INTEGRATED COMMUNITY CARE 4ALL SEVEN PRINCIPLES FOR CARE

Strategy paper to move ICC forward

TransForm Integrated Community Care

Transnational Forum on Integrated Community Care
https://transform-integratedcommunitycare.com/

ABOUT THIS PAPER

The strategy paper is the result of a two-day expert workshop hosted by TransForm, to consolidate the learnings from the three TransForm conferences held in Hamburg (2018), Turin (2019) and Vancouver (2019). To facilitate knowledge sharing among all parties, TransForm requested Philippe Vandenbroeck and Tom Braes from shiftN, facilitators of the workshop, to co-develop a strategy paper bringing together important learnings and take-away messages on Integrated Community Care.

Authors Philippe Vandenbroeck, Tom Braes (shiftN), March 2020

ACKNOWLEDGEMENTS

We gratefully acknowledge the authors and all participants who attended the expert meeting on 28-29 November 2019 in Brussels for sharing their knowledge and expertise with us. The list of participants is at the end of the paper.

For more information about TransForm please contact
giulia.barnhisel@nef-europe.org
www.transform-integratedcommunitycare.com

Content use disclaimer: This content has been developed by the TransForm partnership and the authors of this paper. While we encourage you to share and use this content, we kindly ask for you to credit *TransForm: the Transnational Forum for Integrated Community Care.*

CONTENTS

1 Integrated community care: towards new principles for care 4

2 The transform coalition 4

3 Beyond integrated care 5

3.1 From delivery to genuine co-production 5
3.2 Through the eyes of key stakeholders 6
3.3 A shifting context 7
3.4 A typology of ICC practices 8

4 7 effectiveness principles for icc 9

4.1 The need for guidance in complexity 9
4.2 Key challenges 10
4.3 Measuring progress 11

5 The landscape of icc practices 12

5.1 Community health centres 12
5.2 Caring communities 13
5.3 Healthy place-making 14

6 A systems view on integrated community care 16

7 Wrap up 18

Annex 1
List of participants to the expert workshop 19

1 INTEGRATED COMMUNITY CARE: TOWARDS NEW PRINCIPLES FOR CARE

Integrated Community Care (ICC) is moving to the forefront of an international policy and practice agenda. This paper aims to reinforce the case for Integrated Community Care by charting the state of play around this much needed shift in health and social care systems. ICC bundles three generic concepts: "integrated", "community" and "care". In its most rudimentary form, ICC is recognized as a much-needed and valuable expansion of the more typical notions of integrated care, with explicit recognition of the value, potential and power of communities, citizens and 'laypeople'. Or, as a formula: ICC = IC + C. However, this is a rather shallow vision on ICC. In the present paper we would like to underscore the distinctiveness of the approach beyond a community-flavored version of 'integrated care'. Additionally we want to give a feeling for the richness and diversity of ICC. Integrated Community Care is not a standardized practice, but manifests itself in a range of practices that share a common core. The challenge in this paper, therefore, is: to illuminate both the distinctiveness and diversity of what is understood today by Integrated Community Care.

2 THE TRANSFORM COALITION

This paper was commissioned by TransForm, the Transnational Forum for Integrated Community Care. TransForm is a joint initiative of Foundations in Europe and Canada that aims to put the community at the centre of primary and integrated care. Integrated Community Care recognizes people and communities as co-producers of care. It seeks to examine how partnerships that engage and empower people in local communities can be developed through trans-disciplinary and cross-sectoral collaborations. The overarching aim of the Forum is to mobilize change at policy and practice level by engaging policymakers, practitioners and key stakeholders in knowledge generation and sharing of promising and best practices.

The TransForm partnership is hosted by the Network of European Foundations and comprises: Compagnia di San Paolo (IT), Robert Bosch Stiftung (DE), Fondation de France (FR), Fund Dr. Daniël De Coninck, managed by the King Baudouin Foundation (BE), Graham Boeckh Foundation and Conconi Foundation (CA). The International Foundation for Integrated Care provides content and management support to the project.

TransForm has been instrumental in strengthening the international ICC community through a series of conferences held at Hamburg (2018), Torino (2019) and Vancouver (2019). Many of the insights and messages from these gatherings have found their way into this strategy paper, developed together with members of the TransForm ICC com-

munity during the Brussels expert workshop (November 2019). This document wants to frame and spur the debate.

TransForm will continue its campaign of building the ICC community of practice and deepening knowledge. Therefore, the Forum is investing in a collective reflection on the numerous innovations and the hurdles that have been overcome to tackle the Covid-19 pandemic. A mixture of online and live events will take place in 2020-2021. These include a series of webinars and opinions by experts and practitioners published on the website.

3 BEYOND INTEGRATED CARE

3.1 / FROM DELIVERY TO GENUINE CO-PRODUCTION

Integrated Community Care in many respects represents a paradigm shift. Certainly, ICC shares the ambition of Integrated Care to improve the quality of care and quality of life for individuals, families and communities. It also reflects the understanding that health and social care services are performed by co-productive partnerships and intersectoral and interdisciplinary collaborations. However, key is the move beyond 'delivery' to genuine 'co-development' with the individuals and communities that are traditionally seen as recipients. The implications of that co-creative approach to delivery and decision-making are important:

- ICC is **relationship-based and place-based.** It seeks to care for people living in the home environment and focuses on the promotion of health and wellbeing as well as tackling key issues such as social exclusion and social isolation.
- ICC assumes **accountability towards a territorially defined population.** This is a fundamental distinction with integrated care that looks at individual cases through the lens of problems (e.g. drug addiction, homelessness). This accountability also provides the rationale behind the link with and involvement of local authorities.
- ICC engages and empowers people in the local communities and thus plays a central role in **valuing the position of the informal care sector.**
- ICC's **'raîson d'etre' goes way beyond 'care'.** It is just as much about activating and reinforcing the social ties between people. ICC is an investment to **improve both health and social cohesion.** ICC sees health as a public good.
- ICC is **goal-oriented in nature, supporting people's priorities and life goals.** Such a goal-directed approach represents a more positive view on care, characterized by a greater emphasis on individual strengths and resources.
- ICC bears **prevention and promotion in its core.** These are essential for enabling and empowering people so they can increase their control over, and improve their health.

It moves ICC beyond a focus on individual behavior towards a wide range of social and environmental interventions.

- ICC has the potential to serve as a participatory community strategy to achieve health in an equitable way. This requires **social, economic and environmental determinants** to be properly addressed.
- ICC requires a dynamic, **assets-based approach to community development,** characterized by non-hierarchical processes, highly engaged communities, and distributed leadership.
- The scope of ICC requires a **social movement** to bring it to life. ICC is first and foremost a societal process, not just a professional or managerial toolbox. That social or activist layer is an essential characteristic. Ideally, ICC invites and engages people.

3.2 / THROUGH THE EYES OF KEY STAKEHOLDERS

We can make Integrated Community Care more tangible by putting ourselves in the shoes of the key stakeholders that need to join forces to make it a reality:

The citizen/user:

- I am the expert on my own health.
- I feel my uniqueness and life goals acknowledged.
- I know where to go for support (access).
- I feel like I am part of my community (social cohesion).

The professional

- I am part of and feel connected to the ecosystem of care.
- I recognize the user as the expert of his/her own health.
- I have access to all the information I need.
- I feel well supported to perform at the highest quality.

The policy maker

- I am part of and feel connected to the ecosystem of care.
- I have a holistic understanding of the notion of health and wellbeing (my decisions are informed).
- I recognize the merits of sharing power and decision making.

The community

- We are embedded in the system.
- We have sustainable resources and funding.
- We have the opportunity, capacity and power to take part in decision making.
- We have the necessary capacity to express and address the needs of our community.

3.3 / A SHIFTING CONTEXT

Integrated Community Care gains pertinence and depth against the background of deep trends in society and in the health care systems embedded in it.

Our understanding of health is undergoing a transformation. The 1948 WHO-definition ("health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity") is very aspirational. The emerging concept of 'Positive Health', that hinges on resilience and self-efficacy, complements this traditional view. Positive Health focuses on "health as the ability to adapt and self-manage, in light of the physical, emotional and social challenges of life". From such a perspective, health encompasses six dimensions: bodily functions, mental functions & perceptions, spiritual dimension, quality of life, social & societal participation, daily functioning. Clearly, Integrated Community Care reflects this empowering concept of health.

Further, in fifty years' time the world will look significantly different. Our global society is faced with the urgent need to engage with multiple transitions — demographic, technological, biological, institutional and social — to find a new, sustainable equilibrium. A systemic point of view helps us to realize how human and ecosystem health are co-dependent. Hence, public health services cannot be seen as a side show to these vital transformations but have to be an integral part of it[1].

The WHO also conveys such a broad, connecting and systemic viewpoint. In its vision on primary health care (A vision for primary health care for the 21st century, 2018), the WHO refers to primary health care (PHC) as having three crucial inter-related and synergistic components[2]:

- Meeting people's (physical, mental and social) health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course , strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;
- Systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behavior) through evidence-informed policies and actions across all sectors;
- Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

1 *G. Rayner and T. Lang.* Ecological Public Health. Reshaping the Conditions for Good Health. *Routledge. 2013.*
2 *https://apps.who.int/iris/handle/10665/328065*

It is an engaging and activating view on primary care. One that explicitly includes a wide spectrum of health and social care services and one that places people, as individuals and communities, as the central focus of all efforts towards PHC. Such a vision seems to match one-to-one with the ethos, rationale and ambitions of Integrated Community Care.

3.4 / A TYPOLOGY OF ICC PRACTICES

TransForm has identified a range of real-world practices, wholly or partially aligned with the principles underpinning Integrated Community Care. In order to create a helicopter perspective on this landscape we propose to construct a typology of these emerging practices. The typology is underpinned by three main dimensions.

Models or practices labelled or perceived as 'ICC' will differ in:

1 **Their main instigators or drivers:** who initiated the initiative? Who are the main 'champions'? Which parties represent the driving forces? There may be several champions or initiators, notably individual citizens, professionals, policymakers, and grassroots organizations. The sliders help to visualize their role and the weight of their involvement.

2 **Their centre of gravity or focus:** What is the dominant rationale? What is the guiding perspective behind the practice? We propose to make a distinction between practices that are dominantly focused on care provision, on community building or on spatial-environmental development of a neighbourhood. Initiatives may start from a certain perspective, and gradually broaden their perspective (in function of the learning curve, the actors involved, knowledge and expertise, and so on). The sliders make it easier to differentiate.

3 **Their core ingredients:** What are the distinctive strengths, assets and infrastructures that are mobilized in the practice? They can be related to the home, to the wider setting (place), to alliances and partnerships and/or to assets.

So it is the interaction between these three dimensions that give rise to a wide range of practices that can be seen as embodiments of ICC.

This typology can be visualized as a set of slider bars, whereby each slider corresponds to one of the key axes. The slider bars illustrate then how the various practices of ICC can be positioned or assessed on these core dimensions or characteristics. Vice versa, the sliders also invite to discover and design novel ICC practices. In section 5 of this paper we will discuss a number of existing practices. The present typology will help to position these practices in the wider landscape of ICC practices.

4 7 EFFECTIVENESS PRINCIPLES FOR ICC

4.1 / THE NEED FOR GUIDANCE IN COMPLEXITY

How to turn Integrated Community Care from aspiration into reality? Rather than to focus on elaborate strategies we want to propose a limited set of effectiveness principles to guide action in a complex transition.

An effectiveness principle is a clear and actionable statement that provides guidance for thinking and behaving toward some desired result. It informs choices at forks in the road, grounded in values about what matters to those who develop, adopt, and attempt to follow them.

Such principles adhere to the GUIDE-criteria[3] (Patton, 2017), meaning: they help with Guidance (priority setting), they have Utility (i.e. actionable), that they are Inspiring (motivating to 'walk the talk'), that they are Developmental (i.e. they are applicable to a range of contexts) and Evaluable (i.e. you can document and judge the results).

Together, they form a framework to guide ongoing developments, formulate responses to challenges and navigate complex dynamic systems. As a set, they provide an overarching agenda for coalitions for collective impact. Here are seven effectiveness principles for Integrated Community Care:

Co-develop health and wellbeing, enable participation

1 Value and foster the capacities of all actors, including citizens, in the community to become change agents and to co-produce health and wellbeing. This requires the active involvement of all actors, with extra sensitivity to the most vulnerable ones.

3 *M. Quinn Patton.* Principles-focused Evaluation. The GUIDE. *Guilford Press. 2017.*

2 Foster the creation of local alliances among all actors which are involved in the production of health and wellbeing in the community. Develop a shared vision and common goals. Actively strive for balanced power relations and mutual trust within these alliances.
3 Strengthen community-oriented primary care that stimulates people's capabilities to maintain health and/or to live in the community with complex chronic conditions. Take people's life goals as the starting point to define the desired outcomes of care and support.

Build resilient communities

4 Improve the health of the population and reduce health disparities by addressing the social, economic and environmental determinants of health in the community and investing in prevention and health promotion.
5 Support healthy and inclusive communities by providing opportunities to bring people together and by investing in both social care and social infrastructure.
6 Develop the legal and financial conditions to enable the co-creation of care and support at community level.

Monitor, evaluate and adapt

7 Evaluate continuously the quality of care and support and the status of health and wellbeing in the community by using methods and indicators which are grounded within the foregoing principles and documented by participatory 'community diagnosis' involving all stakeholders. Provide opportunities for joint learning. Adapt policies, services and activities in accordance with the evaluation outcomes.

4.2 / KEY CHALLENGES

Obviously, there are many challenges in making Integrated Community Care the new norm of care. Here we draw attention to five potential obstacles:

- The challenge of 'meeting halfway': ICC is not solely a case of starting bottom up or initiating things top down. It is about finding the right balance between those two trajectories in order to align them towards a shared goal.
- The need to find champions amongst policy makers. Electoral cycles complicate building and maintaining political support. Expertise and efforts may evaporate and the cycle of identifying champions and building rapport has to start all over.
- The need to train a new type of health and welfare provider who is familiar with working in teams and accounts for context when addressing social and environmental determinants.

- The importance of maintaining focus and overview. The systemic nature of ICC will naturally lead to a wide palette of interventions and social innovations. This risks fragmentation of resources and efforts. Ideally, initiatives are embedded within an overarching vision anchored in the proposed effectiveness principles.
- The need to transcend the typical project or pilot approach and financing. ICC will benefit from a more structural and empowering financial logic. Making initiatives sustainable and designing a viable model should be a key objective, from the outset and for each initiative. This implies that health and welfare systems require a broad financial solidarity basis and a decentral organizational and implementation component.

4.3 / MEASURING PROGRESS

ICC requires a customized measurement and evaluation stance. Traditional paradigms and indicators often focus on measuring and monitoring systems performance, which makes them insufficient. ICC needs its own indicators of success with a focus on, amongst others, social and human capital.

Evaluation should be first and foremost participatory, with citizens as the real starting point for the evaluation. Simply put: the professional benchmarks are secondary to the benchmarks of the community. Assistance in defining and making their goals explicit will be a requirement.

The effectiveness principles are the starting point for building up a relevant measurement framework. It will be important to evaluate to what extent the principles were actually incorporated within a certain activity, organization, community or system, and then to measure to what extent working according to the principles has led to better outcomes. Desired outcomes not only encompass better quality of care and experienced quality of life, but also a better health of the environment, more social capital and social participation and better quality of public services overall.

Maintaining a longitudinal view and vision leaves room for the inevitable but very necessary learning curve. Moving too quickly to a traditional evaluation logic could lead to premature and erroneous conclusions that would underestimate the value and potential of ICC initiatives.

5 THE LANDSCAPE OF ICC PRACTICES

Building on the typology (introduced in section 3.4) and the effectiveness principles discussed above (section 4), we now discuss three examples of practices that are emblematic for the emerging practice of Integrated Community Care ('community health centers', 'caring communities' and 'healthy place-making'). For each practice we include:

- the core idea that supports the practice;
- its positioning in the typological framework;
- its alignment with the effectiveness principles of ICC.

5.1 / COMMUNITY HEALTH CENTRES

CORE IDEA: Community health centers (CHC) aim to meet a territorially defined group of citizens' needs by offering high quality, accessible and integrated primary care from a broad, psychological and social perspective. The patient is considered as someone with a personal history within the context of a family, a community and a professional and socio-economic environment.

CHC usually house several healthcare providers (general practitioners/family physicians, nurses, physiotherapists, social workers, psychologists, etc.) under one roof. These professionals form part of what is commonly known as the "primary care" network and work in a interdisciplinary fashion.

With its activities, a CHC wants to contribute to an open, solidary, just and sustainable society with attention and respect for diversity in all its aspects. In organizing and providing care, the CHC applies the principle of proportionate universalism. The supply is qualitatively and quantitatively attuned to the goals and care needs of patients and local residents. Community health centers have the capability to deliver a broad array of primary and preventive care services, and to offer numerous enabling services such as case management and health education.

TYPOLOGY: The slider bars for ICC could be positioned as illustrated: professionals and grassroots organizations as the main drivers; taking a well-balanced focus and a broad view on intervention, prevention, promotion, empowerment and education and investing heavily in partnerships and community assets as significant building blocks. Since community health services aim to keep individuals and families in better health by taking into account their environment and social conditions, 'environment' was also identified as an important focus.

PRINCIPLES: In light of the effectiveness principles, CHC are almost a textbook example of 'strengthening community-oriented primary care' (principle 3) and 'improving the health of the population and reducing health disparities by addressing social determinants of health and investing in prevention and health promotion' (principle 4).

RELATED PRACTICES: Primary care centers, team-based primary care, community clinics, community mental health centers, Foundry Centers, Headspaces, Medical homes, Maisons médicales...

5.2 / CARING COMMUNITIES

CORE IDEA: Caring Communities (CC)[4] promotes collaboration between different members of the community, capitalizing on the ability of patients and citizens to create social connections and take care of each other. The mission is to partner with patients, citizens, professionals and decision-makers to bridge informal and professional care.

Patient and citizen partners meet with patients on a regular basis to discuss issues related to their illness, social situation, life project, and find ways to reduce the impact of obstacles on their daily life as citizens, by collaborating with other members of the community (e.g. patient's family, clinician, community worker).

The idea of a 'caring community' can represent an enormous diversity of practices, drivers, target groups and aspirations. However, in many cases, CC originated within a primary care setting, where project co-leaders started caring together for patients in situations perceived as "clinical gridlocks" by professionals.

4 www.caring-community.ca

TYPOLOGY: Since balanced power relations and shared problem-solving and solution design are key within the logic of CC, the 'driver sliders' should illustrate this balance.

Regarding the focus, it seems that care issues (in their full breadth) often also serve as a useful vehicle for working together on both personal and community-related care and wellbeing issues.

In CC practices building alliances and partnership seems to be the main ingredient. Investing in these alliances could create a secondary, reinforcing spillover effect: if people are acknowledged and supported in their self-care and informal care capacities, then it is likely that they will take those skills, knowledge and attitudes with them and apply them within their own network and community (i.e. the home, place and assets dimensions).

PRINCIPLES: Most of the effectiveness principles are, to a greater or lesser extent, interwoven somewhere in the idea of CC. For example, there is the valuing and fostering of the capacities of all actors (principle 1), there is the importance of building local alliances, of investing in balanced power relations and of working towards shared goals (principle 2) and there is the overall aim of supporting strong and inclusive communities (principle 5).

RELATED PRACTICES: Vibrant communities, Caring neighbourhoods, Quartiers solidaires, Caring School Communities, Compassionate communities, The FOCUS program (Family AIDS Caring Trust), Franklin County Caring Communities, The Weaver movement (Aspen Institute)...

5.3 / HEALTHY PLACE-MAKING

CORE IDEA: The places we live in have a profound impact on our health and wellbeing. Significant gains in population health can be achieved by working in partnership to improve the built, natural and social environments. Health-promoting infrastructure, activities and opportunities need to be accessible to all, with a targeted focus on groups with the poorest health outcomes.

Healthy place-making[5] works in part by acting as a connector and catalyst in local systems. Participating sites often start with creating a small team of people with explicit responsibility for bringing partners together and facilitating dialogue across sectors. There needs to be concerted action on health inequalities as part of efforts to create healthy places, informed by data on the specific health needs of local communities.

The idea of 'healthy place making' encompasses various layers. On one level, 'place-making' refers simply to the planning, design and management of public spaces. However, it is also used to describe a broader perspective that emphasizes not just the spaces themselves but how people use them, based on the belief that thriving neighborhoods and inviting public spaces play a profoundly important role in community life. When put into practice, the approach often places significant value on collaboration and co-design between professionals and local people. The concept of 'healthy place-making' builds on this by asserting that an explicit goal of those involved in place-making should be to improve the health and wellbeing of the local population.

TYPOLOGY: Health place-making could be initiated in various ways; because of a local policy decision, as result of a grassroots initiative, instigated by primary care organization signaling environmental or planning deficiencies... The dominant focus will usually be wide of scope and rather mixed or hybrid. After all, healthy place-making presupposes a broad vision on health, with ample attention to social determinants, the impact of the environment, etc. Here, too, it is about the local aspect, about strengthening and involving people, about making citizens a partner in what would otherwise be considered purely as planning or policy matters.

5 *https://www.designcouncil.org.uk/resources/report/healthy-placemaking-report*

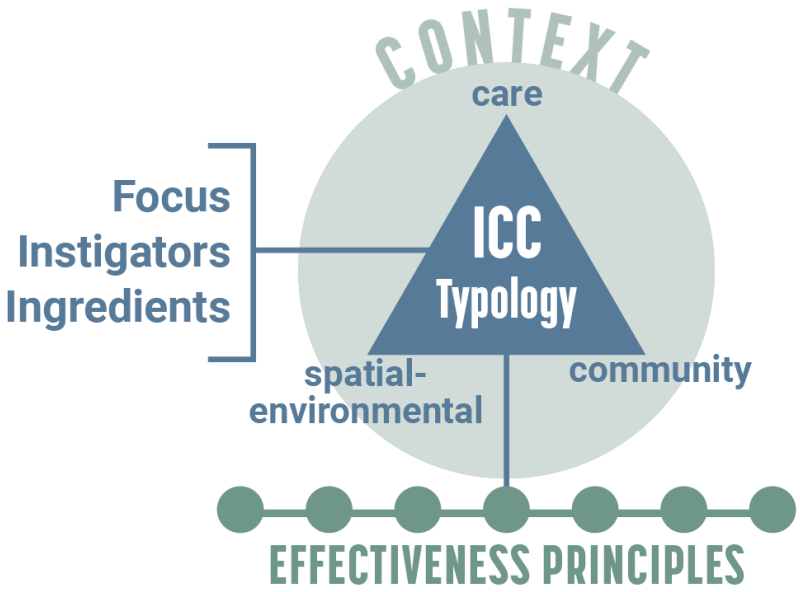
PRINCIPLES: Place-based interventions are often designed to improve population health and strengthen community bonds simultaneously (principle 4 & 5). The practice is highly engaging and activating: citizens are encouraged to voice their concerns and opinions, to think along and to collaborate (principle 2). Such a focus on dialogue and involvement also helps to create informal moments to talk about health, prevention and promotion with local communities and target groups. (principle 3).

RELATED PRACTICES: Healthy New Towns Programme (NHS), Healthy Communities Corridor Project, Good Places, Better Health (Scotland)...

6 A SYSTEMS VIEW ON INTEGRATED COMMUNITY CARE

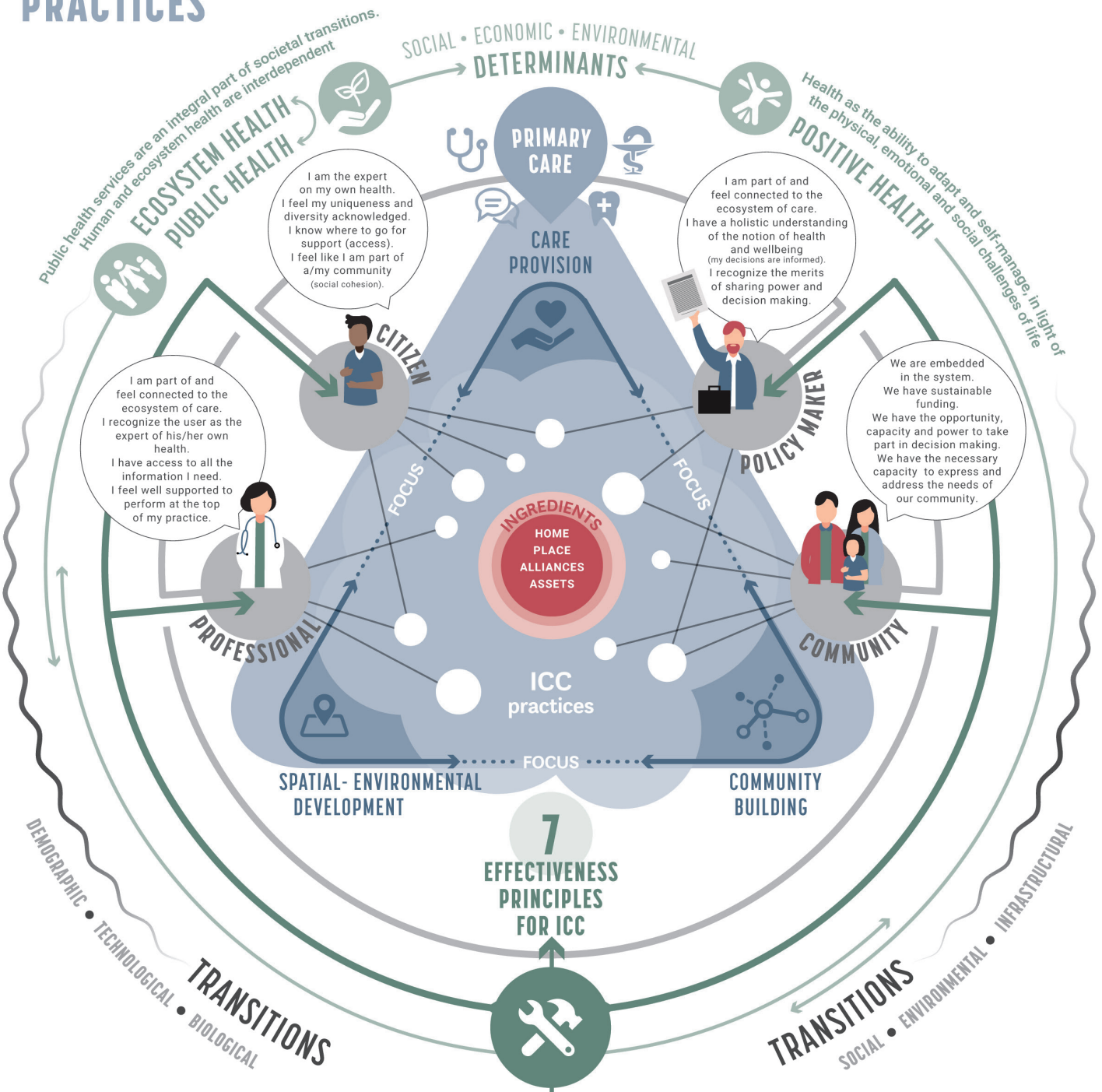
The diagram below summarizes much of the discussion in the previous sections. It schematically represents the landscape of Integrated Community Practices. The visual consists of three basic elements:

- the typology ('slider' model) discussed in section 3.4 (with 'drivers', 'focus' and 'ingredients' as key underpinning elements; represented by the elements connected to the blue triangle at the centre of the visual);
- the context within which Integrated Community Care is taking place (multiple societal transitions, an uptake of positive health, the interdependence of human and ecosystem health and crucial role of public health in enabling these transitions; represented by the concentrically arranged grey elements);
- the seven effectiveness principles for Integrated Community Care (co-develop health and wellbeing; build resilient communities; monitor, evaluate and adapt) at the bottom.



The full diagram is shown below.

THE LANDSCAPE OF INTEGRATED COMMUNITY CARE PRACTICES



1 **VALUE**
and foster the capacities of all actors, including citizens, in the community to become change agents and to coproduce health and wellbeing. This requires the active involvement of all actors, with an extra sensitivity to the most vulnerable ones.

2 **FOSTER**
the creation of local alliances among all actors which are involved in the production of health and wellbeing in the community. Develop a shared vision and common goals. Actively strive for balanced power relations and mutual trust within these alliances.

3 **STRENGTHEN**
community-oriented primary care that stimulates people's capabilities to maintain health and/or to live in the community with complex chronic conditions. Take people's life goals as the starting point to define the desired outcomes of care and support.

4 **IMPROVE**
public health and reduce health disparities by addressing the social, economic and environmental determinants of health in the community and investing in prevention and health promotion.

5 **SUPPORT**
healthy and inclusive communities by providing opportunities to bring people together and by investing in both social care and social infrastructure.

6 **DEVELOP**
the legal and financial conditions to enable the co-creation of care and support at community level.

7 **EVALUATE**
continuously the quality of care and support and the status of health and wellbeing in the community by using methods and indicators which are grounded within the foregoing principles. Provide opportunities for joint learning. Adapt policies, services and activities in accordance with the evaluation outcomes.

CO-DEVELOP HEALTH AND WELLBEING, ENABLE PARTICIPATION

BUILD RESILIENT COMMUNITIES

MONITOR, EVALUATE AND ADAPT

7 WRAP UP

Key in ICC is the move beyond 'delivery' of health and social care systems to genuine 'co-development' with the individuals and communities that are traditionally seen as recipients.
It gains pertinence against the background of deep trends in society and in health care systems.
ICC connects to a positive, empowering conception of health. It also wants to be a positive force for change in the multiple transitions to a new, sustainable equilibrium for our societies.

Therefore:

- ICC engages and empowers people in local communities
- ICC assumes accountability towards a territorially defined population
- ICC is inclusive and reaches out to underserved and marginalised groups
- ICC's activates and reinforces the social ties between people
- ICC is goal-oriented in nature, supporting people's priorities and life goals
- ICC requires social, economic and environmental determinants to be properly addressed
- ICC comes down to a continuous process of whole-system innovation
- ICC requires a social movement to make it a reality.

ANNEX 1
LIST OF PARTICIPANTS TO THE EXPERT WORKSHOP ON INTEGRATED COMMUNITY CARE, BRUSSELS, 28 & 29 NOVEMBER 2019

	Name	Organisation	Country
1	Sibyl Anthierens	University of Antwerp — Research in Primary Care	Belgium
2	Corinne Bebin	City of Versailles	France
3	Tom Braes	shiftN, Strategy consultants	Belgium
4	Valeria Cappellato	Compagnia di San Paolo	Italy
5	Alice Casagrande	Fédération des Etablissements Hospitaliers & d'Aide à la Personne Privés Non Lucratifs (FEHAP)	France
6	Yves Dario	King Baudouin Foundation	Belgium
7	Jan De Maeseneer	Ghent University	Belgium
8	Philipp Dickel	Poliklinik Veddel	Germany
9	Nieves Ehrenberg	International Foundation for Integrated Care	United Kingdom
10	Simona Guagliardi	European Policy Centre	Belgium
11	Stephanie Häfele	Robert Bosch Stiftung	Germany
12	Danielle Kemmer	Graham Boeckh Foundation	Canada
13	Patrizia Luongo	Forum on Inequalities and Diversity	Italy
14	Jean Macq	Université Catholique de Louvain, Institute of Health and Society	Belgium

	Name	Organisation	Country
15	Luisa Marino	Network of European Foundations	Belgium
16	Sari Massiotta	Trieste Local Health Authority	Italy
17	Karine Pouchain-Grepinet	Fondation de France	France
18	Gerrit Rauws	King Baudouin Foundation	Belgium
19	Anita Reboldi	Compagnia di San Paolo	Italy
20	Peggy Saïller	Network of European Foundations (NEF)	Belgium
21	Nathalie Senecal	Fondation de France	France
22	Sanja Simic	Conconi Family Foundation	Canada
23	Monica Sorensen	International Foundation for Integrated Care	United Kingdom
24	Thérèse Van Durme	Université catholique de Louvain, Institute of Health and Society Be.Hive, Interdisciplinary Chair Dr. Daniël De Coninck	Belgium
25	Philippe Vandenbroeck	shiftN, Strategy consultants	Belgium
26	Tinne Vandensande	King Baudouin Foundation	Belgium
27	Emily Verté	University of Brussels & University of Antwerp Primary Care Academy, Interdisciplinary Chair Dr. Daniël De Coninck	Belgium