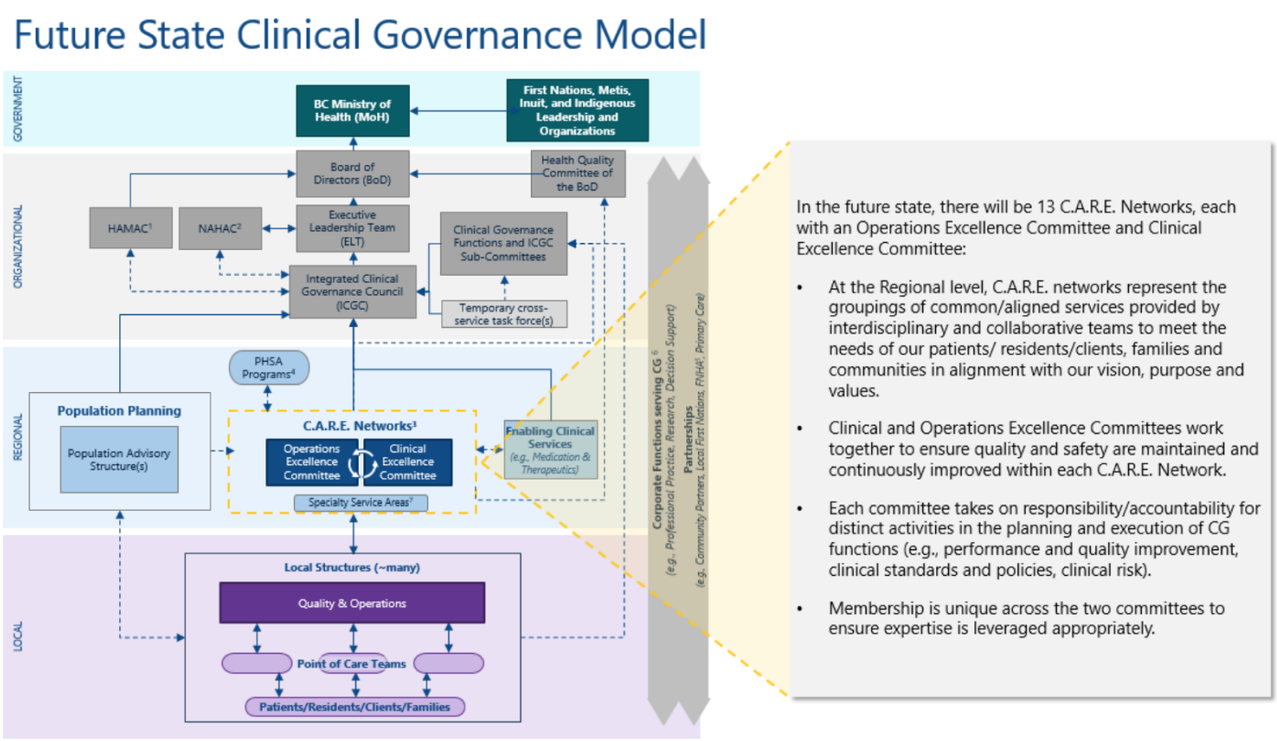
Q&A: C.A.R.E. Networks & Specialty Services

This document was created to support understanding of the C.A.R.E. Networks and is current as of **April 5, 2023.**

For more general information about the Clinical Governance Improvement Initiative, see the General Q&A and other reference materials on the CGII Intranet.

The questions are grouped according to subject area – click on the links below to navigate:

C.A.R.E. NETWORKS



WHAT ARE C.A.R.E. NETWORKS AND WHAT WILL THEY REPLACE?

C.A.R.E. Networks are regional structures within the new clinical governance model that enable shared decision-making to define, monitor and enable quality of care for the services within. The goal of the Networks is to ensure that all point-of-care teams are striving to the same standards of care, and improving health equity of the population, regardless of where the person receives care. **They have no impact on the reporting relationships of individuals to their leader or program.**

Each C.A.R.E. Network is further organized into two primary Committees: Clinical Excellence and Operations Excellence. This achieves the primary objectives of (1) ensuring the right experts to be involved in the right committee decisions, and (2) creating capacity to implement and sustain improvement.

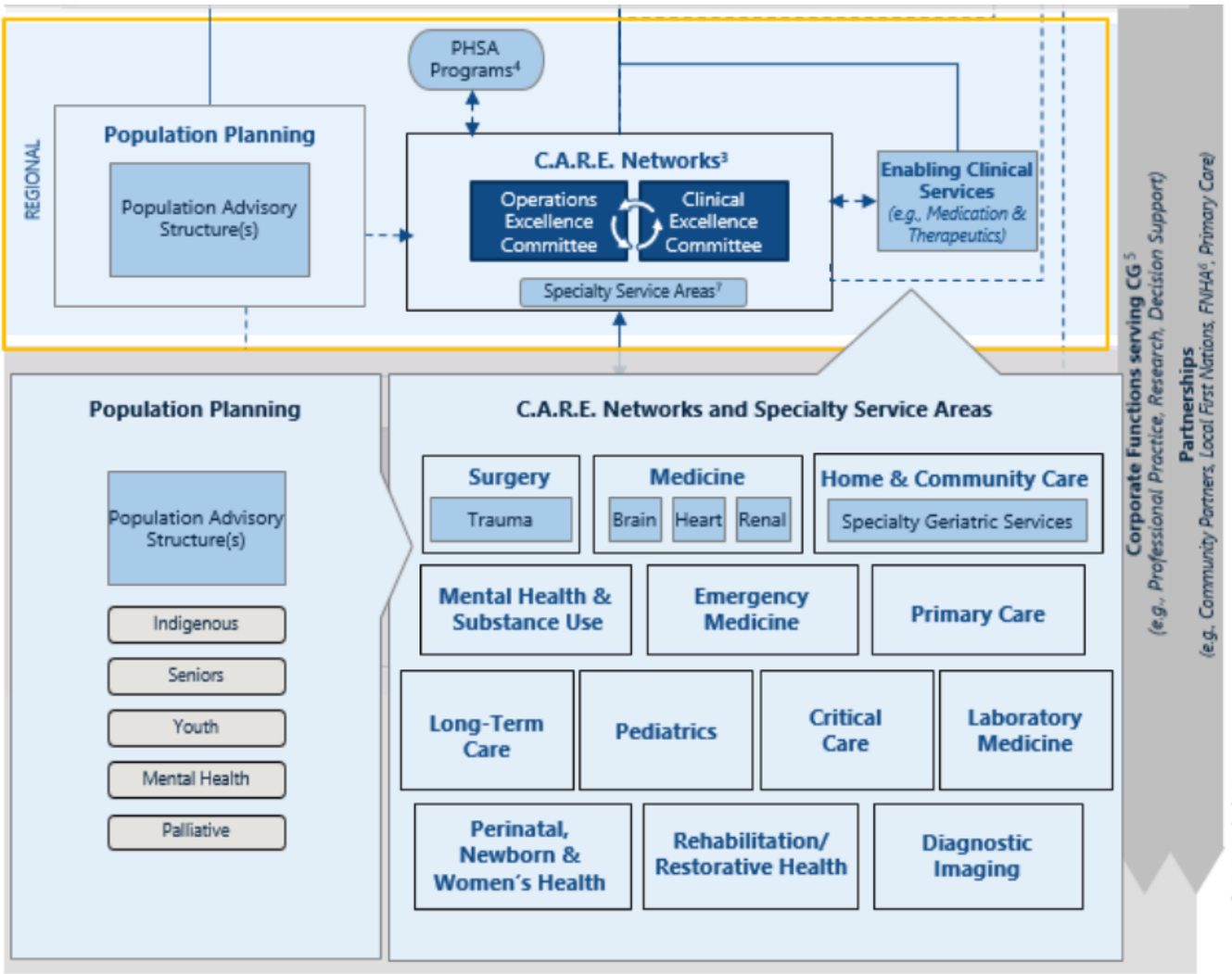
In some cases C.A.R.E. Networks also include Speciality Services. This is to account for highly specialized services, where only a very limited group of specialists or experts in these services are qualified to participate in decision-making, and where the services are not of sufficient size to warrant a separate C.A.R.E. Network.

In addition to C.A.R.E. Networks at the regional level, there will be highly focused, cross-continuum health service committees supporting all Networks and Local Quality and Operations. At this time proposed committees include Medication and Therapeutics. Others may be added during transition discussions.

C.A.R.E. Networks and Specialty Services will replace Quality Councils and other regional committees as deemed appropriate. To ensure priority work in progress is not delayed or missed, workshops will be held with current committees in February and March to design a safe transition plan.

NEW: WHAT ARE THE INTERIM C.A.R.E. NETWORKS AND SPECIALTY SERVICES?

The diagram below shows the interim C.A.R.E. Networks and aligned Speciality Services (*italicized*) that have been approved by the CGII Steering Committee and Island Health's Executive Leadership Team.



WHAT IS HAPPENING WITH PROGRAMS THAT DON'T HAVE A NETWORK?

While not all programs and services are C.A.R.E. Networks, all are important and their voices need to be heard. Executive Sponsors are working with leaders in the following areas to define representation in the new governance model.

Population-Oriented

- Chronic Disease Management
- Rural and Remote

Clinical Services

- Population & Public Health
- Ambulatory Care
- Cancer Care

Enabling Clinical Services

- Patient Flow
- Infection Prevention Control
- Electronic Health Record
- Virtual Care

NEW: HOW DO WE ADDRESS POPULATIONS THAT ARE PRESENT IN ALL OF OUR SERVICES BUT ALSO HAVE DEDICATED PROGRAMS (IE: INDIGENOUS HEALTH AND SENIORS HEALTH)?

Populations of focus such as Seniors, Youth, Indigenous, Mental Health and Palliative have a new and important role as Population Advisory Structures. They will be responsible for analyzing population health needs, including community engagements and dialogues to define priorities. They will marry this with evidence of interventions that will have the greatest impact on the health of that population. This information will create accountability for C.A.R.E. Networks to align to population needs.

HOW WILL WE ALIGN IF OUR PROGRAM COVERS MULTIPLE NETWORKS, IE: INFECTION PREVENTION AND CONTROL?

Like populations of focus, there are some programs and departments that provide expertise across multiple C.A.R.E. Networks. Each situation has to be considered on its own to determine the best solution in our clinical governance model. A list of these areas has been generated from all of the engagement sessions held since December, and the sponsors are working through this list with the program teams.

HOW WERE NETWORKS IDENTIFIED?

There is no perfect way to group services. The Networks were developed by establishing design principles *(see design principles below)* in collaboration with the Clinical Governance Steering Committee, key impacted groups, and the advice of Deloitte partners who are connected with global experts in clinical governance. A key principle was how the

patient/client/resident and family access services. Extensive engagement with impacted committee members led to the approved list above. The Networks may change further following the completion of the Clinical Services Plan in 2024.

WHAT ARE THE C.A.R.E. NETWORK DESIGN PRINCIPLES?

Person-centric: Consider how patients, residents, clients, families and communities access care.

Location-agnostic/duty to the population: The scope of accountability for service delivery is tied to the population of need, not the location of the service.

Populations of focus: Consider populations with lower health equity and require a population health approach.

Clinical quality, safety and standards-focused: Ensure service category appropriately represent safety and standards of care.

Primary accountability for service: Focus design on Island Health led and operated services. Provincially-led programs often have designated standard setting bodies that direct Island Health. These services will roll into a Network to avoid duplication.

Streamline and optimize: Maintain a limited set of service categories to minimize dispersion of resources and expertise.

Clinical associations: Services within the Network must have a strong clinical linkages to each other

WHY SPECIALTY SERVICES AREAS AND NOT ADDITIONAL C.A.R.E. NETWORKS?

The number of C.A.R.E. Networks is limited to help our population and staff understand how to navigate issues and decision-making. It is also because we have limited resources to support the number of committees we have operating today, so smaller, highly specialized services such as Heart Health, Brain Health and Renal Services, will be accommodated differently within the clinical governance structure.

HOW WILL SPECIALTY SERVICES INFORM C.A.R.E. NETWORK PLANS?

The Speciality Services are clinically relevant to the C.A.R.E. Network, but have a narrower set of responsibilities. They will still be responsible for staying apprised of best practices, monitoring clinical outcomes and developing improvement priorities that will feed into the priorities of the C.A.R.E Network. Where applicable, Speciality Services may have unique performance reporting requirements (e.g., if mandated by the Ministry of Health), and will be responsible for developing and maintaining aligned standards and policies (e.g. renal policies at the Renal Specialty Area, supported by the Medicine C.A.R.E. Network). They will contribute to their C.A.R.E. Network's single annual quality plan.

WILL EXISTING QUALITY COUNCIL STRUCTURES STAY THE SAME?

C.A.R.E. Networks and Specialty Services will replace Quality Councils and other regional committees as deemed appropriate. Workshops are being held with current committees to ensure priority work is not delayed or missed. In the meantime functioning committees should continue their work.

WHERE DOES PROFESSION-SPECIFIC SUPPORT COME IN?

A new component of this clinical governance model is a coordinated approach to professional development and education that is both profession-specific and inter-professional to support team-based care. A Clinical Education Committee is being struck to provide a coordinated model for professional education.

HOW WILL PATIENTS BE INVOLVED? WHAT IS THE ROLE OF POPULATION ADVISORY GROUPS?

Population advisory groups will enable meaningful engagement with people, communities and specific population groups to inform services and improvement priorities within the C.A.R.E. Networks. More design work is required before we can operationalize these structures. There will also be new ways for Island Health to identify and involve people with lived experience who want to participate in ongoing committees and special projects. Aligned to these structures will be new standards for how teams must engage with people with lived experience, and the communities in which they live.

WHY IS MEDICAL STAFF GOVERNANCE STILL SEPERATE?

Medical staff are governed by a set of provincially-approved bylaws in accordance with the Hospital Act. For more information about Medical Staff Governance in Island Health, please visit: www.medicalstaff.islandhealth.ca/
Island Health's new clinical governance model will support greater understanding of decision-making and provide opportunities for meaningful participation by medical staff, who will be represented at each level of the new governance model.

NEW: WHAT IS THE IMPLEMENTATION TIMELINE FOR C.A.R.E. NETWORKS?

Jan. 31, 2023
Finalize initial C.A.R.E. Network categories, speciality service areas and cross-continuum services

April-May, 2023
Select committee members and transition workshops

June-Sept., 2023
Orientation, education and committee planning

September, 2023
Activate C.A.R.E. Networks

COMMITTEE MEMBERSHIP

WHO WILL BE INVOLVED IN THE OPERATIONAL AND CLINICAL EXCELLENCE COMMITTEES?

The Operations Excellence Committee (OEC) and Clinical Excellence Committees (CEC) in each Network will include representatives from the following groups, with differentiated expertise. Specifically, the Clinical Excellence Committee members will be people with specialized knowledge related to the definition and assessment of the standards that define "quality" while the Operations Excellence Committee members will be those who have specialized knowledge in how to design and implement change effectively. Both committees will have:

- Representatives from local quality and operations structures reflective of the diversity of Island Health communities
- Interdisciplinary staff and medical staff that represent the scope of professions in the service
- Representation from People/Family/Community Advisory Structures

Representatives from resource teams will also be part of these respective committees based on their areas of expertise, and on the stage of committee work. For example the OECs will have members from finance, enterprise change management, and enterprise project management involved, while the CECs will involve members from decision support, research, professional practice, and quality & safety departments.

DO FRONTLINE STAFF HAVE A PLACE IN C.A.R.E. NETWORKS?

Diverse perspectives are essential to ensure that C.A.R.E. Networks operate as intended. A key principle of this work is inter-disciplinary representation. There is no seniority requirement for committee members, and point-of-C.A.R.E. staff will be invited to express interest in joining a C.A.R.E. Network. Committee membership criteria and selection process will be detailed in an Expression of Interest to identify potential committee members.

HOW WILL C.A.R.E. NETWORK COMMITTEE MEMBERS BE SELECTED?

A simple online Expression of Interest will be open from April 19 to May 10. All interested individuals, including current Quality Council members, should use this process to join a C.A.R.E. Network Clinical Excellence or Operations Excellence Committee. Membership criteria and the selection process will be detailed in the EOI portal on Island Health's Intranet and the Medical Staff website.

C.A.R.E. NETWORK ROLE & FUNCTION

HOW WILL WE COMMUNICATE ACROSS THE C.A.R.E. NETWORKS SO EVERYONE HEARS WHAT'S HAPPENING?

To enable cross Network communication, the Chairs of each C.A.R.E. Network will be part of the Integrated Clinical Governance Council (ICGC). In addition, an aligned meeting cadence, support resources and regular interaction between committee chairs will enable communication across C.A.R.E. Networks. We will also have information and communication tools to support transparency of committee business, assignment of work across committees and closed loop communications.

HOW WILL COMMITTEES WORK TOGETHER TO PREVENT "SILOS"?

Operations Excellence and Clinical Excellence committees within each Network will have distinct but complementary functions. Together they will be accountable for the following activities therefore the Chairs of these committees must collaborate on agendas and how to resolve conflicts.

	Operations Excellence Committee	Clinical Excellence Committee
Joint Accountabilities	***Annual QI Plan***	
	• Assessing the feasibility of implementing the QI plan (e.g., resource impact, timeline, etc.) • Developing implementation plan and monitoring implementation progress	• Defining quality improvement priorities through regular review of performance data • Monitoring progress against defined outcomes
	Regional service standards and policies	
	• Assessing impact and resources required to implement clinical standards and policies. • Developing implementation plans and monitoring	• Designing and approving regional service standards and policies within the Network scope
	Clinical Innovations	

- Identify implementation resources, support pilot development and spread of innovation
- Assess appropriateness of innovation, support evaluation and spread of innovation

TRANSITION & SUPPORT

HOW WILL PEOPLE BE INVOLVED IN THE TRANSITION TO THE NEW MODEL?

Transition workshops from current committees to future state C.A.R.E. Networks, Specialty Services Areas will be scheduled in March and April. This will present an opportunity for existing teams to plan and lead their transition to the new model. Current Quality Council members will be key in helping with this change to ensure work in progress is not interrupted. Other committees impacted by this change will be assessed for continuation based on a review of Terms of Reference and meeting minutes.

WHAT SUPPORTS WILL BE PROVIDED TO TRANSITION AND OPERATE IN THE NEW MODEL?

Operating in the new model will require new skills and knowledge and new types of support resources. A working group has been formed within the project team to design change and orientation plans. The details of what's to come will be fleshed out during the first set of transition workshops in April and May. The project team is also assessing current support resources and drafting a proposal for future needs. Committees can expect to see all the familiar faces in the quality department and decision support and for new relationships to develop with experts in research and evaluation, professional practice, innovation, planning, education, change management, project management, finance and human resources. Meeting secretariat functions have also been identified as key to a committee's success which is why a new coordinating structure is being planned to assist with more standard processes and improved communication systems.

HOW ARE WE ADDRESSING CONCERNS ABOUT CAPACITY TO PARTICIPATE IN THIS CHANGE?

Executive and Sponsors are committed to approaching this change, not as net new work, but a new way of working. To do this we will critically assess the over 250 committees we have today to remove redundancies and align disconnected work. New committees will make the hard decisions to stop or reschedule work to manage capacity. We will also align other changes and improvements to this one. For example the Great Leader work will focus on building Quality Improvement capacity in 2023. Our annual processes for performance monitoring, enterprise risk and priority setting will be aligned and "fed" by clinical governance committees. Our planning and budget timelines have now been aligned after two years of effort, which will reduce duplicate information requests. Standardized decision-making tools will also reduce time spent on duplicated and revised work. And finally, committee membership and the role of committee chairs will be a recognized part of a person's role, not an add-on.

MORE INFORMATION

If you have questions about anything related to the Clinical Governance Improvement Initiative please email CGII@islandhealth.ca.