

Integrated Health Networks – Executive Summary

1. Integrated Health Networks (IHNs) are the preferred approach to address the burgeoning 'gaps in care' in British Columbia, particularly for citizens with two or more chronic diseases.
2. Citizens with two or more chronic diseases are growing in number. 80% of the total health budget is consumed by individuals with 1 or more chronic diseases.
3. There was agreement that IHNs also have significant potential in ensuring financial sustainability of the health care system in BC.
4. On September 13 and 14, 2007, 92 health professionals and community partners from across the province met in Richmond, BC, to initiate a province-wide implementation strategy for IHNs. The group was composed of a broad spectrum of the BC health system (e.g., each of the six health authorities were represented by a wide array of occupations, including managers, board members, senior executives and clinical professionals; stakeholder groups such as the BCMA, and Canadian Mental Health Association were represented; and community members, such as a community Mayor and a representative of the Vancouver Foundation also attended).
5. There was a strong endorsement of the *Primary Health Care Charter* as the foundation for Integrated Health Networks. The Primary Health Care Charter, and the accompanying Moving Forward document, should be used as a clear articulation of the 'vision' for IHNs in British Columbia.
6. Building on the knowledge of the participants at the session, and from the literature, a clear 'picture' of future IHNs—their structure, its purpose, its scope of work and its key services—was articulated. The following list provides that picture. IHNs:
 - are a preferred approach to address the burgeoning 'gaps in care' in British Columbia; particularly for citizens with **two or more chronic diseases**.
 - employ methods and approaches to ensure **patients are partners** in their care, with emphasis on enabling self-managed care.
 - utilize proactive, planned care methods: they employ a **common care plan** for each client embraced by all health service delivery components—and treat the individual as a whole person.
 - identify clear target population(s) to be served. An evidence-based approach should be used to meet the unique needs of those populations, and services provided accordingly.
 - share responsibility with communities for delivery of care; and create formal agreements/approaches to engage communities as partners, built on the principles of simplicity, mutual trust and reciprocal responsibility.

- Enable and empower multi-professional teams of clinical service providers who have the collective responsibility to address the integrated health needs of clients (individuals and groups) within a specific IHN (with specified role descriptions, and funded by HAs).
 - Provide 24/7 access to supported care, and care information.
 - Have a General Practitioner as the cornerstone of multi-professional teams.
 - Emphasize the use of group support and group clinical visits where a critical mass of clients with a particular condition, or group of conditions, is present.
 - Engage the family as a support system for delivery of care.
 - Are supported by a **well-developed information technology** support system to ensure appropriate data collection for measurement, portability of information and efficiency of service delivery.
 - Exercise **accountability through measurement** of key deliverables (in terms of care) to IHN clients; and systematically examine those outcomes for quality improvement of service.
7. Key leadership lessons learned in the two-day symposium were:
- Relationships, built on collaboration and partnerships, are vital to treating our population's needs; and to maintaining sustainability of the health system.
 - Integrated health networks are the future for Primary Care Health delivery.
 - There is a strong, committed 'system' of leaders in BC for implementation of IHNs. Four key strategies were vital to success, at least in the short term:
 - The specific 'chronic condition' audiences of service delivery should be defined. Programs to meet their needs should be developed—programs in which the client is partner, where providers work together to treat the whole person, and in which access is improved, 24/7.
 - Partnership relationships with physicians are vital to engage them in the creation of IHNs.
 - Having well-developed business plans and sophisticated communication and engagement plans are key to enrolling the larger system in change. These strategies should emphasize the vision and measurable benefits of IHNs to the public.
 - Formal partnerships with patients, communities, families, and amongst providers, and that reduce redundancy of service, should be constructed.

- Transformation is needed; but it is messy, slow, and moves on many different fronts at once. A long term commitment is needed.
8. Significant progress was made in this session because of the cross-pollination opportunities, and learning opportunities provided to its participants. Consequently, opportunities to share knowledge amongst leaders of change and to coalesce them regularly around the vision and key principles, is fundamental to success. As a consequence, a second session for the leaders of IHNs was held in February 2008.

Source: *Moving Forward On Creating Integrated Health Networks in BC* (Sept. 2007)