1. **Greetings**

Tony LaRocca welcomed CAC members and shared information about a likely media story that will appear in the London Free Press after a letter describing a negative patient experience in the Emergency Department was sent to the paper. The hospital has been facing an unprecedented increase in the number of patients with mental health issues presenting in the ED requiring hospital admission. LHSC leadership is implementing a variety of measures to address this challenge and sincerely regrets the turmoil and anxiety this is creating for patients, families and the health care teams.

2. **Review and approval of January 24th meeting minutes**

Minutes were moved by Dave Ducharme and seconded by Bill Peel. Minutes were approved as submitted.

3. **Wayfinding Update**

Cathy provided an update on the wayfinding project (information was shared at an earlier CAC meeting). As requested by hospital volunteers, new maps for Victoria Hospital were created and will be handed out to patients and visitors by volunteers and porters. The maps highlight popular programs and services on levels 1 and 2 at VH.

Initial feedback included:

- better signage to more clearly indicate what is “staff only” and public parking in lots #3 & #7
- move some staff parking to level 6 or 7 in the parking garage
- include washroom locations on the map

Cathy encouraged CAC to review the map and send any feedback to her via email.
4. Membership Committee Update
Cathy was asked by Frank Harper (Chair Membership Committee) to share the committee’s work to date. The committee’s mandate is to sustain the CAC and recruit new members. The CAC received copies of the Terms of Reference, proposed diversity matrix, application form, and interview questions. A recruitment process needs to be in place as there have been a number of retirements over the last year and the CAC has identified potential new members in the community, and has also had expressions of interest from the community.

Q: Did you land on an ideal size/number of participants?
A: The CAC Terms of Reference do reference an ideal size of 20, and at least 50% of the membership to be non-hospital based.

Q: Is there a formal approval process for the membership process?
A: We will present an implementation plan, but would like to keep moving forward.
Action: Cathy will send electronic copies of the diversity matrix to the CAC along with the minutes. Feedback will be asked for within 2 weeks of receipt of electronic copies.

5. Partnering in Transformation
Carol Walters, Director of Clinical Services Renewal, presented the Partnering in Transformation initiative which is a component of LHSC’s Clinical Services Renewal (CSR) strategy. Carol reviewed the CSR and the three work streams within it:

Clinical Strategy: This project includes a strategic review of LHSC’s clinical programs in the context of our regional and provincial priorities; making recommendations on health–care delivery models; and prioritizing our strategic programs.

Internal Improvement: This project includes looking at high-intensity, complex areas of the hospital to identify process improvements

Partnering in Transformation: This project involves looking at the high users of the health-care system and determining what system challenges exist for them across the continuum of care. This means analyzing from the patients’ perspective, not just the health care perspective, and finding a solution that is inter-sectorial, inter-professional, and inter-professional. It is also a goal to get all health care system providers to deliver care in a standard way.

Carol presented a graph illustrating current and future patient demographics. Presently there is a dip in the elderly/frail population, however they represent a large number of our current patients and are already causing tremendous pressure on the health care system. This group tends to have multiple health care challenges at once. Soon we will see baby boomers become the frail/elderly.

Understanding the high system user populations will help the hospital to implement changes that will make our service more effective, efficient, and affordable. We are looking to build integrated care for chronic disease management, complex populations (frail/elderly, mental health/addictions) and acute complexity. Carol concluded her presentation by listing some initiatives currently underway:

London Partnership in HealthCare Transformation: Consisting of 80 stakeholders from across London, this project was launched in November to identify challenges in the system from different care provider perspectives (inclusive of patient voices). A small group is now working
together to look more closely at different populations. A lot of challenges heard were in social determinants of health (i.e. transportation is a major barrier for people).

**Transitioning children:** This project involves looking at strategies to better support patients who are no longer 18 and transitioning to an adult health care environment.

**Mental Health Transitional Case Managers:** This project involves partnering mental health patients with a case manager when they are transitioning out of the hospital and into the community to support them for a period of time to reduce the likelihood of them returning to the hospital.

**Addictions Services Case Managers:** This is a similar approach to the Mental Health Transitional Case Managers.

**Connecting Care Collaborative:** Through data analysis the hospital is looking at our most prevalent chronic diseases. The objective is to build a continuum of care that will engage primary care providers and community services differently than ever before. There are three levels of projects and areas: CHF and COPD, diabetes, and mental health. Carol assured the CAC that mental health is not being ignored as our data illustrates that anyone with multiple chronic conditions is also suffering from a mental health issue.

**Mental Health Crisis Centre:** This project is separate from the mobile crisis team that is already up and running. LHSC is undertaking this initiative with CMHA—Middlesex, Mission Services, and London Police Services to create a facility that will treat mental health patients (max. 48 hour stay) who do not require acute care. The intent is to provide appropriate care to patients in a timely manner. The CAC expressed concerns about grouping all mental health patients into one basket. There are those that are sick and require disease management while others need help in an acute mental health crisis. Tony responded that in order to achieve success with these initiatives, it is imperative that LHSC listens to members of the community who have a better understanding of what the issues are so we can create something different than what has been done in the past. Tony concluded that the CAC is encouraged to draw LHSC’s attention to considering other points of view throughout this process.

6. **Refreshment and Networking Break**

7. **Emergency Department Transformation Project**

Dr. Adam Dukelow (Emergency Medicine Physician at LHSC), Carol Rhiger (Director of ED), and David Bailey (Project Manager) presented the Emergency Department Transformation Project. Dr. Dukelow began the presentation by commenting that over the past 10–11 years the ED team has been stressed by the increase of acuity of patients, higher patient volumes, and the number of “boarded” patients in the ED (waiting to be admitted to the inpatient units). The grassroots project is using a value based system called the ED LEAN Toyota Production Value Stream. The project team consists of approximately 50 people from all levels of staff (CEO, VP’s, Directors, Nurses, Support Staff and doctors), with project motivators, drivers, and project leads from within the ED. The team members are encouraged to make incremental improvements that must provide value to patients and/or providers for implementation. Adding value and eliminating waste is done through observation. David Bailey presented the “MUDA” map where the project team had identified all of the waste in the current ED processes. Once a week project team leaders, along with the CEO and VP of Patient
Centred Care conduct GEMBA walks. Through talking with people and observing inefficiencies and ED challenges (process and facility focused) opportunities for improvement have been identified and implemented. In addition to process improvements, the team is looking into redesigning the ED facility based on Toyota thinking and enhancing of “visual cues” that allow staff to more easily see what is going on in the department. This concept includes standardizing and smoothing of clinical pathways, an observational area for ED patients, alternate approaches to admitting patients, and the creation of a patient/provider council. This project has many spin-off mini projects called Kaizens. The project team conducts weekly EDST (Sharing Toyota methodologies) meeting with staff, and a key success to date has been growing physician and staff engagement.

This presentation prompted the following questions from CAC members:

Q: Is there concern that more people will start coming to ED because they can get through so much faster?
A: Yes the volumes will increase, but all we can do right now is try to fix what we have control over.

Q: Is Children’s Hospital (CH)/paeds emerg included in this work?
A: No, but this work will affect their staff and may lead to future adoption of the key lean principles being used to modify work within the CH department. We have had discussions around changing where paed patients wait.

Q: The “value-add” definition – who makes that decision?
A: Providers and patients. We’ve engaged Lisa Hawthornthwaite (patient engagement) and her team. We’re running a simulation on April 9 of this new front-end process to have real patients go through this simulated process.

Q: How are security concerns being factored into the new design?
A: Security of patients and staff/families is of utmost concern and our re-design planning will reflect that, with direct engagement of our security team in the process as we get closer to the redesign phase.

Q: Will this solution include new security equipment?
A: We’re not at that stage yet. Security discussions will take place down the road.

Q: Do you study algorithms and base staffing levels on peak volume times?
A: Yes (but current staffing models have us ramping up when we know we can provide care, not when we know patients are going to show up). This new model would staff based on when patients are actually showing up. And we’re tracking better data to help us design that.

Q: What’s happening to deal with cross-contamination (i.e. infection control)?
A: The shorter your stay, the less likely you are to catch something. We will decrease infection rates based on shorter stays alone. But infection control is also at the table for our design processes.
Q: In US hospitals, there are screens in patient waiting rooms that keep a running total of where you are in the process. Will you do this?
A: From provider perspective we have those screens. Our observation has been that, after time, these screens are no longer having an impact because staff gets so accustomed to a way of providing care. We’re hoping we won’t need the screens in patient areas because patients won’t have to wait the way they do today.

Q: Is there a way to be seen by a nurse practitioner instead of MD?
A: We tried that at UH and it didn’t work. Having medical students and nursing students makes it difficult. There are a lot of value-added NPs at LHSC and the role they play is with inpatient teams where they provide consistency from day to day. In ED, it’s a very different environment.

Q: How will this affect urgent patients like stroke?
A: Emergency patients (CTAS 1 and 2) cases will continue to be seen first.

Q: Do you have databases you can look at for evidence-based models to base care decisions for patients like stroke patients or those presenting with certain symptoms?
A: No, what we have is education, experience, and ability to know what resources we need to make a decision. But no overall database to type in symptoms and come up with a diagnosis (There are some databases for some clinical issues but not most).

8. 2014 CAC Objectives
The meeting ran over time with the ED transformation project so this item was deferred to our next meeting.

9. Wrap-up
The CAC concluded that in the future when there are presentations with a lot to discuss we will leave more time for discussion. The next committee meeting will be May 26, 2014.
Action: Please mark in your calendars our Annual Community Meeting on June 24. CAC members will receive an invitation.