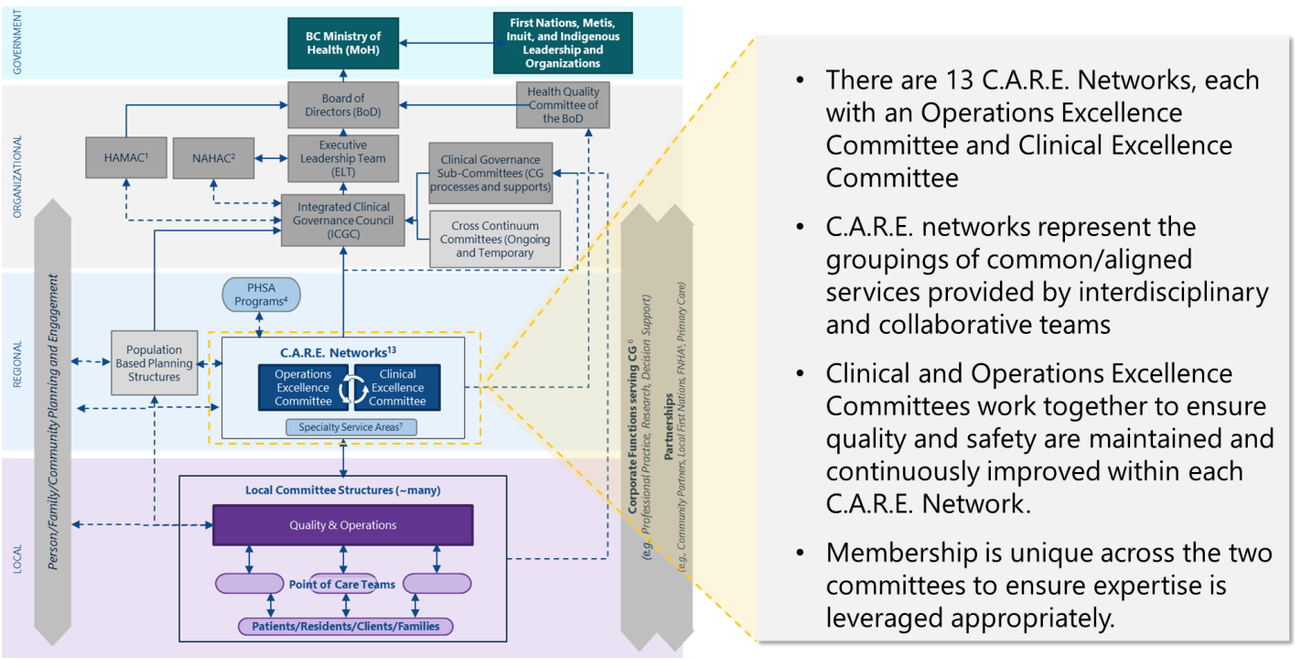
Q&A: C.A.R.E. Networks & Specialty Services

This document was created to support understanding of the C.A.R.E. Networks and is current as of **April 21, 2023.** For more general information about the Clinical Governance Improvement Initiative, see additional reference materials on the CGII Intranet or Medical Staff website.

If you have questions that are not answered here please email CGII@islandhealth.ca

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

C.A.R.E. NETWORKS



- There are 13 C.A.R.E. Networks, each with an Operations Excellence Committee and Clinical Excellence Committee
- C.A.R.E. networks represent the groupings of common/aligned services provided by interdisciplinary and collaborative teams
- Clinical and Operations Excellence Committees work together to ensure quality and safety are maintained and continuously improved within each C.A.R.E. Network.
- Membership is unique across the two committees to ensure expertise is leveraged appropriately.

UPDATED: 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 objectives of (1) ensuring the right experts are involved in the right committee decisions, and (2) creating capacity to implement and sustain improvement.

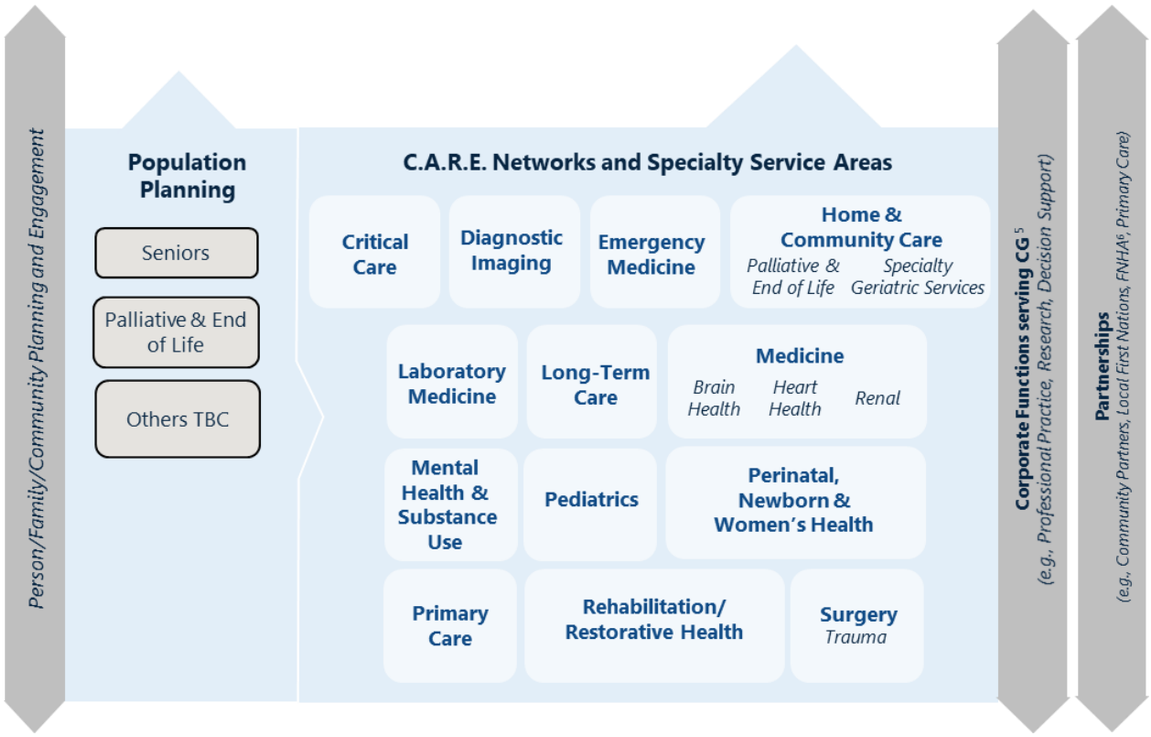
In some cases C.A.R.E. Networks also include Speciality Services. This is to account for highly specialized services, where only a very limited group of specialists or experts in these services are qualified to participate in decision-making, and where the services are not of sufficient size to warrant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

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.

UPDATED: 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.



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 have a new and important role as Population Planning 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 and identify for C.A.R.E. Networks their opportunity to to align to population needs. Accountability for the Networks, to address these needs will be established through an annual planning cycle.

NEW: WHY AREN'T OUR POPULATION AND PUBLIC HEALTH SERVICES INCLUDED HERE?

Public and Population Health leadership has made the decision it will be best for the patients and families, if public health staff are part of several relevant C.A.R.E. Networks. Public health staff who work in services aligned to networks such as Perinatal, Newborn and Maternal Health should apply to the EOI to be part of the relevant Network. Population Health planning opportunities will emerge from the Population Planning Structures and the Clinical Services Plan process.

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. Infection control will have expertise assigned to each C.A.R.E. Network to support them in the work.

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

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

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

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

population of need, not the location of the service.	safety and standards of care.	a Network to avoid duplication.

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?

One of the top six recommendations from the clinical governance review was to establish a standardized approach to person/family/community engagement, and provide more opportunities for diverse representation in decision making. Opportunities for patient partners to sit on committees will continue to be part of the new model, and new ways of engaging with those who we served will be further defined over the next few months.

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.

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

Jan. 31, 2023	April-May, 2023	June-Sept., 2023	September, 2023
Finalize initial C.A.R.E. Network categories, speciality service areas and cross-continuum services	Select committee members and transition workshops	Orientation, education and committee planning	Activate C.A.R.E. Networks

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

NEW: WHAT IS THE DIFFERENCE BETWEEN QUALITY AND OPERATIONS?

Going forward, the intention is to ensure quality is integrated into everything we do. The way we make decisions to improve quality, including access, will run through the new clinical governance structures to enable multi-disciplinary and cross-community decision-making. The day-to-day decisions made to deliver care, align to existing policies, standards and plans will continue to be the responsibility of operational managers and their point of care teams, and the decisions making between providers and patients, clients, residents and families is not impacted.

UPDATED: 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	Joint Responsibilities	Clinical Excellence Committee
Membership:		
• Clinical operations and implementation change expertise	**Regular meetings and interactions between Chairs to align on priorities**	• Clinical and quality improvement expertise
Key Functions:		
• Inform the implementation feasibility of the QI plan (e.g., resource impact, timeline, etc.) • Monitor the QI plan implementation progress	**Develop a feasible annual QI plan and monitor progress**	• Define quality improvement priorities • Monitor progress in meeting the QI priorities
• Inform and plan the implementation of clinical standards and policies	**Develop regional service standards and policies**	• Design and approve regional service standards and policies
• Develop corrective actions to improve performance gaps	**Monitor and manage performance**	• Monitor and assess the quality of care and patient safety through regular data and reporting
• Identify implementation resources, support pilot development and the scale and spread of innovation	**Support the identification and development of clinical innovations**	• Assess appropriateness of innovation, support evaluation and scale and spread of innovation

UPDATED: HOW WILL WE COMMUNICATE ACROSS THE C.A.R.E. NETWORKS?

An aligned meeting cadence, support resources and regular interaction between committee chairs will enable communication across C.A.R.E. Networks. The Chairs of each C.A.R.E. Network will be part of the Integrated Clinical Governance Council (ICGC), and a new secretariat team will be dedicated to the coordination and administration of governance work, including communication. We will have information and communication tools to support transparency of committee business, assignment of work across committees and closed loop communications.

NEW: SOME OF THE CHALLENGE TO QUALITY WORK IS OBTAINING RELEVANT CLINICAL DATA METRICS: WILL THERE BE IMPROVED RESOURCES FOR OBTAINING DATA TO SUPPORT THIS WORK?

Island Health has a wealth of clinical data and a robust Decision Support Team. A member of this team will be assigned to each C.A.R.E. Network to support data needs and understanding how to use the information.

NEW: HOW WILL DECISIONS BE MADE THAT REQUIRE INPUT FROM MULTIPLE NETWORKS?

Issues that require multiple network input will be addressed at the Integrated Clinical Governance Council (ICGC) that is comprised of chairs for each of the Networks. Different approaches will be taken depending on the issue, including temporary cross-continuum task forces.

NEW: ARE THERE DEFINED METRICS TO DETERMINE IF THIS WORK MAKES A MEASURABLE IMPACT ON THE ISSUE?

This is not new work, but a new way of working. The types of measures we will use to determine if this way of working is better, will include such things as the timeliness of decision making, the currency of clinical policies and guidelines, experience of staff and leaders with their level of involvement in improving quality, the orderly scheduling of change implementation, clarity of how to escalate quality of care issues and risks and the reliability of closed loop communications between committees.

NEW: HOW DO OTHER GOVERNANCE STRUCTURES, SUCH AS THOSE FOR IHEALTH, INTERSECT WITH CGII AND AT WHAT LEVEL(S)?

The decisions regarding the intersection of IHealth governance will be made this fall. There will be cross-continuum committees such as the Electronic Health Record and Clinical Documentation in the future-state model.

COMMITTEE MEMBERSHIP

NEW: 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 that reflect 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, while the CECs will involve members from decision support, research, professional practice, and quality & safety departments.

NEW: DO FRONTLINE STAFF HAVE A PLACE IN C.A.R.E. NETWORKS? WHAT ABOUT NON-CLINICAL AND SUPPORT STAFF?

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 anyone who meets the criteria detailed in the C.A.R.E. Network Expression of Interest is welcome to apply. Members of resource teams like Finance or Project Management do not need to apply for C.A.R.E. Network positions - they will be assigned by their leaders to support C.A.R.E. Networks. People in the following occupations may have particular interest in joining a C.A.R.E. Network committee:

- Nursing - (e.g. RN, LPN, RPN)
- Nursing – Clinical Assistants (e.g. health care assistant)
- Medical (e.g. Midwives, Nurse Practitioners, Physicians)
- Non-Clinical Support Staff (e.g. health unit clerk, porters, food services, housekeeping, unit aide, MDR tech etc.)
- Allied Health - Regulated Professions (e.g. RD, OT, PT, SW, SLP, Audiologist, Pharmacist, Dental Hygienist, Psychologist)
- Allied Health - Clinical Assistants (e.g. Activity Worker, Dental Assistants, Lab Assistants, Pharmacy Assistants, Rehab Assistants)
- Allied Health – Technical (e.g. AA, CT, CVT, MRI Tech, ED Tech, MRT, NMT, Perfusionist, Pharm Tech, RT, Ultrasonographer, Lab Tech, Xray Tech)
- Allied Health - Social/ Community (e.g. Child Life Specialist, ECE, Genetic Counsellor, SPO, Infant/ Child Development)
- Allied Health – Therapy (e.g. Rec Therapist)

NEW: WHAT GEOGRAPHIC REGIONS WILL BE REPRESENTED IN C.A.R.E. NETWORK COMMITTEES?

Diversity from all regions where services are provided, e.g. rural and remote, urban centres and small communities, is an important principle of C.A.R.E. Network design. General regions include:

- Vancouver Island North/West (Mount Waddington and Strathcona Corridor)
- Greater Campbell River (includes Quadra, Cortes, Hornby and Denman Islands)
- Comox Valley (includes Courtenay and Cumberland)
- Oceanside/Port Alberni (includes Tofino/Ucluelet)
- Greater Nanaimo (includes Gabriola Island / Ladysmith)
- Cowichan Valley (includes Chemainus, Duncan, Lake Cowichan, Mill Bay, Cobble Hill)
- Western Communities (includes Sooke, Langford, Metchosin, View Royal)
- Greater Victoria (Victoria, Oak Bay, Esquimalt, Central Saanich)
- Saanich Peninsula & Southern Gulf Islands (includes Sidney, Brentwood Bay, Salt Spring, Mayne, Saturna, Galiano and Pender Islands)

NEW: WILL OECS AND CECS HAVE THE SAME MEMBERS?

Each OEC and CEC will have different members. This is to align people with the right skills to the right decisions. People are experts in clinical best practices will sit on the CEC, while people who are experts in how to implement a change in operations and sustain it, will sit on OEC. This is also responds to the feedback that people spend too much time in committee meetings without a clear role.

NEW: DO I NEED TO APPLY TO THE EOI TO JOIN A SPECIALTY SERVICE AREA COMMITTEE?

A separate process will take place to identify members of Specialty Service Area committees. Current committees focused on specialty services should continue their work. SSA members do not need to respond to the EOI for their "hosting" Network (e.e. Heart Heath to Medicine).

NEW: WILL THERE BE REQUIRED REPRESENTATION ON THE COMMITTEES E.G. NURSE, PHARMACIST, OR WILL THAT REPRESENTATION BE PRESENT ONLY IF THERE IS EXPRESSION OF INTEREST?

Where there are gaps in representation from the Expression of Interest the selection committee will seek other ways to include the missing voices for relevant decisions.

NEW: DO CURRENT QUALITY COUNCIL MEMBERS NEED TO APPLY TO JOIN AN OEC OR CEC?

Current Quality Council members who would like to join C.A.R.E. Network committees must submit an Expression of Interest to be considered.

NEW: WHERE WOULD ALLIED HEALTH SUCH AS RT FALL - WHICH CATEGORY?

The C.A.R.E. Networks are designed around services a person accesses and these services are comprised of many disciplines. Committee members will be selected to ensure as many of these disciplines as possible are represented within the Network.

NEW: WHERE WOULD FOOD SERVICES OR NUTRITION CLINICAL SERVICES SIT IN THE NEW STRUCTURES?

The shared governance structure is designed around the services a person accesses - this means some departmental structures that serve many populations will need to be included in decision-making in a wide variety of ways. If a person from food services or nutrition is interested in a being on a C.A.R.E. Network, please express your interest.

NEW: DO WE NEED TO FREE UP DIRECT CARE STAFF TO PARTICIPATE IN A C.A.R.E NETWORK, EVEN IF WE ARE HIGH-RISK STAFFING SPECIALTY AREA?

C.A.R.E. Networks are one opportunity for point-of-care staff to be involved in decision-making that impacts them. If someone from your team approaches you with interest, explore this interest, regardless of the staffing in your area, to determine if they have skills that would be of value to the organization on these committees, or if there are other opportunities for them to be involved in decision-making at a more local/unit level.

NEW: FOR A BIG C.A.R.E. NETWORK, LIKE MEDICINE, HOW MANY COMMITTEE MEMBERS ARE WE THINKING IT WOULD HAVE?

Each C.A.R.E. Network OEC and CEC will have approximately 20 members, not including the chair and patient partners. The exact number of committee members for each Network will be determined by the selection committee to ensure we have the right diversity of membership.

NEW: IF WE ARE PART OF TWO DIFFERENT SPECIALTY SERVICE AREAS WILL WE HAVE AN OPPORTUNITY TO PARTICIPATE IN TWO DIFFERENT NETWORKS?

The plan for committee membership on Speciality Service Areas will be developed in September once the C.A.R.E. Network transition has been completed.

NEW: WILL THERE BE ANY OPPORTUNITIES FOR "SUB-CEC/OECS" ...LIKE A SUB-COMMITTEE?

The C.A.R.E. Networks will establish working groups to complete tasks as needed.

NEW: HOW MUCH TIME WILL COMMITTEE MEMBERSHIP TAKE?

Committee members should expect to dedicate four hours per month to attend two virtual meetings, which will require approximately one hour of preparation.

NEW: WHEN WILL COMMITTEE WORK BEGIN?

C.A.R.E. Network committees will begin functioning in September. Onboarding and education will be provided to members.

SELECTION PROCESS

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

An online Expression of Interest will be open from April 19 to May 10, 2023. 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. A selection committee will include representation from the Medical Staff Association (MSA), Nursing and Allied Health Advisory Committee (NAHAC), Human Resources, Patient Partners and Clinical Governance leads representing quality, patient safety and clinical services delivery. The Selection Committee will review submissions against pre-defined evaluation criteria focused on skills, experience and competencies.

NEW: WHAT IS THE CHAIR SELECTION PROCESS?

The Chairs for Operations Excellence and Clinical Excellence Committees are appointed.

TRANSITION & SUPPORT

NEW: 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 are taking place between April and June, 2023. 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.

NEW: 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.

NEW: 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.