Version 9

COLLABORATIVE SERVICES COMMITTEE, TERMS OF REFERENCE
Central Interior Rural Division of Family Practice

Date: September 27, 2016

BACKGROUND:

The Central Interior Rural Division of Family Practice (the Division), the Interior Health Authority, Doctors of BC (formally the British Columbia Medical Association), the Ministry of Health (MoH) and the General Practice Services Committee (GPSC) (hereafter "the Partners") recognize a shared responsibility for the health of the community. These Partners agreed upon signing the Document of Intent forming the Central Interior Rural Division that they would work together through a Collaborative Services Committee (CSC) to address issues in the health care system.

PURPOSE:

The Central Interior Rural Division CSC embodies the collaborative working relationship among the Partners. Here the Partners will present clinical issues of concern for patient care outcomes, co-determine priorities and co-design solutions, calling on additional voices from patients and the community. This collaborative process is not intended to mirror traditional negotiations.

SCOPE:

The Central Interior Rural Division CSC is an innovative way of co-generating solutions to the complex, serious and interconnected issues facing the health care system, the delivery of care and the experience of care. Supported by the Central Interior Rural Division, it is expected all Partners will work to continually improve patient care and systems efficiencies within their sphere of influence.

MEMBERSHIP:

From the Division: Ideally, physician members from each community of 100 Mile House and Williams Lake.
At least 1 member of the CSC should be from the CIRD Board executive or designate
From the Interior Health Authority: 2 members, one a primary care executive or designate
From the GPSC: 1 member or designate
From the Community: 2 members,

The Division and the Interior Health Authority will co-chair the Central Interior Rural Division CSC.

Additional Division members, Interior Health Authority, MoH, GPSC, or Doctors of BC leaders will be invited to attend discussion and decision making processes where the topic under discussion affects their area of responsibility.

As needed, representation will be requested from the medical community, patients and the community at large to ensure the Central Interior Rural Division CSC is addressing issues that reflect community concerns for primary care, support existing programs and answer the needs of those they are intended to serve.

Working groups of the CSC will have membership as established by the Partners and a Terms of Reference based on this document.

DECISION MAKING:

Decisions will be made by consensus. Consensus is achieved when everyone accepts and supports a decision and understands how it was reached. In meetings where significant decisions are to occur, all partners will be notified and encouraged to attend.

OBJECTIVES:

The Central Interior Rural Division CSC will:

- provide a forum for the Partners to develop a mutual understanding of the problems, priorities, strengths and issues of the community, supporting a population health approach
- provide a forum to bring together those who deliver clinical services and those charged with designing and supporting the health care system, to ensure all Partners understand each others cultures, strategic priorities, ways of working, points of view, priorities, points of leverage and limitations
- enhance working relationships of the Partners, ensuring broad clinical influence in system design, improving opportunities for alignment and supporting the overall sustainability of the system, recognizing that this creates a partnership greater than the sum of its parts.
- co-determine the development of clinical priorities and innovative clinical activities of the work in common, developing and monitoring these initiatives using the principles of continuous quality improvement
- ensure the Partners are supported (through data, administrative assistance, governance systems, etc) to understand and address gaps in patient care or quality of care in community and facility settings
- ensure all Partners understand their role in supporting continuous quality improvement[1] through mechanisms such as imbedding on-going evaluation and measurement to ensure emerging programs are meeting intended outcomes.

EXPECTATIONS OF PARTNERS:

- All Partners agree to use Triple Aim[2] to discuss which issues to move forward and which possible solutions to pursue. The Triple Aim approach ensures three things:
  - an improved patient or provider experience of care
  - an improvement in population health. The population will be defined by the project being considered
  - the financial sustainability of the system. Financial sustainability is defined here as the need to ensure all proposed programs are financially scaleable and able to be offered Province-wide to any appropriate community, physician or patient who wants them
- All Partners will agree to provide or collect data to support or clarify the concerns they bring to the Central Interior Rural Division CSC for consideration, understand the potential impact of solutions and support the on-going evaluation of co-designed programs

[1] See the Institute for Healthcare Improvement website (ihi.org) for resources on continuous quality improvement (CQI). Essentially, programs designed with CQI will have evaluations built in, will be regularly reviewed and, if needed, will be adapted to ensure that the intended results are happening. This contrasts with using evaluation only at the end of a project, when adaption is no longer possible.

[2] See ihi.org for more information on the Triple Aim and examples of projects.

- The Partners agree to bring issues or root causes to the table and not pre-determined solutions, trusting that the co-design of solutions using the perspectives of all Partners will generate innovation
- All Partners will facilitate the sharing of knowledge, success stories and learnings among the Partnership organizations, Divisions, patients and the community.
- All Partners will be transparent with each other about
  - their areas of influence and barriers to influence
  - their strategic and operational priorities for primary care
  - any proposed changes in their organizations that will affect local health care.

ACCOUNTABILITY:

- The Partnership is accountable for the results achieved or not achieved, with an emphasis on continuous quality improvement and a commitment to the ongoing improvement of co-developed programs to ensure the best possible results for patients, providers and the community
- All Partners are accountable to any funding Partner or outside funding agency to ensure funds provided for programs are used effectively. External funders will determine their systems for accountability. When the funding is internal to the CSC, accountability for effective use of funds will be contained in the measures and evaluation sections of any agreement.
- The Central Interior Rural Division of Family Practice is responsible for collecting items for the agenda, compile and circulate the agenda, record minutes at meetings and circulate them promptly with action items clearly listed.
- Members will communicate matters of importance between their own organizations and the Central Interior Rural Division CSC. The minutes and records of the Central Interior Rural Division CSC will be available to members to circulate inside their organizations to cultivate support.

MEETINGS:

Meetings will be held as deemed necessary or requested by the Partners, with a minimum of quarterly meetings. Any Partner can request a meeting of the CSC.

AMENDMENTS:

In the spirit of continuous quality improvement, the Partners will continually evaluate if the CSC structure and terms of reference are supporting innovation and better patient care. Amendments to the terms of reference based on community and regional differences can be made and approved through the consensus of all Partners, represented by their CSC members. If the CSC needs additional support or assistance it may approach the GPSC.

B. Easson.

Berni Easson, CIRD CSC Co-Chair

Dr Bruce Nicolson, CIRD CSC Chair