

Public Board Meeting – June 17, 2013

(The following transcript represents a condensed version of the discussion in the language used by those involved)

David Morris: My main concern, although I have many, is the complete confusion surrounding most functioning ambulatory care departments as to what their plans are in the future. It's something that we've raised again and again and we are still in complete ignorance of it. I was involved in at least two planning programs for the future of ambulatory care, none of which seem to have any involvement in the new hospital. I'm involved in two departments which have been classified as third or fourth level, both of which are models of care for the rest of the community and the world. I would very much like to know who is responsible for deciding who is going to be involved in the new hospital. 2014 is a year away and if I am not involved in the new hospital, we have to make plans for the people I work with to involve them in the new hospital. This is a question to the president and to anybody that is involved in making critical decisions for the future of the hospital.

Normand Rinfret: I would like to ask Ann Lynch and Dr. Sidorowicz, who are both involved in this, to comment on your question but I would first just like to say that we decided to create an Ambulatory Care GPO because major improvements need to occur here, and many changes need to be brought about in a positive sense. I would ask Ewa and Ann to give their perspective. Your question is of major importance and we really need to be working on this over the next year and a half.

Ewa Sidorowicz: Excellent question David. As you know I have taken on the Core Redevelopment Steering Committee mandate in the last 2 months to take a look at the challenges with the implementation of the clinical plan; a huge component of that is the ambulatory services component. The plan is to bring, division by division, information to get the discussions going. I have a meeting on Wednesday with the Medical Advisory Committee, so the Chiefs and Chairs will be discussing just that. Over the last several months, we have been very busy with the budget discussions; the 1st wave and now the 2nd wave of the GPOs. At this point, we need to get on with the implementation of the clinical plan across the MUHC and the Ambulatory part is huge. I agree with you, but we cannot do this through a small committee. It has to be brought down to each division. Each division needs to understand what the real estate is, either at the Gen or at the Glen, the kinds of patients that are being seen, are they new consults or are they follow-ups, where are they coming from and how does the division want to organise its care in the context of the CAPS exercise that we did 2 years ago. All of that needs to come together now. I think that we have a few months ahead of us to get the work done. I am trying to get the methodology organised with the help of Patricia, who has been very helpful in providing data, and Marie-Claire, from transition. The

methodology will be brought home to each division in the next few weeks so we have a lot of work to do. We need to get down to the grass roots to solve this.

Ann Lynch: Just to add to what Ewa said, and you and I have had this discussion David, it will involve your participation and the participation of many individuals. We talked about our partners in the CSSS and in fact we are meeting with CSSS Cavendish next week and you will be hearing a lot more about this as we move along. In complement to what Ewa said, in terms of the data and some proposals that we can work on with our CSSS, as well as the patients that should be seen at the Glen, your participation will be definitely solicited.

David Morris: We need to have some guidelines. The suggestion that I would make to you, and I am proposing this to the Board, is that perhaps there should be a Director of Ambulatory Care because I think that this is something that is so big and so important, for both the teaching and the clinical mandate of the hospital, that actually I think this needs centralizing and organizing right across the board.

Normand Rinfret: I think we agree, and the GPO is looking at this as an important function, as we did open, in the last year, a Director for Education position, which was also much needed. We realize that the question of Ambulatory care is probably going to necessitate very specific attention and in that regard, the GPO is coming up with the governance to meet this need.

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Line Larocque: Je suis la présidente du syndicat des professionnels en soins infirmiers SPSICR au CUSM. J'aimerais commencer par un commentaire. C'est décevant que vous nous demander de faire vite quand on vient au micro parce que les conseils d'administration publics ne sont pas fréquents. Avant de parler des GPO, je voudrais vous dire que j'ai lu récemment une partie du rapport du Commissaire de la santé et bien-être du Québec. Il y avait 4 grandes fonctions qu'un établissement doit faire. Il doit adapter ses ressources à la structure et doit produire des services en quantité et en qualité. Ces valeurs sont à l'origine de la qualité de vie au travail. Ici, on s'est éloigné de tout ça. Quant au GPO staff mix, on ne comprend pas pourquoi qu'une décision a été prise dès le début, d'introduire des infirmières auxiliaires à 20 % dans le but de remplacer une infirmière par infirmière auxiliaire. On n'était pas satisfait. On nous a dit de participer au GPO pour avoir la possibilité de donner nos avis, mais quand on a eu la chance d'exprimer notre insatisfaction ou de pouvoir apporter des commentaires pour le modifier on nous a dit que nous n'avons pas le choix, c'est comme ça. Je souligne notre insatisfaction, et je demande pourquoi le discours du département des soins infirmiers n'est pas le même, parce qu'il y avait des travaux qu'on avait effectués avant avec les gens du département des soins infirmiers parce que le charge du travail est

différent maintenant qu'il y a 30 ans, et on voulait avoir un outil pour mesurer le charge du travail, et par la suite on voulait regarder le staff mix. Pourquoi on n'a pas pris le temps d'évaluer la nécessité du staff mix pour pouvoir appliquer ensuite les changements?

Ann Lynch: Je vais essayer de répondre à votre question. Notez que Madame Johanne Brodeur, co-leader du GPO staff mix est ici aussi. Je comprends très bien, puisque nous avons parlé ensemble de vos inquiétudes concernant l'introduction des infirmières auxiliaires, et je pense que c'est un sujet qui nous touche beaucoup dans l'organisation. C'est un projet pilote qui est en train d'être étudié par le GPO Staff Mix pour mieux comprendre les enjeux. C'est prévu pour l'année 14-15, mais on prend tout l'année de 2013 pour étudier le dossier au complet, et pour avoir d'autres consultations. Je suis sûre que Joanne et Patty vont vous consulter sur comment on doit avancer ce dossier pour pourvoir arriver à un consensus. Je cède la parole à Joanne.

Joanne Brodeur: Je suis un peu surprise de la question, dans les faits, il y deux étapes par rapport aux GPOs, la première partie pour laquelle vous avez refusé d'être présente, puis la deuxième partie, vous êtes inscrit au forum GPO et c'est clair que vous devez être assise autour de la table. La deuxième chose, on n'a jamais parlé de 20 % d'intégration des infirmières auxiliaires. L'intégration des infirmières auxiliaires se fait par le bien d'un projet pilote qui va commencer en janvier 2014, sur 4 unités seulement, pour une infirmière auxiliaire par quart de travail, sur 2 quarts de travail. Donc, on est loin de 20 % dont vous parlez et je ne sais pas d'où ça vient. Par rapport au bloc opératoire, oui effectivement on a prévu une augmentation de 18 % et on l'accroitra entre 20 à 25 % des infirmières auxiliaires, mais pour le reste de l'organisation, il n'y a jamais eu question de 20 %.

Line Larocque: Merci de votre réponse, mais ça ne répond pas à ma question.

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Unknown: Congratulations on the huge progress on the budget file and the presentation on the progress that has been made. In the next step I hope to draw the Community into the consultation as much as possible – hospital community and the community at large. Can you give us a brief sketch on the hospital's exposure and risk from the construction labour interruption and the PPP both in respect to time lost, who is on the hook, and how do we plan to deal with this?

Norman Spencer: The broad answer is that the cost of Glen has been negotiated up front and will be paid over a period of 30 years. There are provisions and contingencies for unexpected items. Whether, those contingencies prove to be adequate remains to be seen. I can tell you that to date, they are

reasonably in line with what has happened. My expectation is that there will not be a material additional cost to the MUHC.

Normand Rinfret: In response to the issue of the strike, we are definitely very concerned. We hope the government is going to come to a quick resolution of this conflict with the unions because as a healthcare institution involved in a project of such magnitude you can imagine that every day we lose is extremely costly to the citizens of Québec. At the end of the day, the way the contract is worked, because it is a PPP, the responsibility of the delivery date is on the shoulders of the private partner who have to compose with the elements associated with the conditions in which they have to work. Clearly, there are a lot of legal documents that could be analysed and differences of opinion could be expressed depending on the duration of the conflict. We will have to monitor this, which we are doing and we will have to report to the Board on this matter.

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Unknown: I notice that many workers in the Hospital have lost their jobs because of cost cutting measures. How many working managers have lost their jobs because of reduction in staff and also, given the tremendous debt the hospital has now incurred is anyone going to be held responsible either by losing their job or by being reprimanded in any way?

Normand Rinfret: The first thing I would like to say is that this question has been asked to the Board more than one time. I would like to state clearly that the numbers of staff affected during the 1st phase of operations is 118 people out of 10,000 employees. Of these 118 people, there were 12 – 13 managers, which represent 10 %. In regards to the 2nd wave, we have met with the media last week to explain to them that it is not possible for the GPOs at the present time, to know how many people will be affected. To give you an idea, there is a turnover of about 10 %, about 1000 people who leave the organisation and who get hired. We hope to be able to deal with the problem without laying anyone off. I cannot answer until the GPOs start their implementation. At the end of the day, we can say that the GPO staff mix has identified 14 managerial jobs that will be cut, and this was released to the media. The total number of managers that will be cut is 27. When taking this into account, our numbers compare extremely well with other University Health Institutions in Québec and this information is available on the AQUESS web site.

Unknown: And the responsibility of the tremendous debt?

Claudio Bussandri: The debt consists of two parts, the first is the ongoing operating debt (operating ratio), and the reality is that we know we need to improve upon this. The Board and this management

takes this responsibility seriously. The second part of the debt is related to a one time decision regarding a foundation donation, which perhaps should not have been taken and which needs to be corrected, and the Board decision to leave 1750, both of which are currently being resolved with the Government. This Board is practicing its best diligence to insure good governance and has been doing this since February of last year. In respect to what we have been doing, we are working very hard to put in place better governance, better management and such in order to insure that we never find ourselves in this position in the future.

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Line Laroque: Je veux juste vous faire part de ma surprise l'autre jour. Il se prépare un forum santé international du 22 au 24 octobre prochain. C'est un grand évènement et c'est un rendez-vous incontournable pour les gens d'affaires, selon ce qui est inscrit dans le document. Je suis surprise qu'au CUSM on a le temps d'organiser des grands forums parce que c'est organiser par les CHUs. Qui au CUSM a le temps d'organiser un grand forum comme cela quand on a des problématiques ici? Qui va participer à ce forum du CUSM? La firme Raymond Chabot Grant Thornton est commanditaire diamant;

Normand Rinfret: Je suis content que la question soit posée parce que quand on regarde notre mission, on doit s'occuper du côté clinique, s'occuper de faire le développement de la recherche et s'occuper de l'enseignement. Dans cet environnement-là la recherche est très importante. Vous savez qu'on a, à peu près 110 lettres patentes en recherche qui ont toutes besoin d'être exploitées, et qui, dans notre responsabilité du transfert de la connaissance à l'entreprise privé, ont besoins d'être exposées, et pour être exposées ça prend des forums. Ça prend des foires, et comme dans tous les pays nord-américains ou même européens, il y a des foires internationales pour se réunir ensemble, pour pouvoir démontrer non seulement au Québec, mais sur la scène internationale, qu'est-ce qui était le portfolio québécois de toutes les inventions et innovations qui pouvaient être utilisées. Dans ce sens-là, pour être responsable, ça nous prenait des genres de commanditaires, et c'est là qu'on a attiré des compagnies qui voulaient bien investir à faire la promotion de leur image, mais aussi de leur savoir-faire, de pouvoir exporter ces innovations-là, soit au Québec, soit au Canada ou dans d'autres pays. Je dois dire que quand on regarde la recherche, pour chaque poste créer d'un chercheur, il y a 6 personnes, du côté de la société, qui ont des postes additionnels. Alors, on a tous intérêt à développer notre recherche et encourager le marché commercial des innovations qui sont des produits de notre recherche.

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Dominic Nelson : My name is Dominic Nelson and I have been working at the hospital now for almost 25 years, 23 of those in the sterilisation department for the MDR (Medical Device Reprocessing) department. I think that one of the things that we use as an organisation to insure that we have proper quality services is the accreditation process. I would like to point out that 3 years ago I came to this very Board and said that we had a serious issue with the sterilisation department, or the MDR department, regarding the accreditation process. The report that was provided to this Board was clearly a misrepresentation of what was happening within that area; subsequently I was removed from the department. I was told by the quality assurance individuals that my input is no longer appropriate because I am no longer in that department. I would also like to point out that the GPOs that have been set up unfortunately seem to be manned by far too many people who were managing those areas before. I find it rather bizarre that we would have a Committee set up to insure that the previous Committee was managing properly. There are a couple of things that we need to be aware of in the fiscal environment that we have now, and that is some of the impact of the some of the cost-cutting measures that we have been doing. You need to please be aware of the fact that we have reduced some of the services that we provide to the patients. For example, we are supplying 3 – 4000 fewer diapers now than we were 12 months ago. What is the impact of that decision? The impact obviously is on infection control and the environment of that patient. Without going into specifics, I would like to say that the fact that I am even here, is considered inappropriate by some, and I think that has to change. I have been through so many reforms and financial crises' and want to know what this Board is going to do to insure that fiscal responsibility is upheld within the MUHC and what they are going to do with those individuals who do not uphold that responsibility?

A CB: You made a lot of comments; you heard from the Chairman of the Audit Committee on the process we have put in place for monitoring the spending program. He gave you an update in terms of what the auditor said that we are doing. We are in a turnaround plan. We got a clean bill of health in terms of how management and how the institution and the employees are performing through their clinical care mandate and that is the best thing that I can tell you in terms that we have oversight not only from this Board, but from the various Committees that I showed you, which is far more than has ever been done before. There are active members, and many new members were appointed a year ago. You heard from the Chairman of the Audit Committee so we are making strong progress on that.

Normand Rinfret: Also Dominic if you have some concerns I would ask you to put them in writing and send them to me. There is a Committee that looks at quality improvement and performance and I welcome receiving your comments, which I will give to the Chair of the Committee, who is here, Mrs. Nacos. So thank you very much for your comments.

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David Morris: In terms of educational accreditation, are the plans for the hospital taking into account the change in structure of the educational facility that we are offering. There is one thing that worries me a great deal because I believe that the next accreditation is creeping quite rapidly up on us and we will be subject to an earthquake. This is really for the Dean to respond to as I would like his input on this.

David Eidelman: Thank you for your question and I think that many people share your concern. There is a close collaboration as you can imagine, between the MUHC and the Faculty of Medicine, we are in constant contact. There is no question that there are challenges that are coming to us. We have a new curriculum starting in the fall. It will involve more time with physicians but that will be family doctors in the community, so there is an adaptation that is taking place with the new curriculum, to spend less time in the hospital. That being said, we need to study very carefully how to deal with the impact of the changes that are inevitably coming to the MUHC and for that reason I am in the process of looking at hiring a consultant who will work with the community to try and develop strategies that will complement the work that is being done by Ewa and her Committee. There is a Committee in the hospital that is looking at how to organise things within the hospital. Obviously there are going to be effects that are going to impact what happens to people that go out of the hospital and that require services as they move to other institutions. Demetra Kafantaris, who most people in this organisation know is working in my office now, has been given the lead on this to work with me and she is working in close collaboration with the folks at the MUHC. As well, I hope we will be able to hire these consultants to help give us the extra manpower so that we can consult widely and get the input that we need.

David Morris: This sounds beautiful, but do you actually have a strategy, knowing what's going to be happening? Because we are both in the dark in terms of knowing exactly what is going to go on.

David Eidelman: The short-term strategy is to be able to make a plan. I think there is a difference between a strategy and a plan. What you are really asking me is do we have a plan. We do not yet have a plan because we still have details that have to be worked out. That being said, we expect by September to have all the information we require in order to have a plan. Obviously the plan will be a grand scheme, but clearly at the local level they have to be very specific plans. So for example the pediatric endocrinology will be different from the plans for ophthalmology and will be different from OBGYN. We are going to try and develop the overriding principles and then of course each unit of the institution will have to look at what the resources are and make appropriate plans. Our job is to support them and try to make sure that they mesh well with the needs of ours.