GTA CLINIC TRANSFORMATION PROJECT

STEERING COMMITTEE MEETING

TUESDAY, MAY 13, 2014
6:00PM-9:00PM
METRO HALL RM 304

PRESENT: Julie Northrup, SECLS; Sharon Majik, SECLS; Steven McCahon, RCLS; Haris Blentic, NLS; Isabella Meltz, KBCLS; Brook Physick, FCLS; Dennis Bailey, CLCYR; Pam Courtot, CLCYR; Mayo Hawco, NPDCLS; Jack Fleming, NPDCLS; Jack De Klerk, NLS; Marjorie Hiley, FCLS; Elisabeth Bruckman, WTCLS; Matt Benson, ETCLS, Luis Mayorga, ETCLS; Noland Merrick, JFCLS; Julius Mlynarski, SECLS; Liz Klassen, SCLS; Christie McQuarrie, WSCLS; Sean Rehaag, PCLS; Joe Myers, WCLS; Yodit Edemariam, RCLS; Nancy Henderson, PCLS; Vanessa Emery, WSCLS; Charinee DeSilva, DCLS; Stewart Cruickshank, ETCLS; Sean Meagher, PI; Leila Sarangi, PI

MINUTES

Agenda Items			Discussion/ Information	Outcome	Action/Discussion Points
1	6:00	Welcome/introductions		Received	
2	6:05	Review of meeting materials	Information	Approval	Received
3	6:10	Review of minutes from April 29 meeting Feedback from Clinics	Discussion	Approval	Received
4	6:15	Working Group Report	Information	Received	Received
5	6:30	Review of Revised Project Timeline	Discussion	Approval	Received and Approved
6	6:40	Catchment Areas	Discussion	Approval	PI will circulate the ppt.
7	7:50	Resource Allocation	Discussion	Approval	Deferred to next meeting
9	9:00	Adjournment and next meeting	Discussion	Approval	Next meeting is Monday May 26, 2014 from 6:00pm – 9:00pm in North York

1. **Welcome/Introductions**

   Welcome and introductions were received.

2. **Review of Meeting Materials**

   Meeting materials were reviewed.

3. **Review of minutes from April 29 meeting; Feedback from Clinics**

   Minutes from the April 29th meeting were reviewed. Feedback from clinics was provided. SECLS had discussion at their clinic and suggested that we may want to consider back office consolidations. It was discussed that in the new system the clinic boards may decide to consolidate their back office functions.

   Each clinic will have their own resources and be able to decide what the best make-up is for them based on the proposed transformational model. Each clinic will be an independent, non-profit corporation governing itself. Each board will have an opportunity to enter into a collaborative agreement as well. These clinics will continue to be governed by community boards, and those boards will decide how the clinic operates.

   CLCYR discussed the implications of the model clinic at their board level. They were surprised at the number of administrative positions, especially given that LAO has been driving to lessen administrative costs. They also noted that with this size clinic, it would limit the number of clinics in the GTA to about 4.

   It was discussed that there are some competing principles, such as working in teams, which implies larger clinics; the presentation today will explore the principles governing catchments.

   It was proposed that there are ways to slim down the org chart, for example, if advice are embedded into teams there does not need to be an advice team leader. It was noted that the Administration Team is not broken out into as much detail as the other teams in the chart.

   It was noted that calling the model clinic 'ideal' may not be the most accurate title. The suggestion was made that 'prototype' or 'conceptual prototype' would be a more accurate concept to use.

   SC requested data that would give an idea of the dollar amount that will be saved as an outcome of transformation and whether there would be enough to impact on the number of clinics. The Transformation Clinic Modelling paper does show that non-admin positions in the new system are estimated to go up by 16 FTE and reallocated to service delivery and community development, but there has not been a cost analysis done of savings in terms of leaseholds, etc.

4. **Working Group Report**

   The Working Group co-chairs provided an update on the first meeting with the LAO transformation coordination committee, which is comprised of representatives from all the regions across the province who are involved in a transformation project. It is reportedly a big group and the sense is that they may not do more than share information with each other about their respective projects. LAO does not want the Association involved in the process but they may get observer status on this committee. A Terms of Reference is going to be drafted for this group. If real coordination is required, the Marjorie and Jack, and others on the committee, still feel strongly that a person will have to be hired to do this.

5. **Review of Revised Project Timeline**

The Project timeline was amended to give more time between the SC receiving the report and boards signing on. As well, another SC meeting was added for June 23.

The amended Timeline was approved by the SC.

6. **Catchment Areas – and – 7. Resource Allocation**

There was discussion as to whether or not any staff positions can be removed from the org chart, for example, the advice team lead, as mentioned earlier, could be taken out and the admin team could be reduced from 6 to 4 staff, but we are expecting input from the Toronto Support Association on this. Caseworkers become more effective and efficient if they can focus on their casework and not on admin duties. There was consensus that there were a variety of possible changes that could add or subtract a few staff, but none that radically altered the size of clinics.

Sean presented the implications of the ideal clinic on catchment areas and the principles that guided the mapping (see ppt emailed May 15). All the maps assume one clinic for York region and one clinic for Peel region, assuming Mississauga and North Peel and Dufferin clinics combine. There are no compelling reasons in the principles to divide up the clinics in those regions.

The first map showed a one large clinic model for the city of Toronto and assumes clear relationships with community partners to be able to have access points.

The two clinic model for Toronto was presented with the seam being down Bayview and the Don River. Clinic B in the map has more population than clinic A.

The three clinic model in Toronto is driven by contiguity of high concentration of low income census tracts. The U clinic in this map is long and determined by the subway system which would provide access to that clinic. This model most closely fits the ideal size clinic.

The four clinic model has a closer connection to community. There was discussion as to whether the North West clinic could be broken out more but it would then become too small to realize benefits of transformation.

The SC had some discussion as to whether there would be an impact on catchments if multiple offices for a service provider, such as OW, are located within the same catchment. It was noted that this is the case for many clinics currently and staff make the relevant connections.

There was discussion as to how community boards will govern larger catchments. Some clinics saw this as a challenge but others felt it was already part of how they reach their communities. FLCS serves a diverse area and their community board has adapted and maintained a sense of community through partnerships, staffing, etc. The York clinic as well is mindful to include people from across their catchment which is extremely diverse. They use satellite clinics and have a diverse board, not only in terms of ethnicity but geography as well.

There was also discussion that knowledge about the information on communities we serve which doesn't always come from the boards, who have some connections but not the resources to consult. Staff work in the communities and connect with them every day and can therefore be responsive.

There was discussion about what makes a clinic too big. It was suggested that if we lose the idea of neighbourhood clinics, then there may not be a difference between 1, 3, or 4 clinics in Toronto. It was noted that currently the system has only a small handful of neighbourhood clinics with small

catchments and that most of the clinics operating in the system have much larger catchment areas. These clinics are not "neighbourhood" any more than the 3 or 4 clinic models would be.

It was suggested to revisit the core areas of law discussion to explore whether the idea of offering less core services with a second tier of services offered by some clinics may be able to reduce the number of staff per clinic. Most clinics currently do not offer immigration, employment and CD and these could be the second tier services. It was noted that the ideal org chart reflects the lower volume of service in these areas in the percentage of staff allocated to them.

The SC requested more information on the principles as they relate to clinic size. When clinics are too big, more layers are required in the org chart. When teams are too large, there is concern that they will work in silos and interrelation between teams becomes more difficult as does management. Also, the qualitative data clearly points towards not becoming part of a machine. We want to try to stay small where we can. It was noted that this is one way to be transformative, and there are other examples such as the Unison model.

There was discussion that each map conforms to principles more or less and we need to carefully consider why we choose to prioritize certain principles. A one clinic in Toronto system that is catchment-less would allow people to get services everywhere and would allow for more specialization. It seems as though different principles carry weight in each map and it would be helpful to know the range and understand that weighting. It was suggested to tag the principles doc with the things they drive, from community governance, to teams to back up, and where they came from (quantitative data, qualitative data, literature).

8. Meeting Adjournment

Meeting Adjourned 8:40pm