

à come risultato dieci, numero magico per eccellenza, che racchiude e concentra in sé il n el cosmo. E infatti il dieci è la formula del Tetractys, il tentato segreto dei pitagorici. ora a cui si attribuisce un formula del Tetractys, il Filolao, il discepolo di Trattato sui Numeri,

The First 200 Days: Cancer Leadership in Ontario

Alan R. Hudson

STRANGE BUT TRUE: THE CANCER CARE ONTARIO SCENARIO

In Ontario, each cancer centre is attached to a host hospital. If a cancer patient straddles the line separating the cancer centre from the host hospital and lifts one foot, that patient is receiving services governed by the board of the hospital. If that same person lifts the other foot, the patient is receiving services governed by the board of Cancer Care Ontario (CCO), with a head office on University Avenue in Toronto. In every other clinical program the emphasis is on the patient receiving the appropriate service in the appropriate setting (inpatient or outpatient) within a single program, under single governance. Why is it that places like Windsor and Thunder Bay have part of a major clinical cancer program managed and governed from Toronto, a huge distance away, while the respective boards of the hospitals govern the other part? This scenario, strange but true, is far from the ideal coordinated plan in which regional cancer centres, host and community hospitals, community care access centres, home-care services, nurses, physicians and surgeons, oncologists and other providers of cancer care align services in a way that can help patients and families seamlessly navigate the corridors of cancer care.

Ontario spends approximately \$1.5 billion annually on cancer services, with demand for services increasing by approximately 7.5% a year. Half a million Ontarians are expected to be living with cancer by 2010. Approximately 20% of this

funding is directed to Cancer Care Ontario, a government agency. In turn, CCO funds a number of provincial programs, but the bulk of the budget supports radiation and systemic therapy services in nine cancer centres throughout the province. Some 50% of the patients suffering from cancer in Ontario do not come into contact with services provided by CCO. A high percentage of Ontario cancer surgery (possibly the majority) is performed in hospitals not associated with CCO.

Ontario's cancer centres are outpatient clinics providing 75% of the radiotherapy in the province (the other 25% is provided by the Princess Margaret Hospital, not part of Cancer Care Ontario). Approximately 50% of systemic therapy is administered through the CCO cancer centres. These cancer centres usually have their own medical records, pharmacies, administrations, admitting procedures and clinical staff caring for the same patients, with the same disease, who are cared for by a different and duplicated administration in the adjacent hospital!

THE SIMPLE QUESTION: DOES CCO ADD VALUE?

Three short years after its establishment, when the government asked if CCO added value to the care of all cancer patients in the province, the answer was so far short of a positive response that the Ontario government considered transferring CCO funding to the global budgets of host hospitals. On May 30, 2001, the government announced its proposal to further integrate CCO's regional cancer centres with host hospitals.

The old CCO model was not working (scarcely surprising, considering the bizarre organizational structure) and needed major restructuring, so just how was this going to be done? The Minister of Health and Long-Term Care, Tony Clement, asked for advice and struck a committee, which I chaired, that was to explore options, alternatives and modifications. With the appointment of the Cancer Services Implementation Committee (CSIC) announced a day later, all the players reiterated the necessity of moving towards an integrated system to ensure that the needs of cancer patients remained the top priority. Every one of the 20 senior and experienced individuals who were asked to participate in the review accepted the invitation eagerly, reflecting their accord of the need for a thorough analysis and a recognition of the lack of confidence in CCO. Most committee members had first-hand experience of cancer in a loved one, a reflection of the incidence of the disease in the community. CSIC's stated objective was "to arrive at a model which best meets the needs of cancer patients in all regions of Ontario and, within each region, of all patients referred to cancer centres."

Focus groups suggested that CCO was regarded by many as a self-indulgent old boys' club, which performed well in certain elements of cancer care, but was essentially irrelevant in others. It was viewed as "an inward-looking, self-congratulating organization not watching the marketplace." Some believed that, as an agency of government, the organization seemed more intent on embarrassing the government in public, rather than attempting to solve problems. CCO board members who had worked conscientiously and diligently (as volunteers) within a structure not of their making or funding, resented these accusations. There were, of course, two sides to each issue, but a fair summary is that there was a profound and mutual lack of confidence between the government and its own agency. But was there enough to save CCO and turn it into a vibrant agency that truly could fulfil its original mandate, refine its mission and, more important, serve the patients with renewed accountability and strong leadership? One main finding, repeatedly reinforced, was that CCO needed to become a new and different organization so that it could truly influence the quality of care for *every* cancer patient in the province, not simply the 50% it served.

Cancer patients consistently had to surmount a series of waiting lists as they moved through a relatively discontinuous series of diagnostic and therapeutic services. The individual interactions in these various aliquots of service were frequently good or excellent, but the overall patient journey was fractured and at times bewildering to already anxious patients and their families. Many were unsure of the role of CCO relative to the 150-plus organizations in Canada that have "cancer" as part of their title.

The CSIC completed its work on time towards the end of

2001 and handed it over to Minister of Health Tony Clement. We all felt we could effect massive change in Ontario's ability to provide coordinated cancer services since it was apparent to us that current efforts were much like a series of separate cottage industries and the linkages among them were not optimal. As structured, CCO could not govern a modern, integrated cancer system for all Ontario patients suffering from cancer.

Subsequent to the report, and following a traditional search process, I was appointed CCO's President and CEO on – I believe unintentionally – April Fool's Day, 2002.

Aliquot: *n.* able to divide a number or quantity without leaving a remainder; 3 is an aliquot part of 12.

THE FIRST 200 DAYS

The fundamental issue in my leadership role was balancing the need for incremental change with revolutionary change. Clearly, small incremental change was not going to achieve the new vision in a turbulent healthcare world, but revolutionary change carries risk, which would potentially be borne by our cancer patients. Key healthcare providers are in short supply so that the appetite for change had to be finely gauged. Most of our partner hospitals had their plates full with restructuring and fiscal challenges. If incremental change alone would not cut it, just how much revolution could be supported?

Visits were undertaken to each of the cancer centres so that the simple, clear-cut goals of the "new" CCO could be expounded. Closed and open meetings allowed advice gathering, as well as an estimation of attitudes. We deliberately chose to enunciate a limited number of goals as an initial communication approach. These goals, derived from the CSIC recommendations, were repeated at each stop on my tours of the cancer centres. As some either did not understand, or chose not to understand, the messages were delivered in a variety of formats.

CREATING THE "NEW" CCO: GOALS FOR CHANGE

1. Integration

- (a) The so-called cancer centres and the so-called host hospitals are to be integrated with a view to improving the quality of patient care that has previously eluded them. CEOs of the host hospitals will appoint the leader of the local cancer centre as a senior manager in the host hospital so that that individual reports jointly to the hospital and CCO. Their charge is to promote a smooth journey for the cancer patient through the inpatient and outpatient components

of diagnosis and treatment in a single, integrated cancer program (ICP). The board of CCO and the provincial office in Toronto will progressively get out of governing and managing direct patient services as these services will become the responsibility of the ICPs and regional cancer programs (RCPs). CCO will retain its budget, and this budget will be transferred to the host hospital under a contractual agreement between the CCO board and the host hospital board. In this manner, the CCO board will retain its responsibility for ensuring a quality cancer system and will assist and partner with the host hospital (and other necessary providers) as it pursues its quality agenda.

- (b) The Vice-President of the ICP is responsible for integrating the entire spectrum of cancer prevention, screening, acute, supportive and palliative care.
- (c) It is anticipated that the newly formed ICP will be the hub of the RCP, integrating the services of surrounding referring hospitals and healthcare facilities. Whereas the Vice-President has the authority delegated by the CEO of the host hospital and the CEO of CCO in the integrated cancer program, other elements of the leadership role will have to be by persuasion and coordination of the many healthcare facilities and individuals providing cancer services in the region, each with its own governance and management.

2. Cancer Quality Council of Ontario

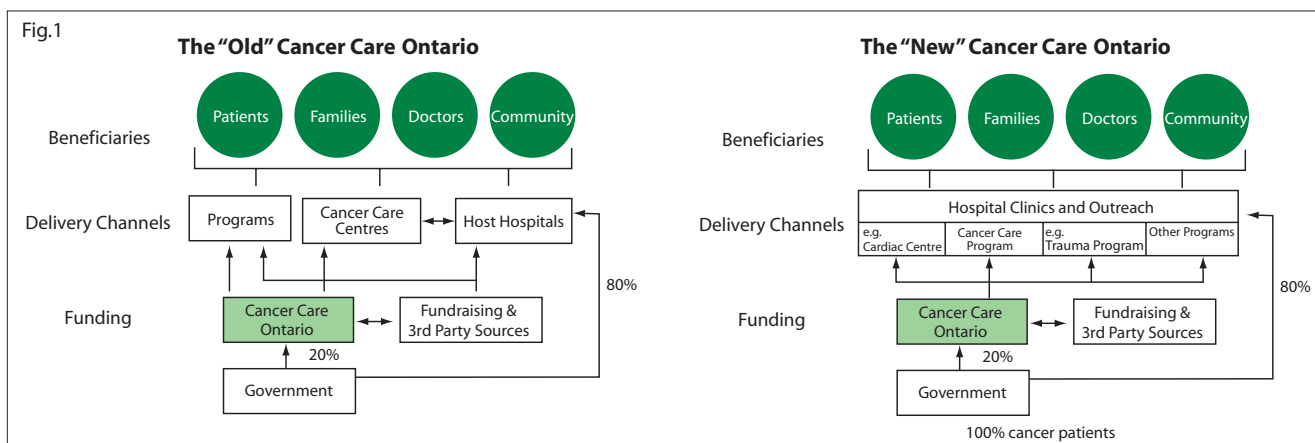
The Cancer Quality Council of Ontario, announced in late September of this year by Minister Tony Clement, is a major change for CCO. This council, chaired by Michael Decter, was established to set quality standards, audit and evaluate services for every cancer patient in Ontario. The council is at arm's length from service providers and will publish an annual review as well as specific focused reports. It is anticipated that this unique council will be central to the new Ontario cancer system. The CCO board advises government, and it will be able to do so using Cancer Quality Council findings.

3. Surgical Oncology

Although by far the most common intervention in a cancer patient, surgical oncology has been the "Cinderella" compared to the other major interventions of radiation and systemic therapy. Leadership in surgical oncology is needed from those surgeons who have either a major or sole interest in cancer treatment, and each designated provincial centre requires leadership from the surgical oncologists whose primary goal is that of improving the quality of surgical care for their patients. They must take their place around the patient with their colleagues in a variety of disciplines so that the quality of the journey for the cancer patient is smooth and seamless. Fundamental data relating to surgical access and other quality issues and fundamental data relating to costs are at a level significantly behind data available for radiation and systemic therapy programs. What data are available suggest significant variations in access and outcomes across Ontario. The first task, therefore, must be one of measurement so that the current standards of surgical care can be established and compared to international norms. Subsequently, surgeons with specific specialist content expertise must become involved in improving the quality of care for all patients, 90% of whom require some form of surgical intervention.

4. Provincial Information Management Program

Like much of the clinical systems, the information management systems in the cancer centres and their adjacent host hospitals frequently are not compatible and therefore do not communicate! The only way a seamless system will be achievable for cancer patients is if our information systems are coordinated and linked in some way. Currently, CCO is leading an initiative that would see a provincial cancer information program for Ontario being created. A striking feature of this very large project is the fact that CCO does not have the governance authority to achieve the goal. Only a consortium of those who have various parts of the governance authority can bring this \$90 million program to a successful



conclusion. A major meeting was held in Toronto on September 25, essentially bringing all components of this megaproject to the starting line. The widespread consultations revealed very significant goal congruence among stakeholders.

A fundamental strategic decision was made initially, which determined that the information management project would lead in virtually every element of the overall cancer strategy. A significant effort has been made to understand the clinical, quality and management needs throughout the Ontario cancer system and then to design the technical architecture in support. The electronic health record will be confined to each region, and only the data that are required will be consolidated at the provincial office. Cross-linkages of existing databases supporting the cancer registry, tumour banks, ICES and other programs will be a priority. External expert review from the Harvard Business School has been sought in the early stage of this megaproject. The provincial office of CCO, progressively handing off direct patient care responsibilities to the regions, will assume management of this great knowledge system. The cancer program will affect every hospital in Ontario, and CCO is working very closely with the Ontario Hospital Association to ensure a powerful collaboration on the e-health front.

5. Regional Cancer Advisory Committees

The “old” CCO had a Cancer Care Ontario Regional (CCOR) system described in a memorandum of understanding between the government and CCO. This system has been abandoned and replaced by Regional Cancer Advisory Committees (RCACs). These committees will have widespread composition, including cancer survivors, advocates, providers, District Health Council members, and other stakeholders of the region. The chair of the RCAC is a board member of CCO, and the function of the RCAC is advisory. (No governance or management authority is vested in the RCAC.) The RCACs ensure a very broad base of advice, and members play a key facilitative role in the region surrounding the ICP.

CAN CCO CHANGE? THE CHALLENGES OF LEADERSHIP

It is a truism that people sitting in comfortable chairs will not move to new seats! Of the various stakeholders, I analyzed which groups had a sense of urgency, which would drive change and which were complacent or obstructive. In that the forces against change are always monumental, an analysis of readiness for change was in order as the amount of energy required to overcome resistance is huge.

Clearly, the government expected a change and had been very supportive in backing the new direction and the creation of a truly comprehensive cancer program. The board of CCO appreciated the necessity for change and a new beginning. Many in the cancer centres, however, were quite comfortable

with their existing situation. They frequently were working in pleasant, new physical facilities and felt a sense of comradeship in working with their colleagues in providing cancer care, which, by their estimation, was first-rate. Many dedicated and conscientious caregivers felt, and still feel, that their standards would be lowered if they were integrated into the hospital component of cancer care. Many of these individuals were extremely surprised to hear that Ontario did not have a stellar cancer system – they tended to equate their relatively isolated component of the provision of cancer services with the system as a whole. Some caregivers thought cancer services should be “special” and apart from, rather than an important intrinsic component of, the Ontario health program. The CEOs of the host hospitals were nervous about taking on additional responsibilities when they were struggling with fiscal pressures, frequently with the end results of hospital mergers as decreed by the Health Services Restructuring Commission. All agreed that the proposals of the report of the Cancer Services Implementation Committee were valid and logical, but enthusiasm varied as to taking on a new major commitment at a difficult and stressful time in their lives.

People sitting in comfortable chairs will not move to new seats.

One definition of leadership is the ability to take individuals in a direction they initially do not wish to go. (Cynics add that people will enjoy the process if you are really good at it.) Another definition is that when a leader looks behind, individuals and groups are following. In this situation, characterized by its vast scale and numerous governance constituencies, it was absolutely critical to be careful of a small group of enthusiasts planning this exciting improvement in quality of care, galloping along on their white horses, without sensing how many were following behind. Communication and reiterations of position have, therefore, been of the utmost importance, using a variety of techniques. In addition to communicating with constituents directly involved in programs, face-to-face meetings were held with the board of the Ontario Hospital Association, the board of the Ontario Medical Association, nursing leaders and individually with the leadership of all major unions affected by this plan.

The lead dog of the sleigh team sees the view ahead, while many other team members spend much time looking at the rear end of the dog ahead. Fortunately, CCO has many leaders. The leaders of the ICPs in each of the centres understand both the broad vision of the “new” CCO (which they helped develop), as well as the local realities and politics of their host hospitals

and surrounding areas. Ultimately, the success of the vision will depend on the ability of the integrated cancer program leaders to provide inspired leadership and to solve local problems. Any attempt at a hierarchical command and control structure from University Avenue would be doomed to failure.

All good leaders are good followers, but not all good followers make good leaders. It is critical that all those with leadership authority in the cancer program understand this truism as they combine local leadership with following the broad CCO policy. Sophisticated and experienced leaders cope well with this concept, as well as with the necessity of juggling the ambiguities and uncertainties inherent in change leadership. Those who are excited at the opportunity of significantly improving the quality of patient care embrace the program, along with all its difficulties. As one moves from the “old” to the “new” CCO, personnel changes at a senior level are inevitable and in some way a measurement of the seriousness of change. What is needed are those who argue the points of contention in a rigorous manner and then accept the final consensus decision. Those few who pretend support and then do everything in their power to block progress will be invited to seek employment elsewhere. These individuals suck up a tremendous amount of organizational energy and need to be identified briskly in any change process.

RE-BRANDING CCO: NOT JUST ANOTHER LOGO

It is not simply a new logo that will ultimately change the image of CCO – it requires tangible evidence of a new structure and a new way of doing business. Nevertheless, a new visual expression of CCO is a symbolic yet important part of the change process. The first step in this process was determining what the new brand-promise of CCO should be. Clearly, this is “quality in patient care.” The next step was to define the brand strategy. What image does CCO want for itself, and how will that be expressed in a brand? An endorsement strategy that represents partnership, system integration and quality is being initiated. This new, single logo replaces the individual logos of the various CCO centres and programs (e.g., the breast and cervical screening programs). The endorsement line under the host hospital’s logo will be “a Cancer Care Ontario partner.”

Creating the “new” CCO will involve a brand image that is truly aspirational. We will strive to create a quality organization that is knowledgeable, relevant, evidence-based, and a trusted data creator and resource. The “new” CCO will be partnership-oriented in supporting regional facilities in servicing patients and families and will advocate for and act as the adviser on provincial cancer information and care practices.

COMMUNICATE: NEED I SAY MORE?


I doubt I really need to detail how essential communication is in reaching stakeholders and patients and in liaising with

Aspirational: *adj.* 1) an earnest desire or ambition; longing to achieve or attain. 2. An object of desire or ambition; goal.

professionals. Any organization, especially in healthcare, that does not dedicate time, effort, funds and staff to this highly detailed function – technical, strategic, reputational and long term – will undoubtedly suffer the slings and arrows of deserved criticism. You simply must employ organized communications. If you’re not comfortable speaking with all or anyone who comes in your path, don’t enjoy public speaking, don’t understand how the media work or have an ability to resolve issues, you might consider not being in a position of leadership. Otherwise, get good help from someone who can tell you what needs to be done to achieve timely, reliable and credible communications.

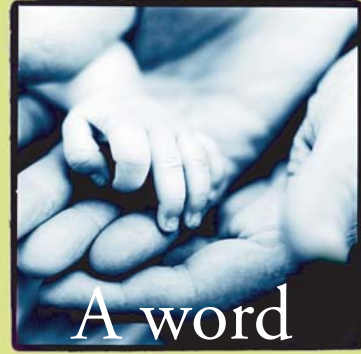
LEADING TOWARDS A SEAMLESS PATIENT JOURNEY

Throughout this process – the implementation committee, tours, successes and now as a leader what I am most struck with is the efforts of the patients to attempt to navigate the complex patchwork of cancer care services on their own. Their journey and their stories inspire me every day. The “new” CCO will be characterized by the fact that cancer service delivery will primarily be the responsibility of the regional integrated cancer programs. Of necessity, these provincially designated units will devote more and more of their resources to cancer in the years ahead, putting pressure on non-cancer programs, particularly in communities served by one major institution. There has been a remarkable degree of goal congruence and unanimity across the province, with a general consensus that the creation of a truly comprehensive cancer program for Ontario was long overdue. Unquestionably, this unanimity of purpose will be strained in the detailed operational negotiations, which are about to begin.

However, as my top-of-mind image, I always remember that we are serving individuals with families, jobs and hopes and dreams – all that human stuff of life that we all too often forget. This must always be remembered as we lead towards seamless patient care for those who experience the broad range of services, whether it be in diagnosis, surgery, chemotherapy, radiation or supportive care. It is hard to deny that improving quality of care is a noble aim, and the degree of cooperation and enthusiasm thus far displayed across the province would suggest that this compelling vision will sustain us in the difficult days ahead. 

About the Author

Alan R. Hudson, OC, MBChB, FRCS(C), FRCS(Ed), FCSA (Hon), DD Tokushima (Hon), is a world authority on peripheral nerve injuries who employs his expertise in surgery, teaching and research. In 1970, Dr. Hudson co-founded a laboratory at St. Michael's Hospital in Toronto that garnered an international reputation for innovation in neurosurgery research. An award winner for excellence in teaching, he served as Chairman of Neurosurgery at the University of Toronto from 1979 to 1989, directing one of the world's top training programs. From 1989 to 1991, Dr. Hudson served as McCutcheon Chair and Surgeon in Chief at Toronto Hospital. Dr. Hudson was President and Chief Executive Officer of Toronto's University Health Network from 1991 to 2000. Over his tenure, he led the hospital corporation with integrity and to a balanced budget. Dr. Hudson attended the University of Cape Town, University of Toronto, Oxford University and Harvard Business School. He was granted a fellowship from the Royal College of Physicians and Surgeons of Edinburgh. He has authored or co-authored 125 papers and co-authored two textbooks. On behalf of the Minister of Health, Dr. Hudson chaired the Cancer Services Implementation Committee and is currently the President and CEO of Cancer Care Ontario. Dr. Hudson received the Order of Canada in April 2000. His licence plate likely reads, "I'd rather be sailing."



A word of thanks...

...to all the health care workers across Ontario and the staff of the Ontario Hospital Association.

For all that you do, we wish to express our heartfelt gratitude on behalf of all our staff, patients and families.



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