Community Advisory Committee Roundtable Notes
February 6, 2014

1. How should the CAC be structured? In other words, what is the relationship between the CAC and the Hospital Board?

Group 1	• Should not be a "mouthpiece" for the Board • Should have a voice on the Board – CAC chair should be a full voting member • Board should seek CAC for input on policy • Not a one-way communication channel • No need for a Foundation member on the CAC • CAC should be a standing committee on Board
Group 2	• There must be an independent relationship between the CAC and hospital Board. We need the freedom to criticize if required • Must have the ability to report. Our mandate is to keep the Board accountable to taxpayers and patients – we need to be able to take a strong stance if there is a crisis • Drawback of the Rouge model is that it is chaired by a Board member. Loses aspect of independence/credibility • Need to speak publicly with the community and have in-camera sessions from CEO and Board if needed – autonomy • Report to Board on monthly basis • Ability to to meet in camera, if necessary • Public transparency important • No cross-appointment between CAC and Board – need to be separate • Reporting relationship between CAC and Board • Board and CAC should have equal standing and reporting relationship to CEO
Group 3	• Board member should be at CAC meetings • CACs need to be put in new hospital constitution • Must be recognized as volunteer hospital members • Must be a partnership with the hospital • Transparency and accountability
Group 4	• TSH membership is more independent – no Board membership. Reflects to a degree what the community wants • Chaired by the Board = connection to the Board • Influence from hospital outside of Board • Accountable and transparent to communities served • With Board members on CAC delivering reports/views, there is a conflict • Board could sit in, but there needs to be ability for closed meetings – can't vote, but can contribute

	• Flow of communications needs to be strong – linking to ensure information gets to the Board • Background information must float from Board to CAC to properly inform • Management may want to play a role in this too • May not need a voting right – representative to provide info to the Board • Committee gives/writes/presents report to ensure bias is removed • Community communicating to the Board • Role of senior staff – structure of community communicating to Board, laid out in strong terms of reference • Chair reports to the Board; accountable to make sure all CAC (community) voice is heard • Reporting to the Board is not an employee of the hospital • Must align to CAC terms of reference • Less of an agent of the hospital • Must be procedures to communicate why something is not adopted – feedback mechanism • OK to come back with "not good enough" to the Board

2. Identify the preferred composition of the CAC.

Group 1	• Should be independent – not self serving, and not a Board/hospital mouthpiece • Should bring in community values • Should have senior staff support from hospitals • Should have sub-committees to reflect community diversity • Volunteer-based • 5-6 meetings a year, with heavy staff support • Should have more voice and clout as a board committee – as important as doctors and other influential groups
Group 2	• Must be an orientation process • Must have a community feedback mechanism – email address for people to contact • Need adequate commitment for members to communicate to the community
Group 3	• Should be structured by the new hospital organization • Must be a bridge that exists in continuation • Try to merge the best practices from existing CAC/CAG structures • Chair of CAC should be elected • Chair, vice chair, secretary, assistant secretary, CAC members • Needs to reflect the demographics, geography, known stakeholder groups, all of the different cultures and views – gender, representation, etc. • Must be committed and aligned with vision of the hospital

	• Meetings are open to public, but public has observer status only – can't vote – can, however, take part in discussions
Group 4	• Joint composition • Balance of representation within membership • Segmentation between Board and community • Chair – influential, strong person. Elected? Election committee? • Reflective of community being served – culturally, geographically • Do not centralize • CAC positions (e.g., Chair) not influenced by Board • Must allow non-members to attend – open invitation • Issue of invite not being widely spread – hard to get people to volunteer their time

3. How should the members of the CAC be selected?

Group 1	• No service providers represented on CAC – service providers are adjunct to hospital • Non-profit organizations can be represented • Can be difficult to get people to come out • Reflective of diversity of the population – age groups, cultural, etc. • There is a lot of geography to cover • Representation on an individual basis • Skills-based composition • Call for applications – hospitals to administer selection process for members, in the same way as the Board • Geographic representation – equal representation on basis of geography • Diverse area – different cultures should be represented • Deal with cultural and geographic demographic differences through sub committees

Group 2	• RVHS's structure looks for people with complex backgrounds; this is appealing
	• Advertise in newspapers
	• Geographical representation of community/hospital users
	  ○ Note: patients from outside the catchment area access services – should they have a voice on the Board
	• Agencies often speak for patients who can't speak for themselves (young, hospices, etc.) but it is difficult for agencies to be neutral
	  ○ Members can be part of an agency, but that's not a criterion for membership
	• People with backgrounds in health and high level experience dealing with interest groups – should be eligible for membership, but in a private capacity
	• Diversity "in the broadest sense" – have to have cultural, socio-economic, linguistic representation

	• Priority neighbourhoods should be represented. Scarborough Action Network/United Way – something along these lines • Age – not only old people. Mental health problems exist predominantly among youth • Ajax Pickering serves suburban and rural neighbourhoods – both need to be represented • Must be definite criteria for selecting diversity • Background in complex matters very important – need experience working with different groups, at different levels of leadership. Not necessarily health related • Commitment – need a demonstrated history of commitment. If you miss three meetings, you're out • Member selection based on interview – corporate membership, advertising in paper • Need people on CAC who are already in positions to represent others – need to bring more to the table than just one perspective • Newcomers need to be represented • Should not have a city councillor/politician in the group. Politician would represent only his/her riding
Group 3	• Currently, the CAC/CAG groups lack in youth – need younger people • Must be balanced between the ridings • Must ensure members have the correct skills, background, interest and motivation • Strong criteria for selection must be defined • Not by appointment – by interview • Strong recruitment policy needed • Advertisement for CAC seats on website – needs to be impartial • Various community groups should be approached • Age (18 or older) • Term limit – CAC members should reapply – of 2-3 years • Reference check, confidentiality agreement • Members must volunteer time
Group 4	• Official selection committee • Filter through a number of candidates • Advertise in newspaper • Representatives of certain health groups/agencies - representing part of the community • Direct community must remain • Variety of perspectives • Not able to refill roles currently • Process to replenish membership needed • Role vacancies – old candidates should be contacted

4. How many members should sit on the CAC?

Group 1	• Not too big • Start with 15 people
Group 2	• 10-12 members at meetings; 12-18 members total • If you miss more than 3 meetings, you're out
Group 3	• 16 – 18 members – negotiable • We may have to keep it small so that the group is still effective – however, if it's too small, there might be fewer actual meetings • 10-15 members also a good number • Needs to be a quorum to do anything – would tie into the CAC structure (could be 20-25%) • Should be opportunity to call into meetings • 50+1 to conduct meetings; 2/3 if there are issues to be voted on, changes in bylaws • Must be arrangements for if CAC members are ill • People who do not show without reason should be dismissed
Group 4	• Larger than necessary – sometimes members aren't able to attend • "Back up people" • 20 max – currently around 10 • Smaller sub groups – chair and vice chair to attend central meeting to represent each area – each sub group to have roughly 5 people • Shouldn't align with hospital sites

5. Identify goals, roles and responsibilities of the CAC.

Group 1	• Work with hospitals and Health Links • Need to be connected to the whole healthcare spectrum • Must provide real engagement to the community • Can't expect CAC to do all of the outreach – hospitals should conduct outreach as well • Should be the point of reference for providing points of view/advice and attitudes of patients before they fall sick • Ensure focus is on engagement, rather than on fundraising or balancing the budget • Must focus on maintaining levels of services for patients • Not a paper-exercise • Bridge the gap between what community members think healthcare is, versus what hospitals deliver

	• Link between community and hospitals on decisions regarding service • Help with patient experience and navigation • Participate in designing, planning and implementing engagement framework • Need to make sure goals are clear
Group 2	• Must be independent and interactive – input should be asked for and received from the community • CEO and Board should also ask advice of CAC – two way street • Voice to the community – representation and advocacy • Independence • Mandate to keep Board accountable and honest • Insist that there has to be a corporate membership • Quality and risk monitoring • Focus kept on the patient • Provide awareness of what the hospitals provide – e.g. Rouge is the better place for cardiac, TSH is better for nephrology • Members must commit to being informed, staying current, attending and participating • Must reach out to the community, individually – i.e., organize community meetings, outreach meetings to general public • Can support transparency – put onus on hospital to communicate changes to the public. CAC can provide outreach and pressure hospital PR to communicate with public
Group 3	• The goal is to mirror the mission/vision of the hospital • CAC supports the hospital and what it is doing • Provide input from the community and report back • Act as ambassadors of the hospital • Be able to communicate hospital/community needs • Again, bridge the gap • Members need to know the hospital • Orientation must be done independently • Hospitals can currently influence the CAC – this shouldn't happen anymore
Group 4	• Responsibility of CAC membership to collect community feedback • 4 subgroups to CAC – small, adjacent to campuses perhaps • Emphasis to obtain local feedback • CAC role of educating and informing community • Proper mechanisms - meetings, mediums to access communities, subgroups • Ability to broadcast • Organized outreach within subgroups • Ensure you can hit proper market

	• Give CAC ability to access community as ambassador • Hospital to provide support to CAC and subgroups to ensure proper outreach • Restrictive new role of hospital should be defined by CAC to community

6. Any other advice or comments relating to the CAC?

Group 1	• Public Health Act should reflect the community • Look at how Chinese, Muslim and Tamil populations engage with community • Should be called the "Community Engagement Committee" • This is a lot to expect from a volunteer • Must remember that service is for the community • Need to understand what we can and can't offer – must have reasonable expectations • The community has changed – Scarborough's median income is much lower than it used to be • Have to understand that the hospital is part of a health system • Need to play a role in ensuring that the transitioning community is properly engaged
Group 2	• Currently, there are very different structures between the two advisory groups • Ability to meet in camera important • Meetings should move from site to site • CAC members should be included in broad hospital meetings • CAC should have similar process to board development • Need adequate resources to support the CAC – i.e., hospital note taker to do minutes so CAC members can actually participate • "It's very good to start with a blank page, rather than look at what has historically been done. We shouldn't be reconstituting the old guard in developing a new one"
Group 3	• CAC should have its own webpage on hospital site • Should have a mission statement • Needs to abide by rules and regulations • CAC members should resign in writing
Group 4	• Should merge CAC before integration – this is the first step • Currently there is strong leadership, which could contribute a lot to the merger process • CAC to have online portal – announcements, collect info/process, tactical

Discussion

Table 1:

In terms of the first question – how should CAC be structured in terms of relationships between CAC and the Board? - the strongest point is that we aren't a mouthpiece. We don't just want to be a communications pipeline between community and hospital. The CAC should have a voice on the Board, because if the organization doesn't have some teeth it can't be all that effective. It needs to be able to influence the direction moving forward. We'd like to see a CAC with some ability to provide input on policy, no one-way communication (i.e., we should be at the table when things are being decided). Don't see need for a Foundation member to be on the CAC.

Makeup of the actual CAC – looked at it from the perspective of service providers vs. non profit service. We would like to see it represent the community, not the providers to the hospitals. Providers from non-profit sector are fine, because they do represent community, but not the commercial service providers to the hospitals.

In terms of supporting the CAC, there should be senior staff support and a budget; not just volunteer. If you're going to expect certain outcomes, there has to be a budget to deliver.

There has to be a degree of independence. Reporting to the CEO says that we are actually working "for" the CEO and it shouldn't be that way. It should be more like a standing committee, with sub committees working in conjunction with the Board and the hospital.

In terms of the CAC, the relationship between the community and hospital has not been an easy one. There has been an up and down, push and shove relationship because quite frankly the CAC wasn't there for the first go-round. It wasn't a very well developed authority structure, so community wasn't able to really provide input. CAC should be the representative of the community; but that didn't happen the first go-round, the CAC wasn't paid attention to. The CAC should facilitate engagement with the community.

It has to be patient-centric; patients are the community. The community is the end-user of the hospital services, and quite frankly, I don't want to provide feedback if I'm in the hospital as a patient – I'm too worried about what's happening to me right at that point. I'd rather do that while I'm still well.

Public Hospitals Act – if we are serious about it, the Public Hospitals Act has to be reviewed and adjusted. The PHA has given physicians unprecedented control. The hospital administration has to work with the community to get feedback.

Demographics – each portion of the community, culturally, has certain differences, and the CAC should be able to reflect those differences, either to facilitate or provide the education to the community that would allow the bringing together of the community in a more effective voice, the needs and requirements of these segments of the community.

In terms of selecting the CAC, the quality of people is important. We can't just have someone who wants to volunteer – there should be a criteria that people who are on the CAC should undergo the same due diligence as for a Board member.

In terms of getting people involved and invested/motivated/participating – there has to be a bit more focus on how to recruit people to the CAC. It's a lot of work we're asking, and they should be able to deliver.

Table 4

This is a wonderful opportunity for us to have a new beginning – so we shouldn't look at past histories. We should look forward in terms of building a new CAC.

We looked at the structure of the CAC, and you have the chair, vice chair, secretary, etc. but we need to reflect demographics, geography, different stakeholder groups and all the 'isms' in society as much as possible.

We currently lack young people on our CAG. We need young people, and we need to look at geography, ridings, demographics to ensure the entire catchment area is represented, in a balanced way.

There has to be commitment to the vision of the hospital. CAC should support that and be the bridge to the community. The CAC should have a supportive/bridging role – this doesn't mean we will be the "do as they say" group. We will bring our concerns and advice to the Board.

We need to put together a constitution where we can use the best of both TSH and RVHS current structures so it become as coherent working group.

We are recognized as volunteers – not there to be remunerated or paid.

The Chair should be an elected position in the group.

Table 2

When we talked about how members of the CAC should be selected, we were consistent with the views already shared that there should be due diligence going into who should be there. We want to be representative of community, but there should also be recognition of skills and background to provide input.

To find appropriate members, we should advertise in paper; conduct an interview process; and elect the Chair from within the membership.

Suggestions are that members should have background in complex matters, working with different groups (including business processes, corporate membership).

There needs to be adequate process to support member selection.

We will also need to establish an orientation process to ensure members are all on the same page moving forward and have the knowledge about what is required.

Table 3

Size of the membership – we struggled with this. If it's too big it won't work, and if it's too small it won't reflect this larger community.

If you make it too small, no one will show up.

We looked at the possibility of having some backup people – if someone can't attend, there are people who will participate on a "backup need" only/attending occasionally.

In terms of numbers, we see the CAC as a group with a maximum of 20 members, split into sub groups. Each sub group would represent their local community (4 sub groups, of 4-5 people) and one or two people from each sub group would represent that sub group and form the central CAC group that would be in attendance regularly at meetings.

Our general consensus was to follow most of the terms of reference of the current CAC from Scarborough hospital. That was partly because no one at this table represented RVHS – but the general idea is that many aspects of the CAC are good.

Additional Comments

I don't agree that the new group should follow the TSH terms of reference. If you look at the objectives of why the new group will form, bullet 3 is the main goal, and objective ("build and broaden CAC's engagement strategies"). The CAC would be the group who would oversee the design and implementation of the framework of the community engagement. If you look at current CAC from Scarborough, it is a mixed bag of everything. The current group is doing way too much, and it is impossible to do the job effectively.

The CAC will support the hospital and what they're doing, but would also provide input to community and provide feedback from the community – act as community ambassadors. The CAC should communicate the needs of the community and bridge the gap. Members on the outside need to know what the hospital is doing.

There is an orientation process that will need to occur, independently.

The hospital may have influenced the CAC in the past, but shouldn't anymore.

If you come with an agenda other than "helping the community", you shouldn't be part of the CAC.

Meetings are open to the public – the public can attend and have an observer status, but don't have a voting right.

I noticed that another group said they don't want a Foundation member on the CAC – I disagree. It is important to have a Foundation member, because hospitals have a lot of fundraising activities, and you raise funds from the community. It builds another bridge to have a Foundation member on the CAC.

We think that administrative services should be provided by the hospital to the CAC. There should be a note-taker to write minutes of the meetings, because it would create standardization.

There is a need to have possibility for in-camera sessions.

We are looking at the broad strokes at this point, and shouldn't focus on the minutiae right now. We represent two very different hospitals, and the CAC should communicate those differences in expertise between the hospitals to the community.

We shouldn't just blindly say that we will follow the CAC model – we should build on the strengths of both systems.

We should merge the two advisory councils as soon as possible – to create the new council as soon as possible, because there could be additional value provided by creating the CAC sooner rather than later.

Each volunteer CAC member should have a background police check – because we have access to the hospital and safety should be a priority.