

The Changing Face of Leadership

In

January 2006, Cliff Nordal accepted an appointment as shared Chief Executive Officer for his current facility, St. Joseph's Health Care, London, as well as London Health Sciences

Centre, following the retirement of Tony Dagnone. The Boards explained that a shared CEO would facilitate the implementation of several key initiatives following HSRC directives. As Cliff explains, both remain as independent hospitals with their respective boards and mandates.

Both facilities are affiliated with the University of Western Ontario and participate in several joint initiatives in clinical care, teaching and research. By the numbers, the total operating budget under his control and leadership: about \$1.1 billion annual operating budget, with approximately 12,500 staff, 1,000 physicians and about 3,000 volunteers. It also includes the Lawson Health Research Institute and several other shared initiatives.

Ken Tremblay spent a few minutes with Cliff after his first 60 days.



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HQ: At his retirement dinner, Mr. Dagnone's

farewell speech highlighted the unique characteristics and culture of LHSC, making a case that its traditions and history be respected. How do you see yourself balancing the needs of both organizations as you lead each to a secure future?

CN: This will be part of the mandate of the shared CEO. We recognize each hospital will emerge from restructuring with a distinct mission, and from our respective lengthy history of service to our community we know we want to maintain and

honour some distinctiveness. We also recognize each hospital site has distinct programs and its own unique cultures; some traditions go back to the pre-merger days when each was a separate and independent hospital. As long as those cultures support, in a positive and constructive manner, our overarching strategic plans and core values of excellence, respect and compassion, that is probably fine.

What we are doing, however, is moving towards even greater collaboration and interdependence, acting very cooperatively and where possible employing best practice models, be they in administrative or in clinical areas. Rather than focusing on changing culture, we want to pursue together those opportunities where we can gain performance improvements while maintaining or enhancing our clinical and academic excellence.

HQ: In making your appointment the Boards expressed a confidence in you and this model to accelerate the transformations necessary in London. Can you give me a sense of what your top priorities will be?

CN: Completing restructuring is one of my key mandates. This includes completing construction projects at five major sites. St. Joseph's has completed three stages with a further three stages costing \$80 million that will be completed by 2010. At University Hospital, we have a final project scheduled for tender later this year, worth about \$12 million, with completion slated for next year. By 2009, we will complete the new clinical tower at the Victoria Hospital site. That is a \$100 million project to create facilities to enable the closure of our South Street Hospital site.

In mental health, there are two new buildings scheduled to start by 2009 with an estimated cost of \$140 million: one on the Parkwood site of St. Joseph's and the other in St. Thomas. Therefore, building and the associated program restructuring remains a major piece of work over the next few years. When all of the restructuring projects are completed, including the construction of parking garages and research facilities, over \$700 million in new or renovated facilities will have been completed.

HQ: If those are the facility pieces, what are the remaining clinical elements of this restructuring – where are you taking the two organizations?

CN: We have completed, since 1998, 24 program moves between the two hospitals and have several major initiatives left. All clinical activities will be moved out of the South Street Hospital by 2009. That includes the acute mental health program, dialysis, clinics and physician offices. They will relocate to the North Tower of Victoria Hospital. By 2009, St. Joseph's will also have moved its entire perinatal program, including the neonatal intensive care unit, to London Health Sciences Centre. There are also a number of clinical and administrative groups that have been housed in temporary quarters, as part of our restructuring, and we will see them permanently relocated into the various sites within the next three to four years.

HQ: I noticed that some concerns surfaced from other faith-based sponsors about a shared CEO. Any thoughts about how you will lead such distinct organizations?

CN: St. Joseph's Board has been very clear: St. Joseph's mandate will continue as a Catholic organization, fully compliant with Catholic healthcare ethics guidelines and sponsorship requirements with which we are very familiar. My mandate will be to continue to build upon the strengths that are at St. Joseph's. We will continue to uphold all of the expectations that have defined St. Joseph's Hospital in the past. Frankly, I do not see any fundamental changes necessary in my style and approach to retain the special and unique identities of both organizations.

HQ: How will your new relationship change or be affected with organizations like the university, the LHIN, the Ministry of Health and Long-Term Care and the community? Will being the single leader change any of these relationships?

CN: I have two other mandates in my shared role. One of them is to support the transformation projects of the province, including the South West LHIN in terms of furthering the integration that's already taken place in our city and region. For example, we now have all of the eight hospitals in the Thames Valley area using a common PACS system and single patient record for diagnostic imaging. We are moving towards common platforms for our electronic patient record systems as well as our business systems. While they are not fully integrated under a common management, we are supporting a common strategic plan and approach. This creates a readiness for what we hope will be a common electronic patient record in the future throughout the entire LHIN.

HMMS (Hospital Materials Management Services) is already a major supplier of hospital supplies for many of the institutions within our LHIN. We see potential for it to become the preferred buyer for all providers in the region if they choose to participate. There are many examples where we are poised to continue the path towards integration within the LHIN.

The other mandate is to sustain the academic role of these two teaching hospitals in partnership with the University of Western Ontario and Fanshawe College. Each year about 3,700 students spend part of their time at one or both of our hospitals and we are very interested in their success.

HQ: You recently announced some aggressive strategies to reduce staffing and operating costs with the combined organizations. Can you tell us more about how this shared CEO model facilitated that – what struck you differently wearing that hat?

CN: The plans for actual [HAPS] Steps 1 to 5 staffing reductions were made in advance of the shared CEO announcement. With the exception of consolidations at the senior leadership level (where we've eliminated two vice-president positions) most of the savings were specific to each hospital and pre-date the joint CEO announcement.

HQ: How long do you see this shared leadership model in effect? For example, what might be the next generation? Any thoughts about where the two organizations will go from here? If a merger is not possible, any sense of what happens next?

CN: There is no plan to merge the hospitals; each will maintain separate governance with full responsibilities for their own resources. At this time, the shared CEO appointment is intended to enable the next phases of restructuring in London. As well, the agreement between the hospitals is person-specific, meaning that once we are through restructuring and when I leave/retire, the respective Boards will review the benefits and advantages of this model to determine whether they should return to a separate CEO for each corporation. There are no agreements beyond the current restructuring and my particular tenure at this time.

HQ: Your appointment as shared CEO (and resultant scale) makes your approach to leadership the dominant style in all Southwestern Ontario. Have you reflected on the duties and responsibilities that would go with a mandate as large as this?

CN: There are many leaders in this region who demonstrate a collaborative leadership style. I intend to continue with the approach I have used for some time, that is, to actively work with others to build a delivery system that strives to provide integrated healthcare for patients in our area and region. I will continue to be very focused on that important agenda. Certainly, I engage my leadership team in a very collaborative and participative style as I do with all my partners. I believe we can work effectively together when we are focused on a common mandate and agree on how we will work together. I will continue with that style and approach and I hope we can build upon our collective track record of accomplishments.

Insight

HQ: Any other issues in your agenda that take advantage of a single CEO model? Any projects that you think that would be more successful given a single vision?

CN: I certainly intend to sustain and build upon our academic leadership in this region. Since both hospitals share the same student cohort, the shared model allows us to ensure that the positive experience that students have within both hospitals is maximized. It is incumbent upon us – whether it is the teaching environment, student orientation, our approach to care, use of technology or how we utilize practice guidelines – that we are as consistent as possible so we can create one of the best learning experiences we can for our students.

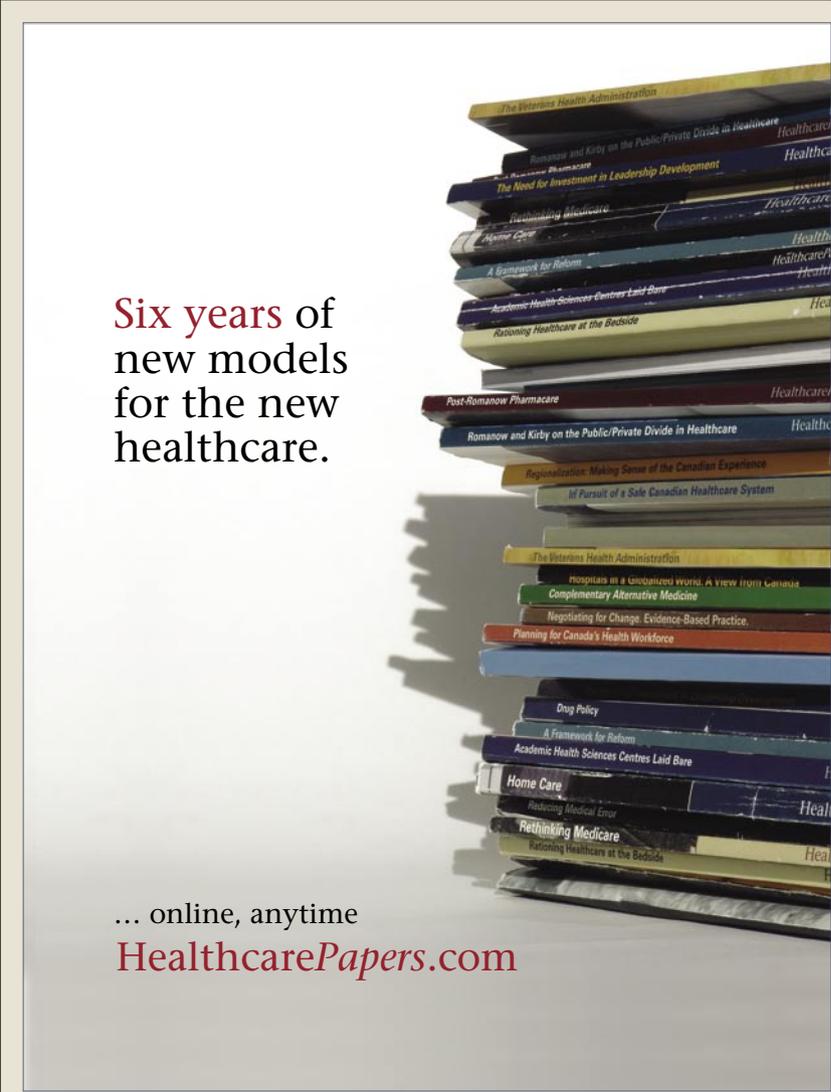
HQ: And research?

CN: Both hospitals support research endeavours through our joint venture called the Lawson Health Research Institute. We are fully committed to retain it as a hospital-oriented/hospital-based research institute. As we plan the future of the Lawson, we are working to ensure that its strategic plan and that of the two hospitals are closely aligned. We are in the process right now of implementing external review recommendations that will help to create stronger alignment and clear objectives for the Institute and hospitals so that our research at Lawson has effective means to transfer discoveries and best practices into hospital practice here and elsewhere.

HQ: Any lessons learned, observations, words of wisdom to the readers of *Healthcare Quarterly*? Anything that caught you by surprise?

CN: The London hospitals have a unique history of working together. This appointment demonstrates that it is possible for two independent organizations that have collaborated well in the past to work even more closely. The shared CEO role signals that our two hospitals are committed to an integrated hospital-based system in the city and region. We are committed to creating a single electronic record for our patients. We want our clinical practices and services aligned and dovetailed between sites and the community so that patients have a seamless experience.

What has become known as the “London model” really started in 1998, when we began this lengthy process of health-care restructuring in London. We formed a number of shared leadership positions and joint ventures and have expanded on those types of arrangements since then. The appointment of a shared CEO was a logical next step in that collaboration, a step where we have another opportunity to demonstrate that two independent organizations can function effectively under a joint and shared leadership model. The reality of my role, however, is that the work pressures are tremendous and a number of process changes and supports are being put in place to make the role sustainable. Leadership is much more than one person; it requires an effective city-wide team of leaders. This was an important factor in the decision taken by our Boards.



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