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 Feb. 27, 2023.

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

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

DESIGN OF C.A.R.E. NETWORKS

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

C.A.R.E. Networks are regional structures within the new clinical governance model, for shared decision-making that 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.**

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

Surgery
Includes Specialty Area: Trauma
Medicine
Includes Specialty Areas: Heart Health, Brain Health, Renal
Emergency Medicine
Mental Health & Substance Use

Primary Care
Long-Term Care
Critical Care
Home & Community Care
Pediatrics

Perinatal, Newborn and Women's*
Rehabilitation / Restorative Health*
Diagnostic Imaging
Laboratory Medicine

**** Names to be confirmed***

NEW: 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. Engagement participants identified the following groups require more discussion regarding fit within the structure. Executive Sponsors will connect directly with these teams in February and March to discuss the best way forward.

Population-Oriented
- Seniors Health
- Palliative and End of Life (Hospice)
- Indigenous Health
- 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, Indigenous and Youth have a new and important role in the CG model. Population Planning and Advisory Structures are envisioned, to be responsible for the population health needs analysis, 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.

NEW: 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 committed to working through this list with the program teams before April, 2023.

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 Service Areas 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 Service Areas 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 will be held with current committees to ensure priority work in progress is not delayed or missed. In the meantime functioning committees should continue their work.

NEW: 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 (e.g., "Nothing about me without me.") More design work is required before we can operationalize these structures. However, we know they will align to populations of focus, such as complex frail seniors and Indigenous communities. 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.

WHAT IS THE IMPLEMENTATION TIMELINE?

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

March-April, 2023
Select committee members and transition workshops

April-May, 2023
Begin orientation and committee planning

June, 2023
Begin work on Clinical Services Plan

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.

NEW: 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. The committee membership criteria and selection process are being developed now. Information about application opportunities will be shared widely when that process begins.

HOW WILL COMMITTEE MEMBERS BE IDENTIFIED?

Our goal is to ensure that everyone who wants to be involved in clinical governance can do so in a way that best aligns to their expertise. This does not mean everyone who wants to be involved in a C.A.R.E. Network will have the ability to do so. This is because we know the current committee memberships at Island Health do not meet our future-state goals of appropriate geographic representation, expertise in the subject area, and representation of all relevant disciplines. We are currently working through the details of committee member selection using the criteria above as a starting point.

NEW: WILL THERE BE STANDARDIZED TERMS OF REFERENCE?

Terms of Reference are being developed for the C.A.R.E. Networks. These standard TOR, which will be shared in draft for feedback, will be consistent across Networks.

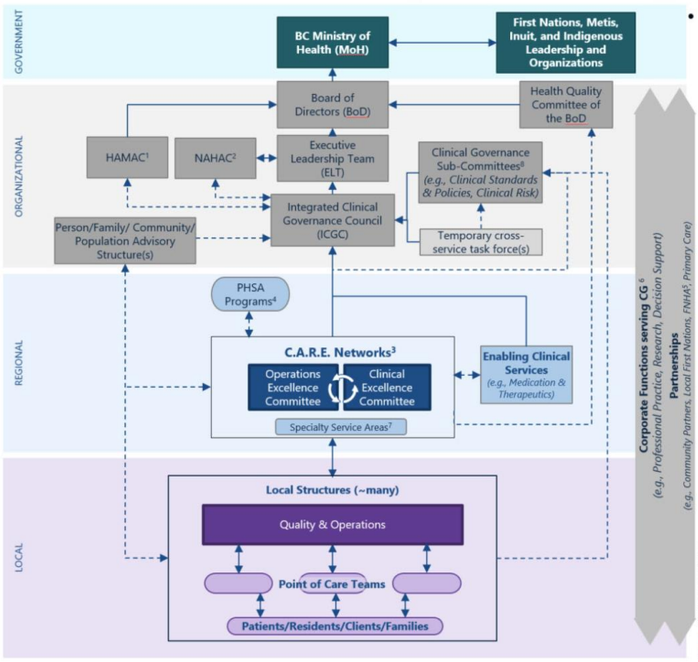
C.A.R.E. NETWORK ROLE & FUNCTION

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

The C.A.R.E. Networks are regional committee structures that complement and support geographic or community organizational structures responsible for the day-to-day service delivery within established standards. There are 13 Networks to begin implementation of the new model (see list under Design of C.A.R.E. Networks).

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.

Future state CG model | What is changing?



- **A single clinical governance structure** to enable shared decision-making for things like clinical standards and policies, long-term service plans, annual quality improvement plans with two way, and cross service information flows.
- **Clinical Governance Sub-Committees** support core clinical governance functions such as performance improvement and quality and clinical audit.
- **C.A.R.E. Networks** include Clinical Excellence and Operations Excellence Committees, as well as Specialty Service Areas, consisting of unique membership and representation of all local structures delivering the services.
- **A system of individual and shared responsibility** supported by standard clinical governance practices/functions and guided by approved plans.
- **A systematic mapping of membership to each committee** to ensure all regions, disciplines, services and where appropriate people/families/communities are represented in decision making.
- **Coordinated resource teams** comprised of experts from all of the organizations support functions such as Decision Support, Research and Human Resources.

In some cases C.A.R.E. Networks also have Speciality Service Areas. 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 Service Areas 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: 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.

Joint Accountabilities	Operations Excellence Committee	Clinical Excellence Committee
	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 March. 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.