RISE
Rapid-Improvement Support and Exchange

# RISE brief 5: Community engagement
(Last updated 7 August 2019)

## Overview

As the name of OHT building block #3 suggests, Ontario Health Teams (OHTs) will need to commit to both patient partnership and community engagement.

Many OHT partners have been steadily 'upping their game' in the first half of building block #3 – patient partnership – by involving patients, families and caregivers in governance (e.g., as board members), leadership (e.g., as Patient and Family Advisory Council chairs), and both co-design processes and rapid learning and improvement processes (e.g., as working group co-leaders), as well as part of the care team. OHTs can now build on this work by involving patients, families and caregivers in many OHT roles, including (but not limited to) governance and leadership positions, co-design processes and rapid learning and improvement processes to improve care experiences and health outcomes for their year 1 priority populations, and in co-design and rapid learning and improvement processes for the full suite of OHT building blocks to lay the foundation for becoming accountable for an entire population. In doing so, OHTs can use the Patient Declaration of Values for Ontario as a vision of what they are moving towards.

### Box 1: Coverage of OHT building blocks & relevance to sections in the OHT full application form

This RISE brief addresses **building block #3**:

1) defined patient population
2) in-scope services
3) **patient partnership and community engagement**
   - **community engagement (domain 12)**
4) patient care and experience
5) digital health
6) leadership, accountability and governance
7) funding and incentive structure
8) performance measurement, quality improvement, and continuous learning

It is relevant to parts of **sections 2 (question 2.10), 3 (questions 3.7.1-3.7.3) and 5 (section 5.4)** in the OHT full application form.

In this RISE brief we address the 'second half' of building block #3 – community engagement – and shift the focus from individuals to community groups. Community engagement can be defined as the "direct or indirect process of involving communities in decision-making and/or in the planning, design, governance and delivery of services."(1) More specifically, we use the term community engagement here to mean the meaningful engagement of diverse community groups and, through them, diverse communities. Community engagement can be a powerful way to engage communities whose voices typically aren't heard, including those who may not be accessing needed services now, and who may not have been well treated when they attempted to access needed services in the past. In particular, OHTs will be required to have particularly well-developed community-engagement approaches for francophone communities and Indigenous peoples.

Good community engagement means:
1) building relationships with the full diversity of community groups in their geographic area;
2) being explicit about the goal of any given community-engagement initiative; and
3) being intentional in the design of a community-engagement initiative.

## Building relationships with the full diversity of community groups

A community can refer to groups who share certain characteristics or interests, such as:
1) living in the same area;
2) having lived experience with (or special interest in) a condition, disability or health topic;
3) age;
4) sex, gender identity or gender expression and sexual orientation;

5) ethnocultural background (including ancestry, colour and race, as well as ethnic origin and place of origin);
6) language spoken at home;
7) employment, union, marital, family and citizenship status, as well as record of offences;
8) socio-economic status (including receipt of public assistance); and
9) creed (or religion).

This list is not meant to be a definitive or comprehensive list, but to illustrate the diversity of community groups that may exist in an OHT's geographic area, many of which may self-identify in relation to an intersection between two or more of these characteristics or interests.

Community groups can vary in whether they are:
1) informal (e.g., informal self-help, support or social groups) or formal;
2) voluntary (where volunteers perform most of the work and which are often advocacy-oriented) or professional (where professional staff perform most of the work and which often have more resources); or
3) not-for-profit (which is the case for almost all formal voluntary community groups and for most community-based professional-service agencies) or for-profit (which is the case for some community-based professional-service agencies).

OHTs are likely to be particularly interested in engaging formal voluntary community groups and community-based professional-service agencies. Faith-based groups are examples of formal voluntary community groups. Community Health Centres and Aboriginal Health Access Centres are examples of community-based professional-service agencies. All three of these examples are groups that have a long tradition of engaging (and serving) socially disadvantaged and hard-to-reach groups.

OHTs may engage community groups in a community-engagement initiative or they may ask their partners leading community groups to engage their respective communities. Alternatively, community groups may engage their respective communities to decide whether and how they participate in an OHT or in an OHT's community-engagement initiative.

## Being explicit about the goal of any given community-engagement initiative

It is important to be explicit about the goal of (or degree of power and control sharing in) a community-engagement initiative. To paraphrase the Ontario government's public-engagement framework (which was inspired by the International Association for Public Participation or IAP2 framework), the goal could be to:
1) share: community groups receive information about an OHT program or decision in an accessible way (communication is one-way from the OHT to community groups);
2) consult: community groups have an opportunity to weigh-in and provide their input (participants advocate for their views on a subject);
3) deliberate: community groups help identify the issue and/or develop a strategy that the OHT commits to deliver (participants take part in varying degrees to find common ground and collectively arrive at an agreement); and
4) collaborate: community groups work with the OHT to define an issue and to develop and deliver solutions (participants share decision-making and implementation of solutions).

OHTs will be increasingly sharing power and control with communities as they move down this list.

## Being intentional in the design of a community-engagement initiative

OHTs will make many decisions when designing, executing and drawing lessons from a community-engagement initiative, including about both the attitudes that they bring to, and the key design considerations for, a community-engagement initiative. Often these decisions and the possible alternatives are not made explicit, even among those involved in the initiative.

OHTs should be intentional in the attitudes that they bring to a community-engagement initiative. To help with this, they can ask questions like:

1) are we modelling an openness to having stories told and issues reframed, as well as a commitment to inclusivity in who is telling the stories and reframing the issues?;
2) are we demonstrating a commitment to being as systematic and transparent as possible in community engagement within the constraints of the decision-making process?;
3) are we showing a willingness to adjust the initiative (methods, timelines, etc.) when needed to engage hard-to-reach groups (and as much as possible to reduce the constraints imposed by the decision-making process)?; and
4) are we seeing the initiative in part as a way to provide future leadership opportunities for members of underrepresented groups?

OHTs can also be intentional in decisions about each of the key design considerations for a community-engagement initiative. They can ask questions that build on what we know about good design,(1; 2) such as:

1) are we clear about the goal? as noted in the preceding section, examples may include:
   a) sharing,
   b) consulting,
   c) deliberating, or
   d) collaborating;
2) are we clear about the focus (when consulting, deliberating or collaborating)? examples may include:
   a) understanding a problem and its causes, or prioritizing among problems and their causes (or among aims),
   b) eliciting values and preferences about options for addressing a problem or its causes,
   c) identifying implementation considerations, and
   d) planning for monitoring and evaluation;
3) are we clear about the relationship to other initiatives? examples may include:
   a) ad hoc or ongoing initiative (with the latter allowing for community groups to play a role in periodically refreshing the membership),
   b) isolated or part of a multi-faceted initiative, and
   c) formally mandated or informally requested;
4) are we recruiting in ways that respect diversity? examples may include:
   a) explicit criteria for groups that capture different types of lived experience, ethnocultural backgrounds, socio-economic status, etc.,
   b) defined pool of potential groups from which to select groups to be invited using explicit criteria,
   c) awareness of which groups are likely to be (and which were) missed and why (e.g., history of poor relations), and
   d) awareness that some issues may make it difficult for groups to put the broader public interest ahead of organizational interests or self-interest;
5) are we providing appropriate supports? – examples may include:
   a) capacity building (such as training or mentoring),
   b) translation,
   c) pre-circulated plain-language brief so groups can prepare,
   d) presentation of key points from the brief (e.g., to help those who may not have fully understood points in the pre-circulated brief),
   e) rules about anonymity (and more generally, clarity that benefits or care won't be affected),
   f) payment for expenses and possibly their time, and
   g) counselling and other resources if the engagement may elicit trauma-related memories;
6) are we using a clear process? – examples may include:
   a) skilled facilitator,
   b) clarity about context and constraints (including timelines),
   c) format, timing and venue acceptable to the groups,
   d) approach to finding agreement (e.g., finding both common ground and differences of opinions versus seeking consensus through formal voting procedures), and
   e) approach to finding other opportunities for groups that aren't a good fit for a particular initiative;
7) are we making appropriate plans for follow-up? – examples may include:

a) capturing what was learned in a document and sharing it,
b) following up with participants about decisions taken; and

8) are we evaluating the initiative, possibly using the 'Patient and public engagement evaluation tool,' and using what we learned to improve future initiatives?

## References


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