Ontario

Local Health Integration Network

Terms of Reference

SOUTH WEST CLINICAL QUALITY TABLE

Table of Contents

1. BACKGROUND/CONTEXT 3
1.1. Purpose and Scope: 3
1.2. Objectives 3
1.3. Accountability 4
1.4. Principles 4
2. MEMBERSHIP & ROLES OF COMMITTEE MEMBERS 4
2.1. Membership 4
2.2. Chair 5
2.3. Duration of Service 5
2.4. Individual Roles of Committee Members 5
3. LOGISTICS AND PROCESSES 5
3.1. Role of the Chair 5
3.2. Committee Support 5
3.3. Frequency of Meetings 5
3.4. Decision-Making Process 6
3.5. Linkages & Partnerships 6
3.6. Quorum Requirements 6
3.7. Delegates 6
3.8. Meeting Agenda and Minutes 6

1. BACKGROUND/CONTEXT

The Clinical Quality Table (CQT) represents a partnership between the South West LHIN and Health Quality Ontario (HQO) and provides a mechanism to advance the foundations for clinical quality improvement in support of the South West LHIN Integrated Health Service Plan and initiatives of HQO. The CQT will serve as an important mechanism for clinical leadership to achieve progress and momentum on quality.

1.1. Purpose and Scope:

The South West CQT will establish a more coordinated approach locally for the adoption of clinical care standards aimed at improving outcomes and reducing unnecessary variation in quality of care. In addition, the CQT will champion a culture of quality that will enable improved patient outcomes, experience of care and value for money.

A clinical care standard is a concise set of evidence-based, measurable statements that establish important elements of high-quality health care for patients with specified conditions. These standards support:

- Patients to know what care may be offered by their health care system, and to make informed decisions in partnership with their clinicians;
- Clinicians to make decisions about appropriate care for their patients; and
- Health services to examine their performance and make improvements to care.

Clinical care standards play an important role in helping clinicians ensure their patients receive consistent, appropriate care, with the goal of reducing unwarranted variation. They define the care patients should expect to be offered or receive, regardless of where they are treated in Ontario, and support health system planners in ensuring that appropriate access to care. They take into account current evidence-based clinical guidelines and standards, information about gaps between evidence and practice, the professional expertise of clinicians and researchers and issues important to patients.

1.2. Objectives:

The South West CQT is an action-oriented, clinically-focused body, concentrated on the adoption of clinical care standards, aligned with provincial quality priorities and HQO's Ontario Quality Standards Committee. The objectives of South West CQT will include:

- Supporting the advancement of key priorities within the Integrated Health Service Plan focussed on improving quality of care
- Monitoring quality of care key performance indicators within the scope of CQT
- Championing a culture of quality and local provider adoption and measurement of clinical care standards, including identification of enablers and barriers to clinical practice change
- Improving partnerships and integration amongst providers and partners in providing quality patient-centered care

- Enhancing reciprocal communication and knowledge exchange to inform provincial priorities and directions and to accelerate local implementation

1.3. Accountability

The South West CQT is accountable to the South West LHIN CEO and HQO Chief, Clinical Quality and Vice President, Quality Improvement.

1.4. Principles

The following list of principles will serve to guide the work of the quality table to accomplish its mandate. The table will be:

- Person centred
- Quality and performance improvement oriented
- Transparent, action oriented and data driven
- Equitable
- Consultative, collaborative and inclusive of all system stakeholder voices

2. MEMBERSHIP & ROLES OF COMMITTEE MEMBERS

2.1. Membership

Membership will be comprised of individuals from across the LHIN geography with pragmatic experience and clinical leadership insights to the mandate above.

Specifically, it will include representation as follows:

- Academic Health Sciences representatives (Family Medicine (1) and Specialists (1))
- Southwest Regional Cancer Program Primary Care Lead
- HQO representative
- LHIN Chief Clinical Lead
- LHIN Sub-Region Clinical Leads (5)
- LHIN Physician Leads, including Internal Medicine, Critical Care, Emergency Department, Palliative Co-Leads
- LHIN Vice President, Quality, Performance and Accountability
- LHIN Director, Quality
- Nurse Practitioner representative
- Public Health representative

*Others may be asked to consult or to participate as required.

2.2. Co-Chair

The LHIN Chief Clinical Lead and LHIN Director, Quality will co-chair.

2.3. Duration of Service

Non-LHIN members will be appointed for an initial 2-3 year term with opportunities for renewal. Terms will be staggered to ensure stability and continuity.

2.4. Individual Roles of Committee Members

Individual Committee members will:

- Actively and regularly attend committee meetings;
- Participate fully in the exchange of information and identification of issues of relevance to stakeholders;
- Consider ideas and different perspectives when providing guidance and input;
- Consider patient, system level and organizational implications and impacts;
- Understand the strategic implications and outcomes of initiatives being pursued;
- Be genuinely interested in the objectives being pursued; and
- Act as ambassadors for quality of care and disseminate quality initiatives into sub-regions and other relevant settings.

3. LOGISTICS AND PROCESSES

3.1. Role of the Co-Chairs

The co-chairs will be responsible for actively engaging all committee members in order to advance agenda objectives and overall mandate of the committee. The LHIN Clinical Quality Lead will serve as liaison with HQO. The co-chairs will be the official spokespeople for the CQT.

3.2. Committee Support

The CQT will be supported by the LHIN and HQO as partners. The LHIN will accountable for coordinating meeting dates, times, location of meeting and development of the meeting agenda.

3.3. Frequency of Meetings

Meetings will take place on a bi-monthly basis or at the call of the Chair. Meetings will be held in person, with remote participation available as required.

3.4. Decision-Making Process

The group will make decisions based on consensus. Consensus is a decision-making strategy where the members are comfortable with the decision and are supportive of its implementation. In order for consensus decision making to be successful, it is paramount for members to actively participate in the discussion.

3.5. Linkages & Partnerships

Specifically, the CQT will ensure that it seeks advice and input from local partners, clinicians and administrators and will ensure alignment occurs with other committees (i.e. Patient & Family Advisory Committee, Sub-Region Integration Tables, Health System Advisory Committee) of the LHIN and others relevant to the CQT's mandate.

3.6. Quorum Requirements

To constitute a formal meeting and conduct business, 50% plus one member including the one co-chair must be present. Decisions or actions taken in the absence of a quorum are not binding on the Committee.

3.7. Delegates

It is expected that members will attend all meetings. Given the mandate and membership, delegates won't be permitted. Based on the focus of individual agenda items, there may be times when additional individuals will be invited to participate in meeting discussions. Permission for guests to attend must be sought from the co-chairs in advance of the meeting.

3.8. Meeting Agenda, Minutes, and Materials

All documentation of the CQT will be located on HealthChat. All meeting materials will be posted five days prior to meeting date. Minutes will be posted within 2 days of the meeting. At the end of each meeting, key messages will be confirmed by the co-chairs.