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PRIMARY PROVIDER RELATIONSHIP MODEL FOR IMPLEMENTING HEALTH CARE PATHWAYS

The USAID Local Health System Sustainability Project

Task Order 1, USAID Integrated Health Systems IDIQ

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The USAID Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will strengthen local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Abt Associates
6130 Executive Boulevard | Rockville, Maryland 20853
T: 301.347.5000 | F: 301 652.3916 | www.abtassociates.com

CONTENTS

ACRONYMS

APS	Primary Healthcare
DTS	Health Territorial Directorate
EAPB	Benefit Plans Administration Entity
IVC	Inspection, Surveillance, and Control
MIAS	Healthcare Model
MSPS	Ministry of Health and Social Protection
PAHO	Pan American Health Organization
PAIS	Comprehensive Health Care Policy
PPSS	Policy of Social Participation in Health
PSPIC	Public Health Plan for Collective Interventions
RIAMP	Pathway for Maternal and Perinatal Health care
RIAS	Comprehensive Health Care Pathway
RNAO	Registered Nurses' Association of Ontario
RPMS	Pathway for the Promotion and Maintenance of Health care
SGP	Budget Allocation General System
SGSSS	General Health and Social Security System
SIVIGILA	National Public Health Surveillance System
SNS	National Health Superintendence
SOGCS	Mandatory System to Ensure Quality in Health
UPC	Capitation Payment Unit

1. SUMMARY

This document proposes a model to improve the relationship among stakeholders involved in the implementation of the Colombian Pathway for the Promotion and Maintenance of Healthcare (RPMS) and the Pathway for Maternal and Perinatal Health care (RIAMP). The purpose of this effort to improve these relationships is to ensure the successful delivery of the Comprehensive Healthcare Pathways (RIAS), strengthening the Colombian health system to meet the health care needs of migrant and host communities. The proposed model focuses on the needs of the primary care provider which serves as the entry point to the health system. Various national stakeholders, including the Ministry of Health and Social Protection (MSPS) and the National Health Superintendence (SNS) collaborated to prepare the model using a participatory methodology. In addition, territorial entities, including the Territorial Health Directorates (DTS), health secretariats, health insurers (known in Colombia as Benefit Plan Administrators, EAPB), and health care providers in six regions of the country provided input for this model.

The proposed model identifies challenges and requirements for establishing an effective relationship. Based on this information, LHSS developed a theoretical-practical archetype that outlines the foundational elements of the model, its components, and strategies for its implementation. The strategies focus on building trust and respect and establishing a shared purpose among the stakeholders responsible for providing health services to the population. Lastly, following a process to determine the priorities of several system stakeholders, the document provides recommendations for implementing the model with a series of operational tools to ensure the successful delivery of the RIAS.

2. INTRODUCTION

The Colombian health system has extensive experience in adapting its services to the available resources, population needs, and system challenges. Over time, the General System of Social Security in Health (SGSSS) has undergone changes and adjustments to improve its operation. The most recent change to the SGSSS involved the recognition of health as a fundamental human right, as reflected in Colombia's constitution.

In 2015, the MSPS introduced the Comprehensive Health Care Policy (PAIS), which established a new health care model that would be implemented through Comprehensive Healthcare Pathways (RIAS). The RIAS are public policy instruments aimed at improving the health of individuals, families, and communities. Each RIAS is composed of a series of health services or interventions to address specific health conditions, tailored to the risk level of the population.

To ensure proper implementation, the MSPS conducted an analysis of the health status of the Colombian population and identified variations across territories, environments, disease prevalence, and risk factors. This analysis led to the creation of three categories of RIAS: universal RIAS, which focuses on promotion and risk management across different stages of life, RIAS for at-risk groups; and RIAS for special health situations or conditions.

The implementation of RIAS relies on collaboration and the existence of an effective relationship among all SGSSS stakeholders. Each RIAS identifies individual and collective interventions and the parties

responsible for their implementation. However, timely and smooth coordination among stakeholders and effective relationship management are key factors for successfully implementing the RIAS, strengthening the health system's capacity to improve health outcomes for the Venezuelan migrant and host communities.

The current health landscape relies heavily on relationships and implicit agreements among stakeholders, but RIAS requires a specific, defined relationship model to ensure commitments between stakeholders and establish transparent rules for participation and collaboration. Since there were no existing guidelines for developing such a model, it was necessary to create one based on current definitions, models from other sectors, and the experiences of institutions and individuals involved in the system.

This document presents a Relationship Model for the stakeholders involved in the implementation of two specific RIAS: the Pathway for the Promotion and Maintenance of Health Care (RPMS) and the Pathway for Maternal and Perinatal Health Care (RIAMP). To develop this model, LHSS conducted a review of the regulatory framework and technical documents and conducted interviews with key stakeholders from the Colombian health system that are involved in the implementation of these RIAS. This process included health providers, the EAPBs, the departmental, district, and municipal health secretariats, and national entities including the SNS and the MSPS.

This assessment phase allowed LHSS to understand the role of relationships from the stakeholder's perspective and identify the critical issues that could jeopardize the system, as well as determine the elements for a successful implementation. This assessment, along with a methodical approach to information and knowledge management, served as the foundation for the model presented in this document.

3. BACKGROUND / CONTEXT

The MSPS introduced PAIS on June 9, 2015, which marked a strategic reorientation of the health system (Ministerio de Salud y Protección Social, 2016). This policy replaced the Territorial Action Model (MAITE) and its predecessor the Comprehensive Model for Health Care (MIAS). One of the strategies for implementing PAIS is the development of RIAS, through which PAIS aims to strengthen the capacity of system stakeholders to provide high-quality health services and improve the population's health status (Moreno Gomez GA, 2016). The MSPS proposed to first implement the RPMS, which is directed at all residents, and the RIAMP, which targets prioritized, at-risk groups, namely pregnant individuals, mothers, and infants. The MSPS prepared a gradual implementation schedule for these pathways, but the COVID-19 pandemic disrupted this schedule.

Several institutions and entities have started implementing both RIAS pathways, which allowed LHSS to assess the implementation status, analyze any challenges encountered, and define the next steps in this process. The assessment considered the key elements of health systems that utilize the Primary Health Care (PHC) approach, the context of the territories, and the expectations for each stakeholder. A holistic way to approach this assessment was by looking at the relationships among stakeholders to identify the strengths and opportunities of each stakeholder and their relationship with the rest, and how these relationships contributed to expected results (Ministerio de Salud y Protección Social, 2018).

Considering the structure and operation of the Colombian health system, the primary provider plays a crucial role in operationalizing the PAIS. In 2021, LHSS Colombia prepared a proposal titled "*Operational*

model for the primary provider with a comprehensive and territorial health care approach," which validated the important role of primary providers in the system. This document established the following statement:

> "*The primary provider is a functional and administrative unit that organizes and manages health care services included in the primary component of the Health Care Provider Networks. It is the entry point for individuals, families, and communities into the SGSSS; it is the lynchpin for the development of different primary health care strategies aimed at improving the health of the target population*".

Therefore, this process will strengthen the primary provider's capacity to play an intermediary role in delivering comprehensive health care to individuals, families, and communities (Blanco et al., 2021).

As such, primary providers must restructure their processes, fulfill clearly defined duties, and develop the capacity to fulfill such duties more effectively. In addition, they must collaborate with other stakeholders participating in cross-sectoral initiatives. Primary providers are key stakeholders and should exercise effective leadership to drive improvement in the population's health through the implementation of the PAIS, its strategies, and approaches at the territorial level (Blanco et al., 2021).

System stakeholders must collaborate to respond to challenges presented by the epidemiology and demographic makeup of the target population. It is important to note that in the last five years, the Colombian health system has absorbed a substantial portion of the Venezuelan migrant population. This population has not only increased the demand for health services but also brings the risk of increased transmission of diseases across borders. To comply with international agreements, the Colombian health system must adjust to guarantee the migrant population's right to comprehensive health services. As such, the migrant population must be fully integrated into the Colombian health system, from enrollment in insurance to access to services through health networks, including those provided under RIAS. In this context, the Relationship Model can improve primary providers' response to the challenges facing the Colombian health system and advance the sustainability of the primary health care system. This document outlines the process of creating the Relationship Model and includes the components, strategies, and tools necessary to implement the Model. LHSS Colombia and the MSPS selected system stakeholders from six territories to validate the model. To support implementation, LHSS designed a dashboard for primary providers to monitor and evaluate commitments made by the various stakeholders, and developed a virtual, self-guided course to train health provider leaders and managers.

4. FRAMEWORK FOR THE MODEL

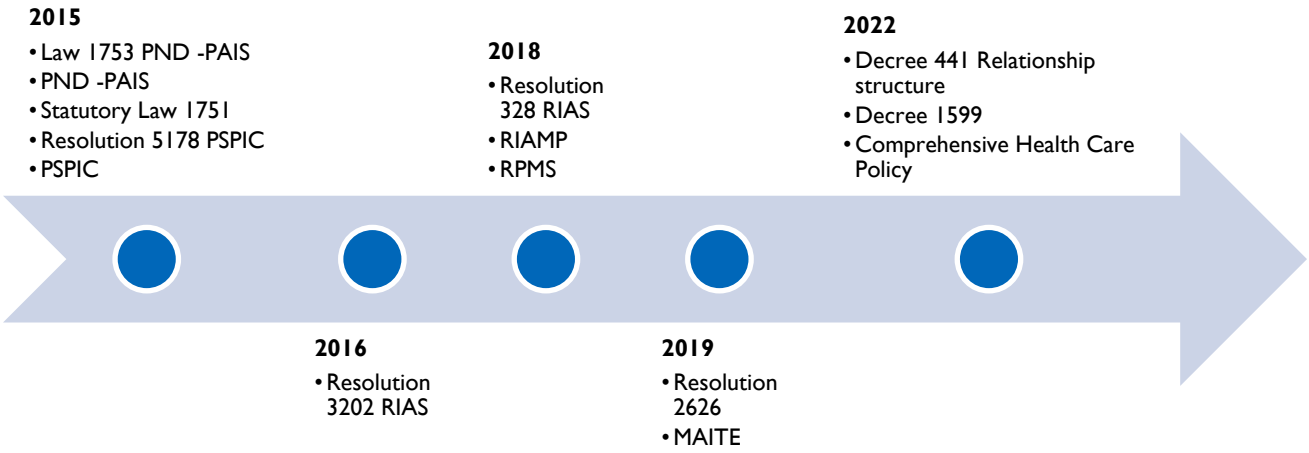
4.1 REGULATORY FRAMEWORK

The current regulatory framework is the starting point in the construction of the Relationship Model since it reflects the intentions of the National Government in its proposals for the adjustment to the Colombian health system. The following timeline (Figure 1) outlines the "Regulatory Milestones" that support the relationships among stakeholders within the framework of the RIAS. These relationships are based on the Health Statutory Law, which reaffirms health as a fundamental right, defines health-related regulations, and guides the relationships among stakeholders in the contractual framework. A chart with the regulatory framework and the hierarchy of laws and regulations is included in Annex 1 (Presidencia de la República, 2022).

In this regulatory context, Decree 4747/2007 (Rodríguez Jiménez, 2007) defined the main rules for the contractual relationship between health providers and entities responsible for the payment of health services. More recently, the MSPS issued a ruling (Ministerio de Salud y Protección Social, Decreto 441de 2022, 2022) that aims to strengthen relationships between providers and insurers by improving the management of contracts and monitoring of execution. The regulation limits the fragmentation of contracts by requiring that that a single institution delivers all services and interventions of each RIAS, in order to avoid delays in services to patients, avoid unnecessary authorization requests, and to improve integration among disciplines.

The EAPBs are responsible for presenting the health care pathways, characterizing the population, and sharing other information required by the service provider. On the other hand, the providers must present their model to deliver health care services, describing their existing capacity and the services they will provide. Both entities integrate indicators from the Mandatory Health Quality Assurance System (SOGCS) into their models.

Figure 1. Regulatory Milestones



Source: Prepared by the authors

Likewise, the contracting process includes technical notes, which can be frequently updated, that contain information on the characterization of the target population, the frequency of use of health technologies, the health care model, the agreed upon costs, and the frequency of conducting monitoring and evaluation processes.

The memorandum of understanding (MOU) between the EAPB and health providers should contain the following elements:

- General information about the target population, including data on their geographical location and demographic profiles.
- Services included under the contract.

- Mechanisms and forms of payment.
- Fees that should be applied for the payment units.
- Process and operation of the referral and counter-referral system.
- Frequency of submission of health care service information to the RIPS information system.
- Frequency and format of the audit program to improve quality and auditing of accounts.
- Auditing, monitoring, and evaluation mechanisms of the obligations during the MOU period of performance.
- Mechanisms to resolve disputes.
- Mechanisms and terms for liquidating and terminating the MOU according to the regulatory framework specific to each case.

Designing a proposal for a realistic and sustainable relationship model requires understanding the regulatory provisions that guide stakeholders who serve as the guarantors of the fundamental right to health and comprehensive primary health care.

4.2 HEALTH CARE PATHWAYS AND THEIR STAKEHOLDERS

The RIAS is a tool that brings together health sector stakeholders and their responsibilities and determine the necessary conditions to ensure the provision of adequate, comprehensive health services to individuals. RIAS also determine the systemic interventions needed to promote the well-being of people in different environments. The RIAS define prevention, diagnosis, treatment, rehabilitation, and palliative care interventions (Ministerio de Salud y Protección Social, 2018).

The RPMS and the RIAMP define comprehensive health care services essential for improving the health of individuals, families, and communities. These pathways are mandatory operational tools to be implemented throughout the country. The pathways also indicate the health sector stakeholders involved in implementing these pathways (territorial health directorates, EAPB, entities responsible for special schemes, and health providers) and the conditions required to promote health and prevent disease. In addition, RPMS and RIAMP contribute to the creation of a culture of care for all individuals, families, and communities to guarantee the fundamental right to health (Ministerio de Salud y Protección Social, 2018).

The following sections feature an inexhaustive list of the core elements that guide the implementation of the RIAS. This section also identifies the critical responsibilities of the following stakeholders: departmental, district, and municipal health directorates, the EAPBs, and the health providers. Annex 2 outlines these duties according to the regulatory framework.

4.2.1 PATHWAY FOR THE PROMOTION AND MAINTENANCE OF HEALTHCARE: CORE ELEMENTS

- Recognizes individuals, families, and communities living in a territory (urban, rural, and dispersed rural) as the target population, with particular needs and environmental conditions that should be considered for the provision of health services.
- Specifies the health services required throughout the different stages of life, recognizing that these stages are highly interdependent. Additionally, it describes how health-related experiences are cumulative over time and impact the health and development of future stages.

- Recognizes one's surroundings as: i) spaces that promote well-being and healthy individual and collective development; ii) management units where actors from different sectors participate in the wellbeing and development of beneficiaries.
- Identifies territorial needs and utilizes the services offered by the individual and collective benefit plans to address such needs. This enables the provision of complementary and adequate health services to ensure comprehensive health care throughout different stages of life.
- Organizes the management and provision of holistic health services utilizing an individual, family, and community-centered approach, which implies moving past a health care management approach fragmented across specific programs or thematic strategies.
- Brings together a complete and adequate network of health providers to guarantee the implementation of the RPMS interventions in primary care.
- Coordinates the RPMS interventions needed by individuals and families and those recommended by the multidisciplinary health teams as part of the comprehensive primary health care plan.
- Complies with quality standards and respectful treatment of patients, creates spaces for dialogue to address the concerns and expectations of individuals, families, and communities, and ensures the confidentiality of patient information.
- Conducts nominal and longitudinal monitoring of the health outcomes, facilitating the assessment of potential exposure to physical and social risks that could impact the population's health.

4.2.2 PATHWAY FOR PERINATAL AND MATERNAL HEALTHCARE: CORE ELEMENTS

- Recognizes women of child-bearing age as health care beneficiaries, aiming to fulfill their rights included in international human rights treaties, particularly those that safeguard the right to health and a life free of violence.
- Provides health care services to women during stages of their reproductive cycle without inflicting violence against women, including unjust treatment, psychological violence, negligence, or discrimination based on gender, social class, ethnicity, disability or another condition or situation.
- Organizes the management and delivery of health care services for expectant mothers and their families, which implies moving beyond health care management by individual thematic strategies and towards one integrated strategy to guarantee comprehensive health care.
- Brings together an adequate full-service network that ensures access to primary and complementary RIAMP interventions (Ministerio de Salud y Protección Social, 2016), based on the criteria of proximity, availability, and accessibility. Facilitates access to the interventions included in the pathway without requiring additional authorization.
- Develops the comprehensive primary health care model as an instrument for specifying the health care interventions that are needed by expectant mothers and their families and those recommended by the multidisciplinary health teams.

4.2.3 RESPONSIBILITIES OF THE RIAS STAKEHOLDERS

Managing the collaborative implementation of the RIAS requires identifying the stakeholders and defining their roles and responsibilities. The general responsibilities of the entities responsible for implementing RIAS are defined in the Resolution 3280/2018 (Ministerio de Salud y Protección Social, 2016, 2018) as follows:

MSPS

- Develops the RIAS in accordance with the country's health priorities, which reflect the epidemiological conditions of the Colombian population.
- Provides guidance and technical assistance to the SGSSS stakeholders and other entities responsible for implementing health-related initiatives in strengthening capacities to adopt, adapt, implement, monitor, and evaluate the RIAS.

Territorial Health Directorates - Departments and Districts:

- Provide guidance and technical assistance to strengthen the capacities of SGSSS stakeholders and other related entities within their jurisdiction to adopt, adapt, implement, monitor, and evaluate the RIAS.
- Monitor and oversee the adoption, implementation, adaptation, and evaluation of the RIAS. Report any RIAS interventions not implemented to the SNS.

Territorial Health Directorates - Municipal:

- Participate in activities related to the implementation, adaptation, and evaluation of the RIAS organized by the respective Department.
- Participate in technical assistance processes led by the respective department to develop or strengthen capacities to implement, adapt, and evaluate the RIAS.

Benefit Plan Administrators:

- Adopt, adapt, and implement the RIAS in collaboration with other SGSSS stakeholders that operate in the territory to ensure that the target population receives comprehensive care.
- Collaborate with health providers to determine the mechanisms that ensure effective access to the primary and complementary health care services established in the RIAS.

Health Providers:

- Prepare and adjust the required processes and technologies to ensure the implementation of the RIAS.
- Ensure users' effective access to health services and technologies indicated in the RIAS. Providers should review their health care model and adapt it for the RIAS.
- Establish the mechanisms to monitor and evaluate the operation of the RIAS in collaboration with EAPBs, and other entities responsible for delivering health services.

SNS:

- Monitors and enforces compliance with provisions established in Resolution 3202 of 2016. The departmental, municipal, and district health entities will notify the SNS regarding any breach of the provisions of the Resolution, to which the SNS will respond with corresponding legal actions.
- Performs the actions stated above without undermining the monitoring and evaluation initiatives under the authority of the MSPS and the district and departmental health secretariats.

Annex 2 lists the responsibilities and roles of the stakeholders and their interactions according to Resolution 3280/2016 (Ministerio de Salud y Protección Social, 2018).

The territorial health directorates, the EAPBs, and other territorial-level actors identified the priorities in their jurisdictions. Such priorities will guide their actions to ensure the effective delivery of individual or collective RIAS interventions. In addition, the priorities will guide the implementation of mechanisms to guarantee the complementarity of these interventions (Ministerio de Salud y Protección Social, 2018).

For the proper relationship among stakeholders to function, the EAPBs should engage in contracts to guarantee health services for their insured population. These contracts should aim to coordinate services and ensure effective access to high-quality health services.

The Public Health Plan for Collective Interventions (PSPIC) is vital in implementing the RIAS, particularly the RPMS. The health secretariats are responsible for preparing and executing the PSPIC, usually contracted through health care providers, with a priority given to public providers. Two resolutions regulate the implementation of the PSPIC: Resolution 518/2015, which describes the strategic approach to public health management; and Resolution 3280/2018, which describes the set of interventions, procedures, or activities that aim to promote health and manage risks for different population groups. The PSPIC should be planned and prepared based on the territorial priorities and aligned with the Territorial Development Plan and the Territorial Health Plan.

Collective interventions should consider a population's environments and surroundings, including their home, schools, community, and workplaces, and other institutions. In each of these environments, the health system aims to implement the following activities listed in the technical annex of Resolution 3280/2018 through the following activities:

- Analyzing social and environmental context.
- Disseminating health information.
- Promoting health education and communication.
- Preventing and controlling diseases.
- Forming family health networks.
- Conducting screenings.
- Hosting health workshops.
- Conducting vaccination campaigns.
- Purchasing and distributing medications or inputs for mass distribution to prevent, control, and eliminate public health emergencies.

The government established rules to ensure the implementation of sustainability and efficiency principles provided by Law 1751 of 2015 (Ministerio de Salud y Proteccion Social, 2015). The rules aim to improve

the relationships among agents of the system that procure services and technologies to enhance the quality of health services. To ensure the provision of comprehensive health services, they prohibit fragmenting the responsibility for providing a specific health service in a way that can have a negative impact on the health of patients.

4.3 KEY CONCEPTS

4.3.1 DEFINITION OF RELATIONSHIP

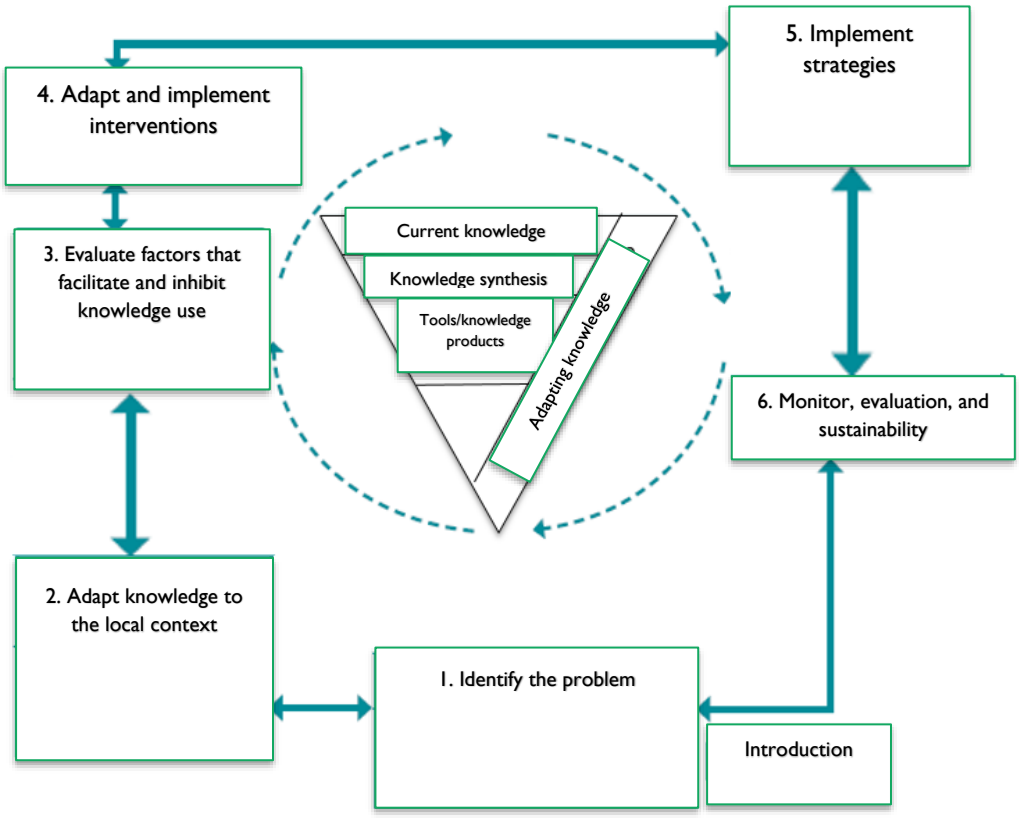
The relationship is the capacity to create, maintain, and expand a network of contacts based on value and trust, to facilitate planning and implementation of initiatives for stakeholders to meet, converse, and establish commitments. The relationship is a cyclical process, as each interaction between two or more stakeholders generates feedback and constant improvement.

4.3.2 KNOWLEDGE-TO-ACTION MODEL

The best way to understand a phenomenon is through those that have experienced it. Understanding the perspective of each stakeholder and the stakeholders as a whole allows the conceptualization of the phenomenon as a model or archetype (Carvajal Villaplana, 2002; Granados Oliveros & Esparza Bohorquez, 2020). Understanding the "relationship" phenomenon requires a theoretical-practical approach to identify its conceptual scope and key elements and define strategies to achieve a shared objective.

Implementing RIAS are considered the most direct way to improve the health of individuals living in Colombia, including the migrant population. After comparing several models, the Knowledge-to-Action framework or model of the *Registered Nurses' Association of Ontario (RNAO)* emerged as the most effective model to explain the relationship dynamics for the implementation of the RIAS. This model is used to create and adapt best practices through two components: creating knowledge through the identification of critical evidence and the creation of knowledge products; and the action, namely, the application of knowledge in practice (Granados Oliveros & Esparza Bohorquez, 2020). The Knowledge-to-Action's complete cycle involves identifying, validating, and adapting relevant knowledge to a specific area in six phases (Figure 2).

Figure 2. RNAO Knowledge-to-Action Model



Source: RNAO Tool (Granados Oliveros & Esparza Bohorquez, 2020)

Phases of the Knowledge-to-Action Model (Granados Oliveros & Esparza Bohorquez, 2020):

1. Identification of the theory and key knowledge of the phenomenon in which one wants to intervene.
2. Adaptation of knowledge to the context; identification of stakeholders and their interests.
3. Identification of barriers and facilitators of the process.
4. Selection, adaptation, and implementation of interventions.
5. Monitoring the use of knowledge and evaluation of results.
6. Ensuring sustainable use of knowledge.

The Knowledge-to-Action model was adapted to design the relationship model for the stakeholders involved in the RIAS. The phases of the relationship model include:

1. Identification of the needs of the system stakeholders in the relationship.
    - Interviews.
    - Bibliographical research.
2. Proposal of the relationship model.
    - Designing a relationship model.
        - Determination of critical points.
        - Conceptualization.

        - Definition of components.
        - Determination of strategies for each component.
    - Creating a training strategy.
    - Designing a monitoring and evaluation tool.
3. Implementation of a pilot project in the territories
    - Presentation and validation of the model.
    - Validation of the training structure.
    - Validation of the monitoring tool.
4. Training
    - Delivery of the course titled "*the presentation of the relationship model between the primary provider and other stakeholders for the implementation of the comprehensive healthcare pathways (RIAS)-RPMS and RIAMP*" and the monitoring tools.
    - Delivery of the course titled "*Training process for Managers and Leaders of the Primary Providers in the Relationship Model for the implementation of the RIAS*."
5. Definition of the relationship
    - A set of interactions among the different health system stakeholders that facilitate continuous, comprehensive health care services to patients and help stakeholders efficiently manage resources to maintain or improve the health of the country's residents.
    - Principles:
        - An environment of trust
        - A relationship based on respect
        - A common purpose
    - Pillars:
        - Transparency
        - Consensus
        - Collaborative work
    - Components:
        - Structural
            1. Management of the RIAS utilizing a territorial approach.
            2. Creation of unified and interoperable information systems.
        - Operational
            1. Strengthened capacities of institutions and human resources for health.
            2. Efficient management of contracting processes.
            3. Strengthened social participation.
            4. Implementation of effective coordination and communication.
            5. Monitoring and evaluation process.

5. MODEL TO STRENGTHEN THE INSTITUTIONAL RELATIONSHIPS FOR IMPLEMENTING THE RPMS AND THE RIAMP

5.1 OBJECTIVE OF THE MODEL

Strengthen the institutional relationship between the primary provider and the other stakeholders from the RPMS and the RIAMP to improve health outcomes. These stakeholders include health care providers (public or private), health secretariats, or other entities responsible for paying for health services.

5.2 THE RELATIONSHIP AMONG THE RIAS STAKEHOLDERS

The relationship is a set of interactions among the different stakeholders of the health system that facilitates the provision of comprehensive, continuous health services to system users and the efficient management of resources to maintain or improve the population's health.

A satisfactory relationship promotes the analysis and use of data, creation of mechanisms for direct communication with other system stakeholders, and implementation of initiatives to modify and improve the system. Relationships expand opportunities for collaboration and maximize the benefit of partnerships to both individuals and companies. In practice, this relationship is maintained through legal mandates or voluntary mechanisms.

An agreement is a mechanism that formalizes the relationship, typically through a contract. Under a contract, an agent (the contractor) agrees to comply with an agreement with another agent (the contracting party). This relationship has administrative, economic, and legal implications for the parties. Consortiums, temporary partnerships, and association agreements are other mechanisms to establish an agreement. Finally, it is important to recognize that some relationships are created by the structure of the health system through political or administrative lines of authority.

Voluntary relationship mechanisms are mechanisms that are not bounded by legal or administrative obligations. These mechanisms respond to a mutual desire to achieve common objectives. Some examples include voluntarily mechanisms for coordination or to solve disputes, such as through consensus meetings.

All relationship mechanisms have a human factor. Relationships, even among institutions, involve an essential interpersonal component. The lack of human engagement between members of the relationship threatens the institutional relationship.

Thus, a relationship model will not only create the conditions for the system stakeholders to establish effective relationships, but will also and consider human interaction as a vital component of the model. The relationship model is founded upon a set of basic principles concerning the ethical conduct of stakeholders. The following section analyzes these principles.

5.2.1 GENERAL PRINCIPLES OF THE RELATIONSHIP

The RIAS is a crucial tool that facilitates the provision of high-quality, timely, and comprehensive user-oriented health services. Collaboration among stakeholders is vital to implement this tool, which is highly dependent upon the existence of functional relationships with the common purpose of providing high-quality, comprehensive health services and meet the health needs of the target population. Various stakeholders of the health system outlined three conditions that are necessary to achieve a satisfactory relationship:

1. An environment of trust: Trust is the belief, expectation, and persistent faith in another person, entity, or group that such party will be competent to act appropriately in a specific situation or circumstance. Trust is reinforced or undermined depending on the results of the partnership.

2. Relationship based on respect: The parties will listen to each other as peers who must collaborate to achieve a shared purpose.

3. A shared purpose: A shared purpose is one of the core elements of the relationship that both stakeholders should want to achieve. In the case of the RIAS, the shared purpose is to improve the health of the target population (individual, family, and community).

5.2.2 FUNDAMENTAL PILLARS

Maintaining an effective and sustainable relationship depends on compliance with the agreed upon conditions, particularly on the creation of trust among the parties. Building trust is a complex process that is supported by three general pillars:

- Transparency: is required throughout the relationship and is defined as “laying all the cards on the table." Each stakeholder clearly understands their role and responsibilities and provides all of their expertise and capabilities to achieve the common purpose.

- Agreement: expressed through different mechanisms such as contracts, pacts, MOUs, and others, and is fundamental to dismantling any power structure within a relationship.

- Collaborative work: To execute the agreements and achieve the common purpose, stakeholders must collaborate and work together. Each of the parties involved must contribute their skills to optimize and overcome group weaknesses.

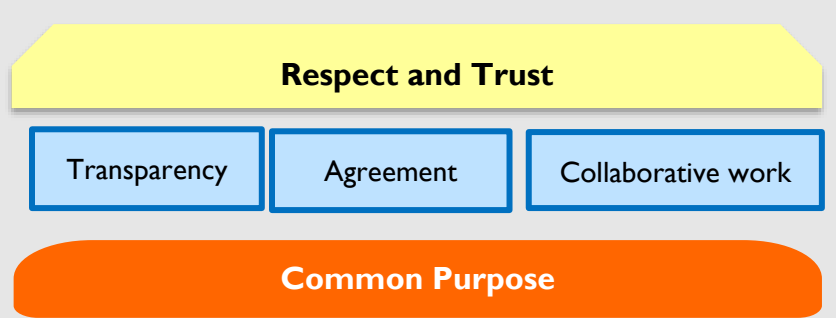
The health system should aim to provide individual and family-centric health services to promote the fundamental right to health. The common purpose is the factor that unifies stakeholders. In the business world, trust is the vector that sustains relationships between organizations and the value that enables effective relationships among the members of organizations. Likewise, trust is critical for implementing collaborative work in health systems; each stakeholder must strive to build and uphold such trust to achieve the common objective.

When creating a common purpose through the implementation of the RIAS, it is important to consider the following elements:

- The target population, based on a proper demographic, epidemiological, and socioeconomic analysis.
- Accurate information on rate of events, frequency of use, and health service costs.
- Agreement on quality standards and expected results.
- Analysis and agreement on the efficiency of the system.

Finally, improving the health of the target population depends on the will of the people who represent the organizations, their personal relationships, and the degree of mutual trust that exists between them.

Figure 3. General principles underpinning the relationship model



Source: Prepared by the authors

5.2.3 CRITICAL ISSUES FOR THE RELATIONSHIP MODEL

The stakeholders must overcome the following critical issues to improve relationships:

1. Mistrust among stakeholders.
2. Lack of coordination and lack of attention to territorial context in the implementation of the RIAS.
3. Regulatory changes that generate confusion among system stakeholders
4. Lack of spaces for collaboration.
5. Asymmetry of information between health providers and insurers.
6. Shortcomings in the institutional and managerial expertise of the primary providers.
7. Shortcomings in the single information system on billing and costs.
8. Lack of coordination between individual and collective actions.
9. Specific weaknesses in the training of human resources for health.
10. High frequency of staff turnover.
11. Lack of systems to monitor and evaluate relationship commitments.
12. Unfulfilled commitments regarding payments.
13. Shortcomings in the information and communication addressing the population.

Qualitative research tools, interviews with experts and regional focus groups determined the critical issues for building relationships. Groups of experts sorted and organized this information into the following categories:

1. The **contracting process** requires tools to assist with decision-making, primarily with finances, scheduling timely payments, billing, preparing technical notes, and creating interoperable information systems.
2. **Improved outreach and stakeholder training** is needed for the implementation of the RIAS**:** although standards are available, understanding these documents in their entirety is challenging.
3. There are shortcomings in the **financial management** process, specifically in the management and coordination of resources within the collective and individual health care systems, portfolio management and the collection of debts.
4. **Strengthening of the primary provider's capacities** is needed with respect to resources, infrastructure, and human resources for health. The assessment identified the following issues for human resources for health: high rate of staff turnover, weak training on the RIAS, and a lack of incentives for workers.
5. There is a need for structured and organized **training and technical assistance** for the relevant health staff, to be facilitated by health secretariats and the MSPS.
6. The creation of **comprehensive and integrated networks** are needed at the territorial level to strengthen the inspection, surveillance, and control processes within the health system.
7. The system requires **effective mechanisms for coordination and communication** that foster collaborative work, groups working to improve population health outcomes, and spaces to build trust among stakeholders.
8. There is a need to **develop effective leadership within the Health Secretariats** to restructure and adapt the services under the management of the EAPBs at the regional level.
9. It is necessary to have **interoperable information systems** that manage databases in real-time to support health-related decision-making processes. The systems should support monitoring and evaluation processes through comprehensive, timely, and reliable data repositories. Information systems are essential to resolving health system challenges, and they represent an opportunity to improve the organizations' processes.
10. **Trust** is a critical cross-cutting issue for stakeholders; all stakeholders must work to build and restore such trust, particularly the trust between each stakeholder and the community.

LHSS Colombia and the MSPS analyzed these ten emerging categories through meetings, and an analytical workshop and created seven components that currently comprise the relationship model.

5.3 COMPONENTS OF THE RELATIONSHIP MODEL AMONG HEALTH SYSTEM STAKEHOLDERS

Trust is the foundation of the model for interpersonal relations and well-being of system stakeholders. A lack of trust results in conflict and hinders the development of relationships and progress. The relationship process must therefore identify and strengthen factors that build and consolidate trust. The collaborative work phase identified several factors that enable the creation of a strong relationship, which are organized in seven categories (components) for building trust:

1. Strengthening institutional and human resource capacity.

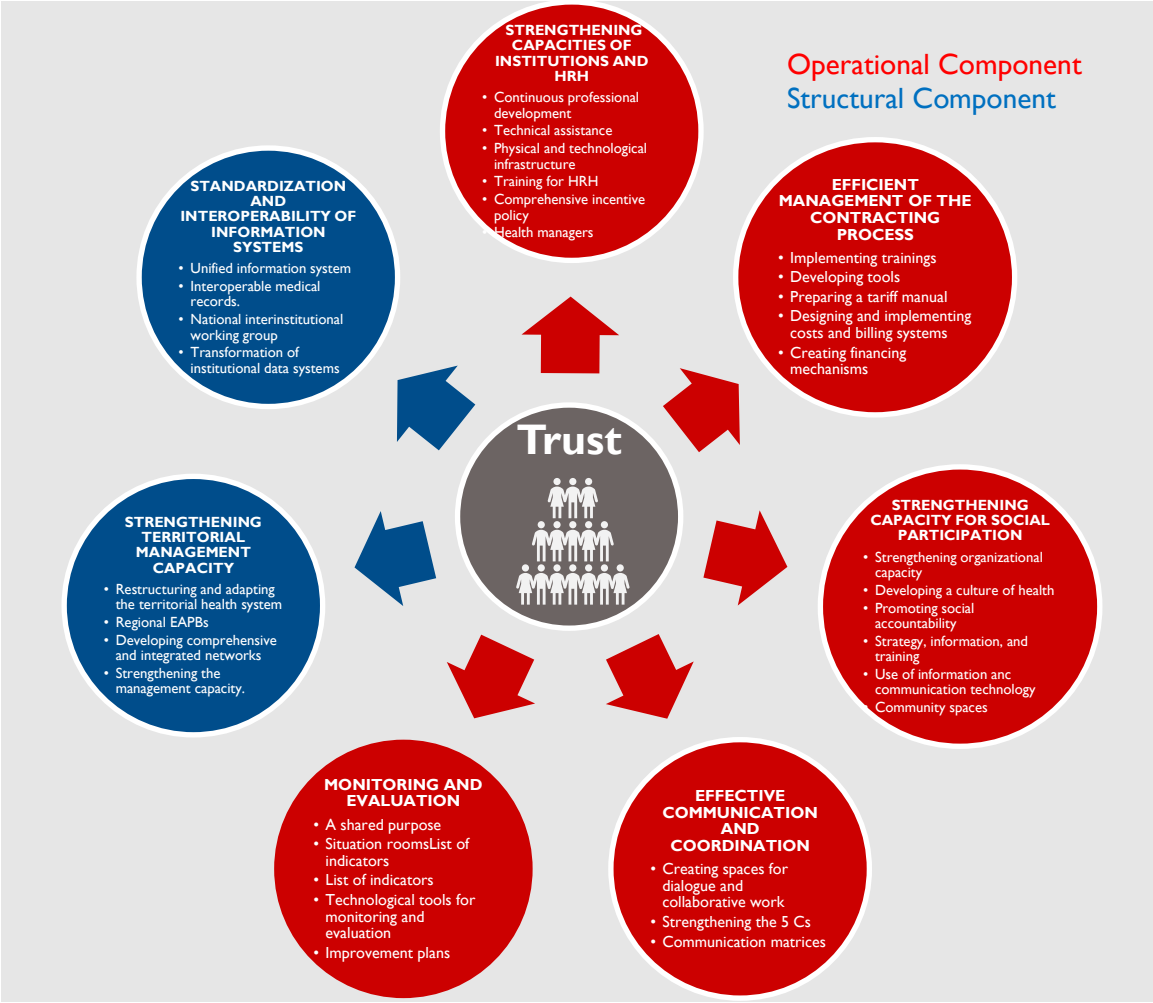
2. Efficient management of the contracting process.
3. Strengthening of social participation.
4. Effective coordination and communication.
5. Monitoring and evaluation processes.
6. Strengthening territorial management.
7. Standardization and interoperability of information systems.

These components comprise two broad categories.

5.3.1 OPERATIONAL COMPONENTS

This component refers to factors that build trust among stakeholders and may be strengthened in the short and medium term through the regular RIAS planning and implementation process within the current operational framework of the health system.

Figure 4. Components of the relationship model



Source: Prepared by the authors

5.3.1.1 STRENGTHENING CAPACITIES OF INSTITUTIONS AND HUMAN RESOURCES

To establish an effective relationship, it is necessary to strengthen the primary provider's technical, administrative, and management capacities. It is fundamental to strengthen the capacities of human resources for health, most importantly at the senior and administrative management levels, in both hard skills (technical) and soft skills (leadership, management, negotiation skills, etc.). On the other hand, it is essential to strengthen the decision-making capacities of public and private primary providers. The establishment of an effective relationship, first with the user and subsequently with the contractor, depends on the successful delivery of the services promised by the system. If the primary provider successfully strengthens its capacity to provide these services, it will build a more equal relationship with a contractor.

Capacity strengthening requires that the organization has a vision and a general framework, and that the organization aims to increase knowledge to solve a specific issue of interest. Through the capacity strengthening process, stakeholders increase their capacity to act, solve problems, establish objectives, and understand and address areas for improvement to achieve objectives in a timely manner. As such, it is necessary to identify the required capacities at an individual (technical and functional skills), administrative (identification of staff and strengthening of supervision and management capacity), and systemic level (improvement of the structural and operational capacity of systems).

It is necessary to strengthen communication, leadership, interpersonal, and creative skills to foster "soft" functional skills and dismantle power dynamics. Likewise, to strengthen financial and regulatory management, it is necessary to improve the advisory processes and technical assistance. There are four pillars of the capacity strengthening process: learning to know, learning to do, learning to be, and learning to experience together (Uribe et al., n.d.). This process promotes constant inquiry to catalyze positive change that strengthens capacities and improves trust among stakeholders. Learning can be measured by the development of individual and collective skills and perspectives, enabling individuals to understand their genuine interests, thus promoting change as a voluntary action, not a requirement (Uribe et al., n.d.).

Table 1. Strategies to strengthen institutional capacity

Strategies to strengthen institutional capacities	Entity Responsible			
	Primary Providers	EAPBs	HEALTH SECRETARIATS	MSPS
Create a permanent program for the professional development of human resources for health. This program will complement the training process according to the health system's specific needs and context. It should involve new educational approaches, including virtual education and the development of technical and administrative skills.				x
Strengthen technical assistance for addressing issues at the territorial level as a complement to the training process. The EAPBs and health secretariats will strengthen their capacity to provide this assistance. The MSPS will guide stakeholders through this process either face-to-face or virtually.		x	x	

Strategies to strengthen institutional capacities	Entity Responsible			
	Primary Providers	EAPBs	HEALTH SECRETARIATS	MSPS
Strengthen the physical and technological infrastructure of primary providers, which involves conducting an inventory of the primary provider's needs to ensure their infrastructure complies with requirements for the implementation of the RIAS. Support should also include the preparation of a finance and development plan for the primary providers, with the aim of strengthening technological capacity and providing the necessary logistical and administrative support, including connectivity.			x	x
Coordinate with the Ministry of Education and higher education institutions that train human resources for health to review the professional profiles and design strategies to improve the skills of graduates. This should take place during the territorial planning processes based on identified needs and intersectoral coordination.				x
Develop a comprehensive incentive policy for human resources for health that aims to reduce the current rate of staff turnover. The policy should include the strengthening of labor relations, a policy on salaries, and other non-financial incentives that improve the distribution, retention, and availability of human resources throughout Colombia.				x
Hire and retain community managers within the framework of the user-centric primary care model. The strategy will implement a policy to identify, train, and support community managers. Community managers are defined as "members of a community living in remote areas that support the development of specific RIAS interventions." It will be necessary to define the role, profile, and participation of the community health managers within the health system.	x			
Update the inventory of tools that support the primary provider's management processes and the implementation of the RIAS. In addition, this process will consolidate these tools and create a plan for dissemination and validation of tools and training of staff to implement them.			x	x
Design a plan to train health provider senior management on negotiation strategies.	x		x	
Strengthen the management capacity of departments, districts, and municipalities. In accordance with the 10-year Public Health Plan 2022-2031 and its strategic focuses, this strategy should target territorial entities through the implementation of a capacity evaluation plan, an assessment of gaps, and a territorial capacity-strengthening plan that aims to improve the following functions: inspection, surveillance, and control and technical assistance to system stakeholders for the implementation of the RIAS.				x

Source: Prepared by the authors

5.3.1.2 EFFICIENT MANAGEMENT OF THE CONTRACTING PROCESS

There is a direct relationship between trust and the contracting process. The execution of a contract not only fulfills legal requirements but also establishes trust among the stakeholders involved in this process (Bart, 2010). Signing a contract is an investment in the relationship, given that it ensures the existence of a level of trust and a shared purpose.

To efficiently manage contracting processes, providers must possess information systems, adequate costing and billing systems, and soft/hard management skills for proper negotiation and contract management. Efficient management will ensure transparency, equal relationships, and contracts based on mutual agreement.

Table 2. Strategies for the efficient management of the contracting process

Strategies for the efficient management of the contracting process	Responsible			
	Primary Providers	EAPB	HEALTH SECRETARIATS	MSPS
Develop simple tools to support primary providers during the three phases of the contracting process: pre-contractual, contractual, and post-contractual, including checklists and guidelines.				x
Analyze the importance of universal tariff manuals, regulatory charts, and form contracts for the implementation of the RIAS.				x
Strengthen costing and billing systems for primary providers.	x			
Develop studies to create proposals to modify the primary provider's financing mechanisms, including supply-side subsidies, locally pooled funds, and other mechanisms to counteract fragmentation in the use of resources and provision of health services.		x	x	x

Source: Prepared by the authors

5.3.1.3 STRENGTHENING SOCIAL PARTICIPATION

Health systems exist to serve their populations. As such, patient-centered comprehensive health services demand establishing practical objectives, channels, and mechanisms to foster effective participation. The user is the foundation and focus of the relationship. Involving the individual in all stages of implementation of the RIAS, from the planning stage to the monitoring and evaluation stage, promotes trust.
The defined participation mechanisms in the system, including user associations, participation committees, and oversight committees should be strengthened. The User Service and Information systems are critical tools to understand the user's ideal vision for health care and catalyze joint discussions between the providers and insurers to create strategies to improve social participation.

The participation of sectoral and extra-sectoral social stakeholders in consensus-building mechanisms allows health services to respond to the social and geographical realities in each territory. Consultation with different stakeholders also demonstrated the need to develop educational processes for users to

improve their understanding of the RIAS and the system's different care pathways. Proper use of these mechanisms reduces conflict and facilitates relationships among stakeholders.

The strategies to strengthen social and community participation are part of the Social Participation Policy in Health (PPSS), a policy regulated by Resolution 2063/2017 (Ministerios de Salud y Protección Social, 2017). This policy guarantees social participation in the health sector under Law 1438/2011, the Health Statutory Law 1751/2015, and the Participation Statutory Law 1757/2015.

To properly execute the relationship model, it is necessary to guide social participation, focusing on components 2, 3, and 4 of the PPSS in accordance with the RIAMP and the RPMS. This includes:

1. Empowerment of citizens and social organizations: it is vital to strengthen the capacity of citizens so that they may play an active role in the development of the health system. In addition, it is critical to strengthen the capacity of formal, independent organizations to promote participatory processes that bolster the influence of the community in the management of health policies, plans, and programs.
2. Promotion of a healthy culture: foster the development of healthy habits in daily life by exercising care (collective) and maintaining self-care (individual) to promote the right to health.
3. Social accountability in health: citizens' ability to ensure accountability for public resources, institutions, and system stakeholders is crucial to guarantee the right to health and promote health in society. Therefore, it is necessary to strengthen the skills of citizens and oversight organizations to promote social accountability.

Table 3. Strategies to strengthen social participation

Strategies to strengthen social participation	Responsible			
	Primary providers	EAPBs	HEALTH SECRETARIATS	MSPS
Develop a mass information and training strategy for users to increase their participation in the implementation of the RIAS, not only as users, but also as managers, overseers, and guarantors of the operation of the RIAS.	x		x	
Create specific community spaces, including sub-commissions for participation committees, to promote community participation in the management of the RIAS.	x			
Design strategies for the implementation of the RIAS through a differential approach, which will allow various population groups to participate in the planning and operation of the RIAS through social and cultural adaptation.	x	x	x	
Promote the use of information and communication technologies, including social networks, to maintain continuous contact with users, listen to their feedback and	x	x	x	

Strategies to strengthen social participation	Responsible			
	Primary providers	EAPBs	HEALTH SECRETARIATS	MSPS
implement measures for improvement based on the actual needs of users.				

Source: Prepared by the authors

5.3.1.4 EFFECTIVE COORDINATION AND COMMUNICATION PROCESSES

This component aims to create spaces for engaging in dialogue and reaching consensus (e.g., working groups) among various stakeholders to strengthen participants' leadership skills. Communication is the foundation for understanding. Effective communication is vital to create clear rules and tools for each stakeholder.

Coordination among stakeholders is essential to achieve positive health outcomes. Furthermore, it is crucial to increase understanding of the general RIAS management process, as Figure 5 demonstrates. The interaction between stakeholders during the planning, formulation, adaptation, execution, monitoring, and adjustment phases is complex and therefore requires effective coordination.

Figure 5 demonstrates the interactions among stakeholders that occur in the provision of health services. During the planning, formulation, and adoption phases, the MSPS will develop the RIAS, fulfill administrative duties, and provide technical assistance to other system stakeholders. The territorial entities will analyze the status of the health system in each of their territories by evaluating the needs of the population and assessing complimentary health services available, adapt the health system to the sociocultural context of the territory, and, in coordination with the EAPBs, identify the services required within the system.

The EAPBs also participate in the planning stage. These institutions are responsible for evaluating the health risks of the population enrolled in the health system of each territory, identifying their needs, and using these needs as a foundation to choose which service networks to use. The EABs and providers will collaborate to create agreements for the provision of health services. Health providers must have the technical conditions necessary to deliver health services according to the contracts established with the EAPBs. The EAPBs should share information on the profile of the users, number of users, support networks, and data that providers should share with the EAPBs.

In the implementation of the RIAS, the health providers are responsible for delivering services and providing information to the EAPBs, territorial entities, and the MSPS. Additionally, they guide individuals, families, and communities on how to access services. They should have referral and counter-referral processes, or a plan to otherwise link patients to the health services described in the RIAS.

The RIAS involves different monitoring and evaluation activities that identify gaps between expectations and actual execution and track data and health indicators. Health providers generate most of the data. However, all stakeholders must evaluate these indicators. This monitoring and evaluation process involves working groups and technical assistance from the MSPS, health secretariats, EAPBs, and health providers.

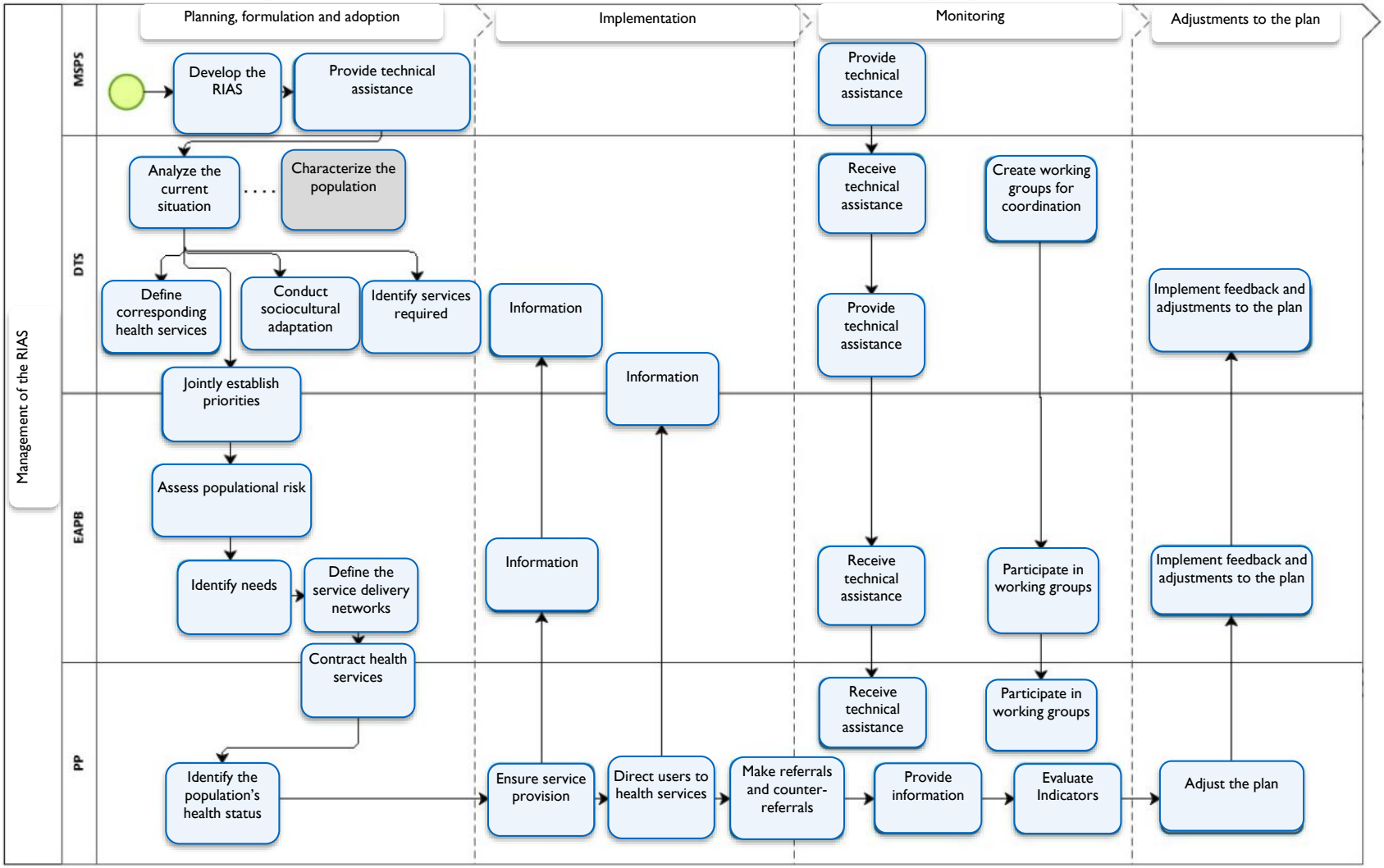
The last stage of the monitoring and evaluation process is to make adjustments. This phase, like the others, is cyclical and ends in the planning stage, thus generating continuous improvement in the implementation of the RIAS and assessment of the population's health indicators.

Table 4. Strategies for effective coordination and communication

Strategies for coordination and communication	Responsible			
	Primary providers	EAPBs	Health Secretariats	MSPS
Create formal coordination spaces for planning, implementing, and evaluating the RIAS (working groups, monitoring committees, and committees for conflict resolution, among others). Health providers, EAPBs, community members, and health secretariats will participate in these spaces. These spaces will include communication channels with clear rules and operating mechanisms.	x			
Develop a mass communication and training strategy for users to improve their participation in the implementation of the RIAS not only as users, but also as managers, overseers, and guarantors of the operation.	x			
Strengthen the leadership of the Territorial Health Directorates to exercise their authority in coordinating actions within the territory, resolving conflict among stakeholders, and reaching consensus.			x	x
Develop communication matrices to establish each stakeholder's role in the communication strategy: when to communicate, with whom, how, and what to communicate. These matrices would help organize the transmission of information, schedules, and implementation processes. The stakeholders would collaborate in the preparation of the matrices to standardize the communication processes and avoid duplication. Annex 3 demonstrates an example of the matrix that stakeholders can standardize to ensure the proper operation of the RIAS.	x			

Source: Prepared by the authors

Figure 5. RIAS Management Process



Source: Prepared by the authors

5.3.1.5 MONITORING AND EVALUATION

The relationship among system stakeholders must include tools to monitor the commitments that were agreed upon. As such, it is vital to have a system to monitor and evaluate the relationship process and its results. This system monitors the process and achievement of the process's objectives, identifies conflict and creates recommendations for adjustment in a timely manner.

Evaluation allows stakeholders to draw large-scale conclusions on design and impact (Millburn, 2010). Evaluation is a vital instrument to continuously improve the quality of health services, and can help providers to assess their decision-making skills, such as the ability to identify problems, diagnose patients, manage patient care, and use therapeutic services and products. Evaluating health service delivery include assessing enforcement of referral criteria, implementation of consent for health services, patients' understanding of their health status, and agreement between patients and health professionals (Villalbí et al., 2003). Finally, evaluation assesses the fulfillment of management and results-related commitments among stakeholders.

Through the monitoring and evaluation (M&E) process, stakeholders collaborate to determine whether or not to adjust their collaboration so that it meets the expectations of their agreement. An M&E process should aim to continuously improve the management process, and thus it should be based on a methodological approach and standards previously agreed upon by the stakeholders. Punitive actions should not be incorporated into the monitoring and evaluation process because this undermines the establishment of trust. While management undoubtedly requires compliance with responsibilities and commitments, in a relationship of trust, the assessment of achievements and results should be based on objective information that facilitates continuous improvement.

It is necessary to design methodologies, develop instruments, and strengthen capacity to facilitate interactions between the parties involved in the implementation of the RIAS so that the M&E process may serve as a mechanism for stakeholders to achieve a shared purpose, and not a reason for conflict or confrontation.

Table 5. Monitoring and evaluation strategy

Monitoring and evaluation strategy	Responsible			
	Primary providers	EAPBs	Health Secretariats	MSPS
Create a joint territorial situation room to encourage joint analysis and decision-making among territorial stakeholders. This process takes place in 4 stages: • Stage 1: Preparation (assessment, needs analysis, and prioritization). • Stage 2: Analysis with key stakeholders (prioritization and training) • Stage 3: Identification of solutions among stakeholders (proposal and meeting). • Stage 4: Monitoring (actions, feedback, and improvement)			x	

Monitoring and evaluation strategy	Responsible			
	Primary providers	EAPBs	Health Secretariats	MSPS
Review the list of RPMS and RIAMP indicators and evaluate their relevance and the sources of information to enable their operationalization and use.	x	x	x	x
Develop technological tools such as dashboards for use by health providers for monitoring administrative and health care-related agreements among the parties. The quality of the data, however, will depend on the primary provider.	x	x	x	x

Source: Prepared by the authors.

5.3.2 STRUCTURAL COMPONENTS

5.3.2.1 STRENGTHENING TERRITORIAL MANAGEMENT CAPACITY

The implementation of PAIS requires a territorial approach. In the analysis conducted, however, stakeholders identified two key issues that must be addressed to effectively manage the health care system using a territorial approach. Solutions for these issues will require long periods of discussion and modifications to current legislation.

It is necessary to restructure the territorial health system to optimize the delivery of health services and standardize them across territories. The MSPS has prepared regulatory proposals to initiate these changes, but legislative reforms will be needed. The restructuring process will also require further discussions on regionalization, municipalities' capacity for health system management, and the strengthening of departmental health surveillance and control capacity.

In the diagnosis conducted during the first stage of this analysis, stakeholders determined that the distribution and proper use of resources are two key factors for effectively implementing the RIAS. They identified the need to review the sources and mechanisms used to allocate resources to the territories and health providers to operate the RIAS, and the need to leverage resources for collective and individual health services, especially for those delivered at the primary care and municipal levels. Finally, it will be important to analyze proposed alternative sources of funding and implement required adjustments accordingly.

Table 6. Strategies to strengthen the territorial management capacity

Strategies to strengthen the territorial management capacity	Responsible			
	PPs	EAPBs	Health Secretariats	MSPS
Prepare a governmental or legislative proposal (if applicable) to review territorial planning in the health sector. This proposal should include the revision of responsibilities and capabilities of health secretariats,				x

Strategies to strengthen the territorial management capacity	Responsible			
	PPs	EAPBs	Health Secretariats	MSPS
the creation and operation of health regions and subregions, and the strengthening of financial resources for collective interventions to promote and prevent diseases, among other measures to improve the territorial management process.				
Under the coordination of the EAPBs, implement effective and comprehensive service delivery networks using a territorial approach.		x		

Source: Prepared by the authors.

5.3.2.2 STANDARDIZATION AND INTEROPERABILITY OF INFORMATION SYSTEMS

Stakeholders must have a single, interoperable information system, as information is essential to achieve effective relationships. As stated by the Pan American Health Organization (2022): "access to universal health coverage must be strengthened through interconnected, integrated, and interoperable information systems that ensure effective and efficient access to quality data, strategic information, and information and communication technology tools for decision-making and well-being".

Standardizing an information system requires integrating data from different sources, standardizing information flows, avoiding the duplication of data, and enabling access to data in real-time. Standardization provides access to reliable information to establish common objectives and to plan, implement, and evaluate health care delivery. Similarly, as defined by Law 2015 of 2020 (Presidencia de la República, 2020), interoperability is the ability of several systems or components to exchange information that is available and accessible from any point in the health care network. This promotes the coherence and quality of data to provide health care and ensure the safety of patients. Interoperable databases enable all parties to access information for the effective planning, monitoring, and evaluation of the health system in real time.

Reliable information is the foundation of fair and balanced negotiation, consultation, and monitoring of commitments regarding management and results. Reliable information is also crucial to strengthen the capacity of working teams, update technological infrastructure, ensure connectivity, promote a culture of data analysis, and ensure the quality, security, and availability of data. All of these elements are essential to the information management processes that support sound decision-making.

Accordingly, stakeholders should implement the following strategies:

Table 7. Strategies for the standardization and interoperability of information systems

Strategies for the standardization and interoperability of information systems	Responsible			
	Primary Providers	EAPBs	Health Secretariats	MSPS
Interoperability of medical records: Law 2015/2020 mandated the creation of interoperable				x

Strategies for the standardization and interoperability of information systems	Responsible			
	Primary Providers	EAPBs	Health Secretariats	MSPS
electronic medical records and other measures over a 5-year implementation period starting May 31, 2020. These records are mandatory to qualify as a health provider. To implement this strategy, it is necessary to regulate certain elements, including relevant data, terms of implementation, medical history, and financing.				
Create an information system that can be managed offline and enables the collection of physical and digital information. This system should integrate data from multiple environments (home, community, family, educational, work, and institutional) and other sources including surveillance and control records, clinical history, the RIPS service delivery information system, the National Public Health Surveillance System, and other databases that can be consolidated into a single information system. This consolidation will enable the timely monitoring of indicators, production of the required reports, real-time monitoring, and the delivery of health services in a timely manner using a risk management approach.				x
Structure a national inter-institutional roundtable with the support of international cooperation agencies to create a single health information system. This system will require dedicated resources to design and launch it within its 5-year term goal.				x
Support health providers' transition towards the use of scalable information systems and away from the use of Excel tools to manage internal information. This will facilitate data management and reporting.		x	x	x
Strengthen the capacity of the primary provider to generate quality and reliable data on time.	x			

Source: Prepared by the authors.

5.4 PATHWAY FOR IMPLEMENTING THE MODEL

Implementing the proposed Relationship Model requires the commitment of all system stakeholders. The MSPS, as head of the health system, must spearhead the implementation of the set of strategies proposed in this model.

In developing this model, national and territorial stakeholders such as the MSPS, territorial entities, EAPBs, and primary providers, participated in discussions to establish consensus on the relevance of these strategies. Through a prioritization exercise, stakeholders categorized 18 of these strategies as high priority and feasible which should be implemented first.

To conduct this process, LHSS gave participants a list of the 30 strategies included in the seven components of the model. Thirty-one groups of participants completed a prioritization matrix. Through this matrix, participants identified the stakeholders that they considered responsible for implementing the strategy with an X, other stakeholders that should participate in the implementation of each strategy, and the degree of importance of each stakeholder for implementation. The working groups matched the strategies and the stakeholders and rated each strategy from 0 to 5 (0 being the lowest priority and 5 being the highest). LHSS developed a matrix that contains the 31 working groups' responses (Annex 4) and prioritized them according to two criteria: (i) over 70% of the groups considered the strategy as applicable to a stakeholder, and ii) the average priority rating was greater than or equal to 4. Based on these criteria, stakeholders identified 18 prioritized strategies that should be implemented first according to a feasibility analysis.

To facilitate the implementation of the Relationship Model, Tables 8 (on p. 29) and Table 9 (p. 35) below group the strategies into two categories: Priority 1 Strategies and Priority 2 Strategies. The first category includes the strategies that will be implemented immediately. The second category includes strategies that will be implemented during Phase II.

The tables present the strategies in order of priority and include the critical issue the strategy aims to resolve, its component, the responsible party, and the estimated period of time for its execution, which is categorized as follows:

1. Short term: Less than a year
2. Medium-term: Between one and two years
3. Long-term: Over two years

Table 8. Priority level 1 strategies

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
1	Create formal coordination spaces for planning, implementing, and evaluating the RIAS (working groups, monitoring committees, and committees for conflict resolution, among others). Health secretariats will lead in these spaces and health providers, the EAPBs, and community members will participate in them. These spaces will include communication channels with clear rules and operating mechanisms.	Mistrust among stakeholders. Weaknesses in informing citizens and communicating.	**Effective coordination and communication processes**	**Short term**	**Primary providers**
2	Update the inventory of tools that support the primary provider's management processes and the implementation of the RIAS. In addition, this process will consolidate these tools and create a plan for the dissemination, validation, and training of staff to implement such tools.	Weaknesses in the unified information system on billing and costs. Weaknesses in the institutional and managerial capacities of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Medium term**	**MSPS, Health secretariats**
3	Coordinate with the Ministry of Education and higher education institutions that train human resources for health to review the professional profiles and design strategies to improve the skills of graduates. This should take place during the territorial planning	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial capacities of the primary provider.	**Strengthening capacities of institutions and human resources**	**Medium term**	**MSPS**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
	processes based on identified needs and intersectoral coordination.	Specific shortcomings in the training of human resources. High rate of staff turnover.			
4	Create a permanent program for the professional development of human resources for health. This program will complement the training process according to the health system's specific needs and context. It should involve new educational approaches, including virtual education and the development of hard, technical, and administrative skills.	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial capacities of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Short term**	**MSPS**
5	Develop a comprehensive incentive policy for human resources for health that aims to reduce the current rate of staff turnover. The policy should include the strengthening of labor relations, a policy on salaries, and other non-financial incentives that improve the distribution, retention, and availability of human resources throughout Colombia.	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial capacities of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Medium term**	**MSPS**
6	Strengthen the management capacity of departments, districts, and municipalities. In accordance with the 10-year Public Health Plan 2022-2031 and its strategic focuses, this strategy should target territorial entities through the implementation of a capacity evaluation plan, an assessment of gaps, and a territorial capacity-	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial capacities of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Medium term**	**MSPS**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
	strengthening plan that aims to improve the following functions: inspection, surveillance, and control and technical assistance to system stakeholders for the implementation of the RIAS.				
7	Strengthen technical assistance for addressing issues at the territorial level as a complement to the training process. The EAPBs and health secretariats will strengthen their capacity to provide this assistance. The MSPS will guide stakeholders through this process either face-to-face or virtually.	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial capacities of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Short term**	**EAPBs** **Health secretariats**
8	Strengthen the physical and technological infrastructure of primary providers, which involves conducting an inventory of the primary provider's needs to ensure their infrastructure complies with requirements for the implementation of the RIAS. Support should also include the preparation of a finance and development plan for the primary providers, with the aim of strengthening technological capacity and providing the necessary logistical and administrative support, including connectivity.	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial expertise capacity of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Long-term**	**MSPS, Health secretariats**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
9	Hire and retain community managers within the framework of the user-centric primary care model. The strategy will implement a policy to identify, train, and support community managers. Community managers are defined as "members of a community living in remote areas that support the development of specific RIAS interventions." It will be necessary to define the role, profile, and participation of the community health managers within the health system.	Weaknesses in the single information system on billing and costs. Weaknesses in the institutional and managerial expertise capacities of the primary provider. Specific shortcomings in the training of human resources. High rate of staff turnover.	**Development of capacities of institutions and human resources for health**	**Short term**	**Primary provider**
10	Under the coordination of the EAPBs, implement effective and comprehensive service delivery networks using a territorial approach.	Lack of coordination and territorial approach in the implementation of the RIAS. Regulatory changes generate confusion among the system parties.	**Strengthening of territorial management capacity**	**Medium term**	**EAPBs**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
11	Develop a mass information and training strategy for users to increase their participation in the implementation of the RIAS, not only as users, but also as managers, overseers, and guarantors of the operation of the RIAS.	Lack of spaces for collective construction.	**Strengthening of social participation**	**Short term**	**Primary providers** **Health secretariats**
12	Design strategies for the implementation of the RIAS through a differential approach, which will allow various population groups to participate in the planning and operation of the RIAS through social and cultural adaptation.	Lack of spaces for collective construction.	**Strengthening of social participation**	**Short term**	**Primary providers** **EAPBs** **Health secretariats**
13	Promote the use of information and communication technologies, including social networks, to maintain permanent contact with users, listen to their feedback and implement measures for improvement based on the actual needs of users.	Lack of spaces for collective construction.	**Strengthening of social participation**	**Short term**	**Primary providers** **EAPBs** **Health secretariats**
14	Strengthen costing and billing systems for primary providers.	Lack of coordination between individual and collective actions. Breaches in payment commitments.	**Efficient management of the contracting process**	**Short term**	**Primary providers**
15	Create a joint territorial situation room to encourage joint analysis and decision-making among territorial stakeholders. This process takes place in 4 stages: • Stage 1: Preparation (assessment, needs	Lack of systems to monitor and evaluate relationship commitments.	**Monitoring and evaluation**	**Medium term**	**Health secretariats**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
	analysis, and prioritization). • Stage 2: Analysis with key stakeholders (prioritization and training) • Stage 3: Identification of solutions among stakeholders (proposal and meeting). • Stage 4: Monitoring (actions, feedback, and improvement)				
16	Review the list of RPMS and RIAMP indicators and evaluate their relevance and the sources of information to enable their operationalization and use.	Lack of systems to monitor and evaluate relationship commitments.	**Monitoring and evaluation**	**Short term**	**Primary providers** **EAPBs** **Health secretariats** **MSPS**
17	Structure a national inter-institutional roundtable with the support of international cooperation agencies to create a single health information system. This system will require dedicated resources to design and launch it within its 5-year term goal.	Asymmetry of information between providers and insurers	**Standardization and interoperability of information systems**	**Short term**	**MSPS**
18	Strengthen the capacities of the primary provider to generate high-quality, reliable data in a timely manner.	Asymmetry of information between providers and insurers	**Standardization and interoperability of information systems**	**Short term**	**Primary providers**

Source: Prepared by the authors.

Table 9. Priority level 2 strategies

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
19	Develop communication matrices to establish each stakeholder's role in the communication strategy: when to communicate, with whom, how, and what to communicate. These matrices would help organize the transmission of information, schedules, and implementation processes. The stakeholders would collaborate in the preparation of the matrices to standardize the communication processes and avoid duplication. Annex 3 demonstrates an example of the matrix that stakeholders can standardize to ensure the proper operation of the RIAS.	Mistrust among stakeholders. Weaknesses in the information and communication processes targeting citizens.	**Effective coordination and communication processes**	**Short term**	**Primary Providers**
20	Strengthen the leadership of the Territorial Health Directorates to exercise their authority in coordinating actions within the territory, resolving conflict among stakeholders, and reaching consensus.	Mistrust among stakeholders. Weaknesses in the information and communication processes targeting citizens.	**Effective coordination and communication processes**	**Long-term**	**Health secretariats MSPS**
21	Design a plan to train health provider senior management on negotiation strategies.	Weaknesses in the single information system on billing and costs. Weaknesses in the primary provider's institutional and managerial capacities. Specific weaknesses in the training of human resources. High rate of staff turnover.	**Strengthening capacities of institutions and human resources**	**Medium term**	**Primary providers; Health secretariats**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
22	Prepare a governmental or legislative proposal (if applicable) to review territorial planning in the health sector. This proposal should include the revision of responsibilities and capabilities of health secretariats, the creation and operation of health regions and subregions, and the strengthening of financial resources for collective interventions to promote and prevent diseases, among other measures to improve the territorial management process.	Lack of coordination and territorial approach in the implementation of the RIAS. Regulatory changes that generate confusion.	**Strengthening of territorial management capacity**	**Long-term**	**MSPS**
23	Create specific community spaces, including sub-commissions for participation committees to promote community participation in the management of the RIAS.	Lack of spaces for collective construction	**Strengthening of social participation**	**Short term**	**PP**
24	Analyze the importance of universal tariff manuals, regulatory charts, and form contracts for the implementation of the RIAS.	Lack of coordination between individual and collective actions. Breaches in payment commitments.	**Efficient management of the contracting process**	**Long-term**	**MSPS**
25	Develop studies to create proposals to modify the primary provider's financing mechanisms, including supply-side subsidies, locally pooled funds, and other mechanisms to counteract fragmentation in the use of resources and provision of health services.	Lack of coordination between individual and collective actions. Breaches in payment commitments.	**Efficient management of the contracting process**	**Long-term**	**EAPBs** **Health secretariats** **MSPS**
26	Develop simple tools to support primary providers during the three phases of the contracting process: pre-contractual, contractual, and post-contractual, including checklists and guidelines.	Lack of coordination between individual and collective actions. Breaches in payment commitments.	**Efficient management of the contracting process**	**Short term**	**MSPS**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
27	Develop technological tools such as dashboards for use by health providers for monitoring administrative and health care-related agreements among the parties. The quality of the data, however, will depend on the primary provider.	Lack of systems to monitor and evaluate relationship commitments.	**Monitoring and evaluation**	**Short term**	**Primary providers** **EAPBs** **Health secretariats** **MSPS**
28	Support health providers' transition towards the use of scalable information systems and away from the use of Excel tools to manage internal information. This will facilitate data management and reporting.	Asymmetry of information between providers and insurers	**Standardization and interoperability of information systems**	**Medium term**	**EAPBs** **Health secretariats** **MSPS**
29	Create an information system that can be managed offline and enables the collection of physical and digital information. This system should integrate data from multiple environments (home, community, family, educational, work, and institutional) and other sources including surveillance and control records, clinical history, the RIPS service delivery information system, the National Public Health Surveillance System, and other databases that can be consolidated into a single information system. This consolidation will enable the timely monitoring of indicators, production of the required reports, real-time monitoring, and the delivery of health services in a timely manner using a risk management approach.	Asymmetry of information between providers and insurers	**Standardization and interoperability of information systems**	**Long-term**	**MSPS**
30	Interoperability of medical records: Law 2015/2020 mandated the creation of interoperable electronic medical records and other measures over a 5-year implementation period starting May 31, 2020. These records are mandatory to qualify as a health provider. To implement this strategy, it is necessary to	Asymmetry of information between providers and insurers	**Standardization and interoperability of information systems**	**Short term**	**MSPS**

Strategies					
Priority	**Strategy**	**Critical Issue**	**Component**	**Implementation Term**	**Responsible Party**
	regulate certain elements, including relevant data, terms of implementation, medical history, and financing.				

Source: Prepared by the author

To implement the Relationship Model, LHSS recommends the following next steps:

1. The MSPS should formalize the Relationship Model as a standard technical document titled *Guidelines for the relationship of stakeholders, with an emphasis on the Primary Provider, for implementing the Maternal Perinatal Health care Pathway and the Promotion and Maintenance Health care Pathway*.
2. Appoint a unit within the MSPS to lead the implementation of the model.
3. Disseminate the model among the health secretariats, EAPBs, and health providers.
4. Prepare a plan to implement the model according to the prioritization and execution deadlines. The plan should be implemented at the national, territorial, and institutional levels (EAPBs and health providers) in accordance with the structure of the health system. It is important to consider the possibility of implementing the model in phases by territory, starting with a pilot project in the cities involved in the model's diagnostic and design processes. The lessons learned from the pilot project can be used to adjust the model and implement it in other territories.
5. Identify and allocate resources to implement the plan, focusing on the resources required to strengthen technical and technological capacity and the capacity of infrastructure and human resources for health for primary providers.
6. Prepare a training plan targeting the primary providers that aims to improve leadership management as an integral part of this model.
7. Ensure that the tools required to implement this model that were designed by the MSPS or international cooperation agencies are available to the primary providers. These tools include a dashboard tool for monitoring and evaluating the commitments of stakeholders within the relationship model.
8. Establish a mechanism to monitor the model's implementation plan that enables the adaptation of the plan according to the changes that may occur in the health system's structure, organization, and functioning.

To ensure its sustainability, it is important that the Model remains aligned with the health system's regulatory and policy framework. Accordingly, the Relationship Model is consistent with the vision provided by the 10-year Public Health Plan 2022-2031, in which coordination between stakeholders is deemed as a requirement to implement on-going improvements in the social determinants of health:

> *"By 2031, upon executing the 10-Year Public Health Plan, the country will have made progress in guaranteeing the fundamental right to health and improving the well-being and quality of life of the inhabitants of the Colombian territory. This plan impacts the social determinants of health through intersectoral, territorial, institutional, and social actions in a coordinated, differential, and sustainable manner*".

On the other hand, regardless of the structural adjustments made to the health system, the relationship among stakeholders will be the foundation for providing comprehensive health services, which is the general goal of all health systems. Given the confirmed relevance and importance of the Relationship Model for territorial stakeholders, its sustainability will largely depend on the continued support of the MSPS.

Stakeholders have determined that contracting is still a very sensitive issue. It is important to continue defining clear rules for the contractual relationship within the "mutual agreement" framework, which has evolved and progressed significantly with the creation of governmental Decree 441/2022. This decree regulates agreements "among entities responsible for the payment of health care services, the providers

of health care, and the providers of health technologies[...] ". This decree has created many expectations among system stakeholders, particularly among providers, and thus its implementation should continue.

Finally, given that one of the objectives of LHSS is to strengthen the capacity of the Colombian health system to provide comprehensive health services to the migrant population, Colombian returnees, and host communities, it is crucial to continue integrating the Venezuelan migrant population into the health system. It is also important to continue enrolling this population in health insurance, as health insurance allows the target population to realize their right to health. The development of the Relationship Model demonstrated that unenrolled populations are at a higher risk of receiving fragmented, discontinuous, or untimely health services.

Therefore, it is necessary to implement the strategies provided in Circular Letter 035 of 2022, which dictates that within the framework of the principles of coordination, concurrence, complementarity, and subsidiarity, the departments and districts must create a roadmap that considers five strategic lines to strengthen inclusion of the Venezuelan migrant population into the SGSSS and the provision of health care services for this population (Ministerio de Salud y Protección Social, 2022):

1. Enrollment in health insurance.
2. Strengthening of the supply of health services and improvement of the migrant population's access to health services.
3. Integration of the migrant population into public health strategies, programs, and collective interventions within the framework of the 10 Year Public Health Plan 2022-2031.
4. Identification and allocation of financial resources.
5. Coordination with Colombia's Strategy for Cooperation and International Relations in the Health and Social Protection Sectors.

5.5 TOOLS

The implementation of RIAS poses operational and practical challenges and will require the use of simple and functional instruments to help relevant institutions to carry out required tasks. These instruments include standardized procedures for registering and consolidating information and tools to access information on current regulations or the costs of delivering services. These tools will enable providers and insurers to determine tariffs or contracting mechanisms to reach fair agreements.

The MSPS designed various tools, including guidelines, technological applications, and technical documents, among other tools, with its own resources or the support of international cooperation agencies. It is necessary to disseminate these tools among the system's stakeholders and to provide training and technical assistance to use them effectively.

Annex 5 features a collection of tools to support the implementation of the Relationship Model. This collection of tools is based on an inventory conducted by the MSPS that includes some of the tools developed through international cooperation projects. The collection is not exhaustive and must be continuously updated as the health secretariats, EAPBs, and providers develop additional tools to be disseminated across the system.

5.6 LESSONS LEARNED / BEST PRACTICES

LHSS identified the following lessons and best practices during the development of the Relationship Model, trainings, and the monitoring tool:

1. It is important to define clear expectations about the anticipated product and the shared objective among all parties involved to achieve the desired results.
2. An environment of trust is important for co-development processes.
3. Establishing agreements is critical to achieving the proposed objectives.
4. The structure of the products must be simple, friendly, and concise, as these products will be used as tools by primary providers. If products are too long and complex, the personnel responsible for their implementation may disregard or underutilize them.
5. Face-to-face meetings between stakeholders are a relationship-building strategy that has helped establish trust and agreement among participants.

5.7 RECOMMENDATIONS

The recommendations are focused on incentivizing collaborative work and establishing the shared objective of delivering health services to users within the framework of the RIAS.

Through the prioritization process in the six territories, each stakeholder provided their recommendations. The stakeholders should work to implement these measures to improve the relationships among all system stakeholders.

5.7.1 FOR PRIMARY PROVIDERS

Strengthen the capacity of Institutions and Human Resources for Health

- Hire and retain community managers within the framework of the user-centric primary care model. The strategy will implement a policy to identify, train, and support community managers. Community managers are defined as "members of a community living in remote areas that support the development of specific RIAS interventions." It will be necessary to define the role, profile, and participation of the community health managers within the health system.

Strengthen Social Participation

- Develop a mass information and training strategy for users to increase their participation in the implementation of the RIAS, not only as users, but also as managers, overseers, and guarantors of the operation of the RIAS.
- Promote the use of information and communication technologies, including social networks, to maintain permanent contact with users, to listen to their feedback, and implement measures for improvement based on the actual needs of users.
- Design strategies for the implementation of the RIAS through a differential approach, which will allow various population groups to participate in the planning and operation of the RIAS through social and cultural adaptation.

Efficient Management of the Contracting Process

- Strengthen costing and billing systems for primary providers.

Standardization and interoperability of information systems

- Strengthen the primary provider's capacity to generate high-quality, reliable data in a timely manner.

5.7.2 FOR EAPBS

Strengthen Capacity of Institutions and Human Resources for Health

- Strengthen technical assistance for addressing issues at the territorial level as a complement to the training process. The EAPBs and health secretariats will strengthen their capacity to provide this assistance. The MSPS will guide stakeholders through this process either face-to-face or virtually.

Strengthening the Territorial Management Capacity

- Implement effective and comprehensive service delivery networks using a territorial approach.

Strengthening of Social Participation

- Design strategies for the implementation of the RIAS through a differential approach, which will allow various population groups to participate in the planning and operation of the RIAS through social and cultural adaptation.
- Promote the use of information and communication technologies, including social networks, to maintain continuous contact with users, listen to their feedback, and implement measures for improvement based on the actual needs of users.

Monitoring and Evaluation

- Review the list of RPMS and RIAMP indicators and evaluate their relevance and the sources of information to enable their operation.

5.7.3 FOR HEALTH SECRETARIATS

Effective Coordination and Communication

- Create formal coordination spaces for planning, implementing, and evaluating the RIAS (working groups, monitoring committees, and working committees for conflict resolution, among others). Health secretariats will lead in these spaces and health providers, the EAPBs, and community members will participate in them. These spaces will include communication channels with clear rules and operating mechanisms.

Strengthening the Capacities of Institutions and Human Resources for Health

- Strengthen technical assistance for addressing issues at the territorial level as a complement to the training process. The EAPBs and health secretariats will strengthen their capacity to provide this assistance. The MSPS will guide stakeholders through this process either face-to-face or virtually.
- Update the inventory of tools that support the primary provider's management processes and the implementation of the RIAS. In addition, this process will consolidate these tools and create a plan for the dissemination and validation of tools, and training of staff to implement them.
- Strengthen technical assistance for addressing issues at the territorial level as a complement to the training process. The EAPBs and health secretariats will strengthen their capacity to provide this assistance. The MSPS will guide stakeholders through this process either face-to-face or virtually.

Strengthening of Social Participation

- Develop a mass information and training strategy for users to increase their participation in the implementation of the RIAS, not only as users but also as managers, overseers, and guarantors of the operation of the RIAS.
- Design strategies for the implementation of the RIAS through a differential approach, which will allow various population groups to participate in the planning and operation of the RIAS through social and cultural adaptation.
- Promote the use of information and communication technologies, including social networks, to maintain continuous contact with users, to listen to their feedback, and implement measures for improvement based on the actual needs of users.

Monitoring and Evaluation

- Create a joint territorial situation room to encourage joint analysis and decision-making among territorial stakeholders. This process takes place in four stages:

  Stage 1: Preparation (assessment, inventory of needs, and prioritization)

  Stage 2: Analysis with key stakeholders (prioritization and training)

  Stage 3: Identification of solutions among stakeholders (proposal and meeting).

  Stage 4: Monitoring (actions, feedback, and improvement)

- Review the list of RPMS and RIAMP indicators and evaluate their relevance and the sources of information to enable their operationalization and use.

5.7.4 FOR THE MSPS

Strengthen Capacities of Institutions and Human Resources for Health

- Develop a comprehensive incentive policy for human resources for health that aims to reduce the current rate of staff turnover. This policy should include the strengthening of labor relations, a policy on salaries, and other non-financial incentives.
- Strengthen the physical and technological infrastructure of primary providers, which involves conducting an inventory of the primary providers' needs to ensure their infrastructure complies with the requirements for the implementation of the RIAS. This support should also include the preparation of a finance and development plan for primary providers, which aims to strengthen technological capacity and provide the necessary logistical and administrative support, including connectivity.
- Update the inventory of tools that support the primary provider's management processes and the implementation of the RIAS. In addition, this process will consolidate these tools and create a plan for the dissemination and validation of tools, and training of staff to implement them.

- Coordinate with the Ministry of Education and higher education institutions that train human resources for health to review professional profiles and design strategies to improve the skills of graduates. This should take place during the territorial planning process based on identified needs and intersectoral coordination.

- Create a permanent program for the professional development of human resources for health. This program will complement the training process according to the health system's specific needs and context. It should involve new educational approaches, including virtual education and the development of technical and administrative skills.

- Strengthen the management capacity of departments, districts, and municipalities. In accordance with the 10-year Public Health Plan 2022-2031 and its strategic focuses, this strategy should target territorial entities through the implementation of a capacity evaluation plan, an assessment of gaps, and a territorial capacity-strengthening plan that aims to improve the following functions: inspection, surveillance, and control and technical assistance to system stakeholders for the implementation of the RIAS.

Standardization and interoperability of information systems

- Structure a national inter-institutional roundtable with the support of international cooperation agencies to create a single health information system. This system will require dedicated resources to design and launch it within its 5-year term goal.

6. ANNEXES

The following Annexes are available in Spanish as separate documents:

Annex 1 Regulatory framework chart

Annex 2 Responsibilities and functions of the RIAS

Annex 3 Communications Matrix

Annex 4 Prioritization Matrix

Annex 5 Tools

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