

Cancer Care Ontario
Action Cancer Ontario

our health
**our
future**

2013–2014

ANNUAL REPORT



Ontario

Cancer Care Ontario
Action Cancer Ontario

what's inside

MESSAGE FROM THE PRESIDENT AND THE CHAIRMAN OF THE BOARD OF CANCER CARE ONTARIO

ABOUT CANCER CARE ONTARIO

2013–2014 Highlights and Achievements

CANCER SERVICES

The Ontario Cancer Plan Prevention and Cancer Control

- Prevention and Surveillance
 - Prevention*
 - Program Training and Consultation Centre*
 - Surveillance*
- Cancer Screening Program
- Research
- Aboriginal Cancer Control Unit
- Occupational Cancer Research Centre
- Primary Care Centre of Practice

Diagnosis

- Diagnostic Assessment Programs
 - Diagnostic Assessment Programs – Electronic*
 - Pathway Solution*
- Pathology and Laboratory Medicine
 - Stage Capture*
 - Pathology Reporting*
- Molecular Oncology

Treatment

- Cancer Imaging
- Multidisciplinary Cancer Conferences
- Specialized Services Oversight
- Cancer Surgery
 - Organization of Head and Neck Cancer Services*
 - Organization of Gynecologic Cancer Services*
 - Cancer Surgery Wait Times*
- Systemic Treatment
 - Regional Systemic Treatment Program*
 - Improving Systemic Treatment Wait Times*
 - Computerized Physician Order Entry*
- Provincial Drug Reimbursement Programs
 - New Drug Funding Program*

- Evidence Building Program*
- Case-by-Case Review Program*
- Radiation Treatment
 - Improving Treatment Wait Times*
 - Medical Physics Residency Program*
 - Proton Beam Therapy*
 - Peer Review Quality Assurance*
 - Radiation Utilization*
- Patient Education
- Oncology Nursing
- Psychosocial Oncology
- Symptom Management
- Patient Reported Outcomes
- Survivorship Program
- Palliative Care
- Patient Experience
- Models of Care
- Disease Pathway Management

CHRONIC KIDNEY DISEASE SERVICES

The Ontario Renal Plan Ontario Renal Network

ACCESS TO CARE

- Provincial Information Strategies
 - Surgery Wait Times and Efficiency*
- Diagnostic Imaging Wait Times and MRI Efficiency
- Wait Time Information System – Cardiac Care Network
- Alternate Level of Care
- Emergency Room Information
- Access to Care Provincial Support Model

STRATEGIC INITIATIVES

- Quality Management Partnership
- Health System Funding Reform

INFRASTRUCTURE

- Capital Projects

FINANCIAL REPORTS

APPENDICES

- Board of Directors
- Executive Leadership

message

from the president and the chairman of cancer care ontario

The past year marked a special anniversary for Cancer Care Ontario. It was 10 years ago that we underwent the most significant transformation in our history—from being a direct provider of cancer services to an oversight role in which we purchased services and managed the quality, access and performance of Ontario's cancer system.

During the past decade, we grew in both the size and the scope of our operations. From 244 employees and revenue of \$393 million in 2004, today we have about 1,000 employees and have been entrusted with approximately \$1.5 billion in funding to carry out our work in cancer, chronic kidney disease (CKD) and access to care. We have led the way in making significant improvements in both cancer and CKD care, with a focus on raising quality, increasing accessibility and driving system performance and accountability.

The decade saw CCO create a Wait Time Information System, or WTIS, to improve patient access to key health services, from hip and knee replacements to surgery and cardiac services. Today, the WTIS serves more than 3,000 health system users in Ontario. It's the foundation that has transformed Ontario from having the longest wait times in Canada to having the shortest.

Over the years our rigorous focus on quality and performance has changed the face and future of cancer care in Ontario. In fact, prestigious international medical journals, such as *The Lancet*, have identified Ontario as one of the top performers in cancer survival rates among 12 jurisdictions across six countries. If you live in Ontario and get cancer, you have one of the best chances of survival anywhere in the world.

With the creation of the Ontario Renal Network in 2009, we focused on dialysis services and kidney care, developing Ontario's first renal plan, and creating a Quarterly Performance Management Cycle that allowed us, for the first time, to see renal system performance province-wide and start moving key indicators for quality and access in the right direction.

Through these and other actions over the past decade, we have built the solid foundations of two modern, responsive healthcare systems focused on cancer and CKD. In 2013-14, we continued that work through two complementary streams: continue to build on our progress to date under our third Ontario Cancer Plan and our first Ontario Renal Plan, and strengthen and expand on accomplishments that flowed from our corporate strategy.

In the following pages, you will find highlighted some of our major achievements in 2013-14 that focused on increasing performance and quality in cancer care, kidney and renal care, and access to care.

As with all healthcare organizations in Ontario, CCO is in a period of change. A growing and aging population and the current fiscal environment mean every health dollar spent must provide even greater performance and value. When we launched our corporate strategy in 2012, we took a long-view approach. Our purpose was to drive quality, safety, value and system improvements that would meet the current demands of Ontario's health systems as well as address future healthcare needs.

One of the key accomplishments that flowed from our corporate strategy dealt with our work in Health System Funding Reform, which ties funding to services delivered to patients. We contributed to this transformation through our work in Quality-Based Procedures, or QBPs, which are specific best practices for patients with the same condition or who are receiving the same treatment.

The reason we do this work, of course, is for patients and families in Ontario; their health is at the heart of everything we do.

In 2013, we continued implementing a chronic kidney disease QBP funding framework, completed the development of a QBP for gastrointestinal endoscopy and chemotherapy treatment, and began developing QBPs for colonoscopy and cancer surgery. Once fully implemented, these will improve both the standard of care and its consistent delivery across Ontario.

The past year also saw us partner with the College of Physicians and Surgeons of Ontario to develop Quality Management Programs, or QMPs, for colonoscopy, mammography and pathology. The goal of these programs is to establish high standards of care for these three health services. Since forming this partnership, we've leveraged an expert panel to develop a plan for the first-year implementation of these QMPs.

While we are proud of the advancements and achievements we have made for Ontario's cancer and CKD patients, we recognize there is much more work to be done. Across the province, cancer patterns differ significantly between the Aboriginal population and the general population, with Aboriginal populations having higher incidences of cancer and lower cancer survival rates than other Ontarians. In Aboriginal cancer, we redoubled our efforts this past year, harnessing the power of our organization in a concerted effort to improve Aboriginal health across Ontario. Through protocols we've developed with Aboriginal communities, we are formalizing our relationships and creating accountability for our second Aboriginal Cancer Strategy. In 2013-14, we signed two of these protocols and we will sign more next year.

We also made significant advances in dialysis and renal services during the past year. We improved access and quality for patients by increasing the number of patients receiving home dialysis. Home dialysis not only improves patient outcomes, it improves their quality of life and their independence. Last year, we started to see growth in the uptake and prevalence of home dialysis.

The reason we do this work, of course, is for patients and families in Ontario; their health is at the heart of everything we do. Since establishing our first Patient and Family Advisory Council in 2011, we have continued to build on our work in person-centred care. The councils provide an important forum in which patients lend their voices to help transform our health system and help improve the experience for current and future patients. Over the past year, we have grown the number of patient and family advisors who work with us and we have continued to actively partner with patients and family members in identifying, designing, planning and improving healthcare services.

It is estimated that more than 74,000 new cases of cancer were diagnosed in Ontario in 2013-14 and the prevalence of CKD continues to increase. Today, an estimated 1.5 million Ontarians have – or are at increased risk of developing – CKD and 9,800 Ontarians are currently on dialysis. As Ontario's population continues to grow and age, the challenges of chronic disease and the need for cancer and CKD care will continue to rise.

At CCO, we remain committed to building partnerships and driving improvements in our cancer, renal and access to care systems that will meet these challenges. We are well on our way to our goal of creating the best health systems in the world.



Ratan Ralliar, Acting Chair



Michael Sherar, PhD, President and CEO



ABOUT CCO

Our Vision:

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

Our Mission:

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

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.

ABOUT CCO

As the Ontario government's advisor on the cancer and renal systems, as well as on access to care for key health services, Cancer Care Ontario (CCO) drives continuous improvement in disease prevention and screening, the delivery of care, and the patient experience for chronic diseases. Known for its 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 – through the Ontario Renal Network – 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, it 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 \$1.5 billion in funding 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 about 1,000 staff members, all of whom are critical elements that contribute to the success of this organization.

CANCER SERVICES

As the government's cancer advisor, CCO:

- Implements provincial cancer prevention and screening programs.
- Works with cancer care professionals and organizations to develop and implement quality improvements and standards.
- Uses electronic information and technology to support health professionals and patient self-care, and to continually improve the safety, quality, efficiency, accessibility and accountability of Ontario's cancer services.
- Plans cancer services to meet current and future patient needs, and works with healthcare providers in every Local Health Integration Network (LHIN) to continually improve cancer care for the people they serve.
- Conducts research and rapidly transfers knowledge of new research into improvements and innovations in clinical practice and cancer service delivery.

While CCO's public identity is tied directly to the fight against cancer, the organization also established and houses the Ontario Renal Network and the Ontario government's Access to Care program, which supports the province's Wait Times Strategy.



ONTARIO RENAL NETWORK

The Ontario Renal Network (ORN) was established in 2009 to lead a province-wide effort to better organize and manage the delivery of dialysis and renal services across the province for patients living with chronic kidney disease (CKD). ORN's mission is to work together to improve the life of every person with kidney disease. The ORN works through 26 regional CKD programs to improve the quality of kidney care across the province.

The ORN's goal is to improve CKD management by preventing or delaying the need for dialysis, broadening appropriate CKD patient-care options, improving the quality of all stages of CKD care and building 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 its subsequent Emergency Room/Alternate Level of Care (ER/ALC) Strategy.

The success of these initiatives rested on information and technology capabilities that could collect and report accurate, reliable and timely wait time data. CCO was assigned to develop and deploy the Wait Time Information System to capture and report this data in near real-time. Subsequently, CCO was given the task of implementing key parts of the ER/ALC Information Strategy.

As the service delivery agent for the Wait Times Strategy and ER/ALC Information Strategy, Access to Care enables improvements in the access, quality 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.

2013–2014
Highlights
and
Achievements

Cancer Services

The Ontario Cancer Plan

Since 2005, CCO has created multi-year cancer plans for the province. These Ontario Cancer Plans serve as cancer care roadmaps, charting the ways in which health professionals and organizations, cancer experts, and the government will work with CCO to prevent and fight cancer while improving the quality of care for current and future patients.

The first Ontario Cancer Plan covered the years 2005 to 2008 and focused on building system capacity. The second covered the years 2008 to 2011 and concentrated on reducing wait times, improving the quality of care, improving screening, diagnosis and treatment, and further building capacity.

In 2011, CCO launched its third Ontario Cancer Plan (OCP III), covering the years 2011 to 2015. OCP III continues the transformation of cancer services across Ontario, including the development of new, patient-centred models of care.

OCP III focuses on measurable outcomes and consultation with patients. The patient experience is central to OCP III and recognizes that patients need:

- More control over their own care to improve satisfaction and outcomes;
- Access to tools that enable them to assess and communicate their symptoms effectively, so those symptoms can be better managed by healthcare providers;
- Access to resources and information that meet all of their physical, emotional and educational needs throughout the cancer journey.

OCP III is driven by a commitment to quality in prevention, screening, diagnosis, treatment, follow-up and palliative care. Its impact comes in delivering value for money, managing long-term cost growth, improving patient outcomes and increasing patient satisfaction. CCO monitors its progress against commitments in the OCP III and its impact on the cancer system.

With the OCP III ending in March 2015, CCO has started the development of the OCP IV, which is scheduled to launch in early 2015. The OCP IV will continue to be an important guiding document and will identify strategic areas of focus for 2015-2019 that will build on progress achieved to date, incorporate lessons learned from previous plans, and further drive quality, accountability, innovation and value in the cancer system.

Working with key partners and stakeholders will be critical to the success of this effort. As a reflection of CCO's commitment to engaging patients as partners for change, the co-chair of CCO's Patient and Family Advisory Council committee plays a key role by serving as one of the lead members of the executive steering committee for OCP IV. To ensure CCO builds a collaborative, accessible and measurable plan, CCO will continue to engage with stakeholders, including patients and family representatives, throughout the development of OCP IV to explore how this roadmap can provide Ontarians with the best cancer system in the world.

VISION

Working together to create the best cancer system in the world

MISSION

We will improve the performance of the cancer system by driving quality, accountability and innovation in all cancer-related services

GOALS

1 Help Ontarians lessen their risk of developing cancer

2 Reduce the impact of cancer through effective screening and early detection

3 Ensure timely access to accurate diagnosis and safe, high quality care

4 Improve the patient experience along every step of the cancer journey

5 Improve the performance of Ontario's cancer system

6 Strengthen Ontario's ability to improve cancer control through research

STRATEGIC PRIORITIES

Develop and implement a focused approach to cancer risk reduction

Implement integrated cancer screening

Continue to improve patient outcomes through accessible, safe, high quality care

Continue to assess and improve the patient experience

Develop and implement innovative models of care delivery

Expand our efforts in personalized medicine

GUIDING PRINCIPLES:

- Transparency
- Equity
- Evidence-based
- Performance orientated
- Active engagement
- Value for money

Prevention and Cancer Control

CCO's Prevention and Cancer Control (P&CC) portfolio is responsible for planning, implementing, monitoring and evaluating the programs and initiatives aimed at improving cancer prevention and screening in the province.

In addition, the P&CC portfolio includes other units aimed at easing the burden of cancer in general and specific populations, as well as the Primary Care Centre of Practice program, which helps primary care providers with guidance and expertise to promote and support action in preventing chronic diseases such as cancer and chronic kidney disease.

Prevention and Surveillance

Prevention and Surveillance is comprised of three main areas of work: prevention, surveillance and the Program Training and Consultation Centre (PTCC). The prevention group leads development of CCO's online cancer risk assessment tool, which is a deliverable under the OCP III and part of the first pillar of Ontario's Action Plan for Health Care. The surveillance group turns raw data into meaningful information using sophisticated analytic techniques and interpretation. It develops indicators for and analyzes and interprets the data on risk factors and cancer burden, including monitoring these according to socio-demographic factors. The PTCC – the third program within Prevention and Surveillance – is a tobacco control training and capacity building program that supports the government's Smoke-Free Ontario Strategy.

Prevention

While there is much to be learned about the causes of cancer, there is evidence that a number of modifiable behaviours and exposures can affect an individual's risk. These include tobacco use, alcohol consumption, physical inactivity and unhealthy eating. A goal of the OCP III is to help Ontarians reduce their risk of developing cancer.

One strategic priority under OCP III is to develop and implement a focused approach to cancer risk reduction. To accomplish this, CCO engages in a number of prevention activities, such as involvement in collaborative provincial efforts to establish clear consistent messaging on UV exposure and the development of a provincial food and nutrition strategy.

The PTCC plays a leading role in providing training, consultation and other capacity-building services to

Ontario health intermediaries working in tobacco control. The program also facilitates the coordination of services among other Smoke-Free Ontario resource centres and acts as a knowledge broker between local public health departments, the research community and other organizations working in tobacco control.

Highlights

In 2013–2014, we:

- Conducted user research against the online cancer risk assessment tool prototype to inform the tool development and marketing. Content, design templates and business requirements were finalized for four cancer sites: breast, cervical, colorectal and lung.
- Developed a Regional Cancer Programs tobacco control program pilot. Unit staff worked with the Regional Cancer Program champions and advisory committee to facilitate the implementation of systematic screening for tobacco use of all new ambulatory care patients attending Regional Cancer Centres.
- Continued to advance action by the government and other stakeholders on the recommendations in the Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario report. In line with recommendations in the report, the unit has created Health Works, a comprehensive workplace health promotion program for CCO staff, which will initially focus on increasing physical activity and reducing sedentary behaviour.

Looking Ahead

In 2014–2015, we will:

- Launch the online cancer risk assessment tool in Q4, implement the digital marketing and communications strategies, and promote the tool to health professionals. Develop content for two new cancer sites for inclusion in 2015-16.
- Continue to implement the systematic screening for tobacco use and cessation referrals for ambulatory cancer patients, collect and report on regional data, and evaluate the implementation of the pilot.
- Develop CCO's chronic disease prevention strategy, which will serve to integrate prevention work occurring across CCO (e.g., Aboriginal Cancer Control Unit, Primary Care and the Ontario Renal Network). As part of the strategy, we will also continue to establish a prevention performance measurement framework and develop two new risk domains, tobacco and environmental exposures, for inclusion in the 2015 Cancer System Quality Index (CSQI).

Program Training and Consultation Centre

Highlights

In 2013–2014, we:

- Continued to build the capacity of Ontario's 36 public health departments and seven tobacco control area networks to plan and implement evidence-informed tobacco control programs.
- Implemented 49 training events and approximately 400 consultations to public health departments across the province.

- Facilitated four province-wide communities of practice on priority tobacco control topics. Two communities of practice support knowledge exchange among demonstration projects funded by the provincial government. Completed the documentation of two evidence-informed tobacco control practices on the topics of smoke-free outdoor space bylaws and smoke-free hospitals.
- Continued to support MOHLTC's renewal of the Smoke-Free Ontario strategy through training development, delivery and system-level planning and coordination.

Looking Ahead

In 2014–2015, we will:

- Continue to build the capacity of Ontario's 36 public health departments and seven tobacco control area networks to plan and implement evidence-informed tobacco control programs through training, technical assistance and other capacity-building programs.
- Hold a province-wide knowledge exchange forum on the topic of population-based smoking cessation in June 2014.
- Document additional tobacco control practices using case study evaluation methods and disseminate these case descriptions through various mechanisms (e.g., webinars, presentations, etc.).

Surveillance

Highlights

In 2013–2014, we:

- Published *Cancer Risk Factors in Ontario: Tobacco*, a resource for prevention programming. The report provides information on tobacco use in Ontario as it relates to cancer and estimates the smoking-related cancer risk in the population.
- Provided a detailed analysis of prostate cancer in Ontario for CSQI and CCO's Disease Pathway Management Program's regional engagement sessions.
- Provided detailed analyses of the burden (incidence/mortality/prevalence) of several cancers and cancer subtypes, with appropriate caveats, to support CCO's Planning and Regional Programs and Clinical Programs and Quality Initiatives portfolios in planning for a range of diagnostic and treatment services.

Looking Ahead

In 2014–2015, we will:

- Continue our series of Cancer in Ontario publications with:
 - A report on alcohol consumption and cancer in Ontario;
 - A report on aspects of healthy living – body composition, physical activity and diet – and cancer in Ontario.
- Continue to enhance the production and dissemination of information on cancer incidence, mortality, survival and prevalence in Ontario, and for the first time, generate projections of prevalence (people living with a past diagnosis of cancer). This information assists Ontario and CCO in planning, funding and evaluating cancer services.

Cancer Screening Program

Cancer screening improves early cancer detection and saves lives. In 2007, Ontario committed to improving screening rates for colorectal, breast and cervical cancers, which together account for nearly 30 per cent of all newly diagnosed cancer cases. True to that commitment, in 2012, the MOHLTC outlined the expansion of the province's colorectal, breast and cervical screening programs in its Ontario's Action Plan for Health Care. CCO and the MOHLTC then developed the integrated cancer screening strategy, which aims to reduce cancer mortality by implementing Ontario-wide, population-based, organized cancer screening programs.

CCO's Cancer Screening Program, which leads the planning and operation of screening programs at the provincial and regional levels, is focused on increasing public participation in screening, improving provider performance, and establishing a high quality screening system supported by a common information management and technology infrastructure. It oversees three distinct screening programs for colorectal, breast and cervical cancer: ColonCancerCheck (CCC), the Ontario Breast Screening Program (OBSP) and the Ontario Cervical Screening Program (OCSPP). Cancer screening's role also includes: policy development and advice, education, clinical practice guidelines and standards development, clinical

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engagement, stakeholder engagement functions, program design, program funding, program management, contract management, performance management and evaluation.

Highlights

In 2013–2014, we:

- Worked to centralize and expand the correspondence program for the OCSP, the OBSP and CCC, with the goal of increasing screening promotion and early detection of these cancers. The unit:
 - Expanded the CCC correspondence program to all people aged 50 to 74;
 - Implemented OCSP invitation, recall, reminder and result correspondence to all screen-eligible women in the province;
 - Implemented OBSP correspondence to invite eligible women to get screened for breast cancer.
- During this fiscal year, more than five million pieces of correspondence were sent to Ontarians.
- Completed the replacement of all mammography units in Ontario using digital computed radiography (CR) technology (102 mammography units in 96 sites) to digital direct radiography technology. This was the result of findings from a CCO study that showed that mammography using CR technology was not as effective at detecting cancer as screen-film technology.
- Enhanced the CCC Screening Activity Report (SAR) through the implementation of a user-friendly format to enable primary care physicians in a patient-enrollment model to obtain information on their patients who are due for screening or require follow-up. In addition, the methodology was completed for

a SAR that will have data for colorectal, breast and cervical screening. The goal is to increase screening participation and improve follow-up rates in this patient population.

Looking Ahead

In 2014–2015, we will:

- Continue the transition of non-OBSP mammography into the OBSP, providing both financial and quality benefits to the facilities, as well as further efficiencies and oversight to the provincial program. A key focus will be rebuilding the application that supports the OBSP – the integrated client management system – to ensure a successful and sustainable transition.
- Continue developing best practices around colposcopy services to help determine a funding model, as well as performance management and capacity planning requirements. The planning and development work in 2014-15 will support implementation of the colposcopy quality-based procedure in 2015-16 that will reimburse healthcare providers for the types and quantities of patients they treat, using rates based on efficiency and best practices that are adjusted for each procedure.
- Continue to work with MOHLTC to develop a plan to fund and implement the fecal immunochemical test (FIT) in CCC as the recommended screening test for those at average risk of colorectal cancer. This transition is the result of an evidence-based guideline and Ontario pilot study, which show that FIT will improve the detection of cancer and advanced adenomas (pre-cancerous lesions).



Research

The research unit conducts research on cancer causes, prevention and screening. Much of its work serves as the scientific basis for prevention efforts. The unit aims to increase understanding of cancer risk factors and strengthen the provincial-national network of collaborating researchers, both of which will increase CCO's ability to launch effective prevention initiatives.

The research unit's goals are to increase knowledge of the distribution, causes and determinants of cancer. It explores issues such as the willingness to change, which is relevant to interventions designed to reduce cancer risk. Furthermore, it links the generation of new knowledge to inform CCO policies and practices.

Highlights

In 2013–2014, we:

- Developed a multi-year research strategy for CCO and made recommendations for consolidation of research in the organization.

- Conducted a pilot study of the new procedure for patient contact studies, which will inform CCO research practices more broadly.
- Undertook research to explore possible associations between cancers and risk factors, including obesity, environmental contaminants and occupational exposures. The findings may inform cancer prevention programs and policies.

Looking Ahead

In 2014–2015, we will:

- Organize and host CCO Research Day bringing together scientists (internal and external), research staff, stakeholders and decision makers to exchange knowledge and showcase the depth and variety of research being undertaken across the organization and funded by CCO.
- Conduct a chronic disease prevention workshop to inform future research with an aim of developing interventions to reduce cancer risk.
- Undertake research examining geographical differences in cancer diagnosis and treatment as part of the ongoing International Cancer Benchmarking Partnership.

The Aboriginal Cancer Control Unit

The Aboriginal Cancer Control Unit addresses the issue that cancer rates among First Nations, Inuit and Métis (FNIM) are increasing disproportionately compared with overall Canadian cancer rates. FNIM have higher mortality rates from preventable cancers, show higher rates of some modifiable risk factors and tend to present with later-stage cancers at the time of diagnosis.

The execution of the Aboriginal Cancer Strategy II (ACS II), itself a deliverable of OCP III, will help cancer control stakeholders in Ontario to jointly develop, fund and implement Aboriginal cancer control policies and programs that improve the performance of the cancer system for Aboriginal peoples in a way that honours the Aboriginal path to well-being.

Highlights

In 2013–2014, we:

- Successfully released the first annual report, highlighting progress following a year of implementation of the ACS II.
- Signed relationship protocols with Grand Council Treaty #3 and with the Anishinabek Nation (Union of Ontario Indians). The Nishnawbe Aski Nation passed a resolution confirming the chiefs' approval to sign a relationship protocol, with the signing to occur in spring 2014.
- Successfully recruited Aboriginal patient navigators in nine of the 10 priority regions and Aboriginal cancer leads in eight of the 10 priority regions.
- Drafted regional Aboriginal cancer plans in collaboration with six of the Regional Cancer Programs, FNIM partners and CCO's Aboriginal Cancer Control Unit.

Looking Ahead

In 2014–2015, we will:

- Sign relationship protocols with the Association of Iroquois and Allied Indians, Métis Nation of Ontario, Ontario Federation of Indigenous Friendship Centres, Ontario Native Women's Association, Ontario's Inuit Organization, and continue discussions with the independent First Nations.

- Complete regional Aboriginal cancer plans between CCO, Regional Cancer Programs, and core FNIM health networks (building regional capacity to address Aboriginal cancer) with the remaining four priority regions.
- Deliver a recommendation report to address chronic disease risk factors for FNIM populations in Ontario.
- Disseminate palliative care education materials for FNIM cancer patients and families and implement a FNIM specific palliative care curriculum for healthcare providers.

Occupational Cancer Research Centre

Core funding for the Occupational Cancer Research Centre (OCRC) has historically come from the Workplace Safety and Insurance Board (WSIB), CCO and the Canadian Cancer Society (CCS), Ontario Division. The OCRC was also developed with the support of the United Steelworkers Union. In the five years starting with 2014-15, the WSIB portion of the centre's funding will come from the Ministry of Labour. In addition to the core funding, OCRC receives research funds for individual projects through external grant competitions.

The OCRC's objectives align with the OCP III goal of helping Ontarians lessen their risk of developing cancer and the strategic priority of developing and implementing a focused approach to cancer risk reduction. These goals will be achieved by conducting research on the causes, the surveillance and the prevention of occupational cancer.

Occupational cancer is caused wholly or in part by exposure to carcinogens in the workplace. The OCRC was established to fill knowledge gaps around occupation-related cancers and to help partners and stakeholders translate these findings into preventive programs, policies and practices.

The OCRC is managed by, accountable through and housed at CCO. In addition, the OCRC has a provincial, national and international network of collaborators, including scientists and researchers from other organizations, student trainees, interns, and visiting and adjunct scientists.

Highlights

In 2013–2014, we:

- Received approximately \$1 million in core funding and \$800,000 in grant funding from external granting agencies, such as the Canadian Cancer Society Research Institute, the WSIB, the Canadian Nuclear Safety Commission, the International Development Research Centre and the Canadian Institutes of Health Research.
- Held a lung cancer symposium that attracted over 150 participants.
- Were asked by the Pan American Health Organization to become a collaborating centre of the World Health Organization.

Looking Ahead

In 2014–2015, we will:

- Receive five-year core funding from the Ministry of Labour, renew ongoing funding from CCO and CCS, and launch a new five-year strategic plan for 2014-15 to 2018-19.
- Commence work as a partner of Ryerson University on a research study to help reduce outdoor workers' sun exposure.
- Develop a mining cohort using the Ontario mining master file and develop a mining research agenda with mining stakeholders.

Primary Care Centre of Practice

There is widespread agreement that a strong primary care system is the foundation of a high-performing healthcare system. A key focus of both the Ontario Cancer Plan III and the Ontario Renal Plan I is to strengthen partnerships with primary care providers who play a key role in the patient's journey. To support this focus, the Primary Care Centre of Practice acts as the consultation hub and facilitates the use of primary care knowledge and expertise to support programs across CCO and ORN in identifying and reaching their primary care goals.

The team uses primary care-related tools and supports in their work with CCO's programs to provide primary care providers with best practices, strategies, research and policies to enable them to provide quality care. The centre of practice is a resource centre and single point

A key focus of both the Ontario Cancer Plan III and the Ontario Renal Plan I is to strengthen partnerships with primary care providers who play a key role in the patient's journey.

of contact for primary care information, and provides strategic alignment through its relationships with key external primary care stakeholders: Ontario College of Family Physicians (OCFP), Ontario Medical Association (OMA), Health Quality Ontario (HQP), Ontario MD, Nurse Practitioners Association of Ontario (NPAO), Community Care Access Centres (CCACs), Association of Family Health Teams of Ontario (AFHTO) and Ontario Medical Group Management Association (OMGMA). The centre also facilitates primary care clinical leadership and engagement both regionally and provincially through secretariat support to the Provincial Primary Care and Cancer Network (PPCCN).

Highlights

In 2013–2014, we:

- Continued to support the provincial primary care lead and regional primary care leads (RPCLs) through secretariat support to the PPCCN and expanded to include regional Aboriginal cancer leads. In collaboration with the RPCLs, the centre designed and launched the Mainpro-C accredited presentation The Cancer Journey: From Prevention to End of Life Care – What Primary Care Providers Need to Know for use by RPCLs in their efforts to enable other primary care providers to deliver high quality cancer care across the cancer journey.
- Documented, designed and packaged a standard approach to primary care knowledge translation and

exchange in a toolkit. The toolkit is a resource for CCO's programs and ensures that the methods, approaches and ideas that work well for one program can be adopted and used by others. The toolkit also includes a strategy for primary care referral guidelines as a case study.

- Developed, in partnership with the primary care cancer screening team, a toolkit for family health teams to include advance care planning as part of their quality improvement plan.
- Consulted closely with ORN on the electronic medical record (EMR) project to assist with the development of the point-of-care tools.

Looking Ahead

In 2014–2015, we will:

- Develop and launch a primary care cancer capacity spread plan that will outline the two-year strategy and

leadership structure for the PPCCN for 2014-16 and focus on PPCCN clinical knowledge, quality improvement and leadership training.

- Lead the primary care EMR strategy for CCO through identification of key primary care requirements that could be supported by EMRs.
- Continue stakeholder management in the area of primary care as it relates to cancer care with the following organizations: OCFP, OMA, HQO, Ontario MD, NPAO, CCACs, AFTHO and OMGMA.
- Consult on the development and dissemination of a chronic kidney disease (CKD) toolkit for primary care providers to assist with identification management and appropriate referral of CKD patients.



Diagnosis

Diagnostic Assessment Programs

For many patients, the period from when cancer is suspected to when it is diagnosed or ruled out is marked by anxiety, confusion and stress. This period often requires numerous diagnostic tests, consultations, handoffs and appointments, and a lack of coordination and patient support can compound a patient's stress and confusion.

To improve the diagnostic phase of the cancer journey, CCO supported the development and implementation of Diagnostic Assessment Programs (DAPs) throughout Ontario. DAPs are composed of multidisciplinary healthcare teams that manage and coordinate care for patients from testing to a definitive diagnosis leading into their first treatment. DAPs facilitate access to care and provide the necessary support and information about cancer to patients and their families.

These programs significantly improve the patient experience during the diagnostic process for individuals with suspected cancer, as shown by the high satisfaction rates with the DAP nurse navigator reported on the 2014 CSQI. Through DAPs, CCO helps improve quality and accessibility of care for patients, advance a person-centred approach in diagnostic care, drive integrated care delivery among services and providers, and maximize value of care delivered.

Highlights

In 2013–2014, we:

- Completed the development of a four-year strategic plan, Navigating the Diagnostic Phase for Cancer: Ontario's Strategic Directions 2014-2018. This plan was built through extensive consultation with regional partners, patients and clinicians. The strategic directions will guide the focus areas to ensure continuous improvement to the diagnostic phase of cancer for all Ontarians.
- Met the annual improvement target provincially for lung DAP diagnostic wait times, with 50 per cent of lung DAP patients diagnosed within 28 days. The program increased accountability for regional DAP performance by beginning public reporting on this indicator through the CSQI under the quality dimension of accessibility.
- Continued with provincial DAP implementation and development. There are now 15 lung DAPs, 12 colorectal DAPs and seven prostate DAPs.

Looking Ahead

In 2014–2015, we will:

- Refresh the criteria that define the organizational and practice-setting features expected of DAPs and establish standard entry and transfer of care criteria for lung DAPs to support equity of care for patients across Ontario.

15	Lung DAPs	12	Colorectal DAPs	7	Prostate DAPs
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- Undertake an assessment to understand the existing allocation of DAP funding and current funding challenges.
- Begin development of a risk stratification model to assess navigational needs among patients in the diagnostic phase to provide a patient-centred, evidence-based approach to care.
- Conduct a current state review of diagnostic assessment models for lung, colorectal, prostate and breast cancer diagnosis. Models explored will include DAPs, other organized models for cancer diagnosis and ad hoc/non-organized models of diagnostic assessment.

Diagnostic Assessment Programs – Electronic Pathway Solution

Most healthcare providers track a patient's diagnostic journey using paper-based systems because they lack a centralized tracking system. This makes sharing patient information among providers challenging. To address this, CCO, in partnership with CCS and Canada Health Infoway, designed the Diagnostic Assessment Program – Electronic Pathway Solution (DAP-EPS), an innovative web-based tool that provides DAP staff, healthcare providers and patients with personal information, resources and support throughout the patient's diagnostic journey.

All DAPs using the DAP-EPS are integrated with the hospital they are based in, allowing patient demographics, scheduling information and hospital test result notifications to flow automatically into the system, reducing the need for manual entry and error. The DAP-EPS was piloted in

two regions in summer 2011. Since then it has expanded to three additional regions and has managed over 9,000 patient referrals; over 1,200 patients and caregivers across Ontario have used the DAP-EPS patient portal since its launch. The DAP-EPS has expanded successfully in five Regional Cancer Programs to meet the needs of their DAPs supporting lung, colorectal and prostate cancer diagnosis, as well as regional initiatives supporting breast assessment.

Highlights

In 2013–2014, we:

- Completed phase 2 of the DAP-EPS, which included the release of 14 versions. Each version of the tool focused on adding new features and improving the overall usability and functionality by incorporating continuous feedback from DAP staff and patients.
- Developed and implemented a model for sharing test results and consultation notes in the diagnostic phase with patients online. All DAP-EPS sites have implemented or are working toward sharing results within 21 days or less. A complete redesign of the patient portal that utilized patient feedback helped ensure that new features addressed patient needs during diagnosis to provide a more user-friendly experience.
- Enhanced regional integration between hospital information systems and the DAP-EPS, which led to implementation in 10 hospitals across five Regional Cancer Programs. This increased the completeness of patient data available through the application. Many DAPs are also integrated with additional hospitals as DAP patients often visit more than one hospital to expedite their diagnostic testing. This further



integration has been identified as a key success factor of the tool since it fostered complete, timely and accurate information for patients and their healthcare providers.

Looking Ahead

In 2014–2015, we will:

- Articulate a vision and develop a product roadmap for the DAP-EPS utilizing completed current state assessments and benefits evaluation.
- Begin expansion of the DAP-EPS to three new Regional Cancer Programs.
- Develop a partnership with CancerCare Manitoba to share lessons learned regarding the development of an application that supports the diagnostic phase.

Pathology and Laboratory Medicine

The Pathology and Laboratory Medicine Program (PLMP) focuses on the screening, diagnostic and prognostic/predictive components of cancer care. The PLMP's goal is to establish a province-wide system that will allow pathology

and laboratory medicine providers and professionals to accurately analyze samples and provide relevant consultation reports. The PLMP continues to develop and promote quality initiatives that improve patient care by facilitating timely, accurate and complete diagnosis and cancer staging information. Key initiatives include stage capture and pathology reporting.

Stage Capture

Staging classifies cancer cases according to the extent to which the disease has spread. Cancer stage is an important predictor of survival, and cancer treatment is determined primarily by staging.

The goal of the stage capture program is to enhance data-collection processes and tools that enable timely access to accurate, complete and comparable cancer stage data for the purposes of planning and managing cancer services, and evaluating, measuring and reporting on cancer treatment patterns and outcomes for all Ontario adult cancer patients.

Pathology Reporting

Pathology reporting is critical in the diagnosis and treatment of cancer. The aim of the pathology reporting

initiative is to make cancer pathology reports more complete and consistent by helping hospitals change to a standardized electronic format. The goal was to have all hospitals that electronically submit reports to CCO use evidence-based cancer checklists and capture the data in discrete data field format. Ninety-seven per cent of Ontario hospital labs (116 of 119) are maintaining the highest level of standardized cancer pathology reporting by implementation of electronic cancer checklists developed by the College of American Pathologists.

Highlights

In 2013–2014, we:

- Implemented latest cancer checklist in hospital labs.
- Expanded stage data collection to include thyroid.
- Augmented collaborative staging automation tools to support efficient stage data collection.
- Evaluated the increased efficiency of automatic pathology report coding.

Looking ahead

In 2014–2015, we will:

- Work with hospitals to develop an implementation plan for biomarker templates for lung, colorectal and breast cancer cases.
- Monitor and improve turnaround-time performance for pathology reporting.
- Continue to work with regional leads to build, foster and advance CCO's quality agenda.

Molecular Oncology

Molecular oncology – an area of personalized medicine – is the study of molecular mechanisms of cancer. Molecular oncology uses information about a person's genetic composition to predict cancer and its prognosis, and to diagnose, monitor and select cancer treatments that would most likely benefit the individual patient.

Personalized medicine relies on an understanding of how a person's unique molecular and genetic structure makes him or her susceptible to certain diseases. It also identifies which medical treatments would, therefore, be safe and effective and those that would not.

Molecular oncology uses information about a person's genetic composition to predict cancer and its prognosis, and to diagnose, monitor and select cancer treatments that would most likely benefit the individual patient.

Highlights

In 2013–2014, we:

- Increased by three the number of genetic tests for which CCO provides oversight from last fiscal year.
- Developed a position statement to help standardize and improve patient care and management by recommending an approach to Lynch Syndrome testing, including screening criteria, age for testing, testing methodology, consent and reporting.
- Undertook planning to inform CCO's strategic directions for personalized medicine.

Looking Ahead

In 2014–2015, we will:

- Work with stakeholders to develop a governance structure and strategy for personalized medicine as it relates to oncology.
- Work with stakeholders to implement new genetic tests.
- Continue activities related to horizon scanning and the development of advice documents, such as with BRCA1 and BRCA2 testing.

Treatment

Cancer Imaging

The Cancer Imaging Program at CCO continues to develop and promote the safe and appropriate use of imaging in all phases of the cancer journey.

Imaging is a critical component of care throughout a cancer patient's journey, with imaging technology used to screen for risk; diagnose stage; determine prognoses; predict, deliver and monitor response to treatment; and monitor for recurrence of cancer. Imaging technologies contribute significantly to the cost of a patient's care and may also involve some risk for the patient (such as radiation exposure). Thus, the appropriate use of imaging is paramount in containing system resources and ensuring patients receive high quality care at a minimum cost, optimizing patient safety and value for money.

Highlights

In 2013–2014, we:

- Defined clear and efficient means by which CCO's clinical advisory groups may endorse existing guidelines for appropriate use of imaging, rooted in evidence-based practice and aligned with the patient journey. This methodology was developed with extensive stakeholder feedback, and the format has been leveraged for various disease sites (e.g., lung cancer and colorectal cancer).
- Reported on wait times for priority interventional radiology procedures for oncology (related to inserting catheters and performing lung biopsies under image

guidance) collected from participating institutions using ongoing, standardized methods over almost two years. Targets for these procedures have been recommended based on clinical requirements and informed by the wait time data.

- Established a core clinical and technical team to spearhead the roadmap and implementation of province-wide synoptic radiology reporting, with the aim to provide more complete and easily understood medical imaging test reports. A multidisciplinary clinical advisory panel has been set up to define the minimum clinical content for reports. The project team was instrumental in working with standards-setting organizations to create a synoptic radiology guidance chapter for the next Integrating the Healthcare Enterprise – Cross-Enterprise Document Sharing for Imaging implementation guide. The guide will be instrumental in defining pan-Canadian standards for synoptic radiology reporting.

Looking Ahead

In 2014–2015, we will:

- Continue to develop, implement and evaluate appropriate imaging guidelines for new priority disease sites.
- Continue to advance monitoring mechanisms and provide recommendations regarding frequency for interventional radiology oncology procedures.
- Develop a provincial strategy for synoptic radiology reporting, including identification of enhanced data-use, and work with partners to advance standards development.

Multidisciplinary Cancer Conferences

Multidisciplinary cancer conferences (MCCs) bring clinicians with various areas of expertise together in regularly scheduled meetings to discuss the diagnosis and treatment of individual cancer patients. They are a mechanism for peer review and quality assurance, fostering the development of a multidisciplinary culture and encouraging hospitals across regions to work together.

Participants represent medical oncology, radiation oncology, surgical oncology, pathology, diagnostic radiology and nursing. Other healthcare providers involved in a patient's care – such as dietitians, rehabilitation specialists and pharmacists – may also attend. MCCs ensure that all appropriate diagnostic tests, all suitable treatment options and the most appropriate treatment recommendations are generated for each cancer patient discussed.

There is evidence that cases reviewed at MCCs are more likely to result in patients receiving evidence-based care, having all their treatment options considered and enjoying better outcomes.

CCO provides tools to help hospital staff implement or improve MCCs.

Highlights

In 2013–2014, we:

- Worked toward the target of having all hospitals annually treating more than 35 unique patients with a given cancer, ensuring appropriate patients have access to a high quality MCC discussion.
 - Progress has been steady and significant. Ontario hospitals were compliant with 72 per cent of the minimum MCC quality criteria, surpassing the annual compliance target of 65 per cent. This is up from 38 per cent compliance in 2010–11, 44 per cent in 2011–12 and 56 per cent in 2012–13.
- Are able to report that there are more MCCs in more hospitals than ever before. In 2013–14, approximately 36,000 patients were the focus of multidisciplinary discussions, up from 32,000 in 2012–13 and 26,000 in 2011–12.

Looking Ahead

In 2014–2015, we will:

- Strive to reach the 2015 provincial goal of Ontario hospitals being 80 per cent compliant with MCC quality criteria.
- Ensure more patients are the focus of multidisciplinary discussions.
- Share best practices and tools with the provincial network of MCC coordinators to optimize practices and access across the province.

Specialized Services Oversight

One of the strategies of the OCP III is to provide oversight (including planning and quality management) of specialized services, such as stem cell transplants and acute leukemia and sarcoma services. Such services tend to be low volume, high complexity, high cost, and offered in provincial centres of excellence, as opposed to in every LHIN region. Though the nature of each program varies, a common approach is needed that includes provincial coordination regarding clinical guidelines, quality standards and data standards, and system planning and the introduction of new techniques and technologies.

Highlights

In 2013–2014, we:

- Saw the stem cell transplant oversight program focus on the role of emerging technologies, capacity management and planning for expected growth. Funding continues for the six transplant centres in Ontario: Toronto, Hamilton, London, Kingston, Ottawa and Sudbury. These centres work together to analyze and coordinate referral patterns, establish guidelines and measure system performance. A provincial case conference has been established and guidance has been developed in evolving clinical areas to ensure patients across the province receive high quality care.
- Brought together hospitals in the Greater Toronto Area to further build service delivery plans for acute leukemia patients. The program promotes the timely, safe and high quality delivery of acute leukemia care to patients, where and when it best suits their needs.
- Developed the provincial sarcoma services plan which describes how adult sarcoma services are organized in Ontario. It was developed collaboratively by regional, clinical and patient representatives through a steering committee facilitated by CCO and is designed to:
 - Provide equitable access to the best quality sarcoma services, tailored to the individual needs of patients;
 - Optimize care and the use of sarcoma services across the province;
 - Provide an open and transparent explanation of CCO's process for funding sarcoma services.

Looking ahead

In 2014–2015, we will:

- Continue focusing on quality and access issues in the stem cell transplant program by developing additional clinical practice guidelines and analyzing access and quality indicators to identify areas for improvement.
- Implement a plan for leukemia services in the Greater Toronto Area. This work will be leveraged to provide a platform to expand the services across Ontario in the future.
- Review and make recommendations for the organization and delivery of selected focal tumour ablation services for cancer in Ontario with a focus on access, quality and funding.

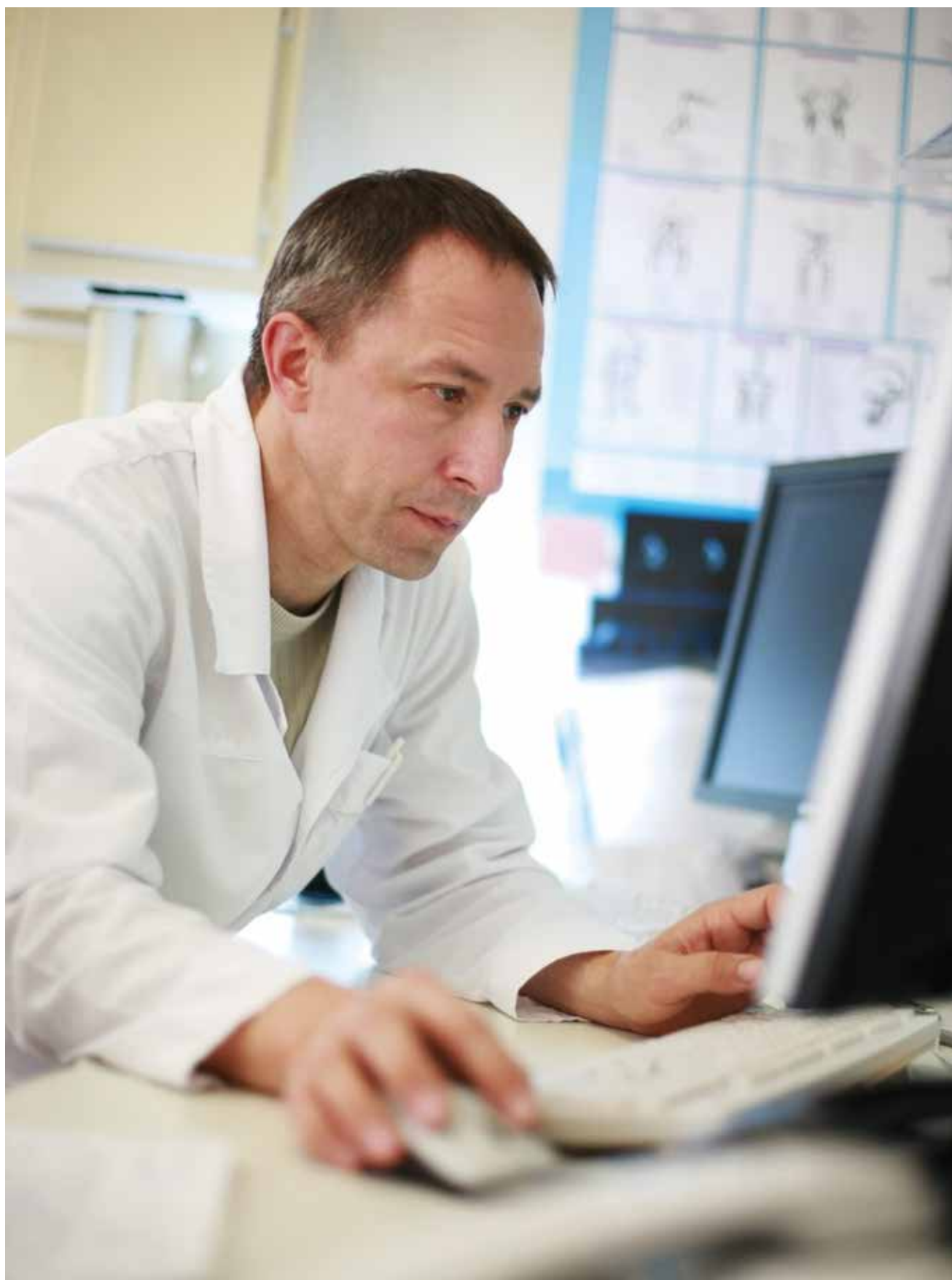
Cancer Surgery

CCO's Surgical Oncology Program works to continually improve the quality of and access to cancer surgery across Ontario. CCO manages the cancer surgery agreement (CSA) with hospitals to enhance system accountability, meet short-term surgery volume requirements and set the stage for longer-term improvements in the quality of cancer surgery and the integration of the cancer system.

CCO has incorporated stakeholder feedback received from the evaluation conducted on the CSA methodology. In 2014-15, cancer surgery will begin a transition from CSA to quality-based procedure funding.

Organization of Head and Neck Cancer Services

To improve patient access to high quality, coordinated head and neck cancer services, CCO undertook implementation of the Management of Head and Neck Cancer in Ontario: Organization and Clinical Practice Guideline Recommendations. The recommendations address the full continuum of care from diagnosis to post-treatment and rehabilitation in adult patients who present with symptoms of, or have been diagnosed with, head and neck mucosal malignancies.



Highlights

In 2013–2014, we:

- Had each region initiate a plan to meet each of the recommendations, including designation of head and neck cancer centres.

Organization of Gynecologic Cancer Services

Data showed variation in care and access to care for women with gynecologic malignancies in Ontario. In response, CCO developed and released the guideline entitled Organizational Guideline for Gynecologic Oncology Services in Ontario which provides recommendations on the optimal organization of gynecologic oncology services in Ontario in order to improve access to multidisciplinary care and appropriate treatment, thereby improving outcomes for patients.

Highlights

In 2013–2014, we:

- Initiated a planning process with each region to meet guideline recommendations including designation of

gynecology centres and building partnerships to organize gynecology oncology services across their regions.

Looking Ahead

In 2014–2015, we will:

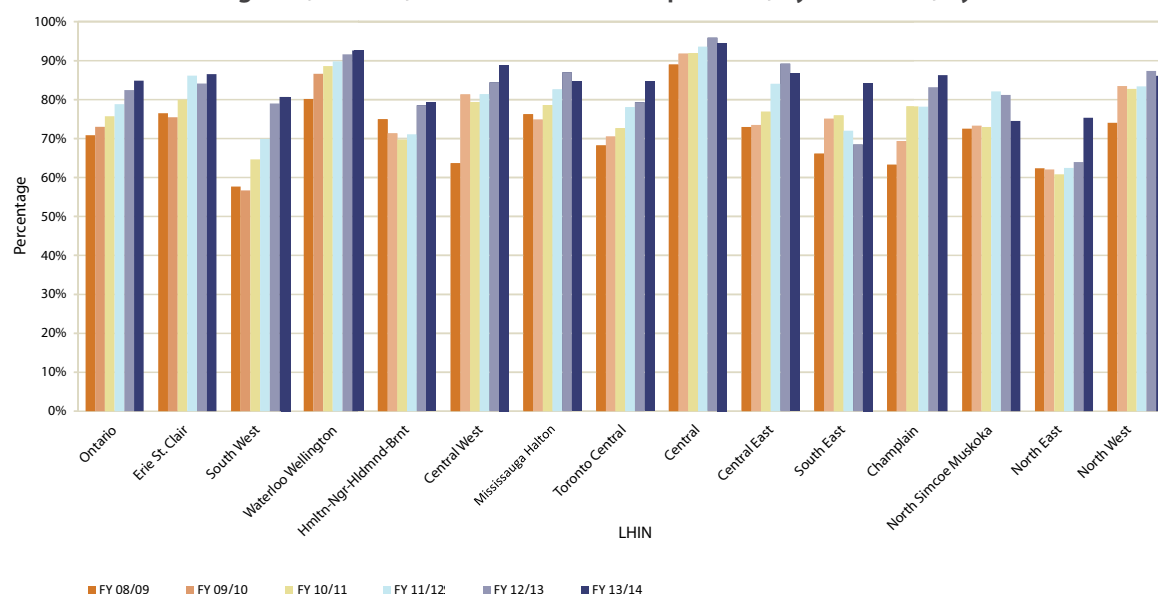
- Continue working with regions to implement the head and neck and gynecology oncology organizational guidelines by designating centres.

Cancer Surgery Wait Times

Surgical wait times are measured by tracking the time between when a decision is made to operate and when the surgery actually takes place. The Ontario government's Wait Time Strategy has set target wait times for different types of surgeries.

As a partner in the Wait Time Strategy, CCO is responsible for directing and managing funding for cancer surgeries. Each patient case is prioritized by the surgeon based on many factors, such as the type of cancer, patient complexity and disease progression.

Wait Times for Cancer Surgery – percentage of cases completed within priority access targets 2, 3 and 4, decision-to-treat to operation, by Fiscal Year, by LHIN



Highlights

In 2013–2014, we:

- Saw 85 per cent of cancer surgeries completed within their target times, an improvement from 82 per cent in 2012–13, 79 per cent in 2011–12 and 76 per cent in 2010–11.
- Most LHINs have shown improvement over time, though there is some variation. The best performing LHINs – Waterloo Wellington and Central – have exceeded CCO's aim of 90 per cent.

85% of cancer surgeries were completed within their target time

Looking Ahead

In 2014–2015, we will:

- Continue to work with Regional Cancer Programs and hospital partners to improve cancer surgery wait times. The goal is to have 90 per cent of cancer surgeries completed within their priority target.

Systemic Treatment

Systemic treatment – or chemotherapy – uses drugs to slow or stop cancer cells from multiplying or spreading. The sooner chemotherapy is given, the higher the likelihood of a better outcome for the patient.

Regional Systemic Treatment Program

The Regional Systemic Treatment Program (RSTP) is focused on ensuring the highest quality of systemic treatment is available to Ontarians as close to home as possible. Through a collaborative combination of regional programs and partnerships, network building, best-practice sharing and the implementation of evidence-based guidelines, the RSTP has been able to establish a number of evidence-based standards for the safe and effective delivery of systemic treatment.

CCO's evaluation of the implementation of the first RSTP provincial plan released in 2009 is informing next steps in service delivery plans for other clinical programs. The program is now in the process of developing a second provincial plan. Additionally, the RSTP is leading the implementation of a new funding model for systemic treatment, as part of Ontario's Health System Funding Reform, to strengthen the link between the delivery of high quality care and funding for services.

Highlights

In 2013–2014, we:

- Undertook the following guideline development and implementation initiatives:
 - Recommendations on use of antiemetics and submitted the clinical evidence and financial impact reports to MOHLTC;
 - Published, with the Program in Evidence-Based Care, updated guidelines on the safe handling of cytotoxics;
 - Evaluated the province on concordance with safe labeling guidelines in 2011–12 and again in 2013–14. Conformity to the guidelines increased from an average of 58.2 per cent across the province in 2011–12 to an average of 77.4 per cent in 2013–14, with some regions in the province scoring 100 per cent.
- Held the 2nd Annual Systemic Treatment Safety Symposium. Over 100 physicians, nurses, pharmacists and administrators from across each region in Ontario participated in an interactive knowledge exchange session focused almost entirely on oral chemotherapy.
- Obtained research ethics board approval for the acute toxicity management (AToM) pilot and began patient enrolment in the Thunder Bay and Toronto regions. AToM evaluates a systematic approach to symptom assessment and management with a focus on systemic therapy-related toxicities among women with breast cancer undergoing adjuvant chemotherapy using a patient reported tool to document treatment toxicities.

Looking Ahead

In 2014–2015, we will:

- Launch the 2014–2018 systemic treatment provincial plan and begin implementing the recommendations.
- In collaboration with the New Drug Funding Program, host a think tank with key opinion leaders and stakeholders to develop an Ontario model for take-home cancer therapies.



- Continue to focus on safety with the introduction of new guidelines on fever management and carry out organized concordance activities with existing guidelines, such as the safe handling of cytotoxics guideline. CCO would also grow and support the regional quality improvement work through the 3rd Annual Safety Symposium and ReQSN.
- Implement the first phase of the new funding model and continue development activities to further enhance the model.

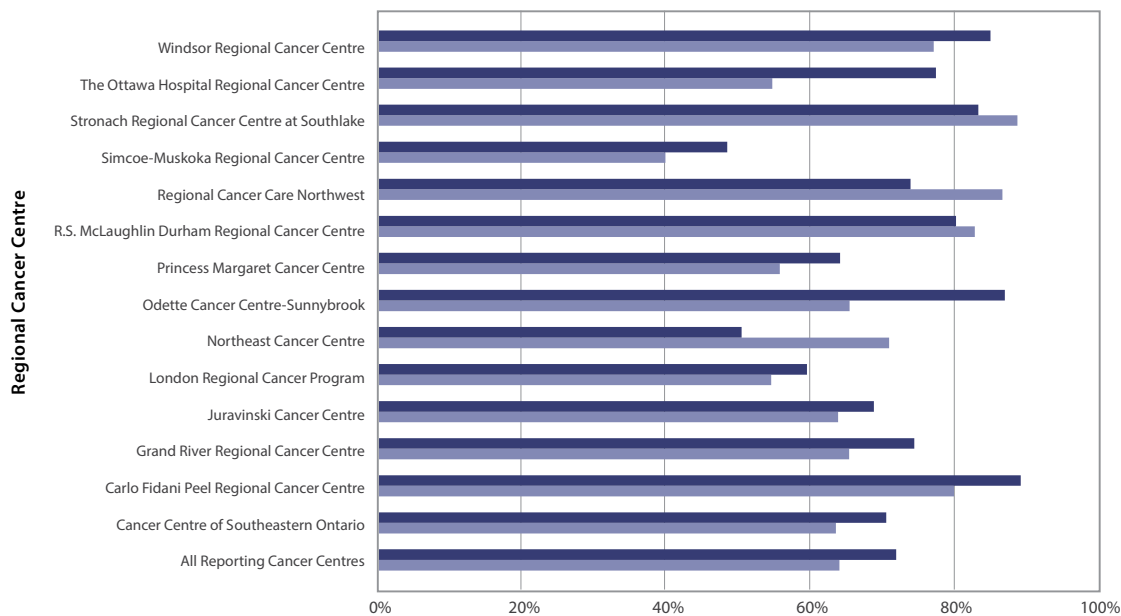
Improving Systemic Treatment Wait Times

Wait times for systemic treatment have improved or remained steady, despite the increasing incidence and prevalence of cancer and the growing demand for cancer services. Systemic treatment wait times are reported for two intervals:

1. Wait times by target for Referral to Consult: the time between a referral to a specialist to the time that specialist consults with the patient. This interval improved since 2012-13 from 66 per cent to 72 per cent of patients in Ontario seen within the 14-day target, as of March 31, 2014.
2. Wait times by target for Consult to Treatment: the time between when a specialist consults with the patient and the time the patient receives his or her first chemotherapy treatment. This has remained somewhat steady, with 71 per cent of patients treated within the 28-day target, as of March 31, 2014.

These wait times targets are set by CCO for the province.

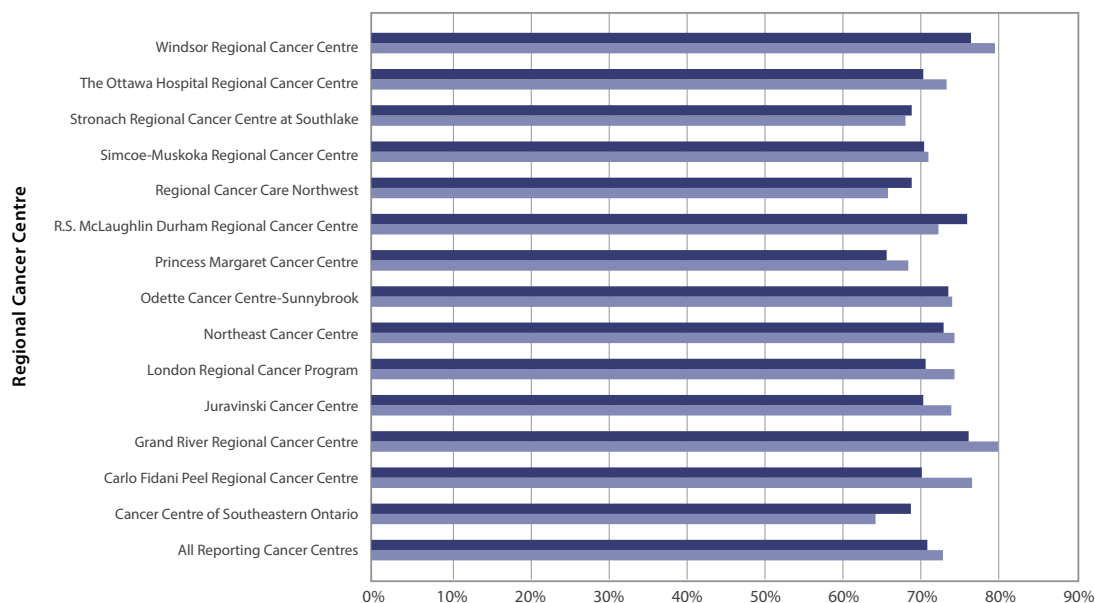
Systemic Referral to Consult - per cent seen within 14 days FY 2012-13 vs. FY 2013-14



Data pull: May 2014
Data source: Activity level reporting
Informatics Centre of Excellence

■ Per cent treated within 1, 7, 14 days FY 2013-14
■ Per cent treated within 1, 7, 14 days FY 2012-13

Systemic Consult to Treatment - per cent treated within 28 days FY 2012-13 vs. FY 2013-14



Data pull: May 2014
Data source: Activity level reporting
Informatics Centre of Excellence

■ Per cent treated within 1, 7, 14 days FY 2013-14
■ Per cent treated within 1, 7, 14 days FY 2012-13

Computerized Physician Order Entry (CPOE)

CCO is expanding and improving the use of the systemic treatment Computerized Physician Order Entry (ST CPOE). CPOE is a critical tool in promoting patient safety by minimizing errors and enhancing the understanding of complex drug regimens. Supported by eHealth Ontario, the CPOE expansion project involved:

- Expanding OPIS, CCO's chemotherapy medication ordering software, to 19 additional hospitals, evaluating concordance to the best practice guidelines for ST CPOE systems and initiating resulting Q1 initiatives.
- Enhancing CCO's drug formulary clinical information tool to improve access at the point of care.
- Launching a ST CPOE community of practice to share lessons learned from all ST CPOE sites (regardless of systems vendor) and help the remaining non-ST CPOE sites find an appropriate ST CPOE system.
- Performance improvement indicators were developed based on data captured in the eClaims system to inform process improvement efforts.
- An improved systematic drug funding forecast model was developed using eClaims data, which enables CCO and MOHLTC to collaborate on drug funding forecast assumptions.
- Worked closely with MOHLTC, CCO's Disease Site Groups, the pan-Canadian Oncology Drug Review, and the pan-Canadian Brand Drug Pricing Alliance to provide comprehensive and timely feedback on the clinical and pharmacoeconomic reviews of the national drug review process, and to secure cost-effective drug product listing agreements. This resulted in nine drugs being approved for 12 different cancer indications for Ontario.
- Developed an evaluation process for drug test pairs in conjunction with MOHLTC and CCO's Pathology and Laboratory Medicine Program.
- Finalized a policy on funding NDFP drugs for patients undergoing clinical trials to ensure providers are aware of the downstream funding policy implications for patients who agree to participate in a clinical trial.

Provincial Drug Reimbursement Programs

Three of Ontario's drug reimbursement programs are administered by CCO's Provincial Drug Reimbursements Programs unit. They include:

New Drug Funding Program

The New Drug Funding Program (NDFP) provides residents with equal access to new, and often expensive, hospital-based injectable cancer drugs. Drugs funded by the NDFP go through a rigorous evidence-based review process that considers clinical and cost effectiveness. The executive officer of the Ontario Public Drug Programs (OPDP) approves all drugs funded through the NDFP. The NDFP administers drug funding policies to approximately 80 hospitals in Ontario and ensures that drugs are used in accordance with established criteria.

Highlights

In 2013–2014, we:

- Implemented eClaims, a web-based reimbursement and claims-adjudication solution that interfaces with CCO's systemic treatment databases and administers many funding policies and rules automatically.

Looking Ahead

In 2014–2015, we will:

- Continue to seek feedback from hospitals on the CCO eClaims solution to inform future enhancements and expand capability to support communication functions for the Case-by-Case Review Program and the Out-of-Country Program.
- Continue to improve and enhance program policies and operations with the support of the Ontario Steering Committee for Cancer Drugs (OSCCD) and through the evaluation of performance indicators.
- Work in collaboration with the Regional Systemic Treatment Program to host a think tank on take-home cancer medications in order to understand opportunities to enhance the safety, equity and quality of care in how these medications are provided.

Evidence Building Program

The Evidence Building Program (EBP) complements and strengthens Ontario's NDFP and the process for drug funding decisions in Ontario. The EBP seeks to resolve uncertainty around the clinical- and cost-effectiveness data related to the expansion of cancer drug coverage within Ontario.

Experience has shown that not all drugs that show promise prove to be useful when they are used in real-world settings. For a drug to be included in the EBP, there must be evolving evidence of its benefits. In keeping with Ontario's evidence-based approach to drug funding, the EBP funds specific drugs on a time-limited basis to allow for the collection of real-world clinical and pharmacoeconomic data that can be used to inform a final funding decision.

Highlights

In 2013–2014, we:

- Continued to analyze current drugs and propose new drugs to be included in the EBP. This year, we published a descriptive analysis of the first drug entered into the EBP: trastuzumab for breast tumours less than 1 cm in diameter. An interim analysis is currently underway to evaluate the safety and toxicity of trastuzumab for these patients.
- Presented a proposal for the funding of rituximab for the treatment of HIV-related lymphoma, which was reviewed and recommended by OSCCD for inclusion into the EBP.
- Recruited hematology and breast cancer disease site team (DST) leads. The DST leads worked closely with clinical experts and CCO clinical programs to provide horizon and jurisdictional scanning, clinical practice guidance, and lead drug submission reviews and evidence-building proposals. The leads also worked to develop disease site-specific drug advisory groups that will be responsible for providing advice to CCO on clinical, program implementation and policy issues.
- Developed an evaluation and reporting framework to measure key performance indicators for the program. Indicators were developed to support program operations and are reviewed on a regular basis with OPDP.

Looking Ahead

In 2014–2015, we will:

- Continue to coordinate and act as the secretariat with MOHLTC for the OSCCD to review proposals for funding consideration under the EBP.
- Appoint additional disease site-specific physicians accountable for ensuring the currency of existing guidelines and working with the Program in Evidence-Based Care on ongoing horizon scanning.
- Work with MOHLTC to assess expanding the scope of the EBP to consider non-hospital (i.e., community-based) cancer drug therapies.

Case-by-Case Review Program

The Case-by-Case Review Program (CBCRP) enables cancer patients who have rare, immediately life-threatening clinical circumstances to access cancer treatments when there is no other satisfactory and funded treatment option. CCO administers the program for all hospital and community-based cancer drugs.

Highlights

In 2013–2014, we:

- Significantly revised the program's policy and communicated these changes to relevant stakeholders in order to promote transparency in how funding requests are evaluated. Program and policy innovations were highlighted at a national conference.
- Worked with MOHLTC to explore additional ways of streamlining the application and adjudication processes, including out-of-country cancer drug requests.
- Developed key performance indicators to evaluate and report on the program to ensure reviews are timely, efficient, consistent and transparent, and to ensure that appropriate resources are in place to sustain operations.

Looking Ahead

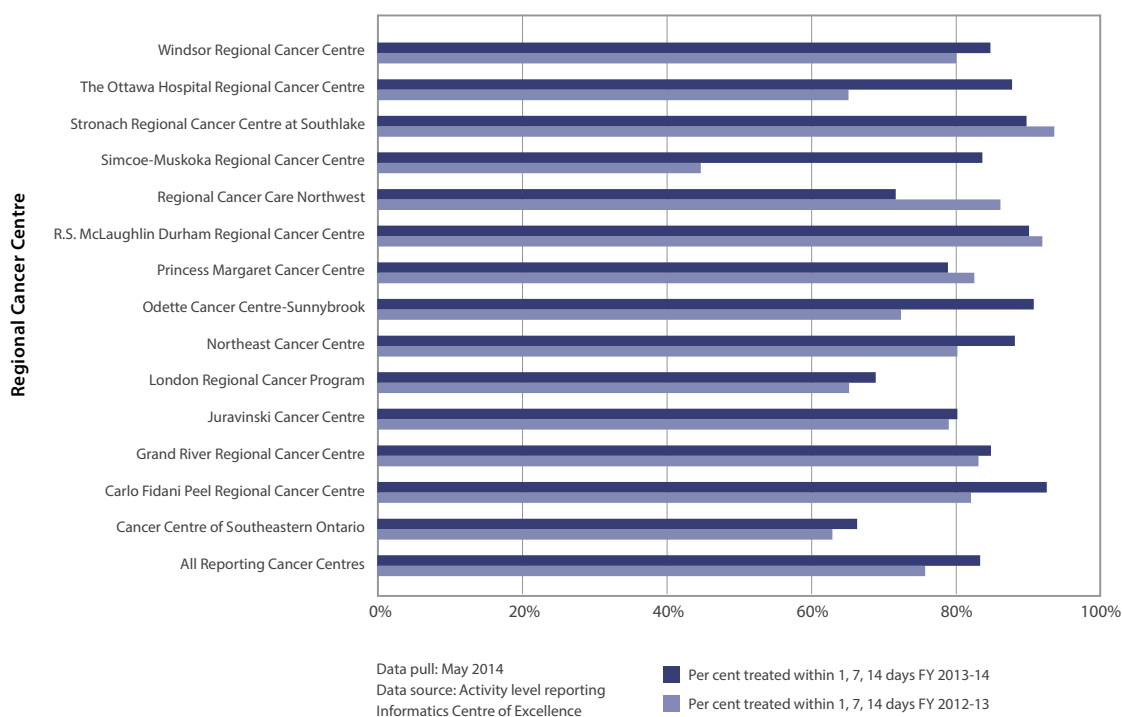
In 2014–2015, we will:

- Work with expert reviewers and the OSCCD to identify potential funding gaps that need to be addressed by MOHLTC's expert committees.
- Evaluate the CBCRP against set performance indicators.
- Integrate the CBCRP process into the new out-of-country process that CCO will begin administering to support MOHLTC's evaluation of cancer drug and service requests.

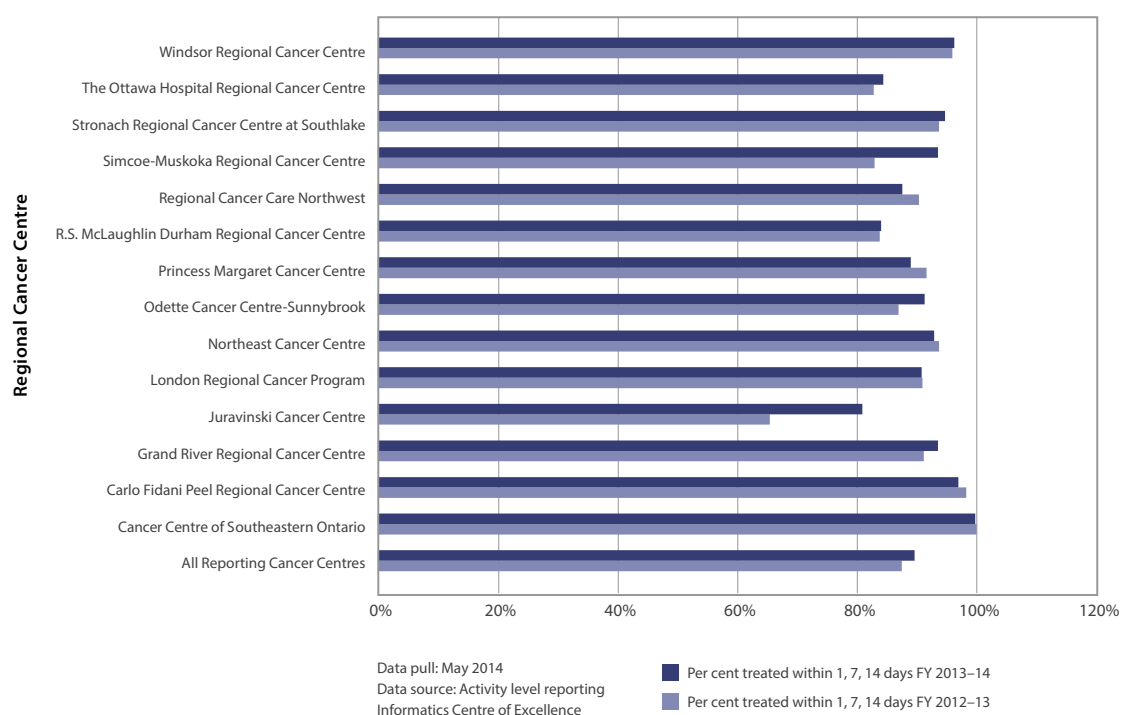
Radiation Treatment

Radiation treatment uses ionizing radiation (X-rays, gamma rays and electrons) to shrink a tumour, destroy cancer cells or provide relief from cancer symptoms. Ionizing radiation is targeted – affecting only the area treated – and is often used in combination with surgery or chemotherapy.

Radiation Referral to Consult – per cent seen within 14 days FY 2012-13 vs. FY 2013-14



Radiation Ready-to-Treat to Treatment – per cent treated within 28 days FY 2012-13 vs. FY 2013-14



Improving Radiation Treatment Wait Times

CCO's Radiation Treatment Program works to ensure timely access to coordinated, safe, evidence-based, technologically innovative treatment. Ongoing reductions in wait times reflect, in large part, the investments made by the province based on advice from CCO. In the past seven years, government investments in radiation infrastructure and equipment have increased the availability of and access to cancer treatments across Ontario. These include the opening of new cancer centres in Newmarket, Niagara and Durham, as well as facility expansions in Ottawa and Kingston, and two new satellite centres in Peterborough and Sault Ste. Marie. Since July 1, 2007, 18 new treatment units have been added across Ontario.

CCO reports on how many patients are being treated within the recommended time targets for two intervals:

1. Referral to Consult: the time between referral and being seen by a radiation oncologist; and
2. Ready-to-Treat to Start of Treatment: the time between the patient being ready for treatment and receiving treatment.

The target wait time for Referral to Consult is 14 days. Wait time targets for the Ready-to-Treat to Start of Treatment interval vary from one to 14 days depending on the patient's condition. These wait times are provincial targets set by CCO.

Highlights

In 2013–2014, we:

- Saw the Referral to Consult interval improve by 7.6 per cent – from 75.3 per cent of patients being seen by a radiation oncologist within 14 days from April 2012 to March 2013, to 82.9 per cent from April 2013 to March 2014.
- Saw the Ready-to-Treat to Start of Treatment interval improve by 2.2 per cent – from 87.4 per cent of patients being treated within the 1-, 7- and 14-day targets from April 2012 to March 2013, to 89.6 per cent from April 2013 to March 2014, despite the deployment of a new, higher complexity treatment technique: intensity modulated radiation therapy technology.
- Facilitated the opening of the Niagara Health System Walker Family Cancer Centre in March 2013, with three linear accelerators.

Looking Ahead

In 2014–2015, we will:

- Continue to further refine the model for capacity requirements to the year 2020 to ensure radiation treatment programs have the capacity to meet increasing demand.

Medical Physics Residency Program

The Medical Physics Residency Program ensures that enough clinical physicists are available to provide high quality, timely and safe treatments for cancer patients using state-of-the-art imaging and radiation facilities. The quality of the program has been recognized in its accreditation by the Commission on Accreditation of Medical Physics Educational Programs. Approximately 70 per cent of staff physicists currently working in Ontario's cancer centres received their training through the program.

Highlights

In 2013–2014, we:

- Maintained the number of medical physics residency positions to ensure Ontario has a steady supply to meet demand.

Looking Ahead

In 2014–2015, we will:

- Ensure the program optimizes the number of medical physics residents who start the Ontario Clinical Physics Residency Program to ensure CCO can meet future demand in the province.

Proton Beam Therapy

Proton beam therapy, which uses a high-energy beam of protons rather than high-energy X-rays to deliver radiotherapy to cancer patients, is increasingly being used in cancer treatment worldwide. While proton beam therapy has existed for more than two decades, its high implementation costs restricted its widespread use. There is some evidence that it may be of particular benefit in pediatric oncology, ocular cancers and base-of-skull tumours.

Highlights

In 2013–2014, we:

- Created a multidisciplinary advisory panel to comprehensively review available literature in order to determine appropriate next steps.

- Created an advice document to identify which patient populations would benefit from the use of proton therapy in Ontario.

Looking Ahead

In 2014–2015, we will:

- Review and explore the development of a business case recommending the implementation of proton beam therapy in Ontario.

Peer Review Quality Assurance

Peer review quality assurance (PR QA) helps increase the quality of radiation therapy delivered province-wide. Under a PR QA program, a second radiation oncologist evaluates components of a radiation treatment plan. The PR QA process is enhanced when it occurs in a multidisciplinary setting with participation from radiation therapists and medical physicists. PR QA processes are designed to ensure that the radiation treatment plan is appropriate from both safety and effectiveness perspectives.

Highlights

In 2013–2014, we:

- Conducted site visits at Regional Cancer Programs to promote PR QA as well as disseminated a guidance document on the structure and function of PR QA activities in Ontario's cancer centres.
- Planned for public reporting of PR QA through CSQI starting in May 2014.
- Evaluated key performance indicators, including the proportion of patients whose treatment plan is peer reviewed.
- Set a provincial target of 60 per cent for fiscal year 2014–15 of treatment plans for patients undergoing curative treatment under the PR QA process.

Looking Ahead

In 2014–2015, we will:

- Develop and implement the radiation therapist PR QA coordinator role overseeing peer-review processes for patients receiving radiotherapy with curative intent by increasing the volume of patients that are peer-reviewed and ensuring data collection.
- Continue site visits at Regional Cancer Programs by the radiation treatment program clinical quality leads to promote peer review quality assurance.

- Continue to develop and refine performance indicators, data-collection methods and reporting mechanisms.
- Evaluate and publicly report key performance indicators, including the proportion of patients whose treatment plan is peer reviewed.

Radiation Utilization

Radiation utilization is a key measure of access to radiation treatment. It measures whether radiation treatment appropriate for a patient's care actually is provided. Radiation utilization is based on where patients live, not on where they are treated.

Radiation utilization does not change drastically year over year, but the trend shows that appropriate care is being provided to Ontario patients. However, there is still room for improvement, with radiation utilization across LHINs still below the recommended 48 per cent rate. As the incidence of cancer increases, the additional volumes for radiation affect utilization rates. A three per cent increase in the number of cases treated is needed to maintain the same utilization rate from one year to the next, and a six per cent increase in the number of cases treated is needed to improve the overall utilization rate by one per cent over a one-year period.

Highlights

In 2013–2014, we:

- Continued to provide data to Regional Cancer Programs to help increase access to radiation for patients who would benefit from it.

Looking Ahead

In 2014–2015, we will:

- Work with MOHLTC to:
 - Ensure that additional capital investment in radiation continues to meet demand;
 - Monitor the human resources requirements for radiation oncologists, medical physicists and radiation therapists, all of which will be needed in concert.

Patient Education

Patient education is a patient-centred process that ensures exchange of knowledge, tools and practices that will

The vision of the CCO Patient Education Program is to improve the experience of people living with cancer by providing evidence-based, person-centred care.

address the needs of patients and families. The program aims to improve the patient's understanding of, and ability to become an active participant in, managing their care. When cancer patients are more informed, they are empowered and better able to navigate the system and make choices based on their values and preferences. By being better informed, patients can have greater influence over their care at every step of the journey.

The vision of the CCO Patient Education Program is to improve the experience of people living with cancer by providing evidence-based, person-centred care. The program contributes to OCP III's strategic priorities by: advancing the quality of patient education services throughout Ontario; enhancing and developing patient education skills and knowledge among cancer care providers; and ensuring that patients and families have access to information, tools, skills and support throughout their journey.

Highlights

In 2013–2014, we:

- Piloted a survey evaluating the provision of cancer patient and family information at three sites in an effort to develop quality indicators. The pilot survey assessed the type of education and information patients and families received, how they received it, and how helpful the education and information was for patients and families in understanding and managing their cancer journey.
- Actively engaged patient and family advisors (PFAs) through membership in the patient education committee. Three PFAs are key participants in the ongoing work of the committee to support the development of best practices in patient education.
- Established a working group to assess the quality of self-management resources related to symptom management. The group has begun scanning for resources and will ultimately evaluate the quality of materials to recommend for provincial use.

Looking Ahead

In 2014–2015, we will:

- Develop and refine indicators and roll out a broader provincial survey to ensure continued access to quality patient and family education and information.
- Continue to support the development of cancer care provider patient-education skills and knowledge by encouraging the uptake of the Maximizing your Patient Education Skills (MPES) course. MPES helps healthcare professionals identify the learning styles of their patients and adjust their delivery of information based on this knowledge.
- Support the development of an evidence-based guideline for therapeutic patient education and its implementation across the province.

Oncology Nursing

The Oncology Nursing Program was developed to advance cancer care through excellence in oncology nursing. The vision of the CCO Oncology Nursing Program is to maximize person-centred care through the optimal utilization of nursing knowledge and clinical expertise across the system. Oncology nurses play a fundamental role in cancer care as they are the professionals most often available for patients and families as they move through their cancer journey across all care settings. Oncology nurses provide a broad spectrum of specialized skills, knowledge and expertise to patients across the lifespan and to their families. This may include administering and monitoring chemotherapy and radiation therapy, working in clinical trials, supporting end-of-life care and pain management, and providing psychosocial support.

Using ISAAC, patients, family members, physicians, nurses and other care providers can track changes in symptoms over time and across care settings. This improves access to information that can be used to support better care.

Across the continuum of care (i.e., prevention, screening, diagnosis, treatment, survivorship and palliation), patients and their families look to the oncology nurses for reassurance and understanding. These nurses help patients regain control in the face of illness and to cope with vulnerability and uncertainty. The program contributes to OCP III's strategic priorities by building nursing competency in the delivery of safe, effective and high quality care, and by improving access to person-centred oncology nursing across the patient journey and health system.

Highlights

In 2013–2014, we:

- Supported an increase in the number of nurses who have obtained Canadian Nurses Association (CNA) specialty certification in oncology and palliative care. In 2013–14, over 100 nurses participated in the de Souza study groups for certification in specialized oncology and hospice palliative care.
- Advanced oncology education through specialized training and lifelong learning in cancer care for nurses and other healthcare professionals.
- Developed two evidence-based guidelines for the safe administration of systemic cancer therapy, highlighting the integral role of nursing in ensuring patient safety. In addition, CCO measured concordance to the guidelines in areas that reflect nursing practices in chemotherapy suites. Concordance to guidelines can improve patient safety and drive widespread practice changes to prevent chemotherapy errors.
- Refined and expanded regimen-based resource intensity weights to include best practice around nursing time for oral chemotherapy and follow-up for IV treatment. This information will be incorporated into the new patient-based funding for quality-based procedures, such as systemic treatment.

Looking Ahead

In 2014–2015, we will:

- Move forward on recommendations generated through a provincial engagement workshop held jointly with the Models of Care Program, which aims to ensure that the right care is provided by the right provider. This includes capacity building of nursing health human resources by supporting new models of ambulatory oncology care that optimizes the scope of practice of nurses and the development of guidelines for the effective use of advance-practice nurses.
- Continue to engage stakeholders to improve data collection and data quality initiatives to support the measurement of nursing activities. Comprehensive, accurate and timely data will support the ability to develop indicators that can help improve the quality and efficiency of patient care across the province.
- Facilitate knowledge transfer across the province through monthly nursing rounds and support of communities of practice for advanced practice nurses and nurse navigators.

Psychosocial Oncology

Psychosocial oncology (PSO) focuses on a whole-person approach to cancer care, addressing the social, psychosocial, emotional, spiritual and functional aspects of the patient journey through a multidisciplinary team and service providers from various care settings. The disciplines include: oncology, nursing, social work, nutrition, psychology, palliative care, psychiatry, rehabilitation, volunteer services and spiritual care.

The vision of the CCO PSO Program is to improve the patient experience through quality PSO care. The program contributes to OCP III's strategic priorities by improving timely access for patients and families to quality PSO care throughout the cancer journey and beyond, and by reducing psychosocial morbidity of patients and families related to unmet physical, emotional, practical and spiritual needs.

Highlights

In 2013–2014, we:

- Led in the development of international best practices in PSO through groundbreaking initiatives in measuring PSO resource intensity weights (RIW). The program determined RIW based on best practices for six disciplines: social work, psychology, nutrition, physiotherapy, occupational therapy and speech language pathology. The PSO RIW ensures that PSO services are incorporated into the new patient-based funding for quality-based procedures, such as systemic treatment, since there is no PSO program funding by cancer program.
- Served as leaders in collecting data on wait times for PSO services internationally. The program has developed an initial indicator related to wait times for access to nutrition services. By measuring wait times, the goal is to improve timely access to necessary PSO services to meet patient needs.
- Collaborated with CCO's Disease Pathway Management and Palliative Care programs to develop the PSO and palliative care pathway that depicts the psychosocial, palliative and end-of-life care a cancer patient should receive, regardless of cancer type. The pathway provides an overview of the evidence-based best practices related to screening for and management of PSO and palliative care needs of cancer patients in Ontario.

Looking Ahead

In 2014–2015, we will:

- Develop and implement quality indicators to ensure continued access to psychosocial services. Measuring the quality of PSO services enables us to identify gaps, implement changes in areas that need improvement and, ultimately, increase access to quality services.
- Further expand on the PSO RIW to better understand best practices by discipline and disease site. PSO RIW information can potentially be used to inform the development of quality indicators and measurement.

- Develop additional evidence-based guidelines in conjunction with the Program in Evidence-Based Care to provide guidance and standard practice around implementing exercise interventions and updating the depression guideline. The program is also in the early stages of the development of a guideline to support managing sexual health outcomes.

Symptom Management

The Ontario Cancer Symptom Management Collaborative (OCSMC) is focused on delivering an excellent patient experience across the cancer journey by improving the quality and consistency of physical and emotional symptom management and care planning for patients.

The OCSMC actively engages all Regional Cancer Programs in promoting the earlier identification, documentation and communication of patients' symptoms. Patients self-report their symptoms using the interactive symptom assessment and collection (ISAAC) tool. In Ontario, we currently use two measures to understand how patients are feeling. The first is the Edmonton symptom assessment system (ESAS), which is a symptom screening tool that asks patients to rate the severity of nine symptoms commonly experienced by cancer patients. In 2013, CCO added a second measurement tool to ISAAC called the patient reported functional status (PRFS) tool. The PRFS allows patients to rate their functional status using a standard four-point scale. This rating helps clinicians to better understand patients' levels of mobility and abilities to stay active, providing additional information to clinicians to guide care planning and treatment decisions.

Before standardized symptom screening was implemented across the province, Regional Cancer Programs did not use a standardized electronic tool to assess and manage patients' symptoms. Through the use of ISAAC, patients, family members, physicians, nurses and other care providers can now track changes in symptoms over time and across care settings. This improves access to vital symptom information that can be used to support better care. When patients are given the opportunity to self-identify their symptom needs, it improves the information on which professionals make decisions and enhances

patients' engagement with decisions made based on conversations with their care providers.

Highlights

In 2013–2014, we:

- Oversaw a steady increase in the proportion of cancer patients screened for cancer symptoms from 53 per cent in 2012–13 to 59 per cent in 2013–14. In total, just over 130,500 patients were screened using ESAS in 2013–14.
- Completed the design phase of a new mobile application for ISAAC. This process also involved a comprehensive usability study of ISAAC that incorporated the patient voice in designing improvements to the electronic tool. As of March 31, 2014, ISAAC is used by more than 27,000 patients each month.
- Invited patients to partner on our provincial symptom management improvement collaborative and on the new ISAAC user group. These groups involve regional partners from around the province in designing and implementing innovative ways to provide high quality symptom management to patients in Ontario.

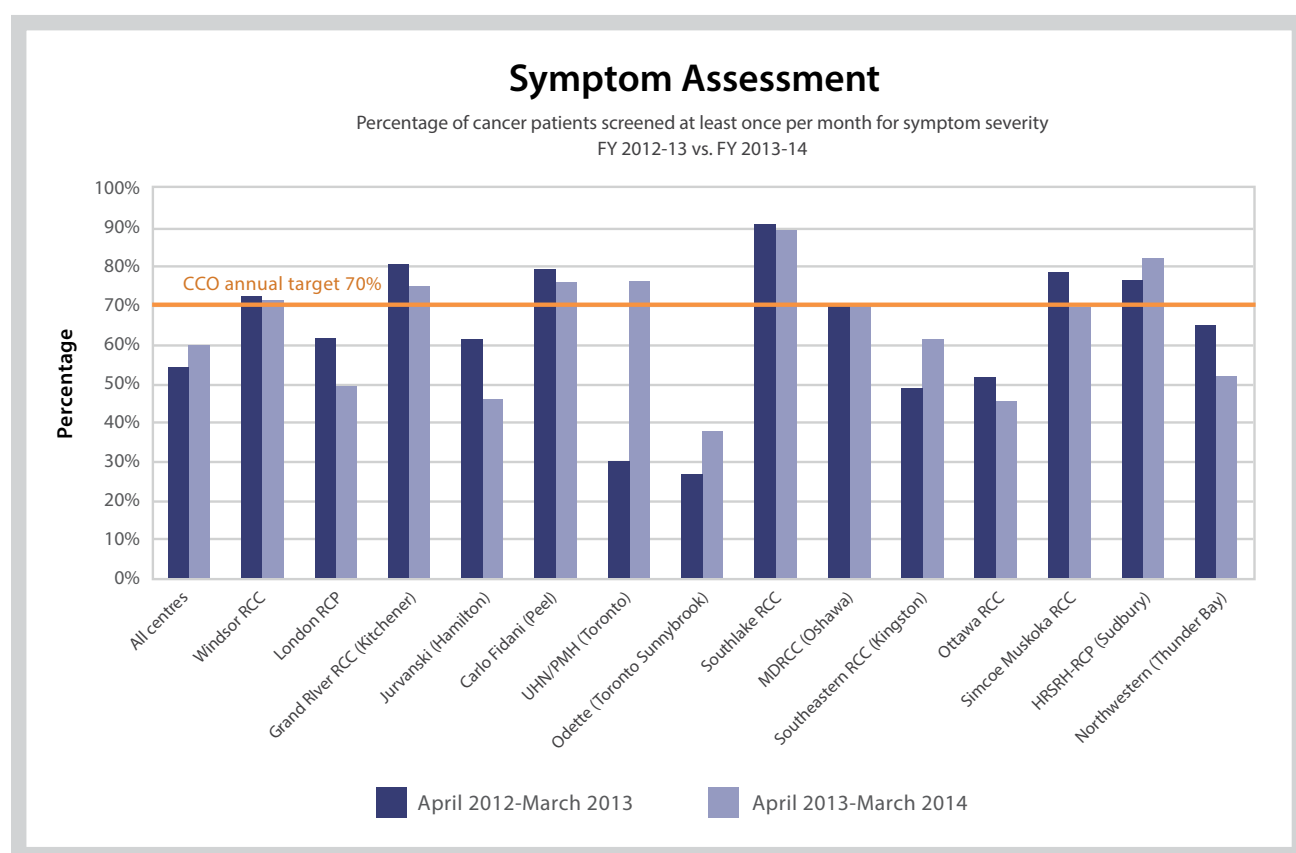
Looking Ahead

In 2014–2015, we will:

- Launch the ISAAC mobile application across the province allowing patients to enter and track their cancer symptoms from their own devices at any time.
- Publish a new symptom management guide for sexual health and launch new patient-facing symptom management guides to support and empower patients.
- Launch pilots for improving symptom management in the Aboriginal setting on Manitoulin Island and in the community through partnerships with CCACs.

Patient Reported Outcomes

Patient reported outcomes (PROs) are measures that assess functioning, symptoms, treatment effects and well-being from the patient's perspective, generally using questionnaires. By integrating the routine collection of patient reported outcome measures into each stage of



the cancer journey and by monitoring changes in patient scores across the cancer system, CCO's vision is to improve the quality of care in the form of better management of symptoms, better health-related quality of life and enhanced satisfaction.

This work is being driven by CCO's patient reported outcomes advisory committee. The purpose of this committee is to advise on the implementation of new validated patient reported outcome measures that better measure symptoms and effects for all cancer patients. This work is based on a foundation of research conducted in Canada and a framework developed in Ontario for the measurement of core and disease-specific patient outcomes.

Integrating a patient reported outcome measurement system into routine clinical care will improve clinical response to symptoms, improve treatment effects experienced by patients, engage patients in self-care, and drive population-based quality improvement. This work will help capture the impact of cancer on the "whole" person for routine use in clinical decision-making and for quality improvement to enhance the experience of patients living with and beyond cancer.

Highlights

In 2013–2014, we:

- Added the first new patient reported outcome tool to ISAAC called the patient reported functional status or PRFS. This rating helps clinicians better understand how patients are physically functioning, providing additional information to guide care planning and treatment decisions.
- Began pilot implementation for PRO measures of chemotherapy toxicity and symptoms related to prostate cancer including bowel, sexual and urinary function.
- Received endorsement from the provincial PSO program to implement PRO measures for anxiety and depression.

Looking Ahead

In 2014–2015, we will:

- Initiate broader efforts to engage patients and clinicians in mapping future areas of focus for new patient reported outcome measures.
- Pilot measures related to anxiety, depression, pain, fatigue and disease-specific symptoms relevant to head and neck cancers.

- Test the measurement of and clinician response to patient reported outcomes in First Nations communities in partnership with the Aboriginal Cancer Control Unit and patients and family members.

Survivorship Program

The vision for the survivorship program at CCO is for survivors of cancer to have access to the right care and information at the right time, and a place to achieve and maintain a positive health status. The program will contribute to the OCP III's strategic priorities by improving the integration between providers to ensure that health-system efficiencies are delivered in a manner that provides survivors of cancer with high quality care.

Highlights

In 2013–2014, we:

- Assessed the impact of the breast cancer survivorship and follow-up care projects. The program measured the number of patients transitioned from specialist oncologists to primary care settings, as well as the patient and provider experiences of care with new models.
- Implemented new models for colorectal cancer follow-up care in the remaining 12 regions to optimize how follow-up care is delivered and create sustainable changes in practice.
- Conducted knowledge and exchange activities with primary care providers to facilitate awareness of survivorship priorities and system needs to assist in providing follow-up care for survivors of cancer.
- Developed additional evidence-based consensus guidelines for follow-up care for lung and prostate cancers.

See also: Models of Care

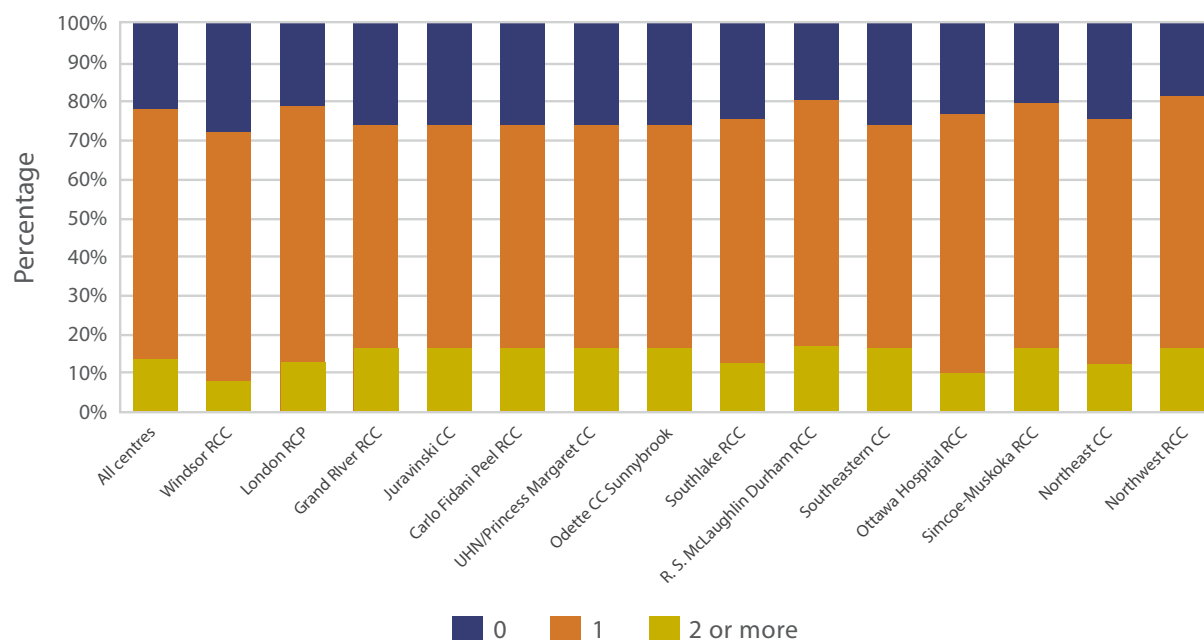
Looking Ahead

In 2014–2015, we will:

- Develop and pilot an approach to measuring the patient experience in the survivorship phase of the cancer journey.
- Develop innovative approaches to enhance provider integration for cancer survivors by developing a residency training curriculum to facilitate early training education and strengthen relationships between primary care and oncology residents.

Survivorship

Percentage of breast cancer survivors diagnosed in 2010 with guideline-recommended mammogram tests in the first follow-up year (13 -24 months from diagnosis)



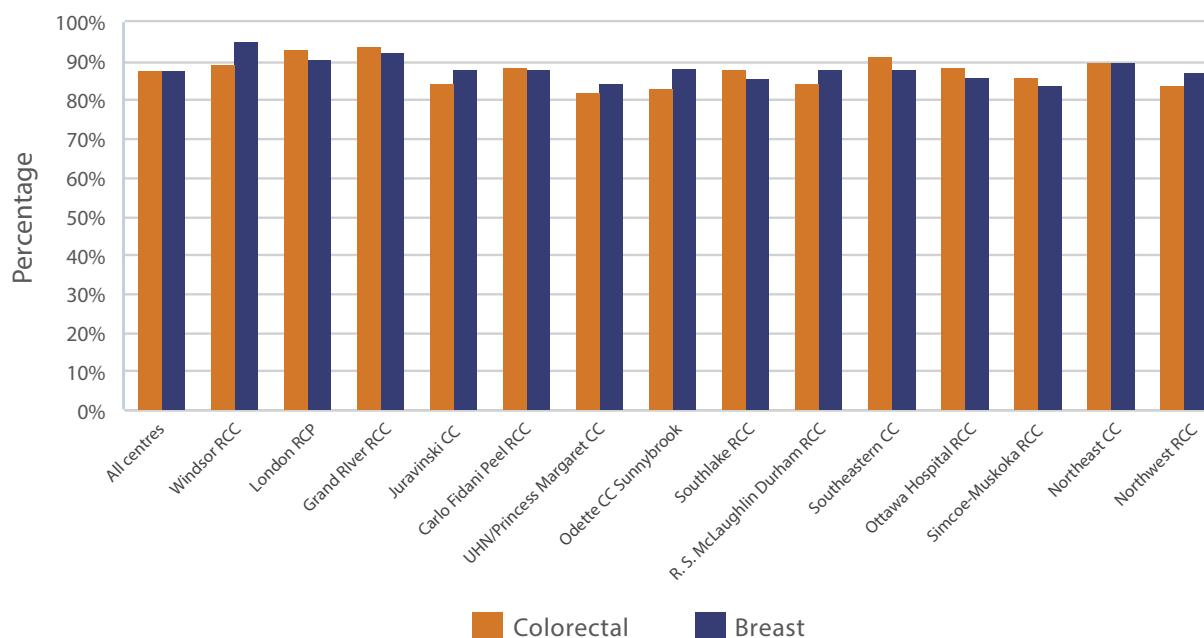
Report Date: January 2014

Source: OCR, ALR, NACRS, DAD and OHIP

Prepared by: Informatics Centre of Excellence, Cancer Care Ontario

Survivorship

Percentage of breast and colorectal cancer patients diagnosed in 2011 who visited their family physician between 13 to 18 months after being diagnosed



Report Date: January 2014

Source: OCR, ALR, NACRS, DAD and OHIP

Prepared by: Informatics Centre of Excellence, Cancer Care Ontario

- Continue to work with primary care providers to understand the specific mechanisms and supports to transition patients to cancer centres upon suspicion of recurrence.

Palliative Care

As the number of Ontarians living with, surviving or dying from cancer continues to rise, there are a growing number of patients and caregivers in the province who could benefit from accessing palliative care earlier and across the cancer journey. Palliative care has been identified as a priority area by CCO and by several provincial and regional organizations and service providers.

Palliative care is more than providing comfort at end of life. It includes: pain and symptom management; caregiver support; psychological, cultural, emotional and spiritual support; as well as bereavement support for loved ones. Patients' palliative care needs vary across the illness trajectory. Needs may be either straightforward – requiring a 'palliative care approach' (primary level service) – or more complex – and require specialist palliative care services (secondary or tertiary level of service). Palliative care introduced earlier in the journey can improve patient care and patient experience and may help to reduce unnecessary healthcare spending at the end of life. CCO continues to advance initiatives to ensure that all Ontarians can benefit from a palliative approach throughout the cancer journey, and ensuring that the right care is delivered by the right person in the right place at the right time.

CCO is also a supporter of the Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action, a strategic planning document for improving the end-of-life experience for Ontarians. This declaration is the result of a collaborative effort from more than 80 stakeholders across the province. CCO sits at the executive steering committee level and is a supporter and driver of the work outlined in the declaration. Working together with partners, CCO strives to improve the patient experience by changing the culture of palliative care in Ontario.

Highlights

In 2013-2014, we:

- Advanced the culture change in palliative care through the development of CCO's position on the levels of palliative care, and launched the PSO and palliative care disease pathway map.
- Worked with the LHINs to create a common approach for identifying palliative services in the province. This asset map will provide a baseline for measuring palliative services in the province and can be monitored on a regular basis, enabling the identification of gaps in the system.
- Worked with provincial partners to identify a provincial set of appropriate and effective performance indicators for palliative care in Ontario.

Looking Ahead

In 2014-2015, we will:

- Enable earlier identification of patients who will benefit from a palliative approach through education and coaching for primary care physicians, oncologists and nursing.
- Provide seamless palliative care through integrated service models that will be piloted in three regions and then rolled out more extensively across the province.
- Enhance healthcare providers' skills for providing effective symptom management and more effectively responding to patient reported functional status scores.

Patient Experience

The Patient Experience Program is committed to measuring the patient experience along every step of the cancer journey. Patient experience is a strategic priority for the OCP III. The outcome is that by 2015 every cancer patient in Ontario will have the opportunity to give feedback on their experience throughout the cancer journey. From a program perspective, the plan includes establishing Regional Cancer Program accountability for improving the patient experience through integration with CCO's performance management process.

CCO continued to show its commitment to improving patient experience by identifying person-centred care as a corporate strategic focus. As well, an important tenet

of person-centred care is meaningful patient and family engagement to improve the patient experience. Patient engagement necessitates patient and family advisors as partners in the design, delivery and evaluation of the healthcare system.

Highlights

In 2013-2014, we:

- Completed business planning for real-time measurement (RTM) including:
 - Development of a request for proposals for a RTM tool and analytics for use in Regional Cancer Centres;
 - Development of a patient experience questionnaire that provides real-time patient experience data that can be leveraged for quality improvement in the cancer centres.
- Developed a person-experience measurement framework, applied across all CCO programs and portfolios, to create a comprehensive and consistent approach to measure person experience throughout the cancer journey.
- Recruited and oriented an additional 40 patient and family advisors beyond the Patient and Family Advisory Council and embedded the patient voice in over 80 CCO initiatives.

Looking Ahead

In 2014-2015, we will:

- Continue to focus on RTM. The priority will be to procure a system that provides real-time patient experience data and to pilot and validate the RTM patient experience questionnaire for the treatment phase.
- Pilot measures of experience across the patient journey with a focus on treatment, survivorship and end-of-life care.
- Disseminate a person-centred care and patient engagement framework within the Regional Cancer Programs in conjunction with the development and implementation of a patient-experience performance scorecard.

Models of Care

Ontario's growing and aging population is driving increasing demand for cancer services. In a constrained economic environment, this threatens the sustainability of our current models of care delivery. As a result, it is

imperative that CCO receive even greater performance and value from every healthcare dollar spent and that the organization helps optimize the use of health human resources (HHR). To achieve these goals, CCO has launched the Models of Care Program, which aims to change how Ontario provides and pays for care, engages patients and reliably plans for the HHR needed in the future.

At its core, this program is informed by the need to implement new and innovative best-practice, patient centred, multidisciplinary models of cancer care that address the challenges facing Ontario's healthcare system.

Highlights

In 2013-2014, we:

- Continued supporting the implementation of a new model of care for patients who have completed their cancer treatment. The new model of care optimizes the roles of specialists and primary care providers, while providing best care for patients (see Survivorship section for more information).
- Began to measure the impact of changes in the model of care on patients, providers and the healthcare system. For the first time, the impact of model changes was quantified and used in HHR planning. New models are helping to slow the need for new doctors in the face of growing demand.
- Partnered with the Oncology Nursing Program to explore new models of ambulatory care. A full-day workshop brought together healthcare providers, administrators, patient and family advisors, and experts in value-stream mapping to recommend future state ambulatory models of care that support appropriate use of HHR, processes and technologies.

Looking Ahead

In 2014-2015, we will:

- Explore opportunities for new models of care for patients with gynecologic cancers.
- Focus on optimizing palliative radiation treatment through broader implementation of the CSRT role.
- Develop a plan to implement the findings from the work with the nursing program on models of ambulatory care.



Disease Pathway Management

Disease pathway management (DPM) is a unifying approach to the way in which we set priorities for cancer control, plan cancer services and improve the quality of care in Ontario. DPM applies a framework for examining the performance of the entire system across the cancer journey – from prevention to recovery to end-of-life care – and identifies any gaps and bottlenecks along the way. DPM addresses the unique issues faced by patients with a specific type of cancer through the development and maintenance of disease pathway maps that set out best practice. They are used to identify opportunities to embed best practice into care-delivery processes, monitor performance against the disease pathway, and catalyze action to address any quality and measurement gaps.

This disease-focused view of the patient journey and the multidisciplinary makeup of its teams make DPM an ideal vehicle for improving processes, quality of care and the patient experience by identifying areas for improvement that the province, Regional Cancer Programs or individual institutions can act upon. It serves as an important catalyst in promoting collaboration and cooperation between clinical programs, with the goal of improving the overall experience for Ontario's cancer patients.

Highlights

In 2013-2014, we:

- Published on the CCO website pathways for colorectal cancer screening, diagnosis and follow-up care, rectal cancer treatment and colon cancer treatment.
- Integrated palliative care and psychosocial care into existing lung and colorectal treatment and follow-up care pathways.
- Released a patient-friendly version of the colorectal cancer screening, diagnosis and follow-up care pathway. It is available as a printable pathway on the CCO website.
- Launched the breast and gynecological cancers pathway development.

Looking Ahead

In 2014-2015 we will:

- Publish breast and gynecological cancer pathways and evaluate availability of evidence-based guidance, measures and quality improvement initiatives.
- Expand the measurement of performance and quality for specific cancers.
- Collaborate with regions to embed pathways in electronic medical records at the point of care.

Chronic Kidney Disease Services

The Ontario Renal Plan

In 2012, the Ontario Renal Network (ORN) introduced Ontario's first renal plan – Ontario Renal Plan (ORP) 2012–2015. With extensive stakeholder consultation, ORN built an ambitious three-year strategy focused on patients with chronic kidney disease (CKD) and on a commitment to measurable quality improvements in health, accountability and value for money. The ORP outlines seven strategic priorities for how the ORN and its partners and stakeholders work together to reduce the risk of Ontarians developing end-stage renal disease, while improving the quality of care and treatment for current and future patients.

Our Core Values

- Patient focused
- Transparency
- Equity
- Evidence-based
- Performance oriented
- Active Engagement
- Value for Money



Ontario Renal Network

As Ontario's population continues to grow and age, and the number of people living with CKD risk factors increases, the prevalence of CKD is also expected to increase. The ORN has implemented a provincial chronic kidney disease strategy (ORP) that will lead to measurable and sustained improvement in care for CKD patients across the province.

The Ontario Renal Reporting System (ORRS) continues to be the backbone to the execution of the Ontario Renal Plan (ORP) including, but not limited to, patient-based funding. In 2013–14, the ORN launched a technical project, ORRS Expose & Upload, that has enabled direct data submission by all dialysis service providers in near real-time. This technical enhancement streamlines the data submission process, increasing accuracy and efficiency, and enables timely measurement and reporting of health system performance, patient outcomes and funding expenditure.

The ORN also forged new partnerships to generate new evidence for high quality CKD care, expanded and enhanced assessments of provincial dialysis capacity, and began evaluation of strategic initiatives to support the ORP priorities and knowledge translation across the entire provincial network of providers and administrators.

Highlights

In 2013–2014, we:

- Built organizational capacity to improve coordination of care, address care and funding issues within the

community, and better support and promote patient-centred care in the renal community. As a result, ORN is starting to see growth in the uptake and prevalence of home dialysis, has defined an improved model of care for assisted peritoneal dialysis, and is developing an increased understanding of patient needs through province-wide consultations with patients and families impacted by CKD.

- Began to build the infrastructure to reduce the progression of CKD by helping primary healthcare providers with the identification and management of CKD. This was accomplished through standardized referral to nephrology, mentorship programs, electronic medical record decision support tools and a primary care CKD toolkit.
- Began a process to ensure that all Ontario regional CKD programs practise a model of patient-centred care that ensures patient and provider safety while driving improvements in efficiency and clinical quality, and that provides access to care as close to home as possible. This is done through the development of organizational standards to guide delivery of evidence-based CKD care province-wide in hospitals and in the community.

Looking Ahead

In 2014–2015, we will:

- Engage regional and provincial stakeholders and patients to complete and launch ORN's second strategic plan, the ORP II 2015–2019. This will serve as a comprehensive roadmap for how ORN will continue to work together as a network to reduce the risk of end-stage renal disease (ESRD), while improving the quality of care and treatment for current and future CKD patients.

As Ontario's population continues to grow and age, the prevalence of chronic kidney disease (CKD) is also expected to increase. The ORN has implemented a provincial strategy that will lead to measurable and sustained improvement in care for CKD patients.

- Support the shift from hospital-based care to community-based care by expanding the patient-based funding framework along the continuum of care, and exploring new CKD self-management tools and innovative models of pre-dialysis care. This will help improve integration, quality and efficiency across the full care continuum.
- Develop an enhanced patient-centred care model for CKD and ESRD using tailored educational material, decision aids and outcome reporting tools for patients and care providers. This will enhance provider knowledge and skills, empower CKD patients to make informed decisions about their care and incorporate patient reported outcomes in the drive toward high quality, cost-effective care.





Access to Care

On behalf of the MOHLTC, Access to Care (ATC) transforms Ontario's healthcare landscape through the design, implementation and management of provincial Information Management/Information Technology (IM/IT) health initiatives as part of Ontario's Wait Time Strategy and Emergency Room (ER)/Alternative Level of Care (ALC) Information Strategy. ATC's recognized service model supports the provincial collection and use of information to improve access, performance, quality and efficiency of care for provincial health-system stakeholders.

Provincial Information Strategies

Surgery Wait Times and Efficiency

Ontario continues to be a Canadian leader in surgical wait-time performance and reporting. ATC's surgical program maintains the infrastructure and daily operational services to track wait times for 92 hospitals and more than 3,100 clinicians. The program also manages operating room (OR) efficiency data for 82 hospitals, covering the duration of a patient's surgical procedure from admission to discharge.

Highlights

In 2013–2014, we:

- Supported MOHLTC and stakeholders to achieve straight A's awarded by the Wait Time Alliance for meeting performance targets in the areas of hip replacements, knee replacements, cataract surgery, radiation oncology and cardiac services.
- Completed the first phase of the surgeon scorecard

pilot that included 23 surgeons, with 82 per cent of the participating surgeons reducing their waitlists.

- Expanded the understanding of the patient journey with the release of the first Wait 1 reports for the province to LHINs and hospitals. Introduced MOHLTC's Wait 1 access targets for surgical oncology to LHINs and hospitals in preparation for future public reporting.
- Introduced surgery data collection and reporting through the Wait Time Information System (WTIS) to three new facilities.

Looking Ahead

In 2014–2015, we will:

- Expand the surgeon scorecard pilot (Phase 2) to further foster surgeon awareness of their wait times to drive accountability and decrease wait times.
- Evaluate the Wait 1 Access Target pilot to determine feasibility of introducing Wait 1 access targets to additional surgical areas.
- Determine the best implementation method for the new SETP performance indicators to identify OR efficiency opportunities.

- Provide MOHLTC with data-driven analysis on central intake models and their impact on wait-time performance.

Diagnostic Imaging Wait Times and MRI Efficiency

Despite the rising number of scans per year, MRI and CT wait times have consistently decreased since the creation of Ontario's Wait Time Strategy. Today, ATC supports the MOHLTC in driving improvement of wait times for 79 sites across Ontario. In 2013, this program expanded to further improve patients' access to MRI services with efficiency metrics from 65 sites and 51 facilities.

Highlights

In 2013–2014, we:

- Fully transitioned the MRI efficiency program from the University Health Network to ATC.
- Introduced diagnostic imaging wait-time collection and reporting through the WTIS for three independent health facilities and one additional hospital.
- Completed requirements gathering and technical development for the automated collection and reporting of MRI data through the WTIS.

Looking Ahead

In 2014–2015, we will:

- Support MOHLTC in optimizing the diagnostic imaging funding allocation model using new MRI efficiency data.
- Partner with sites and facilities to integrate the WTIS as the method of collection and reporting for MRI efficiency data across the province.

Wait Time Information System – Cardiac Care Network

ATC supports the Cardiac Care Network (CCN) by developing, enhancing and maintaining the Wait Time Information System-Cardiac Care Network (WTIS-CCN) application. The system collects vital information to support the CCN and clinicians and ensure quality care for cardiac patients.

Highlights

In 2013–2014, we:

- Achieved a 99 per cent availability of the WTIS-CCN application for the fiscal year.
- Successfully delivered major system enhancements for trans-catheter aortic valve implantation, including an additional 400 new data fields.

Looking Ahead

In 2014–2015, we will:

- Upgrade the WTIS-CCN system to include the ability to act as a vascular repository for data pertaining to aortic aneurysm repair, lower extremity repair and carotid artery repair.
- Modernize the WTIS-CCN system by providing functionality changes to improve the technical performance and end-user experience.

Alternate Level of Care

Patients who occupy hospital beds, but do not require the intensity of a hospital setting, increase costs to the healthcare system and impede high quality access to care for other patients. The alternate level of care (ALC) initiative was established to identify patient flow obstacles in order to facilitate better resource allocation for emergency rooms, hospitals and communities.

Highlights

In 2013–2014, we:

- Successfully integrated two additional facilities for ALC data collection and reporting through the WTIS.
- Led the creation of new ALC hospital groupings to help better evaluate peer performance, identify improvement opportunities and facilitate future target setting.
- Collaborated with MOHLTC, clinical leaders and external agency partners to maximize ALC performance through a new ALC analytical roadmap.
- Launched the newest evolution of ALC reporting with the LHIN monthly ALC performance report. This new report is based on the innovative provincial ALC executive report and focuses on key questions to provide insight on the ALC population in Ontario.

Looking Ahead

In 2014–2015, we will:

- Release hospital benchmarking reports based on new ALC hospital groupings to enable hospitals, LHINs and MOHLTC to support meaningful ALC performance comparisons between similar facilities.
- Execute the ALC analytical roadmap by delivering new indicators to drive accountability, identify performance improvements and decrease ALC wait times.
- In conjunction with MOHLTC, develop a LHIN outreach and consultation program to supplement the new monthly summary reports and identify performance improvement opportunities.
- Enhance reporting to identify drivers behind the ALC 'long waiters' population.

Emergency Room Information

The emergency room (ER) national ambulatory initiative was established to help measure and report how long patients were spending in the ER. ATC partnered with the Canadian Institute for Health Information to leverage the National Ambulatory Care Reporting System for the timely collection of ER wait time data. Today, 92 facilities collect a dataset of 38 ER data elements that capture the patient journey through the ER.

Highlights

In 2013–2014, we:

- Assisted MOHLTC, ER hospitals and clinical leaders to achieve a month-over-month reduction in the amount of time patients were spending in the ER, despite increased volumes across the province.
- Led the creation of new ER hospital groupings to maximize the validity of comparisons between peer hospitals and identify top performers.
- Released new ER performance reports in order to better meet the informational needs of stakeholders' and drive efficiency in report production.

Looking Ahead

In 2014–2015, we will:

- Expand the new ER hospital groupings to include different volume intervals and hospital characteristics to better identify opportunities for improvement.
- Support MOHLTC to drive the right performance behaviours and justify funding decisions through the recognition of top-performing and most-improved hospitals based on ER length of stay.

Access to Care Provincial Support Model

The MOHLTC starts with a healthcare system issue and a commitment to drive change. On their behalf, ATC's clinical engagement team partners with provincial clinical leaders to translate the issue into an information strategy.

ATC's recognized service model executes upon that strategy by providing technical solutions, integration assistance, change management, education and data quality monitoring. Quick, timely and quality support means healthcare providers can focus on providing and improving access to care for their patients.

Highlights

In 2013–2014, we:

- Received significant positive feedback for ATC's first direct customer outreach program. The onsite visits provided a forum for education, direct support and dialogue to improve the impact of performance metrics across Ontario.
- Completed development of release 17 of the WTIS including MRI efficiency metrics and improvements for the ALC, surgery and diagnostic imaging.
- Provided comprehensive business intelligence training (iPort™ Access) based on direct feedback from hospitals.
- Upgraded the technical documentation of the WTIS. The work augmented the documentation of the fundamental structure to mitigate knowledge risk and ensure efficiency in future development projects.

Looking Ahead

In 2014–2015, we will:

- Establish and communicate a new ATC customer satisfaction strategy focused on streamlining customer experience and driving a service culture across ATC.
- Formalize an ongoing customer outreach program to engage hospitals on a regular basis to provide support and collect feedback.
- Provide education and support healthcare facilities to integrate WTIS release 17 requirements into their operations.
- Complete development on release 18 of the WTIS focused on maintenance and increased flexibility of this critical system.

ATC provides technical solutions, integration assistance, change management, education and data quality monitoring. Quick, timely and quality support means healthcare providers can focus on providing and improving access to care for their patients.

Strategic Initiatives

CCO is in a period of significant change. Ontario's growing and aging population, coupled with current fiscal challenges, demand 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, more importantly, the future health of Ontarians.

Following extensive consultation with stakeholders and partners, CCO developed Strategic Direction 2012–2018, an action plan that identifies how CCO 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.

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

Quality Management Partnership

In March 2013, the MOHLTC asked CCO and the College of Physicians and Surgeons of Ontario (CPSO) to form a partnership to design comprehensive quality management programs in three health services: mammography, colonoscopy and pathology.

There was widespread agreement on the immediacy to address variability and gaps in these three areas and to ensure:

- Consistent, clinically driven standards across the province;
- Adequate supports, linkages and programs to promote adherence to those standards;
- System-wide reporting and measurement at all levels of care delivery.

The three services share a foundation of substantial quality management activity already in the field from which to build on.

The goal of this partnership is to ensure that patients receive consistent, high quality services wherever they seek them across Ontario, be it in a hospital or at a clinic. Equally, the partnership seeks to support physicians and care teams in driving for continuous quality improvement. The partnership is collaborating with clinicians, healthcare leaders, patients and other relevant groups to determine how to define and measure quality to support these goals. The two partners bring unique strengths to the

initiative: CCO brings its leadership in continuous quality improvement, and CPSO brings its leadership in quality assurance in physician practice as well as out-of-hospital premises and independent health facilities.

Highlights

In 2013–2014, we:

- Hired clinical leads for each of the health services and formed expert advisory panels that include clinicians, patients, healthcare leaders and healthcare administration.
- Engaged with stakeholders extensively through newsletters, webinars, surveys, presentations and a website to provide information and solicit feedback.
- Developed a Phase 1 report for MOHLTC containing a program conception, a preliminary vision of comprehensive quality management programs in each area, and a set of early quality initiatives for each health service that could be implemented in 2014–15.

Looking Ahead

In 2014–2015, we will:

- Complete the design of the comprehensive quality management program for each health service and produce a Phase 2 report for MOHLTC by the end of 2014 with a request for funding to implement the programs.
- Continue to engage with stakeholders to ensure their voices are heard and that the work is informed by their expertise.
- Implement the early quality initiatives to begin the journey of improving quality in these three health services.



Health System Funding Reform

The MOHLTC introduced Health System Funding Reform (HSFR) in 2012 as part of its transformation of Ontario's healthcare system. HSFR shifts healthcare funding from a predominantly global budget funding system toward a more transparent, evidence-based model where funding is tied more directly to the quality 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 (QBP), 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.

Highlights

In 2013–2014, we:

- Completed the second year of implementing the chronic kidney disease (CKD) QBP funding framework.
- Completed the development of both the gastrointestinal (GI) endoscopy and systemic treatment QBPs.
- Started the development of two additional multi-year QBPs colposcopy and cancer surgery, beginning with prostate and colorectal cancers.
- Set up a funding unit in our Planning and Regional Programs division to lead CCO's development of QBPs and its collaboration with the ministry on HSFR, a collaboration that is helping to position CCO as a thought leader in the province's effort to link funding to quality.

Looking Ahead

In 2014–2015, we will:

- Continue to implement the CKD, systemic treatment and GI endoscopy QBPs, and develop the colposcopy and cancer surgery QBPs.
- Execute the stakeholder engagement strategy, including engagement of LHINs.
- Develop a QBP impact assessment that highlights the potentially unintended consequences of activity-based funding.

Health System Funding Reform 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.

Infrastructure

Capital Projects

One of CCO's primary responsibilities is coordinating capital investments to build and equip cancer diagnosis and treatment facilities. This includes everything from building new cancer centres to implementing the Radiation Treatment and Related Equipment Replacement Strategy, which is designed to ensure that the infrastructure needs and high quality-of-care standards are met for Ontario patients.

Highlights

In 2013–2014, we:

- Worked with regions to develop five-year planning frameworks specific to each region that outlined capital investments for additional radiation treatment capacity based on planning priorities identified in the capital investment strategy.
- Implemented new policies associated with the Radiation Equipment Replacement Grant, including hours of operation, frequency of replacements, updated planning metrics on utilization, reduced timelines associated with equipment deployment and increased local share to maximize the use of the grant. CCO's management of this grant ensures equitable access to quality tools for the delivery of radiation treatment across Ontario.

Looking Ahead

In 2014–2015, we will:

- Manage the radiation equipment replacement grant process to distribute funding based on provincial priorities and continue work to secure additional

funding to better address the need to replace aging radiation equipment.

- Transfer equipment ownership and procurement approaches to partner hospitals to leverage opportunities and further improve the deployment of CCO capital resources.
- Issue a request for proposals to establish provincial pricing agreement arrangements to ensure the radiation capital equipment purchased represents the most current technologies and the most competitive pricing.
- Develop plans to equip existing, but vacant, radiation treatment rooms in regions where demand exceeds treatment capacity.

One of CCO's primary responsibilities is coordinating capital investments to build and equip cancer diagnosis and treatment facilities.





2013–2014
Financial
Reports

Cancer Care Ontario

Action Cancer Ontario

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June 19, 2014

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.

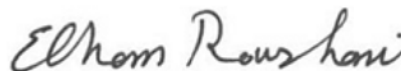
For the fiscal year ended March 31, 2014, Cancer Care Ontario's Board of Directors, through the Audit Finance Committee, was responsible for ensuring that management fulfilled its responsibilities for financial reporting and internal controls. The Committee meets regularly with management, the internal 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



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, 2014 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, 2014 and its financial performance and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Toronto, Ontario
June 19, 2014

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

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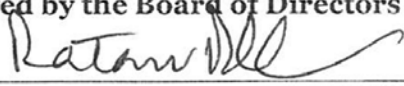
www.auditor.on.ca

Cancer Care Ontario
Statement of Financial Position
As at March 31, 2014

(in thousands of dollars)

	2014 \$	2013 \$
Assets		
Current assets		
Cash and cash equivalents (note 3)	75,124	91,164
Investments (note 4)	93,962	102,921
Receivables and prepaid expenses (note 5)	31,171	54,989
	200,257	249,074
Capital assets (note 6)	152,437	160,147
	352,694	409,221
Liabilities		
Current liabilities		
Accounts payable and accrued liabilities (note 7)	144,931	189,624
Non-current liabilities		
Deferred contributions related to capital assets (note 8)	153,393	169,278
Post-employment benefits other than pension plan (note 9(b))	2,371	2,380
	155,764	171,658
Fund Balances		
Endowment (note 2)	1,288	1,288
Internally restricted (note 2)	1,012	1,550
Externally restricted (note 2)	1,749	2,469
General - unrestricted (note 2)	44,666	37,543
Invested in capital assets (note 10)	3,284	5,089
	51,999	47,939
	352,694	409,221
Commitments (note 15)		
Contingencies (note 16)		
Guarantees (note 17)		

Approved by the Board of Directors

 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, 2014

(in thousands of dollars)

	Restricted		General		Total	
	2014 \$	2013 \$	2014 \$	2013 \$	2014 \$	2013 \$
Revenue						
Ministry of Health and Long-Term Care	-	-	1,479,491	959,244	1,479,491	959,244
Amortization of deferred contributions related to capital assets (note 8)	-	-	39,115	34,687	39,115	34,687
Ministry of Health and Long-Term Care capital funding for Integrated Cancer Programs	-	-	7,569	8,125	7,569	8,125
Investment income (note 11)	18	17	2,730	2,626	2,748	2,643
Other revenue (note 12)	1,915	2,293	5,634	8,611	7,549	10,904
	1,933	2,310	1,534,539	1,013,293	1,536,472	1,015,603
Expenses						
Chronic kidney disease services	-	-	573,605	174,861	573,605	174,861
Integrated Cancer Programs Services	-	7	310,497	300,191	310,497	300,198
Drugs	-	-	281,370	232,323	281,370	232,323
Salaries and benefits	1,902	1,772	79,100	68,124	81,002	69,896
Surgical services - hospitals	-	-	78,401	70,955	78,401	70,955
Amortization of capital assets	-	-	41,064	36,037	41,064	36,037
Medical services	32	6	35,472	28,232	35,504	28,238
Purchased services	857	937	27,102	22,642	27,959	23,579
Mammography equipment funding	-	-	24,624	-	24,624	-
Screening services	-	-	18,476	17,588	18,476	17,588
Hospital systemic therapy services	-	-	16,123	17,761	16,123	17,761
Capital contributions to Integrated Cancer Programs	-	-	12,897	13,712	12,897	13,712
Pension (note 9(a))	-	-	6,536	5,679	6,536	5,679
Occupancy costs	1	-	4,273	4,554	4,274	4,554
Consulting services	27	17	3,898	4,893	3,925	4,910
Professional fees	-	-	797	608	797	608
Post-employment benefits other than pension plan (note 9(b))	-	-	221	141	221	141
Net loss on disposal of capital assets	-	-	415	-	415	-
Other operating expenses (note 13)	301	194	14,421	12,641	14,722	12,835
	3,120	2,933	1,529,292	1,010,942	1,532,412	1,013,875
Excess (deficiency) of revenue over expenses	(1,187)	(623)	5,247	2,351	4,060	1,728

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, 2014

(in thousands of dollars)

	Restricted			General unrestricted \$	Invested in capital assets \$	Total \$
	Endowment \$	Internally \$	Externally \$			
Fund balances - March 31, 2013	1,288	1,550	2,469	37,543	5,089	47,939
Excess (deficiency) of revenue over expenses	-	(484)	(703)	5,247	-	4,060
Net change in invested in capital assets (note 10)	-	-	-	1,805	(1,805)	-
Interfund transfers (note 14)	-	(54)	(17)	71	-	-
Fund balances - March 31, 2014	1,288	1,012	1,749	44,666	3,284	51,999

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

Cancer Care Ontario
Statement of Cash Flows
For the year ended March 31, 2014

(in thousands of dollars)

	2014 \$	2013 \$
Cash provided by (used in)		
Operating activities		
Excess of revenue over expenses	4,060	1,728
Amortization of capital assets	41,064	36,037
Amortization of deferred contributions related to capital assets	(39,115)	(34,687)
Net loss on disposal of capital assets	415	-
Post-employment benefits expense other than pension plan	221	141
Post-employment benefits paid other than pension plan	(230)	(273)
Change in non-cash operating working capital		
Receivables and prepaid expenses	23,818	(26,111)
Accounts payable and accrued liabilities	(44,693)	(23,810)
	<u>(14,460)</u>	<u>(46,975)</u>
Capital activities		
Purchase of capital assets	(33,857)	(62,036)
Proceeds on disposal of capital assets	88	-
	<u>(33,769)</u>	<u>(62,036)</u>
Investing activities		
Proceeds from maturity of investments	102,096	91,428
Purchase of investments	(93,137)	(72,238)
	<u>8,959</u>	<u>19,190</u>
Financing activities		
Amounts received related to capital assets	<u>23,230</u>	<u>63,501</u>
Decrease in cash and cash equivalents during the year	<u>(16,040)</u>	<u>(26,320)</u>
Cash and cash equivalents - Beginning of year	<u>91,164</u>	<u>117,484</u>
Cash and cash equivalents - End of year	<u>75,124</u>	<u>91,164</u>

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

Cancer Care Ontario

Notes to Financial Statements

March 31, 2014

(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 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 service without remuneration. The Organization and the Ministry of Health and Long-Term Care (MOHLTC) entered into a Memorandum of Understanding, effective December 31, 2009. The Organization is primarily funded by the Province of Ontario through the MOHLTC.

During the 2013/14 fiscal year, the Organization's mandate regarding the chronic kidney disease health system was expanded to that of managing all renal services in Ontario as part of the MOHLTC Health System Funding Reform initiative. In addition, the Organization received funding from the MOHLTC, which it flowed to various health care providers, to replace Computer Radiography machines with Direct Radiography machines as they have the ability to detect a wider variety of cancers.

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.

Cancer Care Ontario

Notes to Financial Statements

March 31, 2014

(in thousands of dollars)

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.

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.

(in thousands of dollars)

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 written down amount to the lower of its cost and 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.

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.

Cancer Care Ontario

Notes to Financial Statements

March 31, 2014

(in thousands of dollars)

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.

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 the impairment assessment in the carrying amount of capital assets, amortization of capital assets and 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 \$416 (2013 - \$412), 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

	2014 \$	2013 \$
Guaranteed investment certificates		
Interest at 1.95%, maturing September 5, 2014	43,259	-
Interest at 1.80%, redeemable on demand, maturing May 11, 2015	20,142	-
Interest at 1.80%, maturing October 2, 2014	10,443	-
Interest at 1.80%, maturing October 30, 2014	10,076	-
Interest at 1.80%, maturing January 7, 2015	10,042	-
Interest at 1.50%, maturing September 5, 2013	-	42,516
Interest at 1.89%, redeemable on demand, maturing September 5, 2013	-	30,041
Interest at 1.75%, maturing October 2, 2013	-	10,262
Interest at 1.35%, maturing May 9, 2013	-	10,053
Interest at 1.75%, redeemed on March 14, 2014	-	10,049
	<u>93,962</u>	<u>102,921</u>

Guaranteed investment certificates that have a maturity beyond one year but are redeemable on demand have been included as current.

Cancer Care Ontario
Notes to Financial Statements
March 31, 2014

(in thousands of dollars)

5 Receivables and prepaid expenses

	2014 \$	2013 \$
Accounts receivable	13,138	12,639
Due from MOHLTC	16,100	39,817
Prepaid expenses	1,933	2,533
	31,171	54,989

6 Capital assets

	2014		
	Cost \$	Accumulated amortization \$	Net book value \$
Therapeutic and other technical equipment	308,520	173,498	135,022
Office furniture and equipment	6,146	4,748	1,398
Leasehold improvements	4,415	4,148	267
Land and building	1	-	1
Software	51,352	35,603	15,749
	370,434	217,997	152,437
	2013		
	Cost \$	Accumulated amortization \$	Net book value \$
Therapeutic and other technical equipment	322,480	189,761	132,719
Office furniture and equipment	6,097	3,630	2,467
Leasehold improvements	4,284	3,802	482
Land and buildings	1	-	1
Software	44,990	20,512	24,478
	377,852	217,705	160,147

The cost of capital assets includes software under development of \$997 (2013 - \$3,112) and deposits for equipment and leasehold improvements of \$24,281 (2013 - \$36,526). Amortization of these amounts will commence when the asset is available for use.

Cancer Care Ontario

Notes to Financial Statements

March 31, 2014

(in thousands of dollars)

7 Accounts payable and accrued liabilities

	2014 \$	2013 \$
Trade payables	69,182	125,340
Accrued liabilities	53,724	46,208
Payable to MOHLTC	21,609	17,664
Pension escrow (note 3)	416	412
	<u>144,931</u>	<u>189,624</u>

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:

2014 \$	2013 \$
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Cancer Care Ontario

Notes to Financial Statements

March 31, 2014

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

	2014 \$	2013 \$
Unamortized capital contributions used to purchase capital assets	149,153	155,058
Unspent contributions	<u>4,240</u>	<u>14,220</u>
	<u>153,393</u>	<u>169,278</u>

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.

Cancer Care Ontario
Notes to Financial Statements
March 31, 2014

(in thousands of dollars)

Contributions to HOOPP made during the year by the Organization on behalf of its employees amounted to \$6,403 (2013 - \$5,679) and are included in the pension expenses, which reflect all amounts owing for the year, in the statement of operations.

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 \$230 (2013 - \$273). The actuarial valuation for the post-employment benefits other than pension plan is dated April 1, 2013 and has been extrapolated to March 31, 2014.

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

	2014 \$	2013 \$
Accrued benefit obligation - end of year	3,388	2,754
Plan assets - end of year	-	-
Plan deficit	3,388	2,754
Unamortized net accrual	(1,017)	(374)
Accrued liability - end of year	2,371	2,380
	2014 \$	2013 \$
Interest cost	122	122
Amortization of experience losses	99	19
Total benefit expense	221	141

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:

	2014	2013
Discount rate	4.36%	3.94%
Drug cost trend rate	7.5% in 2014 to 5% in 2018 and after	7.5% in 2013 to 5% in 2018 and after
Hospital, dental and other medical costs trend rate	4% per annum	4% per annum
Employee average remaining lifetime (years)	11.22	10.21

Cancer Care Ontario
Notes to Financial Statements
March 31, 2014

(in thousands of dollars)

10 Invested in capital assets

	2014 \$	2013 \$
Capital assets	152,437	160,147
Amounts financed by deferred capital contributions (note 8)	(149,153)	(155,058)
	<u>3,284</u>	<u>5,089</u>

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

	2014 \$	2013 \$
Purchase of capital assets	33,857	62,036
Increase in deferred contributions related to capital assets	(33,210)	(59,216)
Amortization of deferred contributions related to capital assets	39,115	34,687
Amortization of capital assets	(41,064)	(36,037)
Disposal of capital assets	(503)	-
	<u>(1,805)</u>	<u>1,470</u>

11 Net investment income

Net investment income earned on the Endowment Fund resources in the amount of \$18 (2013 - \$17) is included in the Restricted Fund.

12 Other revenue

	2014 \$	2013 \$
General fund		
eHealth Ontario	1,355	4,080
Public Health Ontario	2,366	2,319
Salary recovery	131	171
Other income	1,782	2,041
	<u>5,634</u>	<u>8,611</u>
Restricted Fund		
Grants	<u>1,915</u>	<u>2,293</u>

Cancer Care Ontario
Notes to Financial Statements
March 31, 2014

(in thousands of dollars)

13 Other operating expenses

	2014 \$	2013 \$
Restricted fund		
Travel	119	71
Education and publications	71	42
General office	61	44
Equipment	49	37
Other expenses	1	-
	<u>301</u>	<u>194</u>
General fund		
Equipment	5,528	6,095
Education and publications	2,607	2,465
General office	4,082	2,077
Travel	1,207	948
Patient service	800	800
Other expenses	197	256
	<u>14,421</u>	<u>12,641</u>

14 Interfund transfers

	2014 \$	2013 \$
Transfer to (from) the General Fund from (to) the Internally Restricted Fund	54	(133)
Transfer to (from) the General Fund from (to) the Externally Restricted Fund	17	(24)
	<u>71</u>	<u>(157)</u>

Transfers to the General Fund from the Endowment and Restricted Funds represent the release of externally and internally restricted reserves approved by the donor or the Organization's Board of Directors, respectively.

Cancer Care Ontario
Notes to Financial Statements
March 31, 2014

(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:

	\$
2015	7,250
2016	5,639
2017	4,799
2018	2,451
	<hr/>
	20,139
	<hr/>

- b) The Organization has committed \$5,087 (2013 - \$6,180) 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 expenses 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. There are no distributions declared by HIROC as of March 31, 2014.

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.

(in thousands of dollars)

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.

Cancer Care Ontario
Notes to Financial Statements
March 31, 2014

(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	13,112	21	5	-	13,138
Due from MOHLTC	16,100	-	-	-	16,100
Amount receivable	29,212	21	5	-	29,238

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, 2014, a 1% fluctuation in interest rates, with all other variables held constant, will have an estimated impact on the value of investments of (\$437) to \$441.

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 maintaining no 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 cashflows) of financial liabilities:

	0 to 30 days \$	31 to 60 days \$	61 to 90 days \$	91 + days \$	Total \$
Trade payables	69,529	12	(3)	(356)	69,182
Accrued liabilities	53,587	-	137	-	53,724
Payable to MOHLTC	-	-	21,609	-	21,609
Pension escrow	-	-	-	416	416
Amount payable	123,116	12	21,743	60	144,931

appendices

BOARD OF DIRECTORS

Neil Stuart, Chair

(June 1, 2010 – May 31, 2013)

Ratan Ralliar, Acting Chair

(November 15, 2006 – November 14, 2015)

D. Scott Campbell

(April 18, 2012 – April 17, 2015)

Kevin Conley

(June 27, 2007 – June 26, 2014)

Malcolm Heins

(February 25, 2009 – February 24, 2015)

Shoba Khetrapal

(December 21, 2006 – December 20, 2016)

Marilyn Knox

(March 23, 2011 – March 22, 2017)

Patricia Lang

(June 20, 2007 – June 19, 2016)

Dr. Andreas Laupacis

(March 23, 2011 – March 22, 2017)

Stephen Roche

(September 20, 2006 – June 30, 2015)

David Ross

(May 29, 2013 – May 28, 2016)

Dr. Walter Rosser

(June 27, 2007 – June 26, 2014)

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 Williams

(April 18, 2011 – April 17, 2017)

EXECUTIVE LEADERSHIP

Michael Sherar, PhD

President and CEO

Rebecca Harvey

Vice-President, Ontario Renal Network

Paula Knight

Vice-President, People, Strategy and Communications

Garth Matheson

Vice-President, Planning and Regional Programs

Dr. Linda Rabeneck

Vice-President, Prevention and Cancer Control

Elham Roushani

Vice-President, Finance, and Chief Financial Officer

Ken Sutcliffe

Acting Vice-President, Chief Information Officer

Dr. Padraig Warde

Interim Vice-President, Clinical Programs and Quality Initiatives