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# 10 TOOLS FOR IMPLEMENTING NEW MODELS OF CARE

## A GUIDE TO CHANGE MANAGEMENT

2017

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This change management toolkit was developed by the Models of Care Program to assist individuals and groups interested in implementing new models of care.

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# Introduction

## Purpose

The purpose of this toolkit is to help individuals and organizations develop a plan to identify, implement and sustain new models of care. This document has been developed through a review of models of care and change management literature, and may be adapted to suit specific needs.

## What is a Model of Care?

Briefly, a model of care describes the way that health services are designed and delivered for a person as they progress through the stages of a condition, injury, or event (Agency for Clinical Innovation, 2013).

Often times when we are talking about models of care, what we are really referring to is a models of care *approach.* A models of care *approach*, is an approach to the design and delivery of health care services using information based on patient needs and clinical best practice to determine how services should be organized and integrated across sectors, professions, and settings (i.e. *what* type of care should be delivered, *where* that care should be delivered, and *who* should deliver that care).

This is the overall approach adopted by Cancer Care Ontario's (CCO's) Models of Care program. The Models of Care program was established in 2011 in response to the need to address the pressures of increasing demands on the cancer system in an environment of fiscal constraints and shortages of health care resources. The program's vision is for a sustainable, integrated, and patient-centred cancer system.

The overall goals of the Models of Care Program at CCO are to:

1) Develop and implement new models of care to promote value for money;
2) Identify and address regulatory, funding, and other policy changes to sustain new models of care; and,
3) Enhance the accuracy of HR planning by incorporating the impact of models of care.

The models of care approach is informed by a number of key principles: quality improvement; evidence-based practice; project management; and, change management[1]. CCO's Models of Care Program has adopted many of these principles to inform the Models of Care Process (Figure 1).

Figure 1: The Models of Care Process

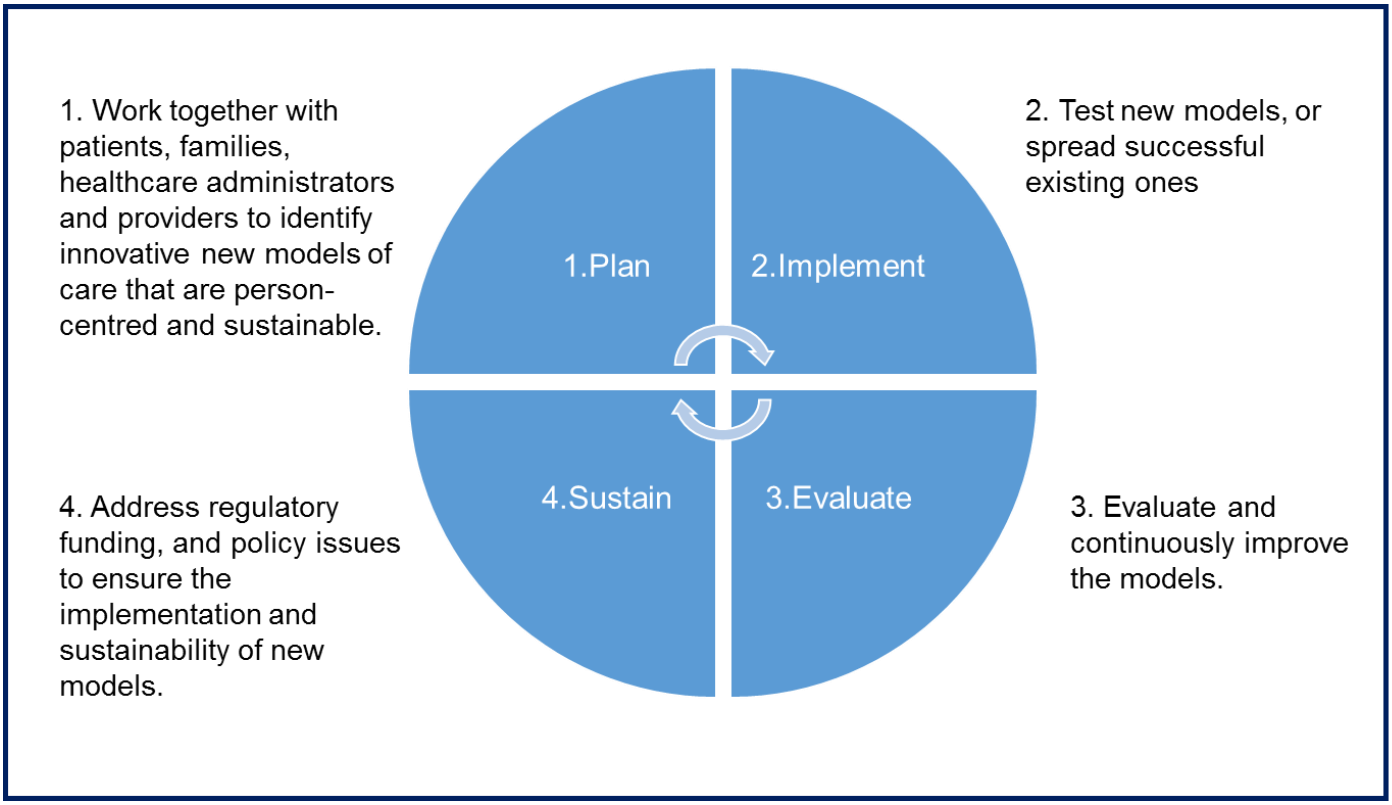



**Figure Description:** The Models of Care Process describes a 4 phase cycle for implementing new models of care. Phase 1 is the Plan: opportunities for Models of Care are identified. Phase 2 is Implement: this involves testing new models or spreading existing ones. Phase 3 is Evaluate: this is to ensure assessment and continuous improvement of the models. Phase 4 is the Sustain: this involves addressing policy issues to ensure the models are supported and sustained.

While this toolkit will touch all of the steps in the process outlined above, the major focus will be on providing guidance for project sites to implement new models of care.

[1] Davidson et al. (2006). Beyond the rhetoric: what do we mean by a 'model of care'?. Australian Journal of Advanced Nursing. 23(3):47-55.

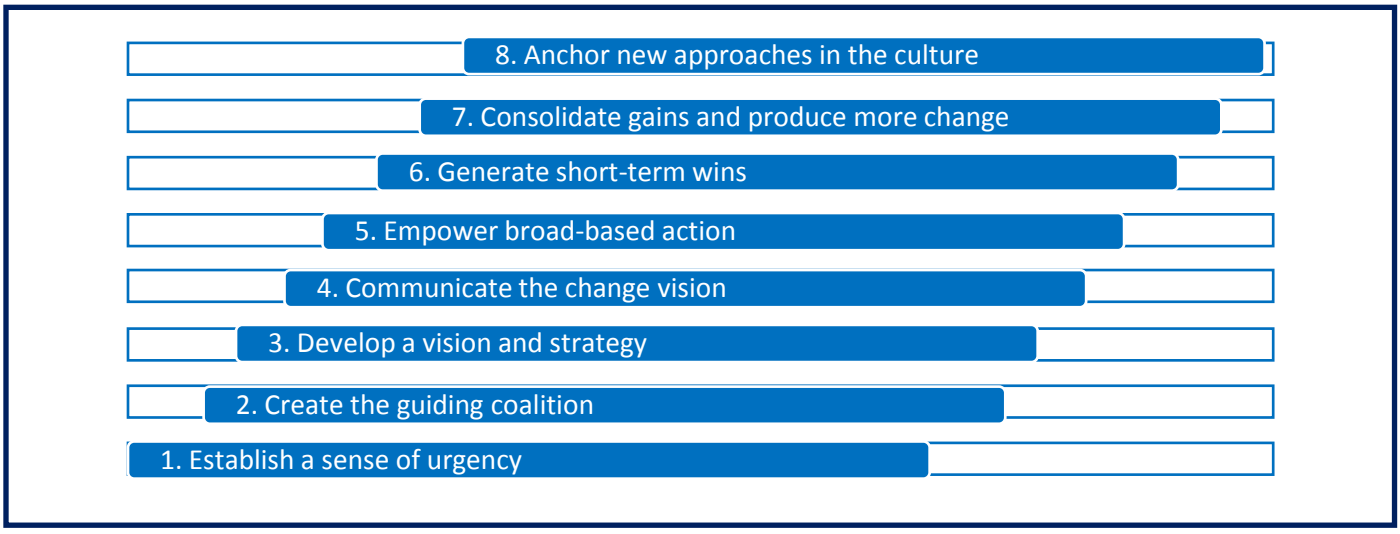
## What is change management?

Change is an inevitable process in the life-cycle of any system, and healthcare is no exception. Change in healthcare can be caused by factors such as emergence of new technologies, shifts in the social environment, and advancements in medical knowledge. Integrating changes into existing practices can be challenging. The change management theory focuses on understanding the nature of change and supporting individuals and organizations in the implementation of change. This support may include identifying the need for change, understanding who will be affected by it, and mitigating risks to achieve the desired outcomes. Support activities need to be planned for and completed in a coordinated, but flexible, fashion.

Several change management strategies have been developed and are described in the literature. One of the earliest models identified was Lewin's (1947) three-stage change model (as cited in Burnes, 2004), where change management was described as a process that involves unfreezing existing practices, transitioning to new practices, and then re-freezing in the desired end state[2].

Kotter (1996) described an eight-stage process that has been widely adopted[3] (Figure 2). Kotter's stages are very similar to Lewin's model, but go one step further to outline elements within each stage of the change process. The first four stages are focused on planning for a change and creating a vision that will be broadly communicated. The next stages begin to implement the change, while the final stage solidifies the change and ensures it is embedded in the new system.

Figure 2: Kotter's eight-step Change Management Approach




[2] Burnes, B. (2004). Kurt Lewin and the Planned Approach to Change: A Re-appraisal. Journal of Management Studies. 41(6):977-1002.
[3] Kotter, J. (1995). Leading Change: Why Transformation Efforts Fail. Harvard Business Review.

Golden (2006) revised previous change management models based on his experience in healthcare and developed the Four Stages of Change model. The four stages of change include: 1) determine the desired end state; 2) assessing readiness for change; 3) broaden support and organizational redesign; and; 4) reinforce and sustain change[4].

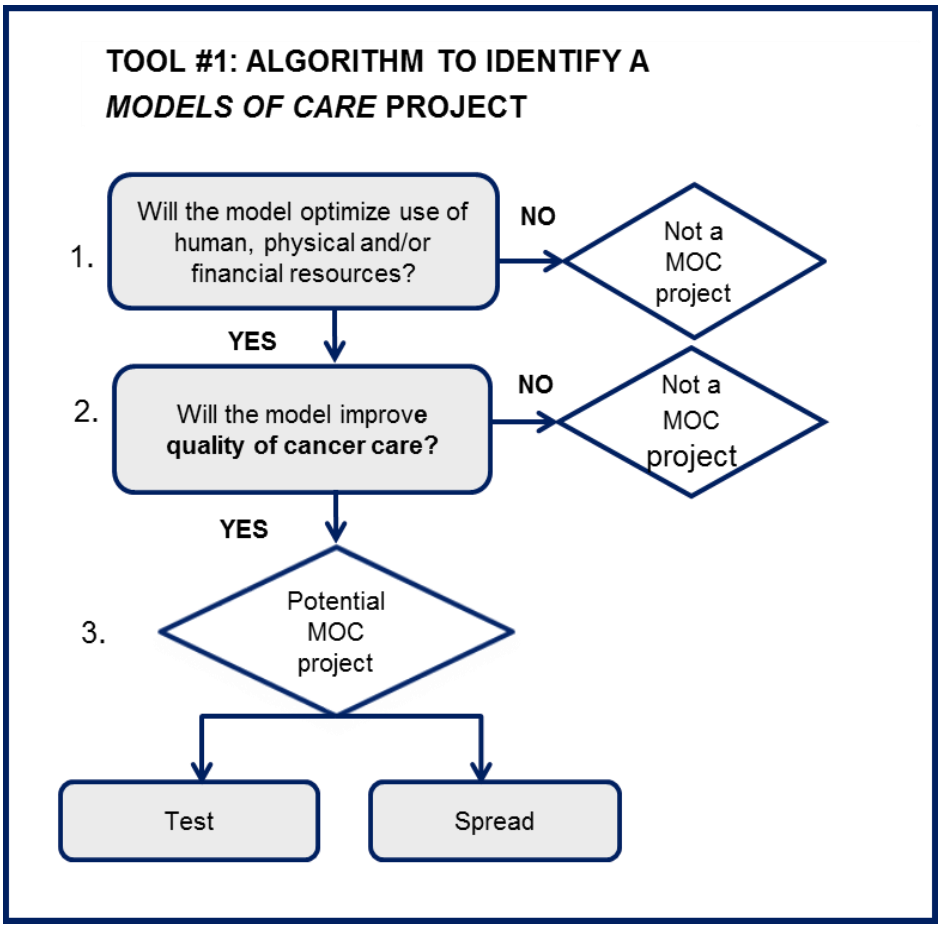
While the following toolkit draws closely upon literature in change management, project management, and program evaluation, Kotter's change management approach was chosen as the primary guiding framework as it most closely supports implementation of new models of care.

[4] Golden, B. (2006). Transforming Healthcare Organizations. Healthcare Quarterly. 10(Sp):10-19.

# Phase 1: Plan

## 1.1 Define the Problem

Before using this toolkit, it is important to test if the proposed change will benefit from a models of care approach. A simple algorithm (*Tool #1*) will help to determine this. As an example, a model that aims to improve the use of health human resources by moving care from an inpatient setting to an ambulatory clinic while improving quality of care and patient experience, could be a potential new model of care, as determined by Tool #1.




When embarking on a change process, it is integral to start with a clear idea of the problem you are trying to address. Once you have an understanding of the problem, you can identify what changes need to be made in order to reach your desired end state. Understanding these three pieces of information (i.e. the problem, the desired end state, and the necessary changes) can help you establish a sense of urgency to gain support for the initiative.

**Figure description:** Tool #1 describes an algorithm to identify a models of care project.

If the answers to either questions 1 or 2 are “no”, the model is not a models of care project. If the answer to questions 1 and 2 are both “yes”, the model is a potential models of care project, that would then either be tested or spread. The algorithm questions are:

Question 1: Will the model optimize the use of human, physical and/or financial resources?

Questions 2: Will the model improve quality of cancer care?

Once you have an understanding of which type of approach may be appropriate for your project, *Tool #2* (below) can be used as a guide to help you consider important questions when defining the changes that need to be made to move from your “current model” to a “new model”

## TOOL #2: MODEL OF CARE MATRIX

### Part 1: General Information about the model

| Item | Description | Old Model | New Model |
|---|---|---|---|
| **Objectives of the model** | What is the change in the model trying to achieve?<br>(e.g. improve access, optimize provider scope of practice and improve efficiency, optimize use of healthcare settings) | | |
| **Visits/Treatment** | Describe the type and intent of the visits *(e.g. consultation, treatment)* | | |
| **Patient population** | Describe the patient population (e.g. disease site; stage), if relevant to your model | | |
| **Setting** | Describe where care is delivered *(e.g. ambulatory clinic, inpatient care, home).* | | |
| **Start of model/referral to model** | Describe the start of the episode *(e.g. referral to medical oncologist; decision to treat)*. | | |
| **End of model/discharge from model** | Describe the end of the episode *(e.g. discharge from the centre; end of treatment)* | | |
| **# of patients** | Describe the number of patients who participate in the model in a given period of time. If the model is operating at full capacity, how many patients can receive the service on a weekly basis in the model? | | |
| **Staffing profile** | Describe overall human resource requirements and the roles of multidisciplinary team members in this model *(e.g. types and FTEs of key members of the team)* | | |
| **Facilitators/Key Considerations** | Describe any facilitators that make the model successful *(e.g. champions, funding, technology)* | | |
| **Challenges** | Describe any challenges that may hinder adoption and sustainability of the model. | | |
| **Gaps** | Describe any gaps in knowledge or practice that may impact planning and implementation of the model | | |

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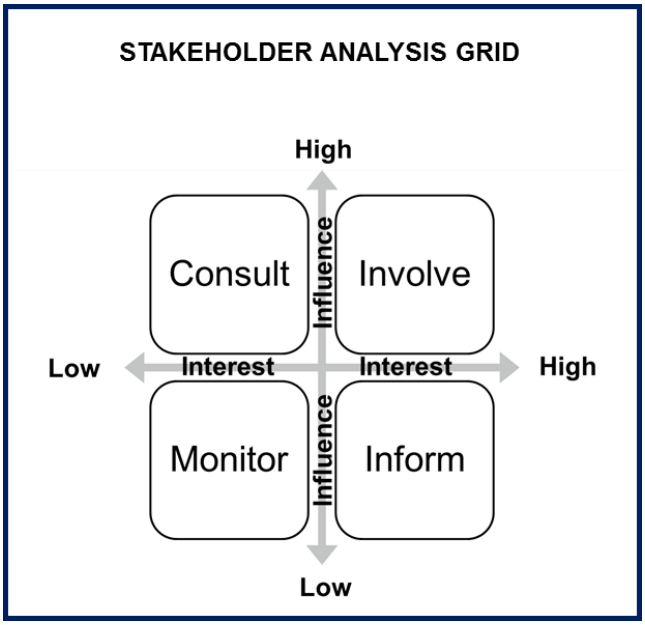
## TOOL # 2: MODEL OF CARE MATRIX

### Part 2: Details of the model of care

| **Patient Pathway: Identify major interactions with the healthcare system within your model.** | ***Current Model:* Setting** (Where is care delivered? Eg. Ambulatory, inpatient, home-care, etc) | ***Current Model*: Staffing profile** (Who are the key members of the team? What type of service are they providing?) | ***New Model*: Setting** (Where is care delivered? E.g. Ambulatory, Inpatient, Home-care, etc) | ***New Model*: Staffing Profile** (Who are the key members of the team? What type of service are they providing?) |
|---|---|---|---|---|
| e.g. Referral | | | | |
| e.g. Treatment | | | | |
| e.g. Follow-up | | | | |

## 1.2 Create a guiding team

Implementing new models of care will likely affect a wide range of key stakeholders, requiring strong collaboration across disciplines and healthcare organizations. Before embarking on a change process, it is important to:




- Ensure an appropriate governance structure is in place to guide and inform the implementation of new models;
- Identify change leaders within stakeholder groups who can leverage their existing relationships and networks and assist with engaging others;
- Have clear guidelines outlining the roles and responsibilities to help facilitate the work and create a sense of ownership and accountability; and,
- Communicate regularly with these groups and use this expertise to help generate support in the program work.

*Tool #3* can be used to help you identify relevant stakeholders, understand their optimal role in the project, and start to think about approaches for engagement. The level of influence and level of interest can help identify the most appropriate means of engagement.

**TOOL #3: STAKEHOLDER ANALYSIS TABLE**

| **Stakeholder Name** | **Level of influence *(low, neutral, high)*** | **Level of interest *(low, neutral, high)*** | **Specific interests and concerns of the stakeholder** | **Strategy for Engaging stakeholder** |
|---|---|---|---|---|
| | | | | |
| | | | | |

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## 1.3 Develop a project work plan

A project work plan should break down the overall objectives of the project into manageable work streams with associated tasks, timelines, and accountabilities. Completing project deliverables within timelines can help create credibility and buy-in for the project, and provide project staff with a means to measure the overall progress of the project. A sample work plan has been provided below (*Tool #4*).

**TOOL #4: PROJECT WORK PLAN TEMPLATE**

| Initiatives/Deliverable(s) | Activities | Timelines | Indicators/Outcomes/Measures |
|---|---|---|---|
| | | | |
| | | | |

## 1.4 Communicate the vision for change and create urgency

Clear communication is essential to any change management process[5]. Supporting the process of clear communication requires identifying:

- *What* the message is;
- *How* the message will be communicated (i.e. the communication medium, timing, and responsible parties); and,
- *Who* the intended audience is.

The following checklist may be used to help you develop a one-pager of key messages which can be tailored to different audiences.

**TOOL #5: CHECKLIST FOR KEY MESSAGES**

- ☐ Provide an overview of the current state and the impetus for change;
- ☐ Outline the vision of the change and the desired end goal(s);
- ☐ Describe the strategy to move towards the desired end state;
- ☐ Clarify why one model is being proposed over another at this time;
- ☐ Detail what the new model means for those involved (i.e. the changes required), including changes in practice, behavior, infrastructure, and relationships;
- ☐ Address how the new model will be evaluated for effectiveness;
- ☐ Outline who is leading the initiative, and how others are currently – or will be – engaged; and,
- ☐ Describe the mechanisms by which feedback can be provided and used to improve future models.

[5] Varkey, P. & Antonio K. (2010). Change Management for effective quality improvement: a primer. Am. J Med Qual. 25(4):268-73.

Once key messages have been drafted, they should be refined and made relevant to the target audience. Cancer care involves a large number of stakeholders including patients, caregivers, clinicians, administrators, and the government. For providers, different disciplines are likely represented by various practice groups, medical associations and regulatory bodies. Engagement of these communities can help you identify opportunities to develop new models of care that optimize the use of health human resources, create a sense of urgency, generate support and buy-in, as new models are implemented and refined.

**TOOL #6: COMMUNICATION PLAN TEMPLATE**

| Stakeholder | Objectives | Mechanism & Medium | Timing | Responsibilities | Measure |
|---|---|---|---|---|---|
| Who is the target audience? | What is the purpose of this communication? | How will this communication be delivered? | When should this communication be delivered? | Who is responsible for delivering this communication? | How will we know whether we achieved the objective of this communication? |
| | | | | | |

When developing messages, you may also consider engaging local patient and family advisory council members to help refine and spread your message. This kind of engagement is essential in the creation of person-centred model of cancer care.

You will need to determine how these messages will be conveyed, i.e. by whom, at what time, at what frequency, and using which methods. To be effective, these messages should use clear, focused language and include examples or analogies where possible.

# Phase 2: Implement

## 2.1 Empower action by removing obstacles

When implementing models of care, resistance to change is often associated with the following:

- Lack of recognition of need for change;
- Lack of confidence in sustainability of new model due to financial and provider support;
- Inconsistencies in availability of health human resources across cancer centres;
- Lack of knowledge of how the new model provides value for money;
- Resistance providers to broaden scope of practice without an increase in compensation;
- Resistance by providers due to possible loss of income;
- Lack of infrastructure support (tools/training) and resources;
- Lack of communication mechanisms between providers and across disciplines;
- Lack ongoing engagement and communication;
- Workload issues (too much or too little);
- Lack of acceptance of existing evidence-based guidelines;
- Regulatory and policy barriers, such as limitations of the scope of practice for nurse practitioners;
- Discrepancy between existing medical education curriculum and new model.

Understanding what the obstacles are to implementing the change is a key step in supporting sustained change. A number of excellent resources have been developed to help individuals and teams understand “readiness” or “resistance” to change from both an organizational and individual perspective.

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## RESOURCES FOR ASSESSING RESISTANCE (AND READINESS) TO CHANGE:

**Canada Health Infoway, Organizational Change Readiness Assessment (2012).**

This questionnaire is designed to give a quick snapshot of the organization's readiness to adopt change. Managers, supervisors, change agents, clinicians and others involved should fill out the questionnaire. This questionnaire should be repeated at different points in time during the change process to gauge the progress. The questionnaire prompts users to assess "levers" for change within the following domains: external environment; leadership; strategic direction; organizational structure; management processes and communication; and, culture, norms, and morale.

**National Collaborating Centre for Methods and Tools, Organizational readiness to change assessment (ORCA) tool (2013).**

The ORCA is a structured survey based on the Promoting Action on Research Implementation in Health Services (PARIHS) framework intended to assess organizational readiness for change when attempting to implement a specific, evidence-based practice. The ORCA tool consists of 3 subscales corresponding to the core elements of the PARIHS framework: 1) the perceived strength and nature of the evidence; 2) the quality of the organizational context; and 3) the capacity of the organization to facilitate or promote the practice change from within.

**Project Management Institute, Change Readiness, Focusing Change Management Where it Counts (2014)**

A simple framework to assess change readiness by focusing on three drivers of change: commitment, capacity, and culture. The framework includes key questions used to help assess capacity (i.e. work processes, physical resources, organizational systems, and technology); commitment (i.e. value alignment, involvement, skill, perceived value, and time); and culture (i.e. values and mechanisms), as well as guidance for individuals interested in measuring these constructs.

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You are encouraged to visit the resources below to understand what obstacles to change (*Tool #7*) if any, exist within your model of care, and subsequently start identifying action items to address these obstacles (*Tool #8*).

**TOOL #7: RISKS AND ISSUES LOG**

| **Type (Risk, Issue)** | **Description** | **Implication/ Impact** | **Level of impact (High, Med, Low)** | **Mitigation Strategy** | **Owner** | **Status (Open, Closed)** |
|---|---|---|---|---|---|---|
| Risk = potential problem<br><br>Issue = existing problem | Please provide a short description of the risk/issue | Please describe the implications/ impacts of the risk/issue | Identify the likelihood of the risk/issue impacting completion of the project. | What action items need to be completed to manage the issue/risk | Who is responsible for resolving the issue/risk | |
| | | | | | | |

# Phase 3: Evaluate

## 3.1 Create short-term wins to produce long-term change

Evaluation should be considered early on, ideally during project development, to ensure alignment of outcome measures with the overall objectives of the project. It is important to describe the outcomes of the new models of care as they progress for a number of reasons:

- Early results showing a high return-on-investment can help encourage buy-in;
- Paying attention to the implementation process through ongoing monitoring and evaluation provides an opportunity to identify risks earlier in the process and help mitigate them before they become issues;
- Lessons learned and process improvements can be integrated in real-time, to avoid repeated mistakes;
- It provides an opportunity for clinicians, administrators, and researches from across the cancer system to learn from others, and apply these learnings to their own work.

Logic models can provide stakeholders with a road map describing the sequence of related events connecting the need for the planned program, with the program's desired outcomes. The visual representation of the master plan in a logic model is flexible, points out areas of strength and/or weakness, and allows stakeholders to run through many possible scenarios to find the best.

Effective evaluation and program success relies on clear stakeholder assumptions and expectations about how and why a program will solve a particular problem, generate new possibilities, and make the most of valuable assets. A clear logic model illustrates the purpose and content of your program and makes it easier to develop meaningful evaluation questions from a variety of program vantage points: context, implementation, and results (which includes outputs, outcomes and impacts).

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Cancer Care Ontario's Models of Care Program has developed a logic model for the provincial Models of Care program. This model may be used as a template for other programs or regions when developing their own model of care.

Figure 3: CCO's Models of Care Logic Model

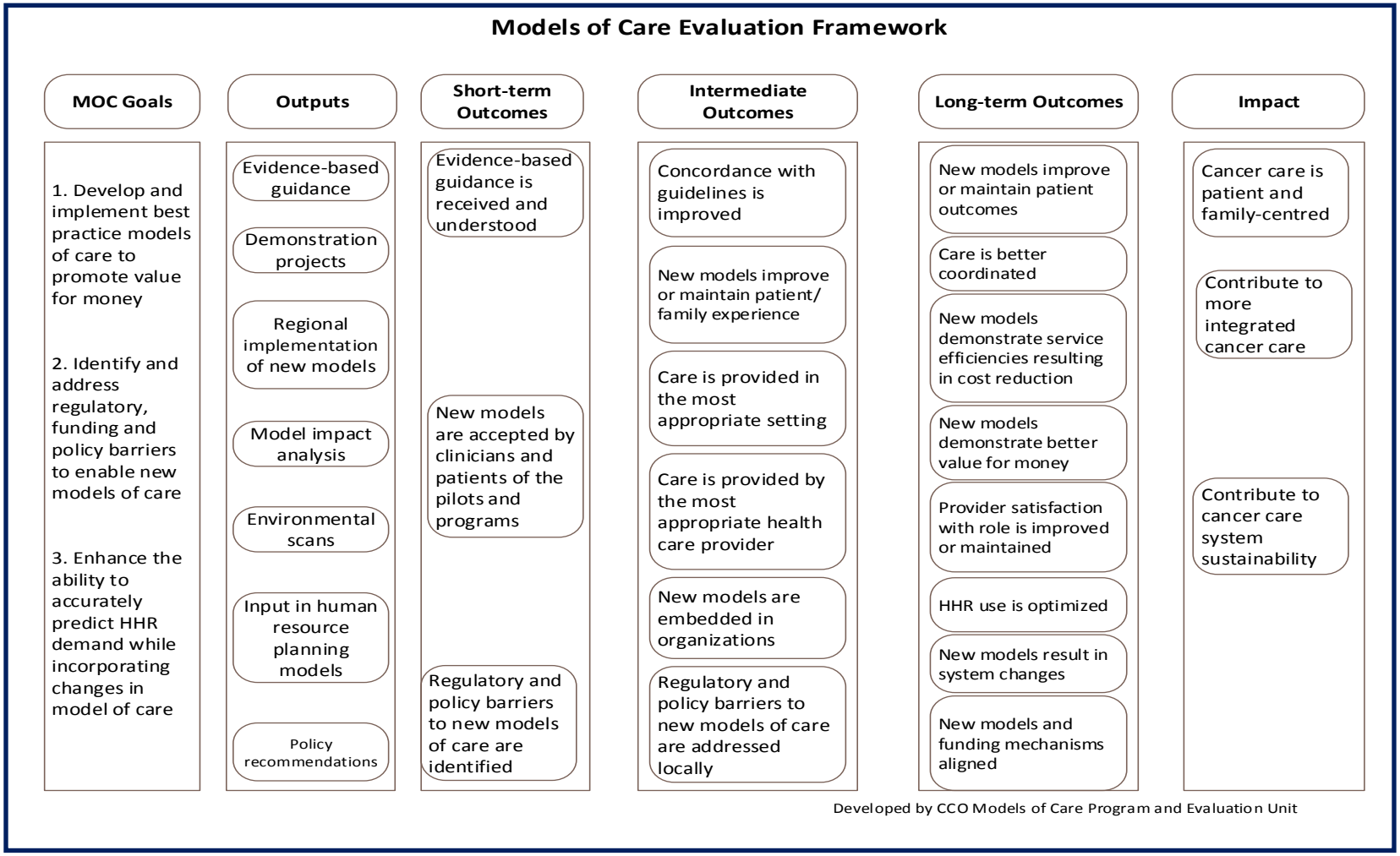

**Figure Description:** CCO's Models of Care Logic Model illustrates the program's evaluation framework. The framework describes:

1) The Goals of the Program
2) Outputs
    - Evidence-based guidance
    - Demonstration projects
    - Regional implementation of new models
    - Model impact analysis
    - Environmental scans
3) Short-term Outcomes
    - Evidence-based guidance is received and understood
    - New models are accepted by clinicians and patients of the pilots and programs
    - Regulatory and policy barriers to new models of care are identified
4) Intermediate Outcomes
    - Concordance with guideline is improved
    - New models improve or maintain patient/family experience
    - Care is provided in the most appropriate setting
    - Care is provided by the most appropriate health care provider
    - New models are embedded in organizations
    - Regulatory and policy barriers to new models of care are addressed locally
5) Long-term Outcomes
    - New models improve or maintain patient outcomes
    - Care is better coordinated
    - New models demonstrate service efficiencies resulting in cost reduction
    - New models demonstrate better value for money
    - Provider satisfaction with role is improved or maintained
    - HHR use is optimized
    - New models result in system changes
    - New models and funding mechanisms aligned
6) Impact
    - Cancer care is patient and family-centred
    - Contribute to more integrated cancer care
    - Contribute to cancer care system sustainability

In addition, a number of excellent resources also exist for programs or regions interested in developing their own logic model and overall evaluation plan.

## EVALUATION RESOURCES:

**W. K. Kellog Foundation, Logic Model Development Guide (2004).**
Provides practical assistance and examples for creating logic models, and advice for using logic models to develop evaluation plans.

**W.K. Kellog Foundation, Evaluation Handbook (2004)**
A comprehensive handbook outlining the steps in planning and implementing project evaluations.

**Centre for Development Innovation, Making Evaluations Matter: A Practical Guide for Evaluators (2011)**
A comprehensive handbook focused on developing and carrying-out evaluation plans with a focus on ensuring the outcomes of the evaluation are of value to the end-user.

**Centres for Disease Control, Developing an Effective Evaluation Plan (2011)**
A comprehensive guide to planning and conducting evaluations, including an extensive collection of exercises, worksheets, and tools of interest to anyone interested in conducting program evaluations.

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# Phase 4: Sustain

## 4.1 Anchor new approaches in the organization culture

Ensuring change is sustained when implementing new models of care involves continued incorporation of the language and principles associated with the new models of care, thereby establishing this philosophy in daily practice that is shared across the organization.

One key sustainability factor is the knowledge, skills and behaviours that enable individuals to undertake change projects and to work and thrive in a changed organization. It is important to assess and provide resources for staff development in any change project plan. The following tool can be used as a guide to identify and track training opportunities for all staff involved (directly and indirectly) in the project.

**TOOL #8: STAFF LEARNING AND DEVELOPMENT TOOL**

**Name of project:**

**Author/project manager:**

| **Who is involved? (Individuals and groups)** | ***During the Project*: What do they need to know/be able to do?** | ***Longer Term*: What do they need to know/be able to do?** | **Development/training options** | **Action** |
|---|---|---|---|---|
| Core Project Change team | | | | |
| | | | | |
| | | | | |
| People affected by change | | | | |
| | | | | |
| | | | | |

Sustainability is an ongoing process; many of the tools outlined in this document may be used and revised on an ongoing basis to support the sustainability of the model. For example, the *Communication Plan Template* (*Tool #6*) should be used to support ongoing knowledge translation associated with the initiative, including success stories and lessons learned. Additionally, the *Risks and Issues Log* (*Tool #7*) should be re-visited towards the end of the project in order to identify any ongoing risks or issues that could impact the sustainability of the model of care. In addition to the *Risks and Issues Log* (*Tool #7*) consider the following checklist (*Tool #9*) as a guide as a starting point to develop an overall *Sustainability Plan* (*Tool #10*).

## TOOL #9: SUSTAINABILITY FACTORS CHECKLIST

| Sustainability Factors | Sustainability Actions (examples) |
|---|---|
| **Champions** | ✓ Strengthen and/or maintain champion roles to sustain the innovation. |
| **Leadership** | ✓ Regularly communicate vision and goals of the change to senior leadership to ensure continued buy-in.<br>✓ Regularly communicate outcomes associated with the change to senior leadership to ensure continued buy-in.<br>✓ Regularly demonstrate how the change aligns with the organizational priorities.<br>✓ Assess and enhance, where necessary, the network among key stakeholders. |
| **Effectiveness** | ✓ Demonstrate the quality and integrity of the change by implementing and reporting on process evaluation.<br>✓ Demonstrate effectiveness of the innovation by implementing and reporting on outcome evaluation. |
| **Physical Resources** | ✓ Ensure adequacy and availability of required space.<br>✓ Ensure adequacy and availability of required equipment. |
| **Financial Resources** | ✓ Ensure adequacy and availability of required financial resources. |
| **Human resources** | ✓ Ensure availability of human resources required to support the change.<br>✓ Build and/or maintain expertise to sustain the innovation (i.e. ensure human resources have appropriate knowledge/skills/abilities required to sustain the change). |
| **Policies & Procedures** | ✓ Strengthen or maintain formal governance structures to support ongoing decision-making and problem solving.<br>✓ Develop or strengthen feedback and information systems that can be used to implement, integrate, and sustain change.<br>✓ Develop or strengthen measurement systems to continually assess the degree to which behaviours are consistent with the goals of the change.<br>✓ Review/revise policies and procedures (may be formal, or just accepted practice) that contradict proposed change and consider exclusion or elimination.<br>✓ Review/revise reward systems (compensation or other non-monetary rewards) to ensure alignment with the goals of the change. |

*Adapted from Johnson et al. (2004). Building capacity and sustainable prevention innovations: a sustainability planning model. Evaluation and Program Planning. 27:135-149.*

The *Sustainability Factors Checklist* (*Tool #9*) can be used as a starting point to develop an overall *Sustainability Plan* (*Tool #10*).

**TOOL #10: SUSTAINABILITY PLAN**

| Sustainability factor | Sustainability Actions | Owner | Timelines |
|---|---|---|---|
| Describe which factor you want to address. Examples provided in Tool #8 above. | Describe what actions you will take to address your objective. Examples provided in Tool #8 above. | Who is responsible for implementing the action items? | By when should the action be completed? For ongoing action items, describe the frequency. |
| | | | |

Change management is a necessary aspect of the work envisioned by the Models of Care program, and successful implementation is required to ensure the adoption and sustainability of new models of care.

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## Appendix A: Additional Tools and Resources

**Change Management:**

Kotter, Leading Change: Why Transformation Efforts Fail. Harvard Business Review (1995).
A seminal articles in the study of change management; outlines 8 steps to transforming an organization.

Golden, Transforming Healthcare Organizations. Healthcare Quarterly (2006).
Describes updated healthcare-centric change management framework.

Canada Health Infoway, A Framework and Toolkit for Managing eHealth Change People and Processes (2013).
A comprehensive resources with tools and education to support individuals in change management initiatives. Maybe of interest to change management leaders, front line clinicians, managers, and individuals new to change management.

National Health Service, the NHS Change Model (2013).
Provides an overall approach as well links to useful tools and resources to support a standardized process of change.

**Evaluation:**

W. K. Kellog Foundation, Logic Model Development Guide (2004).
Provides practical assistance and examples for creating logic models, and advice for using logic models to develop evaluation plans.

**Project Management:**

Project Management Institute, A Guide to the Project Management Body of Knowledge (PMBOK Guide) (2013).
Available for purchase from the Project Management Institute. Provides a global standard for project management.

**Quality Improvement:**

Health Quality Ontario, HQO Quality Improvement Framework.
Provides extensive resources and advice for the entire quality improvement cycle.

Institute for Healthcare Improvement, How to Improve.
Describes a simple, powerful framework for accelerating improvement using the Plan-Do-Study-Act (PDSA) cycle.

**Models of Care:**

Nelson et al. Optimizing Scopes of Practice: New Models for a New Health Care System (2014).
Describes the barriers and enablers related to optimizing scopes of practice from a macro- (structural), meso- (institutional/ organizational) and micro- (practice) level.

NSW Agency for Clinical Innovation, Understanding the process to implement a Model of Care (2013).
Describes process and key considerations for implementing and evaluating new models of care.

Queensland Health, Changing Models of Care Framework (2000).
Describes process and key considerations for identifying, implementing, and evaluating new models of care.

For inquiries, please contact us at: ModelsofCare@cancercare.on.ca