mrs Rima Vaitkienė  
Head, Health Policy and Planning  
Ministry of Health  
Vilnius str. 33  
LT-01506 Vilnius

Tel: +370 5 266 1400  
email: rima.vaitkiene@sam.lt

### **Luxembourg**

Dr Martine Debacker, MD, PhD, MPH, MSc  
Ministère de la Santé - Direction de la Santé  
Villa Louvigny - Allée Marconi  
L-2120 Luxembourg

Tel: +352 247 85516  
email: Martine.Debacker@ms.etat.lu

**Montenegro**

Ms Natasa Terzic, Msc.  
Director of the Center for Health System Development  
Institute of Public Health of Montenegro  
Dzon Dzekson nn  
81000 Podgorica

Tel: +382 20 412 812  
email: natasa.terzic@ijzcg.me

**Norway**

Ms Maren Skaset  
Deputy Director General  
Department of Municipal Health Services  
Royal Ministry of Health and Care Services  
Einar Gerhardsens Plass 3  
N-0030 Oslo

Tel: +47 22 24 85 88  
email: maren.skaset@hod.dep.no

**Poland**

Mr. Tomasz Pawlega  
Deputy Director  
Health Insurance Department  
Ministry of Health  
38/40 Długa Str.  
00-238 Warsaw

Tel: +48 22 53 00 121  
email: t.pawlega@mz.gov.pl

**Portugal**

Mr Alexandre Lourenço  
Chief Health Services Officer  
Central Administration for the Health System  
Ministry of Health  
Avenida João Crisóstomo, n.º 9  
1049-062 Lisbon

Tel: +351 21 792 58 00  
email: alourenco@acss.min-saude.pt

**Republic of Moldova**

Dr. Rodica Scutelnic  
Head of the Hospital and Emergency Care Department  
Ministry of Health of the Republic of Moldova  
Vasile Alecsandri str., 2 sector 1  
MD-2009 Chisinau

Tel: +373 22 26 88 71  
email: rodica\_scutelnic@ms.gov.md

**Romania**

Ass. Prof. Dr. Florentina Ligia Furtunescu, MD, PhD, MPH  
Department of Public Health  
University of Medicine and Pharmacy "CAROL DAVILA"  
010024 Bucharest

Tel: +40723537913  
email: florentina.furtunescu@umf.ro

**Serbia**

Dr Milena Vasic  
Chief of Department for Research in the Field of Public Health  
Institute for Public Health of Serbia "Dr Milan Jovanovic Batut"  
Dr Subotica 5  
11000 Belgrade

Tel: + 381 11 2062752  
email: milena\_vasic@batut.org.rs

### **Slovakia**

Dipl.Ing.Bc. Stefan Mesaros, PhD.  
Project Manager  
Institute for Health Policy  
Ministry of Health of the Slovak Republic  
Limbová 2  
837 52 Bratislava 37

Tel: +421 2 59373 229  
email: Stefan.Mesaros@health.gov.sk

### **Slovenia**

Ms Eva Murko  
Vice-secretary  
Division of the quality and safety of health care  
Ministry of Health  
Stefanova 5  
1000 Ljubljana

Tel: +3861 476991  
email: Eva.Murko@gov.si

### **Spain**

Ms Isabel Peña-Rey  
Head of Unit, Strategies in Health  
Ministry of Health, Social Policy and Equity  
Paseo del Prado 18-20  
E-28071 Madrid

Tel: +34915961358  
email: ipenarey@msssi.es

### **Sweden**

Mr Bo Lindblom  
Senior Advisor, "Socialstyrelsen"  
The National Board of Health and Welfare  
Stockholm

Tel: +46 752473602  
email: bo.lindblom@socialstyrelsen.se

### **Switzerland**

Ms Marie-Thérèse FURRER  
Tariffs and Service Providers Section  
Health and Accident Insurance Directorate  
Federal Office of Public Health  
Seilerstrasse 8  
CH-3003 Bern

Tel: +41 31 323 70 68  
Email:  
marie-therese.furrer@bag.admin.ch

### **Tajikistan**

Dr Shaidullo Sharipov  
Head of Department for Medical Care Provision

Tel: +992372211072  
email: shaidullo@mail.ru

Ministry of Health and Social Protection  
Shevchenko 69  
734025 Dushanbe

## Turkey

Dr. Seda Usubütin  
Senior Advisor  
General Directorate of Foreign and EU Affairs  
Ministry of Health, Turkey  
Kültür Mah. İçel Sokak No: 2  
06420 Kizilay-Çankaya Ankara

Tel: +90 312 5856625  
email: seda.usubutun@saglik.gov.tr

## Observers

Ms. Milva Ekonomi  
Deputy Minister for Health  
Ministry for Health  
Bulevardi 'Bajram Curri' nr. 1  
1000 Tirana  
Albania

Tel: +355 42364663  
email: milva.ekonomi@moh.gov.al

Dr Gulnara Kulkaeva  
Deputy Director  
Department for Health Service Organization  
Ministry of Health  
13, Imanova Str  
010000 Astana  
Kazakhstan

Tel: +77015250756  
email: g.kulkaeva@mz.gov.kz

Dr Deirdre Mulholland  
Deputy Chief Medical Officer  
Department of Health  
Hawkins House  
Dublin 2  
Ireland

Tel: + 3531 635 4419  
email:  
deirdre\_mulholland@health.gov.ie

Ms Monica Skjoeld Johansen  
Department of Municipal Health Services  
Royal Ministry of Health and Care Services  
Einar Gerhardsens Plass 3  
N-0030 Oslo  
Norway

Tel: +47 22 24 85 88  
email:  
Monica-Skjold.Johansen@hod.dep.no

Dr Dilbar Burakova  
Head of Department for Primary Health Care  
Ministry of Health and Social Protection  
Shevchenko 69  
734025 Dushanbe  
Tajikistan

Tel: +992 5710103  
email: buracova\_65@mail.ru

Dr Ashir Mammedorazovich Atayev  
Deputy Minister of Health and Medical Industry  
Ministry of Health and Medical Industry  
20 Archabil shayoly  
Ashgabat, 744036

Tel: +99312 48 94 14  
email:



Turkmenistan

Dr Doniyor Mirazimov  
Chief of Treatment and Prevention Department  
Ministry of Health  
Navoi st., 12  
700011 Tashkent  
Uzbekistan

Tel: +998 (71) 244-10-30  
email:

### Temporary Advisors

Prof Volker Amelung  
Medical School Hanover  
Carl-Neuberg-Straße 1  
30625 Hanover  
Germany

Tel: +49 171 38 44 960  
email: amelung@berlin.de

Dr Ran Balicer  
Director  
Health Policy Research and Planning  
Clalit Health Services  
101 Arlozorov st.  
62098 Tel-Aviv  
Israel

Tel: +972 54 4757447  
email: rbalicer@netvision.net.il

Dr Rafael Bengoa  
Director  
DEUSTO Business School Spain  
San Sebastian Campus  
Camino de Mundaiz, 50  
20012 ES San Sebastian Guipuzcoa  
Spain

Tel:  
email: rafael.bengoa@deusto.es

Prof Liesbeth Borgermans  
Vrije Universiteit Brussel  
Laarbeeklaan 103  
1090 Brussels  
Belgium

Tel: +32 473 99 10 90  
email:  
liesbeth.borgermans@vub.ac.be

Dr Evgenia Geliukh  
In-country researcher for Ukraine  
Zlatopolska str., 4K, apt.98  
Kyiv  
Ukraine

Tel: +380 50 405 30 45  
email: evg\_geliukh@mail.ru

Dr Aldona Jociute  
In-country researcher for Lithuania  
S. Žukausko str. 49-59  
09131 Vilnius  
Lithuania

Tel: +370 682 45780  
email: joaldona@mruni.eu

Prof Aleksandras Laucevicius  
Director General  
Professor of Cardiology  
Vilnius University Hospital Santariškių Klinikos  
Santariškių g. 2  
08661 Vilnius

Tel: +370 5 236 5010  
email: cardio@cardio.lt

Lithuania

Dr Ellen Nolte  
RAND Europe  
Westbrook Centre, Milton Road  
Cambridge, CB4 1YG  
United Kingdom

Tel: +44 1223 353 329  
email: enolte@rand.org

Dr Nicholas Goodwin  
Chief Executive Officer  
International Foundation for Integrated Care  
7200 The Quorum  
Oxford Business Park North  
Oxford  
United Kingdom

Tel: +44 745 329 62 34  
email:  
nickgoodwin@integratedcarefoundation.org

Dr Maria Luisa Vazquez  
Consortium for Health Care and Social Services of Catalonia  
Av. Tibidabo 21  
08022 Barcelona  
Spain

Tel: +34-932531820  
email: mlvazquez@consorci.org

### **World Health Organization, Secretariat**

Ms Erica Barbazza  
Consultant, Health Services Delivery, Division of Health Systems and Public Health

Dr Tamás Evetovits  
Head of Barcelona Office, a.i., Division of Health Systems and Public Health

Mr Andrei Matei  
Health Systems Officer, WHO Country Office in Republic of Moldova

Dr Hernan Montenegro  
Health Systems Adviser, WHO Headquarters

Ms Hanne Bak Pedersen  
Programme Manager, Health Technologies and Pharmaceuticals, Division of Health Systems and Public Health

Dr K. Viktoria Stein  
Consultant, Health Services Delivery, Division of Health Systems and Public Health

Dr Juan Tello  
Programme Manager, Health Services Delivery, Division of Health Systems and Public Health

Dr Lola Yuldasheva  
National Professional Officer, WHO Country Office Tajikistan

## **Rapporteur**

Dr Lourdes Ferrer  
Managing Director  
International Foundation for Integrated Care  
7200 The Quorum  
Oxford Business Park North  
Oxford  
United Kingdom

Tel: +44 745 329 62 34  
email:  
[lourdesferrer@integratedcarefoundation.org](mailto:lourdesferrer@integratedcarefoundation.org)

## Annex 3. Programme

<b>Monday, 03 February 2014</b>	
<b>12:00 – 13:00</b>	<p><b>Registration</b></p> <p><b>Introduction of Participants (Buffet Lunch)</b></p>
<b>13:00 – 13:30</b> 13:00 – 13:01 13:02 – 13:07 13:07 – 13:17 13:18 – 13:30 13:31 – 13:40	<p><b>Opening and welcome address</b></p> <p><b>Chair:</b> Juan Tello</p> <ul style="list-style-type: none"> <li>• <i>Strengthening People-centred Health Systems in the Context of the European Policy - Health 2020: Welcome address (Hans Kluge via Webex) – whenever possible</i></li> <li>• Kick off Technical Meeting Agenda and Objectives (Juan Tello)</li> <li>• WHO Strategy on People-centred and Integrated Health Services Delivery (Hernan Montenegro)</li> </ul> <p><i>Presentation of the WHO Global Strategy on People-Centred and Integrated Health Services as a means to reach universal health coverage.</i></p> <ul style="list-style-type: none"> <li>• Development of a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) in WHO European Region: where we are and where we are going (Viktoria Stein)</li> </ul> <p><i>Overview of key phases and milestones in developing the framework.</i></p>
Scope and Purpose	<p><b>Session 1 - Coordinated/Integrated Health Services Delivery (CIHSD) Initiatives in the WHO European Region</b></p> <p>Experiences on coordination and integration of health services delivery in WHO European Region will be presented using reports on the pilot case studies and interventions from member state focal points and members of the Expert Advisory Team as well as first results from the open call for coordinated/integrated health services delivery (CIHSD) initiatives. The knowledge gathered during the implementation processes will be summarised in a keynote on the lessons learned.</p>
13:40 – 14:30 13:42 – 14:02 14:02 – 14:05 14:05 - 14:10 14:10 – 14:20 14:20 – 14:30	<p><b>Pillar 2: Coordinated/Integrated Health Services Delivery (CIHSD) Initiatives in the WHO European Region</b></p> <p><b>Chair:</b> Juan Tello</p> <ul style="list-style-type: none"> <li>• The Eastern Lithuanian Cardiology Programme (ELCP) – A story of integration.</li> </ul> <p>Keynote by Aleksandras Laucevicius</p> <p><i>The initiator and manager of the ELCP will tell the story of how this CIHSD initiative was realised, what were the drivers and enablers for change and what were the challenges and lessons learned.</i></p> <p>Short question and answer session</p> <ul style="list-style-type: none"> <li>• Intervention by the CIHSD Focal Point for Lithuania</li> </ul> <p><i>Country's specific policies towards CIHSD and implications from the keynote.</i></p> <ul style="list-style-type: none"> <li>• Ukraine pilot case study (Evgenia Geliukh)</li> </ul> <p><i>Preliminary findings and results of the pilot case study on integrating TB/HIV services in Ukraine.</i></p> <ul style="list-style-type: none"> <li>• Plenary Discussion</li> </ul>

<b>14:30 – 15:00</b>	<b>Coffee break</b>
15:00 – 16:30	<b>Pillar 2: Coordinated/Integrated Health Services Delivery (CIHSD) Initiatives in the WHO European Region cont.</b>
15:00 – 15:02	<b>Chair:</b> Ellen Nolte
15:02 – 15:20	<ul style="list-style-type: none"> <li>Setting a policy agenda for Integrated Care: the experience of Germany. Keynote by Volker Amelung <i>Overview of the legal and policy reforms launched by the German government to foster CIHSD implementation and their results.</i></li> </ul>
15:20 – 15:25	Short question and answer session
15:25 – 15:40	<ul style="list-style-type: none"> <li>CIHSD Focal Points Interventions and Reflections: Serbia, Slovakia, Sweden <i>Key policies that support CIHSD in their respective countries and how agenda setting worked/works, e.g. who promoted it, is it on-going, are there specific laws.</i></li> </ul>
15:45 – 16:00	<ul style="list-style-type: none"> <li>Using Integrated Care to improve outcomes: the experience of Clalit in Israel. Keynote by Ran Balicer <i>Overview of how data analysis can inform equitable organisation of care and outcomes-led management of health services delivery by looking at the example of Clalit from Israel.</i></li> </ul>
16:00 – 16:05	Short question and answer session
16:05 – 16:20	<ul style="list-style-type: none"> <li>CIHSD Focal Points Interventions and Reflections: Bulgaria, Finland, Georgia <i>How data analysis and collection support CIHSD in countries and how health outcomes inform health services delivery.</i></li> </ul>
16:20 – 16:30	<ul style="list-style-type: none"> <li>Plenary Discussion</li> </ul>
<b>16:30 – 17:00</b>	<b>Water break</b>
17:00 – 18:00	<b>Pillar 2: Lessons from Implementing Coordinated/Integrated Health Services Delivery (CIHSD) Initiatives</b>
17:00 – 17:02	<b>Chair:</b> Nick Goodwin
17:02 – 17:25	<ul style="list-style-type: none"> <li>Systems Transformations in Health Care: Lessons from Implementation from a Leader's point of view. Keynote by Rafael Bengoa <i>Insights of lessons learned from 4 successful CIHSD implementation cases, focusing on the role of leadership.</i></li> </ul>
17:25 – 17:30	Short question and answer session
17:30 – 17:45	<ul style="list-style-type: none"> <li>CIHSD Focal Points Interventions and Reflections: Denmark, Hungary, Tajikistan <i>Lessons learned from CIHSD implementation in their respective countries and whether leaders can be made or whether it is good luck to find one.</i></li> </ul>
17:45 – 18:00	<ul style="list-style-type: none"> <li>Plenary Discussion</li> <li>Wrap up of Day 1– <i>actively ask TKM</i></li> </ul>

<p>Scope and Purpose</p>	<p><b>Session 2 Suggestions for Areas for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) in the WHO European Region</b></p> <p>Building on a synthesis of evidence, and the case studies, possible Areas for Action towards CIHSD will be presented, which commonly need to be addressed in order to achieve coordinated/integrated health services delivery. Their relevance and validity will be reflected on and discussed. Member States CIHSD Focal Points and the Expert Advisory Team will be asked to comment and intervene in order to clarify what the Areas for Action could be.</p>
<p>09:00 – 10:30</p> <p>09:00 – 09:02</p> <p>09:02 – 09:23</p> <p>09:23 – 09:53</p> <p>09:53 – 10:30</p>	<p><b>Pillar 1: Suggestions for Areas for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) for the WHO European Region</b></p> <p><b>Chair:</b> Hanne Bak Pedersen</p> <ul style="list-style-type: none"> <li>• Proposed Areas for Action on Coordinated/Integrated Health Services Delivery in the context of People-Centred Health Systems in WHO European Region (Viktoria Stein)</li> </ul> <p><i>The presentation will introduce the concept and the evidence for 7 proposed areas for action, which need to be tackled to achieve CIHSD.</i></p> <ul style="list-style-type: none"> <li>• <b>‘Communication’</b> as an Area for Action towards CIHSD</li> </ul> <p><i>Strengthening communication skills and establishing channels and platforms of communication for patients and providers; effectively gathering, sharing and using information by means of appropriate technologies, including eHealth, mHealth and telemedicine.</i></p> <ul style="list-style-type: none"> <li>○ Expert: Hernan Montenegro</li> <li>○ CIHSD Focal Point: Ireland</li> <li>○ Plenary Discussion</li> <li>○ Summary of Discussion Points and Open Questions</li> </ul> <ul style="list-style-type: none"> <li>• <b>‘Knowledge’</b> as an Area for Action towards CIHSD</li> </ul> <p><i>Ensuring a skilled, motivated and available workforce of health professionals; educating people, consumers and patients as experts in their own care; raising health literacy.</i></p> <ul style="list-style-type: none"> <li>○ Expert: Liesbeth Borgermans</li> <li>○ CIHSD Focal Point: Romania</li> <li>○ Plenary Discussion</li> <li>○ Summary of Discussion Points and Open Questions</li> </ul>
<p><b>10:30 – 11:00</b></p>	<p><b>Coffee break</b></p>
<p>11:00 – 12:30</p> <p>11:02 – 11:30</p>	<p><b>Pillar 1: Suggestions for Areas for Action towards CIHSD for the WHO European Region cont.</b></p> <p><b>Chair:</b> Hanne Bak Pedersen</p> <ul style="list-style-type: none"> <li>• <b>‘Resources’</b> as an Area for Action towards CIHSD</li> </ul> <p><i>Aligning financial incentives; adjusting current infrastructure and working environments to CIHSD requirements; planning human resources according to epidemiological and demographic needs.</i></p> <ul style="list-style-type: none"> <li>○ Expert: Tamás Evetovits</li> <li>○ CIHSD Focal Point: Portugal</li> <li>○ Plenary Discussion</li> </ul>

<p>11:31 – 12:00</p> <p>12:01 – 12:30</p>	<ul style="list-style-type: none"> <li>○ Summary of Discussion Points and Open Questions</li> <li>● <b>‘Policy’</b> as an Area for Action towards CIHSD <i>Ensuring strategic policy frameworks and effective governance, coalition building, regulation, attention to system-design, priority setting and accountability; empowering competent leaders to foster and sustain change; promoting a health in all policies and whole-system approach.</i> <ul style="list-style-type: none"> <li>○ Expert: Ellen Nolte</li> <li>○ CIHSD Focal Point: Latvia</li> <li>○ Plenary Discussion</li> </ul> </li> <li>○ Summary of Discussion Points and Open Questions</li> <li>● <b>‘Care’</b> as an Area for Action towards CIHSD <i>Defining care pathways; providing organisational frameworks to work across professions and sectors; strengthening communities to create their own solutions for healthy ageing, home-based care and a healthy community; defining roles and responsibilities.</i> <ul style="list-style-type: none"> <li>○ Expert: Maria Luisa Vazquez</li> <li>○ CIHSD Focal Point: Turkey</li> <li>○ Plenary Discussion</li> </ul> </li> <li>○ Summary of Discussion Points and Open Questions</li> </ul>
<p><b>12:30 – 13:30</b></p>	<p><b>Lunch</b></p>
<p>13:30 – 15:00</p> <p>13:32 – 14:00</p> <p>14:01 – 14:30</p> <p>14:31 – 14:55</p>	<p><b>Pillar 1: Suggestions for Areas for Action towards CIHSD for the WHO European Region cont.</b></p> <p><b>Chair:</b> Lourdes Ferrer</p> <ul style="list-style-type: none"> <li>● <b>‘Values’</b> as an Area for Action towards CIHSD <i>Transforming and fostering attitudes, values, organisational and professional cultures conducive to holistic and integrated service delivery; enabling distributive and inclusive leadership to support the change process and inspire people to work towards a common goal.</i> <ul style="list-style-type: none"> <li>○ Expert: Rafael Bengoa</li> <li>○ CIHSD Focal Point: Norway</li> <li>○ Plenary Discussion</li> </ul> </li> <li>○ Summary of Discussion Points and Open Questions</li> <li>● <b>‘People’</b> as an Area for Action towards CIHSD <i>Encouraging people to take active interest in the design and organisation of the health system, motivating professionals to lead change. Empowering people to make healthy choices and actively engage in building a healthy society.</i> <ul style="list-style-type: none"> <li>○ Expert: Ran Balicer</li> <li>○ CIHSD Focal Point: Spain</li> <li>○ Plenary Discussion</li> </ul> </li> <li>○ Summary of Discussion Points and Open Questions</li> <li>● Plenary Discussion <ul style="list-style-type: none"> <li>○ Reflection on Areas for Action as a whole to summarise (Maria Luisa Vazquez)</li> </ul> </li> </ul>

14:55 – 15:00	<ul style="list-style-type: none"> <li>○ CIHSD Focal Point Interventions and Reflections: Kazakhstan, Luxembourg, Slovenia</li> <li>• The way forward (Juan Tello and Viktoria Stein)</li> </ul>
<b>15:00 – 15:30</b>	<b>Coffee break</b>
Scope and purpose	<p><b>Session 3 Drivers for Change towards Coordinated/Integrated Health Services Delivery (CIHSD) in WHO European Region</b></p> <p>Based on a review of existing literature on change management in health services delivery and based on the findings from the concept note (pillar 1) and the field evidence (pillar 2) an outline for developing a manual for designing, implementing and managing change in CIHSD will be presented and discussed.</p>
15:30 – 17:00	<p><b>Pillar 3: Drivers for Change – First Outline for Designing, Managing and Implementing Change towards Coordinated/Integrated Health Services Delivery (CIHSD) in WHO European Region</b></p> <p><b>Chair:</b> Volker Amelung</p> <ul style="list-style-type: none"> <li>• Drivers for Change towards CIHSD: what we know and what we don't know. Keynote by Nick Goodwin <i>Overview of the evidence on change management, which policies worked and which didn't, and the key messages often forgotten.</i></li> </ul> <p>15:30 – 15:33</p> <p>15:33 – 15:50</p> <p>15:50 – 15:55</p> <p>15:55 – 16:10</p> <p>16:10 – 17:00</p> <ul style="list-style-type: none"> <li>• Short question and answer session</li> <li>• CIHSD Focal Point Interventions and Reflections from: Montenegro, Poland, Switzerland <i>Reflections on the key messages from the keynote from their respective country's perspective.</i></li> <li>• Plenary Discussion</li> <li>• Wrap up of Day 2 – <i>actively ask EST</i></li> </ul>
<b>19:30</b>	<b>Social Event and Dinner</b>

**Wednesday, 05 February 2014**

Scope and purpose	<p><b>Session 4 Open call and in-depth case studies on CIHSD in WHO European Region: practical issues</b></p> <p>The questionnaires of the open call and the in-depth case studies will be discussed and open questions concerning terminology used and roles of focal points will be answered.</p>
09:00 – 10:30	<p><b>Pillar 2: Open call and in-depth case studies: practical issues</b></p> <p><b>Chair:</b> Lola Yuldasheva</p> <ul style="list-style-type: none"> <li>• Open call first results (Erica Barbazza) <i>Overview of the first results from the open call for CIHSD initiatives will be presented and further steps outlined.</i></li> </ul> <p>09:02 – 09:10</p> <p>09:10 – 09:30</p> <ul style="list-style-type: none"> <li>• Methods and tools: open-call questionnaire and in-depth case study (Erica Barbazza and Viktoria Stein) <i>The open call questionnaire will be presented in depth, the target audience and the means of distribution, as well as the set-up and purpose of an in-depth case study. The presentation will be interactive, with participants being asked to intervene at any time.</i></li> </ul>



09:30 – 09:45	<ul style="list-style-type: none"> <li>• Experiences from the Pilot Case Studies: Aldona Jociute (LTU) and Evgenia Geliukh (UKR)</li> </ul> <p><i>Presentation about how the interviewees were selected and approached, what challenges were encountered and which were the key lessons learned.</i></p>
09:45 – 10:00	<ul style="list-style-type: none"> <li>• Interventions from: <ul style="list-style-type: none"> <li>○ CIHSD Focal Points: Austria, Belarus, Moldova</li> </ul> <p><i>Each of the three focal points will shortly bring their experiences with the open call to the audience, and how to improve reach of call.</i></p> <li>○ Expert Intervention: Liesbeth Borgermans</li> <p><i>Short intervention from a senior researcher on how to conduct surveys and case studies, important lessons for preparing and conducting interviews and how to analyse results.</i></p> </li> </ul>
10:00 – 10:30	<ul style="list-style-type: none"> <li>• Plenary Discussion</li> </ul>
<b>10:30 – 11:00</b>	<b>Coffee break</b>
11:00 – 12:00	<p><b>Next steps, Q&amp;A session, Closing</b></p> <p><b>Chair:</b> Andrei Matei</p>
11:02 – 11:20	<ul style="list-style-type: none"> <li>• The Role of the CIHSD Focal Points: discussion with CIHSD Focal Points led by Erica Barbazza and Viktoria Stein</li> </ul> <p><i>Discussion on how focal points can get involved in the development of the Framework for Action towards CIHSD, how the open call can further be supported and what they need in order to fulfil this role.</i></p>
11:20 – 11:50	<ul style="list-style-type: none"> <li>• Plenary Discussion: Feedback and final remarks</li> </ul> <p><i>Chair opens floor for further comments and discussion with participants, and invites participants to take a final round of the pin boards with the 7 Areas for Action to value and prioritise issues raised.</i></p> <ul style="list-style-type: none"> <li>○ CIHSD Focal Point Interventions from: Albania, Bosnia and Herzegovina, Uzbekistan</li> </ul>
11:50 – 12:00	<ul style="list-style-type: none"> <li>• The next steps in developing the Framework for Action towards CIHSD (Juan Tello)</li> </ul> <p><i>Final outlook on next steps for 2014.</i></p> <ul style="list-style-type: none"> <li>• Closing of the meeting</li> </ul>
<b>12:00–13:00</b>	<b>Buffet Lunch and Departure</b>

## **Annex 4. List of presentations**

- Setting a policy agenda for Integrated Care: the experience of Germany. (Volker Amelung)
- Using Integrated Care to improve outcomes: the experience of Clalit in Israel. (Ran Balicer)
- Systems Transformations in Health Care: Lessons from Implementation from a Leader's point of view. (Rafael Bengoa)

**Tuesday, February 4<sup>th</sup> 2014**

**Wednesday, February 5<sup>th</sup> 2014**

<http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery>

You may also contact the CIHSD Secretariat at [cihsd@euro.who.int](mailto:cihsd@euro.who.int) and we will send the presentations to you.

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Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
The former Yugoslav  
Republic of Macedonia  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

The Roadmap to develop a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) places a strong emphasis on a participatory approach to ensure ownership in the process of its development. This includes input from Member State Technical Focal Points on CIHSD and the Expert Advisory Team. In order to achieve the highest possible engagement, a kick-off technical meeting was called for to capture feedback and input from these groups and to incorporate the country perspectives. This meeting gave the Member States Technical Focal Points and Expert Advisory Team the opportunity to discuss the progress made to develop the Framework for Action towards CIHSD with the team that is coordinating the process at the Division of Health Systems and Public Health, WHO Regional Office for Europe. The report at hand and the feedback received during this meeting will be used to further develop and refine the Framework for Action, ensuring the highest possible relevance and practicability for Member States.

**World Health Organization  
Regional Office for Europe**

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00

Fax: +45 45 33 70 01

Email: [contact@euro.who.int](mailto:contact@euro.who.int)

Website: [www.euro.who.int](http://www.euro.who.int)