1. **Greetings**

Tony LaRocca welcomed CAC members and introduced LHSC guest, Laurie Gould, Executive Vice President, Patient-Centred Care. Tony shared that Murray Glendining was appointed on May 7th as the President and CEO for LHSC.

2. **Approval of Minutes**

Minutes were moved by Frank Harper and seconded by Carol Young-Ritchie. Minutes were approved as submitted.

3. **Roundtable Updates**

Based on feedback from members roundtable updates have been added to the agenda as standing item. The following updates were offered:

*Cathy Cuylle* explained that she lives in the Riverforks Community across from the former Bethesda Centre which has been purchased by LHSC. Neighbours have been reaching out to her in her official capacity with the hospital and also as a neighbour with generally positive community responses.

*Bonnie Doxtater* works at Southwest Ontario Aboriginal Health Access Centre (SOAHAC), which recently purchased a building on Dundas St. to accommodate the expansion of new programs and services. SOAHAC has also recently established satellite offices in Owen Sound, Windsor, in addition to the Chippewa of the Thames office.

*Dwayne Linner* sits on the London Regional Cancer Program Patient Advisory Council. The council nominated Dwayne to assess the process for accessing your own health record at LHSC. The minimum cost of obtaining your record is $25 and Dwayne learned that you need to be specific about what records you are seeking (for example, cancer records only versus general hospital records). Dwayne is also a member of Lions Club which has recently opened a home for deaf and blind persons in London.
Charlene Beynon is working casually in a family physician practice after retiring 3 years ago as a public health nurse and continues to see patients she interacted with as a public health nurse.

John Irvine wanted to know the hospital’s perspective on the future of the Cardiac Fitness Institute given the leave of absence of the sole physician.

Response – Laurie Gould provided context around the situation at CFI and reported that LHSC is working to find a solution to ensure continued care for patients.

Frank Harper reported that he has heard comments and concerns from community members related to media reports about ED wait times and the purchase of the former Bethesda Centre.

Response: Tony offered to help provide CAC member with additional context regarding issues they’re seeing in the media to ensure informed discussions with community.

Dr. Scott McKay has been working as the Primary Care Lead with the LHIN. Through Health Links he has been working with others to review strategies to best meet the needs of high users of the health care system; this work is on hold until after the election. Dr. McKay is also working with Health Links to better organize primary care physicians and enhance their communication networks. Dr. McKay provided positive feedback on his experience with HUGO’s roll out, describing the system as intuitive and well supported.

Carol Young-Ritchie provided updates on how HUGO has given the hospital an opportunity to look at how we can do our work differently. For example, clerical staff is no longer required to process orders so their role can now be expanded to act as a conduit between hospital and community (especially family physicians) to improve the hand-off of information. Carol provided an update on the ED Transformation Project, noting they are currently obtaining patient satisfaction data.

4. Membership Committee Update
Frank Harper reviewed the updated membership committee materials (Terms of Reference, Diversity Matrix, Application Form, and Interview Questions). Currently CAC members serve a two-year term, renewable for maximum of 3 terms (i.e. 6 years). January 2013 marked the beginning of the term for all current members and since then, 6 members have retired/resigned from the CAC. The membership committee’s goal is to recommend 5 or 6 new potential candidates to the CAC co-chairs for consideration and to have new members in place by January 2015.

CAC members were asked to complete the diversity matrix to give the membership committee a better picture of current skill sets and backgrounds. Frank also encouraged members to submit possible candidate names that would be appropriate for CAC membership.

The membership committee will now follow a planned implementation:
1. Post the application information to LHSC’s public website
2. Begin targeted recruitment using CAC member’s networks and groups
3. Encourage potential candidates to apply
4. Membership committee to conduct interviews
5. Candidate recommendations to be put to CAC co-chairs
Question: Other advisory groups often put ads in the newspaper. Are you planning to do that?  
Answer: Yes, if necessary following the targeted recruitment.

Leslie Meredith commended the membership committee (Frank Harper, Michelle Quintyn, Lisa Hawthornthwaite and Cathy Cuylle) for their work on this initiative.

**ACTION:** All CAC members are encouraged to forward names/contact info of potential candidates to Cathy.

5. Partnering in Transformation Presentation
Laurie Gould provided CAC members with an update on the Partnering in Transformation work stream which is part of LHSC’s Clinical Services Renewal strategy. The presentation focused on two projects to address complex patient populations with mental health concerns, specifically LHSC’s purchase of the former Bethesda Centre and the creation of a Mental Health and Addiction Crisis Centre.

**Purchase of former Bethesda Centre**
Laurie reported that LHSC is supportive of the need for system change and saw the sale of the former Bethesda Centre to be an opportunity to provide new and improved ways to deliver better care. The centre will become the home of the Adult Eating Disorders Service, which is a community-based program provided through a strong partnership between LHSC and the Canadian Mental Health Association Middlesex. Both the current outpatient clinic and residential treatment component of the program, which are currently located in separate leased spaces in the community, will be co-located at the new centre. By consolidating both components of the program, we will be better able to serve the needs of the patients and can do so without increasing costs to the hospital. As well, there is additional capacity at the former Bethesda facility for other programs such as FEMAP (First Episode Mood and Anxiety Program) or PEPP (Prevention and Early Intervention Program for Psychoses).

The next steps include:
- Final validation of additional preferred programs to relocate
- Community consultation
- Planning for moves in partnership with community, programs, patients and other health providers like CMHA Middlesex

Q. What was the relationship of the community with the old Bethesda?

*Answer* (Cathy): Good. The community is used to having organizations (London Community Living, Rothholme Women’s Shelter, Children’s Museum, St. Francis House and St. Clare House) within the community. Neighbours have expressed a desire to be included in the planning to ensure integration of residents and patients to the Riverforks community. It is not their desire for the building to be isolated from the residential neighbourhood.

Q. If I lived there, my question would be if there's a mental health crisis what's in place to deal with it?
**Answer:** It’s LHSC best practice to have security on site to mitigate any potential risk.

**Q. Is this simply geographically relocating services, or is it an expansion of services?**

*Answer:* Clinical evidence shows that outpatient programs like Adult Eating Disorders, FEMAP and PEPP best serve their patients in a non-hospital setting. We are not looking at expanding programs at this time; however, freeing up space in the hospital allows us to look at how we can best serve all patient populations including mental health patients, and colocation of community services provides a better patient experience as well.

**Q. What's the bus service like?**

*Answer:* There is a stop in front of Children’s Museum, on Stanley and on Horton Street. Accessibility was a factor in purchasing the space.

**Q. Is there a plan for patient involvement when designing the moves?**

*Answer:* The Partnering in Transformation work stream is seeking patient representative on the Steering Committee. At the program level, patients will certainly be involved in the planning as we want to include the patient perspective in everything we are doing.

**Q. Laurie asked the CAC if they had any thoughts/recommendations regarding the community consultation.**

*Answer:* Feedback from CAC was that it will be important to really listen to what the community has to say, and to go with enough people so that you feel supported, but not so many that it looks like the “cavalry is coming”.

**Mental Health and Addictions Crisis Centre**

Laurie next presented on the proposed Mental Health & Addictions Crisis Centre, which is focused on enhancing crisis services and response. Often, LHSC has up to 12 patients per day coming to the ED with mental health issues. Our experience is that not all of them need to be in hospital or ED, but require crisis intervention and support. The former Red Cross Building on the VH site has been identified as a possible site. Laurie noted that Crisis Centre is community-based partnership service with CMHA-Middlesex, Addictions Services of Thames Valley, Mission Services Police, SW LHIN, Distress Centre and LHSC coming together to provide the best care possible to patients experiencing a mental health crisis by managing their needs and them out of the hospital.

The Crisis Centre will eventually be a 24/7 facility with crisis beds, transitional case managers, and crisis assessment teams. A pre-capital request to the Ministry of Health has been submitted for necessary renovations but due to the upcoming election we have to wait. In meantime, all partners are coming together and modeling what the service(s) are going to look like.

**Q. How is WOTCH involved?**

*Answer:* WOTCH is now part of CMHA-Middlesex and they remain actively involved in the project planning.
Q. Will ED patients be sent to a crisis centre?
Answer: Yes, where appropriate, but also vice versa – which is why a location close to the ED is important.

Q. When will the centre open?
Answer: This service is much-needed, however we require capital funding.

Q. WOTCH has a residential component; will they move into this space?
Answer: No, this isn’t a residential model. It’s urgent care/short-term crisis.

Q. If police pick someone up and go into the ED queue, would they go to this building instead?
Answer: Potentially. They may go to the ED and get triaged, but could then go right over to the crisis centre and get immediate intervention.

Q. One of the problems with untreated mental health is safety issues, so if you have a population that merges, from a public safety standpoint there are some advantages to moving them to different locations. Would there be psychiatrists at the crisis centre location with capacity to deal with Form 1 (involuntary) patients?
Answer: Form 1 patients generally come to the ED and likely require inpatient admission to the hospital. However, if patients are voluntarily seeking help and depending on how they are triaged, it might be more appropriate and effective to have an intervention in the crisis centre. This is also for the safety of the mental health client. Often long waits in the ED can lead to functional decline.

Q. So will this help with releasing police services and ambulance back into community sooner?
Answer: Yes.

Q. Would there be some kind of information brochure out to family physicians about this service?
Answer: Yes. There will be communications strategy to explain the service. Equally important is to determine when a patient comes in, how to get information back to their family care doctor to ensure everyone is following same care pathway.

Q. If LHSC is not the lead provider of the Mental Health Crisis Centre but it’s on LHSC property what type of security will be utilized?
Answer: We haven’t got to that stage of planning yet.

Q. Because you’re focused on sustainable integration, what is your big picture thinking around prevention? With the baby boomer predictions about stress to system, where does the hospital jump into prevention game? The “lead player” or just stakeholder? It’s a void right now and I don’t see anybody stepping up to lead.
Answer: Laurie answered with her own perspective: our job is not to create a health care system but a system for health. What we do right now is create a system where you get a little of this and that, but what I want to see is a system for health. Meaning we have to step back and start preventing and working on self-management and helping people understand their role in their health care. If we
don’t do something dramatic, the health care system isn’t sustainable. We have to start with our children. What about social housing, food, schools – how do we prevent illness and get them to think differently? As an acute care provider we can influence social policy. We need to prevent people from becoming high 5 users.

CAC had a general discussion about the role of hospitals as health care leaders and how far “upstream” we can go to impact the social determinants of health in London.

6. Wrap-up

The CAC concluded with a request for future updates on the former Bethesda Centre purchase and the Mental Health Crisis Centre. The next committee meeting will be September 15\textsuperscript{th}, 2014.

\textbf{Action:} Please mark in your calendars our Annual Community Meeting on June 24.