Annual Report

2015/16

Ontario

Cancer Care Ontario

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Our Mission

Together, we will improve the performance of our health systems by driving quality, accountability, innovation and value.

Our Vision

We will work together to create the best health systems in the world.

Our Guiding Principles

- The people of Ontario are at the core of everything we do.
- We will be transparent and foster a culture of open communication.
- We will ensure fairness across regions in the development of strong provincial health systems.
- We will make decisions and provide advice based on the best available evidence.
- We will consult widely, share openly, and collaborate actively to achieve our goals.

Message from the President and CEO, and Board Chair of CCO

Michael Sherar
President and CEO

Ratan Ralliaram
Board Chair

As the Ontario government's principal advisor on cancer and chronic kidney disease (CKD) care, as well as on access to care for key health services, CCO has a long history of working together with our many partners to improve healthcare for all Ontarians. This past year has been particularly significant, as we began the implementation of our latest health system plans, Ontario Cancer Plan IV (OCP IV) and Ontario Renal Plan II (ORP II), which both launched in March 2015. Building on the significant accomplishments of their predecessors, these plans are the road maps guiding the work we undertake from 2015 to 2019 to reduce the risk of Ontarians developing cancer or advanced CKD, while continuing to ensure the delivery of high-quality services for current and future patients. This past year, we also continued our work on our access to care commitments and strategic initiatives that enable broader health system improvements.

In 2015/16, CCO oversaw approximately $1.9 billion of healthcare funds for hospitals and other cancer and CKD care providers. While the majority of these funds—just over 60 per cent—supported cancer services (radiation, chemotherapy, surgical treatments and drug reimbursement, as well as prevention and screening initiatives), approximately one-third of these funds went toward CKD services, primarily dialysis. The remaining funds went toward program management support, as well as access to care programs, which support the collection and use of information to improve access, performance, quality and efficiency of healthcare in Ontario.

At CCO, we recognize that we have a tremendous responsibility to the people of Ontario to use these funds to continually improve the performance of our health systems by driving quality, accountability, innovation and value. In order to strengthen our ability to meet the challenges of today's healthcare environment, we have focused on building competencies in five key areas:

- Patient-centred care
- Prevention of chronic disease
- Integrated care
- Value for money
- Knowledge sharing and support

Both our cancer and renal system plans share these common areas of focus, while also addressing the unique needs of their patient populations. Cancer Care Ontario and the Ontario Renal Network engaged with an unprecedented number of our partners and stakeholders—including patients and their families—in identifying priorities for each plan. Stemming from these consultations, six themes emerged and became the goals of OCP IV: quality of life and patient experience; safety; equity; integrated care; sustainability; and effectiveness. Similarly, collaboration and consultations with members of the CKD community identified key themes that became the goals of ORP II: patient and family support; integrated care; and improved access to care.

As we continue to focus on implementing our cancer and kidney care system plans, we also recognize CCO's unique opportunity to be part of broader health system solutions. There are a number of areas where, working together with our partners, we have the opportunity to leverage our assets and competencies to support the government's broader health system transformation agenda. For example:

- A two-year partnership with the mental health and addictions community is making use of CCO's assets and expertise in data analytics to help establish a preliminary framework for collecting data and reporting access to care and wait times within this sector.

- The Quality Management Partnership, with the College of Physicians and Surgeons of Ontario, leverages existing Cancer Care Ontario data assets and collects new data, to produce physician-, facility- and system-level reports on the quality of colonoscopy, mammography and pathology services.

- CCO is partnering with the Local Health Integration Networks to improve palliative care for all patients in Ontario, no matter their disease. The Ontario Palliative Care Network, with its secretariat and other support hosted within CCO, will implement a provincial approach to palliative care improvement, using guidelines, standards, measurement, patient and provider engagement, and clear provincial and regional accountability.

As the details of this Annual Report attest, steady progress is being made toward improving our health systems for all Ontarians. Yet we also face continuing challenges, particularly in regards to rising demands for healthcare services. The growing need for stem cell transplant, for example, has increased greatly in recent years despite significant increases in funding to transplant hospitals. This pressure at transplant hospitals, due to advances in technologies and our growing and aging populations, has resulted in more patients than ever before needing and being eligible for this complex, resource-intensive care.

Addressing the challenges of today's healthcare environment will require ongoing collaboration among all partners, including the Ministry of Health and Long-Term Care, healthcare providers and administrators, regional and provincial partners, patients and their families, and our employees. Working together, we will create the best health systems in the world.

As we continue to focus on implementing our cancer and kidney care system plans, we also recognize CCO's unique opportunity to be part of broader health system solutions.


CCO
Our future health built with care

About CCO

As the Ontario government's principal advisor on the cancer and kidney care systems, as well as on access to care for key health services, CCO drives continuous improvement in disease prevention and screening, the delivery of care, and the patient experience for chronic diseases. Known for our innovation and evidence-based approaches, CCO leads multi-year system planning, contracts for services with hospitals and providers, develops and deploys information systems, establishes guidelines and standards, and tracks performance targets to ensure system-wide improvements in cancer, chronic kidney disease and access to care.

CCO began life in April 1943 as The Ontario Cancer Treatment and Research Foundation. More than a half-century later, in 1997, the organization was formally launched and funded as an Ontario government agency. CCO is governed by the *Cancer Act* and is accountable to the Ministry of Health and Long-Term Care (MOHLTC).

CCO directs and oversees approximately $1.9 billion of healthcare funds for hospitals and other cancer and chronic kidney disease care providers, enabling them to deliver high-quality, timely services and improved access to care.

CCO employs 1,100 staff members, all of whom are critical to the success of our efforts with our partners to improve Ontario's healthcare system.

Cancer Care Ontario

As the government's principal cancer advisor, Cancer Care Ontario implements provincial cancer prevention and screening programs; works with cancer care professionals and organizations to develop and implement quality improvements, standards and accountability for cancer care; and uses electronic information and technology to increase accessibility to Ontario's cancer services, and to advance the safety, quality and efficiency of these services, in order to support health professionals and patient self-care. In order to meet current and future patient needs, Cancer Care Ontario also works with healthcare providers in every Local Health Integration Network (LHIN) to plan services that will continually improve cancer care for the people they serve. In addition, Cancer Care Ontario conducts research and also transfers knowledge of new research into improvements and innovations in clinical practice and cancer service delivery.

Ontario Renal Network

The Ontario Renal Network, the government's principal advisor on chronic kidney disease (CKD), leads a provincewide effort to reduce the burden of CKD on Ontarians and the kidney care system through the effective management and funding of CKD services in Ontario. Working through 26 Regional Renal Programs, the Ontario Renal Network's goal is to improve CKD management by preventing or delaying the need for dialysis, broadening appropriate care options for people with CKD, improving the quality of all stages of kidney care, and working with patients, families and healthcare providers to build a world-class system for delivering care to Ontarians living with CKD.

Access to Care

In 2004, Canada's First Ministers made a national commitment to reduce wait times for key healthcare services. In Ontario, this commitment resulted in the MOHLTC's Wait Time Strategy and the subsequent launch of its Emergency Room/Alternate Level of Care (ER/ALC) Strategy in 2008. The success of these strategies relies on information and technology capabilities to collect and report accurate, reliable and timely wait time data. CCO was assigned to develop and deploy the Wait Time Information System (WTIS) to capture and report this data in near real-time. Subsequently, CCO was given the task of collecting and reporting information to support the goals and objectives of the ER/ALC Strategy.

CCO's Access to Care program enables improvements in the access to, quality of and efficiency of healthcare services. It also helps to reduce wait times by implementing and using information management/information technology solutions, and by tracking patients as they move across the continuum of care.

Access to Care

Access to Care (ATC) was established to understand, analyze and report on health system performance, centred on the patient. Data analysis provides meaningful information to provincial health system stakeholders to improve access, performance, efficiency and quality of care. ATC focuses on the design, implementation and management of provincial information management/information technology (IM/IT) initiatives that support the Ministry of Health and Long-Term Care's (MOHLTC's) Wait Time Strategy and Emergency Room/Alternate Level of Care (ER/ALC) Strategy.

Information Management Programs

SURGICAL INFORMATION PROGRAM

ATC maintains the infrastructure and daily operational services to collect and report near real-time surgery wait times data (Wait 1 [referral to consult], Wait 2 [decision-to-treat to surgery]) using the Wait Time Information System (WTIS) with more than 3,200 surgeons across 122 healthcare sites. In addition, surgical efficiency (operating room) data are collected for 105 healthcare sites, covering the duration of the patient's surgical procedure from admission to discharge.

2015/16 Highlights

- The ATC Surgeon Wait Time Dashboard was expanded and distributed to approximately 3,200 surgeons in Ontario, enabling surgeons to review their data and compare to peer surgeons, to help them identify opportunities for practice improvements.
- Wait 1 access targets for benign (non-cancer) surgical procedures were established, enabling surgeons to standardize prioritization of consults and improve access to services for patients.
- New surgical performance reports were developed to share surgical wait time and efficiency information with stakeholders more effectively.

DIAGNOSTIC IMAGING INFORMATION PROGRAM

ATC maintains the infrastructure and daily operational services to collect and report near real-time diagnostic imaging wait time data, using WTIS, for magnetic resonance imaging (MRI) and computerized tomography (CT) services for 107 healthcare sites across Ontario. Expansion of WTIS to capture new wait time efficiency data for MRI (2013) and CT (2015) enhances ATC performance reporting capabilities to support MOHLTC in identifying opportunities to improve operational efficiency of service delivery and capacity planning.

2015/16 Highlights

- WTIS was deployed to 107 healthcare sites to expand the collection of near real-time MRI and CT wait times and efficiency data. This information supports systematic and provincial access improvements to diagnostic imaging services.
- New diagnostic imaging performance reports were developed to better support stakeholder needs and to understand health system performance.
- A Local Health Integration Network (LHIN) MRI Allocation Tool was developed to support LHINs in healthcare-facility-level resource planning, with the goal of optimizing resources to reduce diagnostic imaging wait times at a regional level.
- MRI Efficiency Performance Benchmarks were established to enable healthcare sites to understand and drive a performance management culture.

EMERGENCY ROOM INFORMATION

ATC partners with the Canadian Institute for Health Information to leverage the National Ambulatory Care Reporting System for the timely collection of ER wait time data. A total of 126 ERs collect a dataset of 38 ER data elements that capture the patient journey from triage/registration until the time the patient leaves the ER.

2015/16 Highlights

- A new pay-for-results forecasting tool was released to support, plan and evaluate the program's impact based on projected performance and volumes.
- ATC supported MOHLTC's strategy to drive continued performance improvement and accountability through the integration of Ambulance Offload Time into the Pay for Results program funding methodology.

ALTERNATE LEVEL OF CARE

ATC maintains the infrastructure and daily operational services to collect and report near real-time wait time data, using the WTIS, with over 190 data elements for patients designated as requiring an alternate level of care. Information is collected from and reported for 186 healthcare sites across Ontario. ATC further supports and works collaboratively with MOHLTC to drive ongoing improvement in performance management with hospital, LHIN and Community Care Access Centre partners.

2015/16 Highlights

- ALC system and process gaps were identified by leveraging data linkages between WTIS, community sector and clinical data to better understand the patient journey and identify opportunities for enhanced access to care for patients designated as ALC.
- The ALC rate indicator was included in the Ministry LHIN Accountability Agreement. This supported both Ministry and stakeholder decision-making and target-setting for access to care for patients designated as ALC.
- A methodology to compare similar hospitals across LHIN boundaries was developed. It took into consideration hospital and community factors such as rurality, availability of community resources, and hospital type. This comparison will allow for performance improvement opportunities to be identified and leveraged across the province.

WAIT TIME INFORMATION SYSTEM–CARDIAC CARE NETWORK

ATC supports the Cardiac Care Network (CCN) by developing, enhancing and maintaining the WTIS-CCN application. Key services include system design, software development, IT operations and technical service desk support. The system collects vital information to support CCN and clinicians in delivering quality care for cardiac patients.

2015/16 Highlights

- The WTIS-CCN system and its administrative tools were enhanced to improve workflow and layout and to expand functionality for managing the WTIS-CCN application.

ACCESS TO CARE PROVINCIAL SUPPORT MODEL

ATC works with provincial stakeholders to define data standards, definitions and information enhancements to the existing ATC systems. Since 2006, ATC has leveraged its clinical, technical and service expertise to plan, design, develop, schedule, deploy and support a number of large-scale provincewide healthcare system IM/IT solutions for a growing number of healthcare facilities and end users.

2015/16 Highlights

- WTIS was expanded to include the collection and reporting of new ALC and diagnostic imaging efficiency data elements and accurate Wait 1 priority data collection.
- More than 190 healthcare sites were supported with daily operational services and technical support.
- ATC's business intelligence tool (iPort™ Access), stakeholder communication vehicles and information systems were managed to support stakeholders in their use of IM/IT solutions and report development.

ELECTRONIC CANADIAN TRIAGE AND ACUITY SCALE SOLUTION

The Canadian Triage and Acuity Scale (CTAS) is leveraged by clinicians to triage emergency department (ED) patients according to the urgency of their needs. The 2010 Auditor General's report identified significant variation in how clinicians interpret and apply the CTAS guidelines. On behalf of MOHLTC, ATC is establishing an electronic CTAS (eCTAS) decision-support solution to standardize the application of the CTAS guidelines, ensuring patients are triaged in a safe and consistent manner across the province.

2015/16 Highlights

- More than 100 health system stakeholders from across the province were engaged to establish and participate in a comprehensive governance structure to ensure strategic oversight and direction for the design and development of the eCTAS technical system.
- A representative cross-section of ED and hospital leadership was engaged to assess current state and design a system to accommodate varying clinical practices and technical systems across the province. Twenty-four site visits were completed within extremely tight timelines.
- Twenty-three healthcare sites volunteered to participate as early adopters in Phase 1 implementation.

MENTAL HEALTH AND ACCESS WAIT TIMES

In 2011, MOHLTC launched Ontario's Comprehensive Mental Health and Addictions (MH&A) Strategy with an objective of improving the delivery of MH&A services to Ontarians. In 2015, MOHLTC engaged Ontario's four specialty mental health organizations (Centre for Addiction and Mental Health, Ontario Shores Centre for Mental Health Sciences, Royal Ottawa Health Care Group and Waypoint Centre for Mental Health Care) to build on the MH&A strategy and develop a Mental Health and Addictions Access to Care (MHATC) initiative in partnership with CCO. The overall goal of the MHATC initiative is to develop a comprehensive provincial approach to improving access to care for MH&A services in Ontario by measuring and reporting on wait times across the sector.

2015/16 Highlights

- ATC collaborated with the MH&A partners to conduct a current state analysis and assess the feasibility of collecting and reporting three MH&A priority indicators and four MH&A wait time segments, which together represent a patient's entire journey through MH&A services.
- Collection and reporting of information for priority indicators and wait times from the four organizations was initiated.

Strategic Initiatives

The healthcare landscape is in a period of significant change. Ontario's growing and aging population, coupled with current fiscal challenges, demands that health organizations provide even greater performance and value from every health dollar spent.

In 2012, in recognition of these challenges, CCO undertook the development of a new corporate strategy. The purpose was to drive quality, safety, value and system improvements, not only to meet the current demands of Ontario's health systems, but to also address future healthcare needs and the future health of Ontarians.

Following extensive consultation with stakeholders and partners, CCO developed *Strategic Direction 2012–2018*, an action plan that identifies how we can support health system improvements through a set of specific goals, aligning work in pursuit of those goals, and creating a platform that enables greater improvements in the cancer and chronic kidney disease health systems and in access to care. Beyond these current areas of focus, CCO will also be active in enabling broader health system improvement by sharing and supporting the use of approaches that have demonstrated success in driving quality, accountability, innovation and value.

CCO actively manages this strategy to ensure its work continues to support the delivery of integrated, accessible, person-centred care, and that the organization's efforts remain true to the needs of every person in Ontario.

CCO's strategic plan ensures our work continues to support the delivery of integrated, accessible, person-centred care for all Ontarians.

Quality Management Partnership

On March 28, 2013, the Ministry of Health and Long-Term Care (MOHLTC) announced the Quality Management Partnership (the Partnership), led by Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO). Since then, the Partnership has been working closely with stakeholders to develop quality management programs (QMPs) for three health service areas: colonoscopy, mammography and pathology. In December 2015, the Partnership received a mandate from MOHLTC to proceed with implementation of the QMPs.

The work of the Partnership supports Ontario's *Patients First: Action Plan for Health Care* (2015) and its broad quality agenda that focuses on continuous improvement and transparency across the healthcare system. The goals of the Partnership are to enhance the quality of care and improve patient safety; increase consistency in the quality of care provided across facilities; and improve public confidence by increasing accountability and transparency.

QMPs include standards and guidelines to improve the consistency of care provided across healthcare facilities; quality reporting at the provincial, regional, facility and physician levels; a clinical leadership structure; and resources and opportunities to support quality improvement. QMPs will contribute to achieving consistent, high-quality care wherever the care is provided. Over time, patients can expect improved access to information about the quality of their care. The Partnership is committed to working closely with the broader stakeholder community to align and leverage the substantial quality management activity already underway.

2015/16 Highlights

- The Partnership recruited three provincial leads, expanded the role of existing regional leads for colonoscopy and mammography, started planning for the recruitment of pathology regional leads and started engaging facilities to begin the recruitment of facility leads. This network of clinical leadership will strengthen accountability for quality at all levels and will promote consistency and transparency in the three health service areas.

- The Partnership released its inaugural report on the quality of the three service areas. The report provides information on the health professionals and facilities that provide these three health services in Ontario, an overview of key provincial quality initiatives that currently exist for each health service, and a summary of performance throughout the province as measured through indicators recommended by the Partnership's expert advisory panels.

- The Partnership recruited members of the public to participate in a new governance table, the Citizens Advisory Committee (CAC). The CAC will provide guidance from the patient/service user's perspective on the overall design and implementation of the QMPs as well as on patient engagement, patient experience indicators and public reporting.

- The Partnership launched the Colonoscopy Provincial Quality Committee. The provincial committee will advise on program priorities, refinements of recommendations and future areas of expansion; provide recommendations for quality improvement opportunities; and support change management and knowledge translation exchange across the province. The Partnership will launch the Provincial Quality Committees for mammography and pathology in fiscal year 2016/17.

- As a follow-up to earlier work to pilot physician-level reporting for colonoscopy, the Partnership collaborated with researchers at Sunnybrook Health Sciences Centre to release 450 physician-level reports to endoscopists as part of a randomized controlled trial. The results of this trial will be used to guide the Partnership in the development and dissemination of its reports.

Health System Funding Reform

MOHLTC introduced Health System Funding Reform (HSFR) in 2012 as part of its transformation of Ontario's healthcare system. HSFR shifts a predominantly global budget funding system toward a more transparent, evidence-based model where funding is tied more directly to the quality of care that is needed and will be provided. It is designed to respond to the emerging healthcare needs of the population and encourage the adoption of cost-effective best practices that result in better patient outcomes.

CCO is playing a leading role in this transformation through the implementation of Quality-Based Procedures (QBPs), clinical procedures or services provided to clusters of patients with clinically related diagnoses or treatments. Each QBP is designed to improve quality outcomes.

CCO's work in HSFR is linked to its strategic focus on value for money to maximize the value of care delivered in health systems by measuring and improving the use of resources.

2015/16 Highlights

- The chronic kidney disease, gastrointestinal endoscopy and systemic treatment QBPs were refined.
- The cancer surgery QBP for prostate and colorectal cancers was implemented. Additional development for the cancer surgery QBP was completed for 2016/17 implementation for two additional cancers (breast and thyroid). Planning is underway for the remaining cancers in future years.
- The development of a QBP Evaluation Framework was completed. This framework will help CCO and MOHLTC understand whether the funding models are achieving intended results, ensuring value for money, enhancing quality and monitoring for unintended consequences. The intended goal for this framework will also include informing design and evaluation of new QBPs and funding models, as well as informing potential redesign of current QBPs. Planning and governance for a pilot of this framework is underway using the chronic kidney disease QBP, with the evaluation of both the framework and the QBP to be completed in 2016/17.
- Capacity building within CCO to measure and report on healthcare costs is ongoing; this includes building the Funding Unit team and the onboarding of a Provincial Lead – Health System Funding and Health Economists as well as ongoing additional data availability.
- Investigation on alternative funding approaches, such as bundled funding, is ongoing.

Ontario Palliative Care Network

In March 2016, the Ontario Palliative Care Network (OPCN) was officially launched. The groundwork for provincial changes in palliative care began in December 2011, when more than 80 stakeholder groups from across Ontario collaborated to develop a report titled *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action* (the Declaration). Over the years, many reports, including the 2012 Cancer Quality Council of Ontario Programmatic Review (which said CCO should look at palliative care for diseases other than cancer), the 2014 *Annual Report of the Office of the Auditor General of Ontario* and the Canadian Cancer Society's recently published *Right to Care: Palliative Care of All Canadians*, have highlighted the gaps in the delivery of consistent, high-quality palliative care.

OPCN introduces a new governance structure for palliative care in the province accountable to MOHLTC, under the leadership of the Local Health Integration Networks (LHINs), CCO, Health Quality Ontario and a broad range of community representatives. As a key partner in OPCN, CCO is committed to improving palliative care for all patients—no matter their disease. CCO will host the OPCN secretariat and performance reporting infrastructure. CCO is also advancing commitments of its corporate strategy to share CCO assets and expertise to support improvements in other health systems beyond cancer and kidney care.

OPCN is a partnership of community stakeholders, health service providers and health systems planners who will provide coordinated, standardized palliative care services in the province. It will work closely with MOHLTC to ensure its work supports and aligns with the Ministry's *Patients First: A Roadmap to Strengthen Home and Community Care* and Parliamentary Assistant John Fraser's *Palliative and End-of-Life Care Provincial Roundtable Report* (March 2016), which highlight a commitment to improved access and equity in palliative and end-of-life care at home and in the community.

2015/16 Highlights

- OPCN was launched and, through the commitment of its partners, was operationalized with the establishment of a governance structure including an executive oversight table, an implementation advisory group and a partnership advisory group, all supported by the OPCN Secretariat.
- As the principal advisor to government on palliative care, OPCN provided recommendations on the expansion of residential hospice in Ontario to MOHLTC, supported by CCO's Capital Planning Team.
- The Performance Measurement Working Group completed an evaluation of the six indicators previously endorsed by Hospice Palliative Care Provincial Steering Committee, and adopted a measurement framework aligned with Health Quality Ontario.

Dementia Capacity Planning

Enhancing and improving dementia care is a key priority identified in the MOHLTC's *Patients First: Action Plan for Health Care*. Currently, initiatives and investments to support people with dementia and their care partners remain fragmented. Development of a comprehensive dementia strategy, rooted in strong long-term planning, has been undertaken by MOHLTC led by Parliamentary Assistant Indira Naidoo-Harris. To support this strategy, CCO is leading the development of the provincial capacity planning framework for dementia, in partnership and collaboration with MOHLTC, the Ontario Brain Institute and the Institute for Clinical Evaluative Sciences (ICES). This two-year project will deliver a dementia system capacity model, planning tools and processes to inform current and future decisions about policy, program, infrastructure, and investment frameworks for dementia care.

2015/16 Highlights

- A collaborative working group with project partners from MOHLTC, Ontario Brain Institute and ICES was established to support and drive project initiatives.
- A health system partner engagement strategy was established. This began with focus groups within one region (moving in future to three) to pilot the test model, leading to a pan-LHIN focus group to provide input on, and validate, model output.
- A focus group was piloted with health system partners in the Champlain LHIN to support the design and validate a test capacity planning model focusing on home and community care.


Cancer Care Ontario

Ontario Cancer Plan IV 2015-19

Cancer Care Ontario launched the Ontario Cancer Plan IV (OCP IV) in March 2015. OCP IV serves as our guide as we move forward together over the next four years and continue to improve the cancer system in this province. It builds on progress achieved to date, incorporates lessons learned from previous plans, and further drives quality, accountability, innovation and value in the cancer system. With OCP IV, we now broaden the scope of work to more fully encompass all stages of the cancer care continuum and advance a person-centred approach.

OCP IV was developed in collaboration with key partners and stakeholders, including patient and family advisors, administrators, healthcare providers and international experts, all of whom were critical in our effort to create a comprehensive plan. As a reflection of Cancer Care Ontario's commitment to engaging patients as partners for change, our Patient and Family Advisory Council co-chair also played a key role in the plan's development by serving as one of the co-chairs of the OCP IV Executive Sponsor Group.

Stemming from extensive environmental scanning and consultation, six key themes emerged and have become the goals of OCP IV. These goals focus on quality of life and patient experience, safety, equity, integrated care, sustainability and effectiveness.

The identified goals cut across the cancer care continuum so that no matter what stage a person is at with regards to prevention, screening, diagnosis, treatment, recovery, survivorship or end-of-life, their needs will be addressed by the goals and initiatives of this plan. Each goal is supported by strategic objectives and several initiatives that are included in the implementation plan.

Cancer Care Ontario has developed a robust measurement and evaluation framework and governance structure for the implementation of OCP IV that includes a comprehensive performance scorecard.

In addition, Cancer Care Ontario is in the process of evaluating stakeholder engagement and the processes and methodologies used to develop OCP IV. This evaluation is an important step to ensuring CCO is continually enhancing our ability to develop future strategic plans.

Ontario Cancer Plan IV Report Cover

OCP IV Goals

Ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum.	Ensure the safety of patients and caregivers in all care settings.	Ensure health equity for all Ontarians across the cancer system.	Ensure the delivery of integrated care across the cancer care continuum.	Ensure a sustainable cancer system for future generations.	Ensure the provision of effective cancer care based on best evidence.

Goal

ENSURE THE DELIVERY OF RESPONSIVE AND RESPECTFUL CARE, OPTIMIZING INDIVIDUALS' QUALITY OF LIFE ACROSS THE CANCER CARE CONTINUUM

Under earlier cancer plans, significant strides were made in terms of measuring and understanding care needs from the patient's perspective. With OCP IV, we will further advance person-centred care, enabling providers and patients to better engage in quality-of-life discussions and improving access to resources to assist patients in fully participating in their own care. We will also continue to promote patient and family engagement at the care, organization and system levels.

This plan was developed in collaboration with key partners and stakeholders, including patient and family advisors, administrators, healthcare providers and international experts.

2015/16 Highlights

- Person-centred care (PCC) education programs, guidelines and tools were developed and implemented to enable Cancer Care Ontario employees to use PCC principles in their work, and to enable cancer care providers in clinical care settings to understand and use PCC principles in interactions with patients and family members.
- The Patient Reported Outcome Measurement (PROM) was expanded by piloting one disease-specific PROM for the prostate cancer population and four symptom-related PROMs across all cancer patients filling out the Edmonton Symptom Assessment Score (ESAS). This enabled Cancer Care Ontario to determine the feasibility and usability for a provincial roll-out of the prostate cancer PROM in 2016/17. These additional PROMs enable care that is based on patient-reported information that is in line with patient needs, values and preferences.
- A pilot initiative was launched for pain and symptom management (using ESAS) through mobile technology on Manitoulin Island with four First Nation community-based partners.
- Recommendations from a patient education evaluation survey were implemented in the development of effective self-management tools, namely Patient Symptom Management Guides. The aim of the Patient Symptom Management Guides is to provide patients with strategies on how to reduce physical symptoms and emotional distress. The fatigue and nausea guides were launched in 2015/16; guides for pain, depression, anxiety, dyspnea, constipation, diarrhea, loss of appetite, and oral care will be launched in 2016/17.
- The Program in Evidence-Based Care guidelines for cancer service providers on depression, exercise and sexual health were developed and implemented across the province. These guides are aimed at improving the quality and effectiveness of psychosocial oncology services.

Goal

ENSURE THE SAFETY OF PATIENTS AND CAREGIVERS IN ALL CARE SETTINGS

Safety is intrinsic to high-quality healthcare, wherever that care is provided. Many steps have been taken to improve safety and reduce avoidable harm in our cancer system. Moving forward, we will focus on understanding the gaps that still exist in safety and work toward addressing them by setting performance benchmarks, promoting the use of safety guidelines and resources, and supporting safety training to both healthcare providers and patients. We will also work with our partners to strengthen the culture of safety that exists and establish stronger governance and accountability around safety for cancer services.

2015/16 Highlights

- The current state of Multidisciplinary Case Conferences (MCCs) in Palliative Care was assessed across the regions, and a strategic plan to further enable palliative MCCs in regions was developed. Peer review of care plans ensures concordance with evidence-informed practice and appropriateness of care that will lead to improved patient safety and clinical effectiveness.

- Radiation treatment incident collection and reporting, including rapid dissemination of critical incidents, has been in place at a provincial level since 2007. Alignment and piloting of a National Incident Reporting System is currently underway in most cancer centres in Ontario.

- Peer review of radiation treatment plans by a second radiation oncologist or multidisciplinary team to prevent treatment errors has been an area of focus since 2011, and improvements continued in 2015/16. Data concerning the percentage and timing of curative treatment plans undergoing peer review are collected and publicly reported to ensure safe delivery of high-quality treatment.

- As part of the development of a comprehensive quality management program for histopathology services in Ontario, recommendations for the minimum clinical information provided on pathology test requisitions and reports for polypectomies were developed.

- An oncology curriculum was developed in collaboration with the University of Toronto targeting community pharmacists and pharmacists new to oncology, ensuring they have the information they need to provide safe, high-quality care within the community.

Goal

ENSURE HEALTH EQUITY FOR ALL ONTARIANS ACROSS THE CANCER SYSTEM

Some Ontarians face significant and often multiple barriers in finding and accessing cancer services based on geography, race, culture, gender, age, sexual orientation, immigration status or education. In recent years, improvements to health equity have been made, but this work is just the beginning. With OCP IV, we will work to better understand the barriers that contribute to health disparities across the cancer care continuum. In addition, we will raise awareness among traditionally underserved populations about what services are available, how to access those services and why it is important to do so.

2015/16 Highlights

- In an effort to increase access to stem cell transplant, Cancer Care Ontario has increased funding from approximately $4.3 million in 2009/10 to $33.1 million in 2015/16 (projected). We have also increased funding for additional cases for 2015/16 as Ontario hospitals have increased their short-term capacity. In addition, we have developed a new funding model that will more adequately support the full cost of stem cell transplants, and we have undertaken planning to better understand anticipated demand and referral patterns. A streamlined process for out-of-country care has been established in order to enable patients to receive timely access to transplants while provincial capacity is developed.

- The third Aboriginal Cancer Strategy (ACS III) was released and implementation is underway. ACS III builds on previous cancer strategies by continuing on the path toward health equity and well-being for First Nations, Inuit and Métis peoples.

- Aboriginal Relationship and Cultural Competency Courses were developed and released free of charge to anyone who wishes to take them. Completion of these courses is monitored and reported on a quarterly basis.

- Cancer Care Ontario and the Chiefs of Ontario collaborated on a new report entitled *Cancer in First Nations in Ontario: Risk Factors and Screening* to address the information gap associated with First Nations-specific health data.

- Cancer Care Ontario and the Métis Nation of Ontario collaborated on a new report entitled *Cancer in the Métis People of Ontario: Risk Factors and Screening Behaviours*.

- A Health Equity Assessment tool (the Ministry of Health and Long-Term Care's Health Equity Impact Assessment, or HEIA) was selected for use in cancer planning, policy development, and program and service design. The tool supports equity-based decision-making and is being piloted in three regional cancer centres for specific projects.

- The Participation Gap Initiative analyzes cancer screening, modifiable risk factor and sociodemographic data, by geographical region, providing valuable information on under-screened populations at the postal code level. From this work, locally relevant policies and programs, in partnership with community service providers, will be developed to improve access to and use of services for under-screened populations.

Goal

ENSURE THE DELIVERY OF INTEGRATED CARE ACROSS THE CANCER CARE CONTINUUM

As people transition through the different stages of the cancer care continuum, they will encounter many different care providers in many different settings. Under OCP IV, we will work to ensure that care is person-centred, coordinated and continuous through the system and across care settings. We will facilitate integrated care by standardizing care and optimizing relationships and information sharing among care providers, patients and families. In addition, we will ensure that patients have a clear understanding of their care plan, how to navigate through the system and who they can turn to for help at every stage of the cancer care continuum.

2015/16 Highlights

- The *2014-2019 Systemic Treatment Provincial Plan* identifies reduced emergency room utilization through enhanced toxicity management as a strategic priority. All regional cancer centres are participating in a two-year initiative to explore new approaches to care toward the long-term goal that all cancer patients receiving chemotherapy will have access to an oncology care provider, in person or virtually, for urgent advice 24 hours/ 7 days a week. The results of this work will enhance communication among all providers across the cancer care continuum and care settings to facilitate smooth care transitions and improve patient safety.

- A palliative care education and mentorship program was developed and implemented to serve First Nations, Inuit and Métis populations. This work included the expanded roll-out of the Learning Essential Approaches to End-of-Life and Palliative Care (LEAP) education across healthcare providers serving Aboriginal populations and incorporated culturally appropriate palliative care education, furthering the standardization and communication of care plans across settings.

- Work is underway to develop models of patient navigation to facilitate patient-centred, integrated care delivery in the diagnostic phase of the cancer continuum.

- Clinical content and reporting standards were developed and introduced in cancer imaging to ensure key radiology report information is communicated to the appropriate experts, such as the referring physician, to facilitate timely clinical decision-making and promote a consistent approach to the interpretation of diagnostic and prognostic factors.

- Work is underway to design and develop integrated models of care for complex cancer patients needing care from within as well as outside of the cancer system, including primary care, community and other providers.

- The pilot INTEGRATE Project took place in four hospitals to test integrated models to enable primary care and oncology teams to identify and manage patients who would benefit from a palliative care approach early and across healthcare settings. The results of this project will facilitate the adoption and dissemination of education to build capacity of primary care providers, oncologists and community providers to identify, link and deliver palliative care in communities.

Goal

ENSURE A SUSTAINABLE CANCER SYSTEM FOR FUTURE GENERATIONS

Ontarians want to know, should they ever face a diagnosis of cancer, that high-quality cancer care services will be available to them and their loved ones in the future. Several strides have been made over the years to build a sustainable cancer system. Moving forward, we will be bolder in our approach to building a sustainable cancer system, using our resources wisely and ensuring patients receive appropriate care in the right setting. We will do this by expanding our cancer prevention and screening efforts, and developing innovative solutions to deliver high-quality services while ensuring the greatest benefit to patients and the cancer system. At the same time, we will measure and respond to patient-, provider- and system-related outcomes as well as conduct robust system planning and ongoing evaluation to inform future decisions.

2015/16 Highlights

- The Cancer Quality Council of Ontario (CQCO) held a Programmatic Review in June 2015 that focused on cancer drug funding sustainability and the activities of Cancer Care Ontario's Provincial Drug Reimbursement Programs. Recognizing sustainability issues are not unique to Ontario, the programmatic review included more than 70 participants, including ministries of health and cancer agencies from across Canada. The review made several recommendations to Cancer Care Ontario to support system sustainability, including two recommendations on the use of real-world evidence to monitor the effects of funding decisions.
- Cancer Care Ontario met with the pharmaceutical industry in October 2015 to begin a dialogue on a framework for collaboration. Effective in 2015 and responding to the OCP IV commitment, all new drugs/indications funded by our provincial drug reimbursement programs are subject to data collection for the purposes of evaluation of real-world benefit. Building on the CQCO's recommendations, we began dialogue with other cancer agencies and ministries in 2015 to support pan-Canadian collaboration on this work.
- Melanoma and kidney cancer were added to My CancerIQ, an online cancer risk assessment tool. As well, the inaugural Prevention System Quality Index, which measures the impact of population-based programs and healthy public policies, was released. These initiatives aim to reduce Ontarians' risk of developing cancer and other chronic diseases.
- Programming was delivered to the Aboriginal community that enhances knowledge, skills, capacity and behaviour to address the high smoking rates among this population. This work is part of the Chronic Disease Prevention Strategy for First Nations, Inuit and Métis populations, which focuses on reducing the incidence and prevalence of the major chronic disease modifiable risk factors and exposures.
- To ensure that all Ontarians receive consistent high-quality breast cancer screening services, non-Ontario Breast Screening Program (OBSP) mammography sites are being integrated into OBSP in a two-year phased approach.
- Improvements to the High-Risk OBSP, including genetics referral criteria and physician referral and assessment forms, were introduced.
- The planning and design of the transition from gFOBT to the fecal immunochemical test (a superior primary screening test for colorectal cancer) was completed.
- An initiative to pilot high-risk lung cancer screening was initiated, which will inform the design and implementation of a provincial program aimed to reduce the burden of lung cancer, the most common cause of cancer death in Ontario.
- A new ambulatory models of care initiative was launched to optimize the scope of practice of oncology nurses in outpatient treatment services to ensure delivery of integrated and sustainable person-centred care.
- Cancer services planning models were improved and enhanced through the use of advance modelling techniques, which consider current and future states using incidence, utilization and referral pattern data to predict supply and demand for services.
- Ongoing initiatives in the Radiation Treatment Program ensured that there is a steady local supply of radiation therapy professionals in the workforce, and that new models of care in radiation treatment are sustainable into the future. The areas of focus included the Medical Physics Residency Program, the Harold E Johns Studentship for Medical Physics and the Clinical Specialist Radiation Therapist Project.

Goal

ENSURE THE PROVISION OF EFFECTIVE CANCER CARE BASED ON BEST EVIDENCE

Effective cancer care means that patients receive appropriate, timely care, based on the best evidence. Notable progress has been made in ensuring that patients receive care based on the best available evidence, but more can be done. With OCP IV, we will strengthen our understanding of whether we are improving outcomes based on the care we are providing. We will ensure new evidence is promptly evaluated and that best practice guidelines are consistently used in practice to optimize patient outcomes. We will also continue to collaborate with our partners to align efforts in the area of molecular oncology (i.e., personalized medicine).

2015/16 Highlights

- Work continues to develop, implement and evaluate the use of appropriate imaging at various stages in the cancer patient journey to ensure that patients with cancer in Ontario receive the right imaging test at the right time. This year saw the completion of new guidelines for the role of magnetic resonance imaging (MRI) in the staging of prostate cancer and appropriate follow-up for lymphoma survivors. Additionally, assessment of the over-utilization of imaging for patients with early-stage breast cancer was performed and will be publicly shared as part of the 2016 Cancer System Quality Index.
- Close to 1,000 patients received a Positron Emission Tomography (PET) scan as part of one of the PET registries established to provide access to emerging indications while enabling robust evaluation of the impact to patient care and to inform system funding decisions. This is in addition to the more than 500 patients who received their PET scan through the Case-by-Case Review (PET Access) Program.
- Under the leadership of the Provincial Drug Reimbursement Program, disease-specific drug advisory committees were established to conduct horizontal scans, identify funding gaps, contribute to the planning and preparation of drug submissions and Evidence Building Proposals, and provide case-specific, clinical or health system advice on drug funding.
- Continuing refinements to Cancer Care Ontario's funding model work took place, and a Cancer Surgery Quality-Based Procedure for prostate and colorectal cancers was introduced.
- Evidence-based pathway maps that lay out evidence-based best practice across the continuum of care were expanded to additional cancers, such as gynecological, thyroid and bladder cancers.
- An approach to monitor local recurrence of breast cancer was developed. Once validated, the approach will allow for better monitoring of the outcomes of cancer treatment.
- Cancer Care Ontario's Program in Evidence-Based Care released 40 new guidelines. These guidelines cover the entire cancer care continuum, from prevention to screening, diagnostic assessment, treatment, palliative care and survivorship. In addition, six manuscripts based on the Program in Evidence-Based Care's guidance documents were published in peer-reviewed journals. This work represents a significant contribution to enabling evidence-based best practice.


CCO
Ontario Renal Network

Ontario Renal Plan II 2015-19

In 2015, the Ontario Renal Network launched its second provincial kidney care strategy, the Ontario Renal Plan II (ORP II). This four-year plan builds on the foundational achievements, experiences and lessons of the first plan. Extensive consultations with key stakeholders outlined several key themes that became the basis of the three goals identified in the new plan. In 2015/16, the Ontario Renal Network launched and continued to support many initiatives that will drive improvement in those three goals identified as critical aspects of kidney care.

To help us deliver on our commitments under ORP II, the Ontario Renal Network has developed a provincial scorecard that will track Ontario's progress toward better health outcomes in kidney care and will drive improvement at a program and system level. Performance and issues management guidelines were also developed, which will strengthen these efforts to improve the performance of the kidney care system in Ontario. In addition, a new Provincial Leadership Table, composed of program and medical representation from each of the 26 Regional Renal Programs, was established to foster collaboration, obtain regional input on strategic plans and activities of ORP II, and ensure our network continues to strengthen.

In alignment with Cancer Care Ontario, the Ontario Renal Network is also evaluating the development process for ORP II in an effort to strengthen the processes used to develop future strategic plans.

This four-year plan builds on the foundational achievements, experiences and lessons of the first Ontario Renal Plan.

Ontario Renal Plan II Report Cover

ORP II Goals

Empower and support patients and family members to be active in their care.	Integrate patient care throughout the kidney care journey.	Improve patients' access to kidney care.

Goal

EMPOWER AND SUPPORT PATIENTS AND FAMILY MEMBERS TO BE ACTIVE IN THEIR CARE

The Ontario Renal Network aims to ensure that all patients who want to take an active role in their care have the support, confidence and opportunity to do so. Initiatives under ORP II focus on ensuring that patients, families and healthcare professionals have the tools, resources and supports needed to enable shared decision-making, self-management and self-reporting of their experiences.

2015/16 Highlights

- In 2015, a Patient and Family Advisory Council was established at the Ontario Renal Network. This group of dedicated and dynamic patients, families and caregivers shares their experiences and perspectives to help guide and inform the development of policies and initiatives that directly impact the way kidney care is provided in Ontario.

- Eighteen CKD programs and over 125 healthcare providers were trained in a shared decision-making approach and supported with tools to coach patients through decisional conflict.

- Since the spring of 2015, the Ontario Renal Network has been working with the Kidney Foundation of Canada (KFOC) to evaluate KFOC's Peer Support Program. In 2015/16, over 1,900 surveys were completed by patients and family members on their awareness and experience of the program. Evaluation results will be used to identify strategies for enhanced utilization of the program.

- The Ontario Renal Network became a proud partner of the Canadians Seeking Solutions and Innovations to Overcome Chronic Kidney Disease (Can-SOLVE CKD), a national partnership that raised $59 million in funds or in-kind support over five years. Can-SOLVE CKD will support the development and implementation of a unique and innovative partnership of patients, researchers, healthcare providers and policy-makers who will develop a patient-oriented research network and knowledge transfer to improve CKD care.

Goal

INTEGRATE PATIENT CARE THROUGHOUT THE KIDNEY CARE JOURNEY

Better integration of care means that patients will experience well-organized care from a multi-disciplinary team, with easy-to-navigate transitions at every stage of their kidney care journey. The focus is on three areas that stakeholders, including patients and families, identified as offering the greatest potential impact for improved integration of care: early detection and prevention of progression of kidney disease; palliative care; and kidney transplant.

2015/16 Highlights

- The *Ontario Renal Network Palliative Care Report* was produced and released. This report provides a framework and six recommendations to advance provincial palliative care work within CKD by ensuring that high-quality, integrated palliative care is available to people with CKD regardless of chosen treatment modality. The report will increase awareness within the renal community around partnerships and opportunities to collaborate on palliative care as part of the Ontario Palliative Care Network.

- The KidneyWise Clinical Toolkit was launched in May 2015. The kit provides guidance to primary care providers on which patients are at high risk of developing CKD, and recommendations on how to properly diagnose and best manage patients to reduce the risk for further disease progression.

- The Ontario Renal Network partnered with the Trillium Gift of Life Network (TGLN) to enhance access to, and improve patients' experiences of, kidney transplantation, with a focus on living kidney donation. The Partnership will ensure an integrated, person-centred, collaborative and continuous kidney care journey, with a focus on pre- and post-transplant care that bridges transitions between CKD programs and transplant centres.

- An Ontario Renal Network-TGLN Executive Steering Committee was established to provide oversight and strategic direction to the Partnership.

- To ensure patients transitioning from primary care to nephrology have timely access to appropriate pre-dialysis care, the Ontario Renal Network worked with all regional stakeholders to revise pre-dialysis clinic eligibility criteria using the latest evidence-based clinical best practices. Starting April 1, 2016, the eligibility criteria for pre-dialysis clinics will be revised to be based on a two-year kidney failure risk, calculated using the kidney failure risk equation.

Goal

IMPROVE PATIENTS' ACCESS TO CARE

Some people with CKD face barriers (e.g., geographic, sociodemographic) in accessing their choice of kidney care, in their desired location. First Nations, Inuit and Métis populations may face unique challenges to accessing care. ORP II takes a person-centred, community-first approach, as many barriers can be reduced when care is offered and supported in the patient's home (including long-term care facilities) or community.

2015/16 Highlights

- In total, 93 body access procedures were completed in 2015/16 by regional Centres of Practice with expanded capacity for vascular and peritoneal access creation and maintenance, in support of hospital programs where access to capacity is a barrier.

- The Vascular Access Education Program (VAEP) was developed to help nurses and cannulators improve their skills to safely and accurately cannulate. Approximately 3,000 cannulating clinicians in Ontario (registered nurses, registered practical nurses and aides) completed the program in 2015/15.

- In November 2015, a priority panel was launched to develop organizational standards to guide the delivery of kidney care provincewide, in hospitals, the community and at home, maximizing the efficient use of resources and emphasizing an approach that is home-first or care as close to home as possible. The panel established an organizing framework and completed a jurisdictional scan and current state assessment of all renal programs in Ontario. The current state assessment demonstrates variation across and within regions, and provides necessary information for regional impact assessments and implementation planning. Addressing this variation will be one outcome of the new organizational standards.

- Among patients on chronic dialysis, home dialysis has shown steady, gradual growth over time. Home dialysis is now at an all-time high since Ontario Renal Network inception—up to 25.5% in 2015 from 22.3% in 2010.

- Home dialysis prevalence rates vary across CKD programs, from 10.4% to 39.5% (as of March 31, 2016). Most of this growth is among younger patients, especially for home hemodialysis.

- The Personal Support Worker (PSW) Assisted Home Hemodialysis Model Pilot program officially launched. Through this pilot, PSWs will receive dialysis training from registered nurses and then be paired with patients who wish to dialyze at home but lack support from a family member or caregiver. In 2015/16, 11 patients began receiving home hemodialysis with a PSW, and 13 are in training.

- The Ontario Renal Network has committed to implement models for the delivery of safe, high-quality and accessible care for people requiring specialized care such as those with complex glomerulonephritis (GN, a group of rare renal diseases that typically affects young and otherwise healthy individuals) and those with kidney disease during pregnancy. As a first step, a comprehensive provincial needs assessment was conducted to better understand the current state of care for people living with GN, to explore the factors contributing to known gaps in care, and to identify provincial initiatives that may close these gaps. Based on the needs assessment, a strategic framework was completed to organize and guide the future provincial work.

- To support current hemodialysis practices and to further support our strategic objective to establish a community-first approach to kidney care, the Ontario Renal Network updated the Hemodialysis Equipment Policy. Changes include increased funding for home installations, and funding for home installations in the event a patient moves. The aim is to implement the updated policy in 2016/17.

Financial Statements
2015/16

June 16, 2016

Management's Responsibility for Financial Information

Management and the Board of Directors are responsible for the financial statements and all other information presented in this financial statement. The financial statements have been prepared by management in accordance with Canadian public sector accounting standards and, where appropriate, include amounts based on management's best estimates and judgements.

Cancer Care Ontario is dedicated to the highest standards of integrity and patient care. To safeguard Cancer Care Ontario's assets, a sound and dynamic set of internal financial controls and procedures that balance benefits and costs has been established. Management has developed and maintains financial and management controls, information systems and management practices to provide reasonable assurance of the reliability of financial information. Internal audits are conducted to assess management systems and practices, and reports are issued to the Audit Finance Committee.

For the fiscal year ended March 31, 2016, Cancer Care Ontario's Board of Directors, through the Audit Finance Committee, was responsible for ensuring that management fulfilled its responsibilities for financial reporting and internal controls. The Committee meets regularly with management, the internal auditor and the Auditor General to satisfy itself that each group had properly discharged its respective responsibility, and to review the financial statements before recommending approval by the Board of Directors. The Auditor General had direct and full access to the Audit Finance Committee, with and without the presence of management, to discuss their audit and their findings as to the integrity of Cancer Care Ontario's financial reporting and the effectiveness of the system of internal controls.

The financial statements have been examined by the Office of the Auditor General of Ontario. The Auditor General's responsibility is to express an opinion on whether the financial statements are fairly presented in accordance with Canadian public sector accounting standards. The Auditor's Report outlines the scope of the Auditor's examination and opinion.

On behalf of Cancer Care Ontario Management,

Michael Sherar, PhD
President and CEO

Elham Roushani, BSc, CPA, CA
Vice President & Chief Financial Officer

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Ontario
Cancer Care Ontario

Office of the Auditor General of Ontario
Bureau du vérificateur général de l'Ontario

Independent Auditor's Report

To Cancer Care Ontario
and to the Minister of Health and Long-Term Care

I have audited the accompanying financial statements of Cancer Care Ontario, which comprise the statement of financial position as at March 31, 2016 and the statements of operations, changes in fund balances, and cash flows for the year then ended and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of Cancer Care Ontario as at March 31, 2016 and the results of its operations, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Toronto, Ontario
June 16, 2016

Bonnie Lysyk, MBA, CPA, CA, LPA
Auditor General

Cancer Care Ontario

Statement of Financial Position

As at March 31, 2016

(in thousands of dollars)

	2016 $	2015 $
Assets		
Current assets		
Cash and cash equivalents (note 3)	55,500	73,769
Investments (note 4)	66,141	95,388
Receivables and prepaid expenses (note 5)	49,094	10,932
	170,735	180,089
Capital assets (note 6)	6,047	6,825
	176,782	186,914
Liabilities		
Current liabilities		
Accounts payable and accrued liabilities (note 7)	119,196	126,813
Non-current liabilities		
Deferred contributions related to capital assets (note 8)	4,277	6,049
Post-employment benefits other than pension plan (note 9(b))	2,511	2,438
	6,788	8,487
Fund Balances		
Endowment (note 2)	1,088	1,088
Internally restricted (note 2)	99	670
Externally restricted (note 2)	1,867	1,731
General - unrestricted (note 2)	45,974	45,097
Invested in capital assets (note 10)	1,770	3,028
	50,798	51,614
	176,782	186,914

Commitments (note 15)

Contingencies (note 16)

Guarantees (note 17)

Approved by the Board of Directors

S. Khetrapal Director Director

The accompanying notes are an integral part of these financial statements.

Cancer Care Ontario

Statement of Operations

For the year ended March 31, 2016

(in thousands of dollars)

	Restricted		General		Total	
	2016 $	2015 $	2016 $	2015 $	2016 $	2015 $
Revenue						
Ministry of Health and Long-Term Care	-	-	1,923,965	1,720,943	1,923,965	1,720,943
Ministry of Health and Long-Term Care capital funding for Integrated Cancer Programs	-	-	-	33,181	-	33,181
Amortization of deferred contributions related to capital assets (note 8)	-	-	2,092	13,476	2,092	13,476
Other revenue (note 12)	2,968	2,665	4,298	4,567	7,266	7,232
Investment income (note 11)	12	17	2,441	2,584	2,453	2,601
	2,980	2,682	1,932,796	1,774,751	1,935,776	1,777,433
Expenses						
Cancer and prevention related services	10	8	633,867	507,768	633,877	507,776
Chronic kidney disease services	-	-	621,421	612,557	621,421	612,557
Provincial drug reimbursement program	-	-	349,879	320,098	349,879	320,098
Screening services	-	-	153,534	147,993	153,534	147,993
Salaries and benefits (note 9)	2,322	2,003	100,703	97,446	103,025	99,449
Capital contributions to cancer related services	-	-	35,699	32,904	35,699	32,904
Other operating expenses (note 13)	233	190	26,180	28,069	26,413	28,259
Purchased services	673	985	6,255	9,015	6,928	10,000
Amortization of capital assets	-	-	3,667	15,364	3,667	15,364
Clinical translational research	-	-	2,149	3,344	2,149	3,344
Net loss on disposal of capital assets	-	-	-	74	-	74
	3,238	3,186	1,933,354	1,774,632	1,936,592	1,777,818
Excess (deficiency) of revenue over expenses	(258)	(504)	(558)	119	(816)	(385)

The accompanying notes are an integral part of these financial statements.

Cancer Care Ontario

Statement of Changes in Fund Balances

For the year ended March 31, 2016

(in thousands of dollars)

	Restricted					2016	2015
	Endowment $	Internally $	Externally $	General unrestricted $	Invested in capital assets $	Total $	Total $
Fund balances - March 31, 2015	1,088	670	1,731	45,097	3,028	51,614	51,999
Excess (deficiency) of revenue over expenses	-	(396)	138	(558)	-	(816)	(385)
Net change in invested in capital assets (note 10)	-	-	-	1,258	(1,258)	-	-
Interfund transfers (note 14)	-	(175)	(2)	177	-	-	-
Fund balances - March 31, 2016	1,088	99	1,867	45,974	1,770	50,798	51,614

The accompanying notes are an integral part of these financial statements.

Cancer Care Ontario

Statement of Cash Flows

For the year ended March 31, 2016

(in thousands of dollars)

	2016 $	2015 $
Cash provided by (used in)		
Operating activities		
Excess (deficiency) of revenue over expenses	(816)	(385)
Amortization of capital assets	3,667	15,364
Amortization of deferred contributions related to capital assets	(2,092)	(13,476)
Net loss on disposal of capital assets	-	74
Post-employment benefits expense other than pension plan	244	243
Post-employment benefits paid other than pension plan	(171)	(176)
Change in non-cash operating working capital		
Receivables and prepaid expenses	(38,162)	20,239
Accounts payable and accrued liabilities	(7,617)	(18,118)
	(44,947)	3,765
Capital activities		
Purchase of capital assets	(2,889)	(6,517)
Investing activities		
Proceeds from maturity of investments	94,777	93,078
Purchase of investments	(65,530)	(94,504)
	29,247	(1,426)
Financing activities		
Amounts received related to capital assets	320	2,823
Decrease in cash and cash equivalents during the year	(18,269)	(1,355)
Cash and cash equivalents - Beginning of year	73,769	75,124
Cash and cash equivalents - End of year	55,500	73,769

The accompanying notes are an integral part of these financial statements.

(in thousands of dollars)

1 Nature of operations

Cancer Care Ontario (the Organization) is the provincial government agency responsible for driving health system performance improvement for Ontario's cancer and chronic kidney disease health systems. The Organization also supports achievement of Ontario's Wait Time and Emergency Room/Alternate Level of Care Strategies through the collection and provision of information that enables the government to measure, manage and improve access quality and efficiency of care. With this mandate, the Organization is responsible for the funding to continually improve health system performance to ensure that patients receive the right care, at the right time, in the right place, at every step of their journey.

The Organization's role includes working with healthcare providers in every region across the province to plan services that will meet current and future patient needs; to support providers in delivering the highest-quality care aligned to evidence-based standards and guidelines; and to work with administrators, doctors and other care providers to improve system efficiency and effectiveness.

The Organization also leads the development and implementation of innovative payment models; implements provincial programs designed to raise screening participation rates; translates research and evidence into standards and guidelines; puts information into the hands of the provincial policy makers; and ensures Ontarians have cancer and renal care systems that are accountable, efficient and of the highest quality by measuring and reporting on the performance of services.

The Organization is primarily funded by the Province of Ontario through the Ministry of Health and Long-Term Care (MOHLTC).

The Organization is a registered charity under the Income Tax Act (Canada) and, accordingly, is exempt from income taxes, provided certain requirements of the Income Tax Act are met. Members of the Board of Directors and Board Committees are volunteers who serve without remuneration.

2 Significant accounting policies

Basis of presentation

These financial statements have been prepared in accordance with Public Sector Accounting Standards for government not-for-profit organizations as issued by the Public Sector Accounting Board.

Fund accounting

The Endowment Fund reports contributions subject to externally imposed stipulations specifying that the resources contributed be maintained permanently, unless specifically disendowed by the donor. Restricted investment income earned on Endowment Fund resources is recognized as revenue of the Externally Restricted Fund.

Investment income is recognized on an accrual basis. Interest income is accrued based on the number of days the investment is held during the year.

Cancer Care Ontario
Notes to Financial Statements
March 31, 2016

(in thousands of dollars)

The Internally Restricted Fund reports funds internally restricted by the Board of Directors for education, research or other special purposes.

The Externally Restricted Fund reports donations and grants which have restrictions placed on their use by the donor, primarily related to research. The Organization ensures, as part of its fiduciary responsibility, that all funds received with a restricted purpose are expended for the purpose for which they were provided.

The General Fund accounts for the Organization's MOHLTC and other funded programs. This Fund reports unrestricted resources, all restricted grants from MOHLTC, and restricted grants from others for which the Organization has no corresponding restricted fund.

Contributions

The Organization follows the restricted fund method of accounting for its restricted contributions. Restricted contributions are recognized as revenue of the Restricted Fund if the amount to be received can be reasonably estimated and ultimate collection is reasonably assured. Restricted contributions for which there is no corresponding Restricted Fund (including MOHLTC and other funded programs) are recognized as revenue in the General Fund using the deferral method.

Unrestricted contributions are recognized as revenue of the General Fund when the amount is reasonably estimable and collection is probable.

Unrestricted contributions received for the purpose of capital assets are recorded as deferred capital contributions related to capital assets and are amortized on the same basis as the related capital assets.

Contributions for endowment are recognized as revenue of the Endowment Fund in the year of receipt.

Cash and cash equivalents

The Organization considers deposits in banks, certificates of deposit and short-term investments with original maturities of three months or less as cash and cash equivalents.

Financial instruments

Financial instruments are measured at fair value when acquired or issued. In subsequent periods, financial instruments (including investments) are reported at cost or amortized cost less impairment, if applicable. Financial assets are tested for impairment when there is objective evidence of impairment. When there has been a loss in value of investments that is other than a temporary decline, the investment is written down and the loss is recorded in the statement of operations. For receivables, when a loss is considered probable, the receivable is reflected at its estimated net recoverable amount, with the loss reported on the statement of operations. Transaction costs on the acquisition, sale or issue of financial instruments are expensed for those items subsequently measured at fair value and charged to the financial instrument for those measured at amortized cost.

(in thousands of dollars)

Capital assets

Capital assets are recorded at cost, less accumulated amortization and accumulated impairment losses, if any. Third party and internal labour costs are capitalized under software in connection with the development of information technology projects.

All capital assets are amortized on a straight-line basis at rates based on the estimated useful lives of the assets.

Therapeutic and other technical equipment are amortized over periods ranging from 4 years to 9 years; office furniture and equipment are amortized over periods ranging from 3 years to 5 years; and leasehold improvements are amortized over the term of the leases. Software is amortized over periods ranging from 3 years to 4 years.

Land and buildings for four lodges donated by the Canadian Cancer Society - Ontario Division are recorded at nominal value, as the fair value was not reasonably determinable at the time of the donation.

When a capital asset no longer has any long-term service potential to the Organization, the differential of its net carrying amount and any residual value, is recognized as a gain or loss, as appropriate, in the statement of operations.

Expenses

Expenses are recorded on an accrual basis.

Pension benefits and post-employment benefits other than pension plan

i) Pension costs

The Organization accounts for its participation in the Healthcare of Ontario Pension Plan (HOOPP), a multi-employer defined benefit pension plan, as a defined contribution plan, as the Organization has insufficient information to apply defined benefit plan accounting. Therefore, the Organization's contributions are accounted for as if the plan were a defined contribution plan with the Organization's contributions being expensed in the period they come due.

ii) Post-employment benefits other than pension plan

The cost of post-employment benefits other than pension plan is actuarially determined using the projected benefit method pro-rated on services and expensed as employment services are rendered. Adjustments to these costs arising from changes in estimates and actuarial experience gains and losses are amortized over the estimated average remaining service life of the employee groups on a straight-line basis.

Cancer Care Ontario
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(in thousands of dollars)

Use of estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Items subject to such estimates and assumptions include accruals and receivables related to drug expenditures. Actual results could differ from those estimates.

3 Cash and cash equivalents - restricted

Cash and cash equivalents include $420 (2015 - $417), which is restricted, as it relates to a pension plan that has been dissolved and is being held in escrow in the event that former members put forth a claim. These funds are subject to externally imposed restrictions and are not available for general use.

4 Investments

	2016 $	2015 $
Guaranteed investment certificates, redeemable on demand		
Interest at 1.75%, maturing September 5, 2017	44,861	-
Interest at 1.75%, maturing October 2, 2017	10,830	-
Interest at 1.75%, maturing November 3, 2017	10,450	-
Interest at 1.85%, maturing September 5, 2015	-	23,870
Interest at 1.80%, maturing September 5, 2015	-	10,103
Interest at 1.80%, maturing September 5, 2015	-	10,103
Interest at 1.90%, maturing October 2, 2015	-	10,636
Interest at 1.89%, maturing November 3, 2015	-	10,261
Interest at 1.90%, maturing January 7, 2016	-	10,224
Interest at 1.77%, maturing March 17, 2016	-	20,191
	66,141	95,388

5 Receivables and prepaid expenses

	2016 $	2015 $
Accounts receivable	16,644	7,990
Due from MOHLTC	30,765	1,140
Prepaid expenses	1,685	1,802
	49,094	10,932

6 Capital assets

	Cost $	Accumulated amortization $	2016 Net book value $
Therapeutic and other technical equipment	4,242	4,100	142
Office furniture and equipment	7,426	6,319	1,107
Leasehold improvements	5,056	4,583	473
Land and building	1	-	1
Software	34,411	30,087	4,324
	51,136	45,089	6,047

	Cost $	Accumulated amortization $	2015 Net book value $
Therapeutic and other technical equipment	4,242	3,908	334
Office furniture and equipment	7,166	5,660	1,506
Leasehold improvements	5,052	4,194	858
Land and building	1	-	1
Software	31,786	27,660	4,126
	48,247	41,422	6,825

The cost of capital assets includes software under development of $3,319 (2015 - $746) and deposits for equipment and leasehold improvements of $nil (2015 - $766). Amortization of these amounts will commence when the asset is available for use.

7 Accounts payable and accrued liabilities

	2016 $	2015 $
Trade payables	58,927	50,102
Accrued liabilities	49,207	67,939
Payable to MOHLTC	10,284	8,134
Payable to other funders	358	221
Pension escrow (note 3)	420	417
	119,196	126,813

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(in thousands of dollars)

8 Deferred contributions related to capital assets

Deferred contributions related to capital assets represent the unamortized and unspent amount of funds received for the purchase of capital assets. The changes in the deferred contributions related to capital assets balance for the year are as follows:

	2016 $	2015 $
Balance - beginning of year	6,049	153,393
Amounts received related to capital assets	320	2,823
Amounts transferred to hospitals	-	(136,691)
Amounts recognized as revenue	(2,092)	(13,476)
Balance - end of year	4,277	6,049

During the 2014-15 fiscal year, the Organization transferred ownership of radiation treatment equipment and related software to the Integrated Cancer Program (ICP) Hospitals, where the equipment had been installed. The equipment was fully funded through a deferred capital grant, thus the transfer of ownership was completed at net book value. The equipment had a cost of $326,889 and $190,198 in accumulated amortization at the time of the transfer.

The balance of deferred capital contributions related to capital assets consists of the following:

	2016 $	2015 $
Unamortized capital contributions used to purchase capital assets	4,277	3,797
Unspent contributions	-	2,252
	4,277	6,049

9 Pension benefits and post-employment benefits

a) Pension plan

Employees of the Organization are members of HOOPP, which is a multi-employer contributory defined benefit pension plan. HOOPP members receive benefits based on length of service and the average annualized earnings during the five consecutive years that provide the highest earnings prior to retirement, termination or death.

Contributions to HOOPP made during the year by the Organization on behalf of its employees amounted to $7,817 (2015 - $7,264) and are included in the pension expenses, which reflect all amounts owing for the year, in the statement of operations.

(in thousands of dollars)

b) Post-employment benefits plan other than pension plan

Prior to January 1, 2006, the Organization offered non-pension, post-employment health and dental benefits to its active and retired employees. Effective January 1, 2006, the Organization offers non-pension, post-employment benefits only to its retired employees, who retired prior to January 1, 2006. Benefits paid during the year under this unfunded plan were $171 (2015 - $176). The actuarial valuation for the post-employment benefits other than pension plan is dated April 1, 2013 and has been extrapolated to March 31, 2016.

Information about the Organization's post-employment benefits other than pension plan is as follows:

	2016 $	2015 $
Accrued benefit obligation	2,935	3,635
Unamortized actuarial losses	(424)	(1,197)
Post-employment benefits other than pension plan	2,511	2,438

The movement in the employee future benefits liability during the year is as follows:

	2016 $	2015 $
Post-employment benefits other than pension plan - April 1, 2015	2,438	2,371
Expense related to post-retirement benefits	244	243
Funding contributions	(171)	(176)
Post-employment benefits other than pension plan - March 31, 2016	2,511	2,438

	2016 $	2015 $
Interest cost	117	144
Amortization of experience losses	127	99
Total benefit expense	244	243

Cancer Care Ontario
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(in thousands of dollars)

The actuarially determined present value of the accrued benefit obligation is measured using management's best estimates based on assumptions that reflect the most probable set of economic circumstances and planned courses of action as follows:

	2016	2015
Discount rate	3.00%	3.31%
Extended health care trend rate	6.25% in 2016 to 4.5% in 2023 and after	7.0% in 2015 to 5% in 2018 and after
Dental cost trend rates	3%	4%
Employee average remaining lifetime (years)	9.22	10.22

10 Invested in capital assets

	2016 $	2015 $
Capital assets	6,047	6,825
Amounts financed by deferred capital contributions (note 8)	(4,277)	(3,797)
	1,770	3,028

Change in net assets invested in capital assets is calculated as follows:

	2016 $	2015 $
Purchase of capital assets	2,889	6,517
Capital funding	(2,572)	(4,811)
Amortization of deferred contributions related to capital assets	2,092	13,476
Amortization of capital assets	(3,667)	(15,364)
Net book value of equipment transferred to hospitals	-	(136,691)
Deferred contributions transferred to hospitals	-	136,691
Disposal of capital assets	-	(74)
	1,258	(256)

11 Net investment income

Net investment income earned on the Endowment Fund resources in the amount of $12 (2015 - $17) is included in the Restricted Fund.

(in thousands of dollars)

12 Other revenue

	2016 $	2015 $
General Fund		
Public Health Ontario	2,313	2,351
Canadian Partnership Against Cancer	898	1,056
Other income	1,087	1,160
	4,298	4,567
Restricted Fund		
Grants	2,968	2,665

13 Other operating expenses

	2016 $	2015 $
Restricted Fund	233	190
General Fund		
Equipment	6,849	6,371
General office	5,278	5,655
Occupancy costs	5,176	5,177
Education and publications	3,600	4,225
Consulting services	2,712	4,544
Travel	1,481	1,353
Professional fees	279	505
Other expenses	805	239
	26,180	28,069

14 Interfund transfers

	2016 $	2015 $
Transfer to the General Fund from the Internally Restricted Fund	175	60
Transfer (from) to the General Fund (to) from the Externally Restricted Fund	2	(4)
	177	56

Cancer Care Ontario
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(in thousands of dollars)

15 Commitments

a) The minimum rental payments for lease space and computer and office equipment under the terms of the operating leases are estimated as follows for the years ending March 31:

	$
2017	7,378
2018	4,508
2019	897
2020	579
2021	520
	13,882

b) The Organization has committed $nil (2015 - $3,031) for the purchase of equipment, which is net of deposits disclosed in note 6.

16 Contingencies

The Organization is a member of the Healthcare Insurance Reciprocal of Canada (HIROC), which was established by hospitals and other organizations to self-insure. If the aggregate premiums paid are not sufficient to cover claims, the Organization will be required to provide additional funding on a participatory basis.

Since the inception, HIROC has accumulated an unappropriated surplus, which is the total of premiums paid by all subscribers plus investment income less the obligation for claims reserves and expenses and operating expenses. Each subscriber which has an excess of premium plus investment income over the obligation for their allocation of claims reserves and operating expenses may be entitled to receive distributions of their share of the unappropriated surplus at the time such distributions are declared by the Board of Directors of HIROC.

17 Guarantees

a) Director/officer indemnification

The Organization's general by-laws contain an indemnification of its directors/officers, former directors/officers and other persons who have served on board committees against all costs incurred by them in connection with any action, suit or other proceeding in which they are sued as a result of their service, as well as all other costs sustained in or incurred by them in relation to their service. This indemnity excludes costs that are occasioned by the indemnified party's own dishonesty, wilful neglect or default.

The nature of the indemnification prevents the Organization from making a reasonable estimate of the maximum amount that it could be required to pay to counterparties. To offset any potential future payments, the Organization has purchased from HIROC directors' and officers' liability insurance to the maximum available coverage. The Organization has not made any payments under such indemnifications, and no amount has been accrued in the accompanying financial statements with respect to the contingent aspect of these indemnities.

b) Other indemnification agreements

In the normal course of its operations, the Organization executes agreements that provide for indemnification to third parties. These include, without limitation: indemnification of the landlords under the Organization's leases of premises; indemnification of the MOHLTC from claims, actions, suits or other proceedings based upon the actions or omissions of the representative groups of medical, radiation and gynaecology/oncology physicians under certain Alternate Funding Agreements; and indemnification of the Integrated Cancer Program host hospitals from claims, actions, costs, damages and expenses brought about as a result of any breach by the Organization of its obligations under the Cancer Program Integration Agreement and the related documentation.

While the terms of these indemnities vary based upon the underlying contract, they normally extend for the term of the contract. In most cases, the contract does not provide a limit on the maximum potential amount of indemnification, which prevents the Organization from making a reasonable estimate of its maximum potential exposure. The Organization has not made any payments under such indemnifications, and no amount has been accrued in the accompanying financial statements with respect to the contingent aspect of these indemnities.

18 Financial instruments

The Organization's financial instruments are exposed to certain financial risks, including credit risk, interest rate risk, and liquidity risk. There have been no significant changes from the previous year in the exposure to these risks or in methods used to measure these risks.

Credit risk

Credit risk arises from cash and cash equivalents and investments held with financial institutions and credit exposures on outstanding receivables. Cash and cash equivalents and investments are held at major financial institutions that have high credit ratings assigned to them by credit-rating agencies minimizing any potential exposure to credit risk. The Organization assesses the credit quality of the counterparties, taking into account their financial position and other factors. It is management's opinion that the risk related to receivables is minimal as most of the receivables are from federal and provincial governments and organizations controlled by them.

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(in thousands of dollars)

The Organization's maximum exposure to credit risk related to accounts receivable at year-end was as follows:

	0 to 30 days $	31 to 60 days $	61 to 90 days $	91 + days $	Total $
Accounts receivable	16,167	376	27	74	16,644
Due from MOHLTC	30,415	-	-	350	30,765
Amount receivable	46,582	376	27	424	47,409

As there is no indication that the Organization will not be able to recover these receivables, an impairment allowance has not been recognized.

Interest rate risk

Interest rate risk is the risk the fair value or future cash flows of financial instruments will fluctuate due to changes in market interest rates. The Organization currently is only exposed to interest rate risk from its investments. The Organization does not expect fluctuations in market interest rates to have a material impact on its financial performance and does not use derivative instruments. The Organization mitigates interest rate risk on its investments by purchasing guaranteed investment certificates with short-term maturities and demand features.

As at March 31, 2016, a 1% fluctuation in interest rates, with all other variables held constant, will approximately increase/decrease the value of investments by $351.

Liquidity risk

Liquidity risk is the risk the Organization will not be able to meet its cash flow obligations as they fall due. The Organization mitigates this risk by not incurring debt and monitoring cash activities and expected outflows through budgeting and maintaining investments that may be converted to cash in the near term if unexpected cash outflows arise. The following table sets out the contractual maturities (representing undiscounted contractual cash flows) of financial liabilities:

	0 to 30 days $	31 to 60 days $	61 to 90 days $	91 + days $	Total $
Trade payables	58,923	-	-	4	58,927
Accrued liabilities	48,338	759	15	95	49,207
Payable to MOHLTC	10,284	-	-	-	10,284
Payable to other funders	358	-	-	-	358
Pension escrow	-	-	-	420	420
Amount payable	117,903	759	15	519	119,196

19 Comparative figures

Comparative figures have been reclassified to conform to the expense groupings adopted in the current year.

Appendices

Board of Directors

Ratan Ralliaram
Chair (January 5, 2015 – January 4, 2018)

Bonnie Jean Adamson
May 27, 2015 – May 26, 2018

D. Scott Campbell
(April 18, 2012 – April 17, 2018)

Dr. Euan Carlisle
(January 5, 2015 – January 4, 2018)

Malcolm Heins
(February 25, 2009 – February 24, 2018)

Shoba Khetrapal
(December 21, 2006 – December 20, 2016)

Marilyn Knox *(leave of absence)*
(March 23, 2011 – March 22, 2017)

Patricia Lang
(June 20, 2007 – June 19, 2016)

Dr. Andreas Laupacis
(March 23, 2011 – March 22, 2017)

Carol Poulsen
(December 10, 2014 – December 9, 2017)

Stephen Roche
(September 20, 2006 – June 30, 2015)

David Ross
(May 29, 2013 – May 28, 2016)

Dianne Salt
(April 7, 2010 – April 6, 2016)

Dr. Mamdouh Shoukri
(September 24, 2008 – September 23, 2015)

Betty-Lou Souter
(June 20, 2007 – June 19, 2016)

Harvey Thomson
(April 18, 2012 – April 17, 2015)

David Wexler
(February 10, 2016 – February 9, 2019)

David Williams
(April 18, 2011 – April 17, 2017)

Executive Leadership

Michael Sherar
President and CEO

Elizabeth Carson
Vice-President, Technology Services

Jason Garay
Vice-President, Analytics and Informatics

Rebecca Harvey
Vice-President, Ontario Renal Network

Paula Knight
Vice-President, People, Strategy and Communications

Garth Matheson
Vice-President, Planning and Regional Programs

Dr. Robin McLeod
Vice-President, Clinical Programs and Quality Initiatives

Dr. Linda Rabeneck
Vice-President, Prevention and Cancer Control

Elham Roushani
Vice-President, Enterprise Services (Finance, Procurement and Facilities), and Chief Financial Officer

Working together to create the best health systems in the world

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