Annual Report

2014/15

Ontario
Cancer Care Ontario

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Our Mission

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

Our Vision

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

Our Guiding Principles

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

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

Ratan Ralliaram
Board Chair

Michael Sherar
President and CEO

For more than a decade, CCO and its many partners have worked together towards transforming healthcare for all Ontarians. Significant improvements have been made in the performance of the cancer and chronic kidney disease (CKD) systems as well as access to care. This past year has been no exception as together we continue to improve the performance of Ontario's health systems by driving quality, accountability, innovation and value.

As the Ontario government's advisor on the cancer and CKD systems, as well as on access to care for key health services, CCO oversaw $1.8 billion of healthcare funds in 2014/15. Approximately 60 per cent of these funds went towards cancer, including radiation, chemotherapy and surgical treatments, drug reimbursements, and prevention and screening initiatives. Close to 35 per cent of these funds were related to kidney care expenses, primarily dialysis services, and the remaining five per cent of these funds were for program management support as well as access to care, which supports the collection and use of information to improve access, performance, quality and efficiency of healthcare in Ontario.

At CCO, we take an evidence-based approach to our work. A key outcome of this approach has been the development of provincial health system plans, which are the road maps for how we work with our partners and the Ministry of Health and Long-Term Care (MOHLTC) to improve cancer and CKD services. This past year marked the 10th anniversary of the implementation of the first cancer system plan; since then, three other cancer plans and two CKD plans have been launched. While these plans have had very positive impacts on the health system—both for those who work within it and for those who rely on it for their care—we are continuously working with our partners and MOHLTC to look at what can be done differently to meet the challenges ahead. The most recent health system plans, the Ontario Cancer Plan III (OCP III) and the first Ontario Renal Plan (ORP I), wrapped up this year, and some of the major 2014/15 achievements under these plans are highlighted in this report. These accomplishments, as well as those achieved in access to care, have put Ontario in a strong position to seize the opportunities of today's changing healthcare environment.

The challenges facing our health system are indeed great. Ontario's population is growing and aging, and fiscal realities demand even greater performance and value from every health dollar spent. Together we must reduce the rate of growth in healthcare spending. We must integrate a health system with a distributed governance structure. We need to continue to find innovative ways to share information and use information technology solutions to improve care, and we must better align the funding for providers to the quality of care being provided to Ontarians.

The next health system plans, OCP IV and ORP II, address these challenges and will help guide the work we

undertake together from 2015 to 2019 to reduce the rate of growth in the number of individuals developing cancer and advanced CKD, while continuing to ensure the delivery of high-quality services for current and future patients.

Both plans build on the solid foundation set by their predecessors. The first three cancer plans focused on building system capacity, reducing wait times, improving quality of care, and investing in prevention, early detection and care closer to home, as well as managing rising costs in an evidence-informed way. With OCP IV, the scope of work broadens to encompass all stages of the cancer care continuum more fully and to advance a person-centred care model. In the CKD system, our first plan introduced a systematic approach to addressing the detection, diagnosis and treatment of CKD in Ontario. Work initiated under ORP II will continue to strengthen the health system to better serve the unique needs of people at risk of or diagnosed with CKD.

While each health system plan addresses the unique needs of their patient populations, their goals and objectives share common areas of focus. In creating these plans, we recognized that building competencies in the following five areas will not only strengthen our ability to deliver on the system priorities identified in OCP IV and ORP II but also address broader challenges to Ontario's health systems.

PERSON-CENTRED CARE

There is increasing recognition that high-quality healthcare requires a shift from a provider-centred approach to one that is centred on patients and their families. Individuals who have been through the system have intimate knowledge of what works well and what could be done better. This is why patients and families were invited to play an integral role in the development of OCP IV and ORP II.

PREVENTION OF CHRONIC DISEASE

The MOHLTC estimates that chronic diseases account for approximately 55 per cent of direct and indirect health costs in Ontario. Prevention is critical to the sustainability of our healthcare system. Specifically, we must focus on those modifiable risk factors linked to most chronic diseases, namely tobacco use, alcohol consumption, physical inactivity and unhealthy eating habits. We must also address the disproportionately higher risk of cancer, CKD and other chronic diseases experienced by some sub-populations in Ontario, for example the First Nations, Inuit and Metis communities.

INTEGRATED CARE

Ontario's health system is large and complex. Better integration of care means that patients experience well-organized, person-centred care from a multidisciplinary team throughout the course of their care. We are also looking beyond hospitals to community-based health and social services as the next frontiers for healthcare integration.

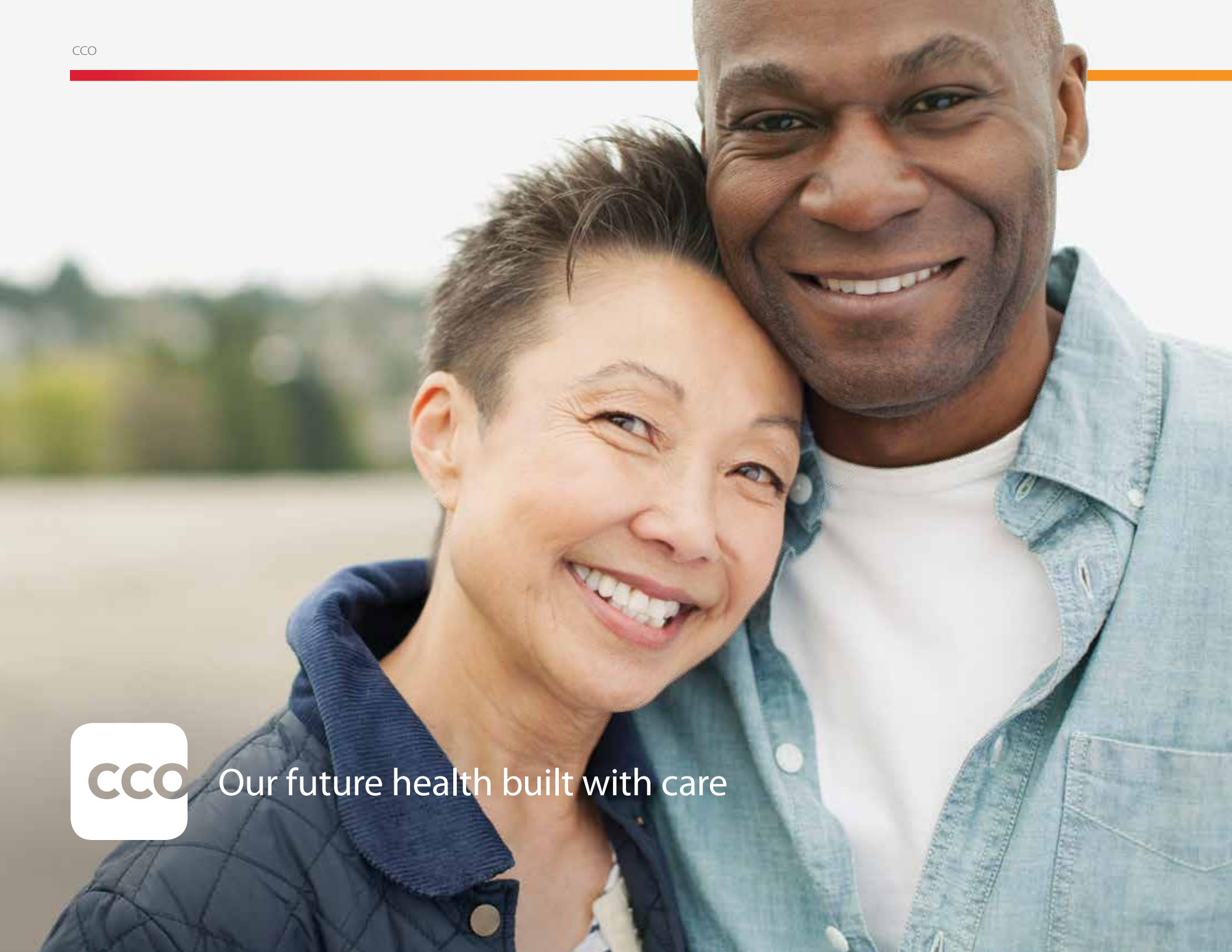
VALUE FOR MONEY

Healthcare dollars must provide the best value possible. To that end, Quality-Based Procedures funding was implemented as part of Ontario's Health System Funding Reform initiative. This evidence- and quality-based selection framework is designed to reduce practice variation and gain efficiencies while protecting and improving high-quality care.

KNOWLEDGE SHARING AND SUPPORT

CCO works closely with our partners to leverage quality and performance improvements both within and across provincial health systems. From building partnerships (such as the Quality Management Partnership with the MOHLTC and the College of Physicians and Surgeons of Ontario) to sharing data holdings, these knowledge-sharing efforts are helping to enhance system performance and inform funding decisions and resource allocation.

These five areas of focus are the underpinning of OCP IV and ORP II. Fulfilling the goals of these plans will require the combined work and dedication of everyone across the health system, including healthcare providers, the MOHLTC, regional and provincial partners, patients and their families, and our employees. Together, we will create the best health systems in the world.



Our future health built with care

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, 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 almost $1.8 billion of healthcare funds for hospitals and other cancer and chronic kidney disease care providers, enabling them to deliver high-quality, timely services and improved access to care.

CCO employs more than 1,000 staff members, all of whom are critical to the success of our efforts with partners to improve Ontario's healthcare system.

Cancer Care Ontario

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

Ontario Renal Network

The Ontario Renal Network was established at Cancer Care Ontario in 2009 to lead a provincewide effort to better organize and manage the delivery of dialysis and kidney care services across the province for patients living with chronic kidney disease (CKD). Our mission is to work together to improve the life of every person with kidney disease. We work through 26 regional CKD programs to improve the quality of kidney care across the province.

The Ontario Renal Network's goal is to improve CKD management by preventing or delaying the need for dialysis, broadening appropriate care options for patients with CKD, improving the quality of all stages of kidney 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.

CCO's Access to Care program 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.

Access to Care

On behalf of the Ministry of Health and Long-Term Care (MOHLTC), Access to Care (ATC) transforms Ontario's healthcare landscape through the design, implementation and management of provincial information management/information technology health initiatives as part of Ontario's Wait Time Strategy and Emergency Room/Alternate Level of Care 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 SURGICAL 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 more than 90 hospitals and more than 3,600 clinicians. In addition, operating room efficiency data is collected and reported for 106 sites, covering the duration of a patient's surgical procedure from admission to discharge.

2014/15 Highlights

- Phase two of the Surgeon Scorecard Pilot was completed with more than 200 surgeons. Results indicate surgeons' improved wait times and a high level of participation achieved with 81% of ophthalmological surgeons, 80% of oncology surgeons and 72% of orthopedic surgeons taking part.
- The Wait 1 access target pilot for surgical oncology was completed, and the Wait 1 benign (non-cancer) access targets for all surgical areas were developed.
- MOHLTC, with support from ATC, evaluated Ontario's orthopedic central intake and assessment centres, resulting in recommendations for future central intake reporting needs.

DIAGNOSTIC IMAGING WAIT TIMES AND MAGNETIC RESONANCE IMAGING (MRI) EFFICIENCY

ATC supports MOHLTC in increasing capacity and decreasing wait times, using the Wait Time Information System for magnetic resonance imaging (MRI) and computerized tomography (CT) services at more than 80 sites across Ontario. ATC continues to build on the foundation laid by Ontario's Wait Times Strategy by achieving reductions in, and monitoring of, provincial MRI/CT data.

2014/15 Highlights

- Public reporting is now available for independent health facility and pediatric diagnostic imaging wait time data on MOHLTC's public website (launched October 30, 2014, and November 27, 2014, respectively).
- An MRI capacity planning model was developed in collaboration with MOHLTC.
- A Diagnostic Imaging Efficiency Advisory Committee and a Local Health Integration Network (LHIN) engagement strategy were established. These will support the dissemination and coordination of guidance on provincial initiatives, projects and operations.

ALTERNATE LEVEL OF CARE

The Alternate Level of Care (ALC) initiative was established to identify patient flow obstacles in order to facilitate better resource allocation for hospitals and communities. ATC supports MOHLTC in the collection of ALC information, using the Wait Time Information System. Information is collected from 183 hospital sites across Ontario to measure and report the time patients wait for an alternate level of care.

2014/15 Highlights

- Analysis of the ALC long-wait case population was completed using information from the Wait Time Information System to identify predictors associated with wait times longer than 30 days.
- LHINs were supported in developing their understanding of the ALC information collected in the Wait Time Information System.
- Hospital benchmarking reports based on new ALC hospital groupings were created. These enable hospitals, LHINs and MOHLTC to support meaningful ALC performance comparisons between similar facilities.

EMERGENCY ROOM INFORMATION

The Emergency Room National Ambulatory Initiative was established to help measure and report how long patients were spending in emergency rooms (ERs). 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 in Ontario. Today, 126 sites collect a dataset of 38 ER data elements to capture the patient journey through the ER.

2014/15 Highlights

- The new ER hospital groupings were expanded to include different volume intervals and hospital characteristics to better identify opportunities for improvement.
- MOHLTC, with the support of ATC, motivated the right performance behaviours and justified funding decisions through the recognition of top-performing and most-improved hospitals based on ER length of stay.
- An ER reference manual was developed and distributed for hospital users to provide an overview of the patient journey, associated data elements and ATC's processes and reporting tools.

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 to ensure quality care for cardiac patients.

2014/15 Highlights

- The WTIS-CCN system was upgraded to include the ability to act as a vascular repository for data pertaining to aortic aneurysm repair, lower extremity repair and carotid artery repair.
- The WTIS-CCN system was modernized by providing functionality changes to improve its technical performance.

ACCESS TO CARE PROVINCIAL SUPPORT MODEL

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.

2014/15 Highlights

- An ongoing customer outreach program was formalized to provide a forum for education, dialogue and direct support to hospitals to identify opportunities for continuous improvement.
- Comprehensive business intelligence training for iPort™ Access was provided, enhancing user capability in accessing data reports.
- Education and support was provided to healthcare facilities to integrate Wait Time Information System Release 17 requirements into their operations.

ELECTRONIC CANADIAN TRIAGE AND ACUITY SCALE SUPPORT TOOL

Research has identified significant variation in how clinicians interpret and apply the Canadian Triage and Acuity Scale (CTAS) leveraged by clinicians to triage patients according to the urgency of their needs. On behalf of MOHLTC, ATC is establishing an intelligent decision support tool to apply the CTAS guidelines in a consistent and standardized manner to improve patient safety and access to care in emergency departments across Ontario.

2014/15 Highlights

- ATC was expanded to include a dedicated program team for effective execution of the new initiative.
- Program plans were established, including a supporting governance structure, communication plan and site visit engagement approach.

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 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, person-centred care, and that the organization's efforts remain true to the needs of every person in Ontario.

Quality Management Partnership

In March 2013, CCO was asked by the Ministry of Health and Long-Term Care (MOHLTC) to enter into the Quality Management Partnership with the College of Physicians and Surgeons of Ontario to develop provincial quality management programs for three selected health services: colonoscopy, pathology and mammography. The work of the partnership supports Ontario's *Patients First: Action Plan for Health Care* (2015) and its broad quality agenda that focuses on continuous improvement and transparency across the health system.

The goals of the partnership are to increase the quality of care and improve patient safety; increase consistency in the quality of care provided across the facilities; and improve public confidence by increasing accountability and transparency. The partnership is committed to working closely with the broader stakeholder community to align and leverage the substantial quality management activity already underway.

From March 2013 to March 2015, the partnership focused on conducting extensive stakeholder engagement activities, and developing and finalizing design recommendations for the provincial quality management programs. Moving forward, the partnership will begin implementation of these recommendations.

2014/15 Highlights

- Design recommendations were refined through continued work with the three expert advisory panels. The early quality initiatives and implementation planning began.
- The broader stakeholder community was engaged to build awareness and refine design recommendations through newsletters, webinars, surveys, presentations, consultations and a website.
- A phase two report for MOHLTC was developed and submitted. It included the design recommendations for the quality management programs for each health service area, a high-level implementation plan, an evaluation framework and a request for funding to implement the programs.

Health System Funding Reform

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

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

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

2014/15 Highlights

- The third-year implementation of the Chronic Kidney Disease QBP funding framework was completed. Funding was introduced for services for home care and long-term care home patients receiving peritoneal dialysis.
- The gastrointestinal endoscopy and systemic treatment QBPs were refined.
- Development for cancer surgery QBPs for prostate and colorectal cancers was completed. The development of cancer surgery QBPs was started for two additional cancers (breast and thyroid); the development of the colposcopy QBP continued.
- The development of a QBP Evaluation Framework started. This framework will help CCO and MOHLTC understand whether the funding models are achieving intended results, ensuring value for money, enhancing quality and monitoring unintended consequences. The intended goal for this framework will also include informing design and evaluation of new QBPs and funding models, as well as informing potential redesign of current QBPs.

Cancer Care Ontario

Ontario Cancer Plan III

2014/15 HIGHLIGHTS AND ACHIEVEMENTS

Since 2005, Cancer Care Ontario has created multi-year cancer plans for the province, each working progressively towards our vision of creating the best cancer system in the world. With our first two plans, we focused on building system capacity, reducing wait times and improving the quality of care.

The Ontario Cancer Plan III (OCP III), which covered the years 2011 to 2015, called for improvements in prevention, early detection, care closer to home and research-informed ways to manage growth in costs. Its impact came in delivering value for money, managing long-term cost growth, improving patient outcomes and increasing patient satisfaction.

Ontario Cancer Plan III
Report Cover

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.

OCP III Goals

1	2	3	4	5	6
Help Ontarians lessen their risk of developing cancer.	Reduce the impact of cancer through effective screening and early detection.	Ensure timely access to accurate diagnosis and safe, high-quality care.	Improve the patient experience along every step of the patient journey.	Improve the performance of Ontario's cancer system.	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 oriented
- Active engagement
- Value for money

Many of our prevention activities focused on developing tools, programs and resources to help Ontarians reduce their cancer risk

Strategic Priority 1

DEVELOP AND IMPLEMENT A FOCUSED APPROACH TO CANCER RISK REDUCTION

While there is still much to be learned about the causes of cancer, there is evidence that an individual's risk is affected by certain modifiable behaviours and exposures, such as tobacco use, alcohol consumption, physical inactivity and unhealthy eating. OCP III sought to reduce Ontarians' risk of cancer by developing and implementing a focused approach to prevention.

In 2014/15, our Population Health and Prevention program provided detailed analyses of the burden of and risk factors for several cancers and cancer subtypes to guide Cancer Care Ontario's planning for a range of diagnostic and treatment services. In addition, we developed a prevention strategy to support our work with key partners in reducing modifiable risk factors. This is supported by our 2015 Prevention System Quality Index, a prevention initiative measurement framework that serves as a resource for all partners who have a role in prevention.

Many of our prevention activities focused on developing tools, programs and resources to help Ontarians reduce their cancer risk, including an online cancer risk assessment tool and smoking cessation initiatives. Other initiatives addressed the unique cancer risks facing certain populations, such as Aboriginal communities and certain workers. We also undertook several research projects that will increase our understanding of cancer risk factors and strengthen our ability to develop effective prevention initiatives.

2014/15 Highlights

- **My CancerIQ launched**. This online cancer risk assessment tool will help motivate Ontarians to reduce their risk of developing cancer and increase their participation in cancer screening.
- All Regional Cancer Centres developed programs to screen ambulatory cancer patients for smoking status and refer smokers to **smoking cessations programs**.
- Two resources for prevention programming were produced: ***Cancer Risk Factors in Ontario: Alcohol*** and ***Cancer Risk Factors in Ontario: Healthy Weights, Healthy Eating, Active Living***. These reports provide information on the associations between cancer risk and alcohol consumption and obesity, respectively.
- Cancer Care Ontario signed relationship protocols with the Ontario Indigenous Friendship Centres, Nishnawbe Aski Nation, Big Trout Lake First Nation and the Métis Nation Ontario, as part of the ***Aboriginal Cancer Strategy II***. These protocols outline how we will work together to address increasing cancer incidence and mortality rates among the province's First Nations, Inuit and Métis communities in a way that honours the Aboriginal path to well-being. In additional, regional Aboriginal cancer plans were developed and Aboriginal-specific fact sheets about breast, cervical and colorectal screening programs were released.
- The **Occupational Cancer Research Centre** core funding from the Ministry of Labour and the Canadian Cancer Society (Ontario Division) was renewed, and a new five-year strategic plan was adopted. This centre is dedicated solely to the study of cancers caused by exposure to potentially harmful substances in the workplace.

- **Sun safety policies** and programs for outdoor workplaces were developed in partnership with Ryerson University.

- The **Ontario Uranium Miners Study** was updated and submitted to the Canadian Nuclear Safety Commission. A pilot occupational cancer surveillance program was also completed.

- A **chronic disease prevention workshop** was conducted with Canada-wide experts to develop recommendations for survivor preventive intervention research.

- **Research** was undertaken to examine geographical variations related to the time intervals from symptom onset to diagnosis and treatment of cancer; this work is part of the multi-year International Cancer Benchmarking Partnership.

- **Research grants** were received from Canadian granting agencies that will allow Cancer Care Ontario to work in partnership with other Canadian cancer scientists on studies examining spatial patterns of cancer incidence, modifiable lifestyle factors in breast cancer survival, and possible cancer risks associated with agricultural pesticide exposures.

- Input was provided into Bill 45, the Making Healthier Choices Act, which was introduced into reading in 2014 and is comprised of the Healthy Menu Choices Act, 2014; the Electronic Cigarettes Act, 2014; and amendments to the Smoke-Free Ontario Act. This work builds upon **evidence-informed recommendations** in the *Taking Action to Prevent Chronic Disease* report from Public Health Ontario and Cancer Care Ontario.

Strategic Priority 2

IMPLEMENT INTEGRATED CANCER SCREENING

Cancer screening programs allow cancer to be found at an earlier, more treatable stage (or even prevented in some cases). In order to increase early detection and facilitate the effective treatment of cancer, OCP III called for the implementation of an integrated cancer screening strategy. The resulting Cancer Screening Program oversees the delivery of cancer screening for colon, breast and cervical cancers. This single integrated strategy offers patients and primary care providers a consistent and coordinated cancer screening experience.

Our recent efforts have focused on increasing cancer screening participation, improving primary care provider performance in screening, and reducing variations in screening quality.

2014/15 Highlights

- The **Screening Activity Report** (SAR) was expanded to identify all patients of Patient Enrolment Model physicians needing screening and followup for breast, cervical and colorectal cancers. This report promotes increased screening participation by providing physicians with their relative screening performance and helping them understand and manage their patients' screening activity and appropriate followup.

- The **GI Endoscopy Quality-Based Procedure** was implemented as part of the Ministry of Health and Long-Term Care's (MOHLTC's) Health System Funding Reform in order to increase the quality of gastrointestinal endoscopy services in Ontario. Cancer Care Ontario collaborated with MOHLTC and the College of Physicians and Surgeons of Ontario to establish the foundation to fund community clinics that provide eligible gastrointestinal endoscopy services.

- The ***Registered Nurse-Performed Flexible Sigmoidoscopy 2013 Implementation and Outcomes of the Ontario Pilot Project Report*** was disseminated to provincial and regional stakeholders. This pilot transitioned to an active project, thus promoting operational excellence and program stability in RN-performed flexible sigmoidoscopy.

Strategic Priority 3

CONTINUE TO IMPROVE PATIENT OUTCOMES THROUGH ACCESSIBLE, SAFE AND HIGH-QUALITY CARE

With OCP III, Cancer Care Ontario continued to focus on providing accessible, safe and high-quality care with the goal of improving patient outcomes. Many Cancer Care Ontario programs and initiatives address the various aspects of this wide-ranging strategic priority, which touches on all phases of the cancer care continuum.

To unify our approach to setting priorities and improving the quality of cancer care, Cancer Care Ontario developed Disease Pathway Management. This more person-centred (e.g., for patients with breast cancer or prostate cancer) view applies a framework for examining the performance of the entire system across the cancer care continuum and identifies any gaps within the system along the way.

A coordinated approach to improving patient outcomes is also reflected in the regional Diagnostic Assessment Programs (DAPs). DAPs rely on multidisciplinary healthcare teams to manage and coordinate the entire process of a person's diagnostic care, from testing to a definitive diagnosis or rule-out of cancer. Similarly, multidisciplinary cancer conferences (MCCs) bring together clinicians from various fields to discuss and identify diagnostic tests and treatments for individuals with cancer.

Safe and timely access to high-quality services—including radiation, systemic treatment, surgery, imaging and pathology reporting—is also critical to improving patient outcomes. Cancer Care Ontario continues to take steps to reduce wait times, improve access and increase safety in the use of systemic treatment. The peer-review quality assurance program helps increase the quality of radiation treatment delivered provincewide. Cancer Care Ontario also provides oversight (including planning and quality management) of specialized services, such as stem cell transplants, Positron Emission Tomography (PET) and acute leukemia and sarcoma services.

2014/15 Highlights

- The **clinical leadership model** was enhanced by adding disease site–based leaders to strengthen Cancer Care Ontario's accountability, ensuring that issues and gaps are identified and prioritized for specific cancers.

- Patient pathways that lay out the evidence-based best practice for **breast, cervical and ovarian cancer pathways** were developed.

- ***Navigating the Diagnostic Phase of Cancer: Ontario's Strategic Directions 2014-2018*** was launched. This plan sets the foundation to optimize the diagnostic phase of care by improving quality and accessibility of care for patients, advancing a person-centred approach, driving integrated-care delivery among services and providers, and maximizing the value of care delivered.

- The ***Lung Cancer Tissue Pathway*** was published, providing an overview of the clinical work-up and diagnostic process involved in the diagnosis of lung cancer.

- Ontario hospitals implemented or improved MCCs, which have been shown to improve patient outcomes. This past year, approximately 38,000 patients were the focus of multidisciplinary discussions, which is approximately half of all patients newly diagnosed with cancer. In 2014/15, 79% of hospitals met the minimum MCC quality criteria (i.e., to treat more than 35 unique patients with a given cancer each year), surpassing the annual compliance target of 75%. This is up from 72% in 2013/14, 56% in 2012/13 and 44% in 2011/12.

- **Wait times for referral, surgery and radiation treatment improved**, despite the increasing incidence and prevalence of cancer and the growing demand for cancer services:

    - The referral-to-consult interval improved by 2.8%: from April 2014–March 2015, 85.2 % of patients saw a radiation oncologist within 14 days of referral, compared to 82.9% of patients seen within the target in the previous year (April 2013–March 2014).
    - The ready-to-treat to start-of-radiation treatment interval improved by 1.9%: from April 2014–March 2015, 91.3% of patients were treated within the one-, seven- and 14-day targets, compared to 89.6% of patients in the previous year. This improvement was seen despite the deployment of a new higher-complexity treatment technique.
    - 81% of patients had a surgical consult within the 10-, 21- and 35-day targets.
    - 85% of cancer surgeries were completed within their 14-, 28- and 84-day targets, compared to 85% in 2013/14, 82% in 2012/13 and 79% in 2011/12.

  - 76% of patients were seen by a medical oncologist within 14 days of referral in 2014/15, compared to 72% in 2013/14.
  - 71% of patients received their first chemotherapy treatment within 28 days of consultation.

- Cancer Care Ontario, MOHLTC, the pan-Canadian Oncology Drug Review and the pan-Canadian Brand Drug Pricing Alliance worked closely to provide input on the national drug review process and to secure cost-effective drug product listing agreements. This resulted in the **funding of 10 different cancer indications** for Ontario.

- The **Case-by-Case Review Program** enabled approximately 60 patients with cancer who have rare, immediately life-threatening circumstances to receive treatments with drugs that would otherwise be unfunded.

- The **Evidence Building Program** facilitated funding for 345 patients while collecting real-world data on each medication's clinical and cost-effectiveness.

- The CCO **Out-of-Country Program** was launched to assist the ministry with the review applications for prior approval of funding for medically necessary and generally accepted out-of-country cancer services that are either not performed in Ontario, or cannot be obtained in Ontario without a significant medical delay.

- The *Quality Person-Centred Systemic Treatment in Ontario:* ***Systemic Treatment Provincial Plan*** *2014–2019* was launched, a plan intended to drive the highest-quality evidence-based systemic treatment available to Ontarians as close to home as possible.

- Timely, safe and high-quality **acute leukemia care** was promoted through the implementation of a new service delivery model in the Greater Toronto Area.

- A **provincial sarcoma services plan** was implemented, promoting equitable access to the best-quality services, tailored to the individual needs of patients.

- A framework for the delivery and organization of **focal tumour ablation services** was developed, with a focus on access and quality.

- The quality, safety and effectiveness of radiation treatment improved under a new **peer-review quality assurance program**.

- Equitable access to quality tools for the delivery of radiation treatment across Ontario was managed through the **Radiation Equipment Replacement Grant** process. New radiation treatment units in Southlake and Grand River were approved, which will provide treatment to more than 800 additional patients each year.

Cancer Care Ontario continues to take steps to reduce wait times, improve access and increase safety in the use of systemic treatment

Strategic Priority 4

CONTINUE TO ASSESS AND IMPROVE THE PATIENT EXPERIENCE

In order to create the best cancer system in the world, Cancer Care Ontario recognizes that patients must have more control over their own care. Through OCP III, a commitment was made to measure the patient experience along every step of the cancer care continuum and more fully involve patients and their families in the design, delivery and evaluation of the cancer system.

We are engaging patients as never before. We asked for their perspectives about their treatments and symptoms, the challenges and barriers they face in accessing cancer services, and how the system can better address their physical, emotional and educational needs. Their input was instrumental in the development and validation of new resources that will result in better management of symptoms, better health-related quality of life and enhanced satisfaction. Tools have also been developed to help healthcare providers communicate effectively with patients, and to encourage patients to become more active partners in the management of their care.

2014/15 Highlights

- **Patient surveys** were developed and/or completed to gather information about a range of experiences, including the provision and quality of education for people with cancer and their families in all 14 Regional Cancer Programs; patient experience during treatment and survivorship; the patient and caregiver experience at end of life; and patient satisfaction with ambulatory oncology. The results of these surveys will be used to identify opportunities for quality improvement.
- Data on **wait times for psychosocial oncology services** was collected across the province, with the goal of improving timely access to these services to meet patient needs.
- There has been a steady increase in **screening for cancer symptoms**: 576,901 screens in 2014/15, compared to 544,662 in 2013/14. When patients are given the opportunity to self-identify their symptom needs, it improves the information on which health professionals make decisions and enhances patients' engagement with decisions.
- The first new **patient-reported outcome measure (Patient-Reported Functional Status) was added to ISAAC**, the interactive symptom assessment and collection tool that allows patients to self-report their symptoms. This rating helps clinicians better understand how patients are physically functioning, providing additional information to guide care. As of March 31, 2015, ISAAC was used by more than 37,000 patients each month.
- Patient-reported outcome measures related to **prostate cancer** were implemented.
- Tools were developed to measure the **experiences of cancer survivors** and ensure that they have access to appropriate care and information. Primary care providers were engaged to improve transition of patients to cancer centres upon suspicion of recurrence of cancer.
- Communication between patients and healthcare providers improved with upgrades to the **Diagnostic Assessment Program–Electronic Pathway Solution** (DAP-EPS). New features to this innovative web service mean better usability, security and access, providing real-time access to diagnostic information, appointments and patient education materials. Patients can even invite family and friends to follow their progress.
- Patients in First Nations, Inuit and Métis communities received guidance in moving through the cancer system from **Aboriginal patient navigators** who were recruited in all of the 10 priority regions. Aboriginal cancer leads were also recruited in nine of the 10 priority regions.
- Patient-friendly **symptom management guides** were created, providing patients with information on how to better manage their cancer-related symptoms.

- Through the **Maximizing your Patient Education Skills** course, cancer care providers learned to identify their patients' learning styles and adjust their delivery of information based on this knowledge.

- An online tool kit promoting **primary-level palliative care** was developed, a provincial set of performance indicators for palliative care in Ontario was developed, and a wait time indicator for access to outpatient palliative services in cancer centres was added to the regional score card.

- A person-centred care clinical practice guideline for **adult oncology services** in Ontario was developed and will be implemented in 2015/16.

- Evidence-based guidelines were developed on **exercise interventions** for patients with cancer and the **management of depression** in adults with cancer. Both guidelines will provide recommendations for cancer centres and practitioners on how to better provide whole-person care.

- Cancer Care Ontario and the Ontario Renal Network hosted **a patient and family advisor summit** with more than 180 participants from across the province to co-design a provincial plan for knowledge translation and quality improvement with respect to the patient experience.

Strategic Priority 5

DEVELOP AND IMPLEMENT INNOVATIVE MODELS OF CARE

Ontario's growing and aging population is driving an 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 Cancer Care Ontario receive even greater performance and value from every healthcare dollar spent by optimizing the use of health human resources (HHR) and healthcare settings. OCP III called for the development of new models of care that will make the best use of the skills and expertise of cancer care professionals and address funding, incentives and remuneration issues. Cancer Care Ontario's Models of Care Program aims to change how Ontario provides and pays for care, engages patients, and reliably plans for the HHR needed in the future.

2014/15 Highlights

- An **evaluation framework** was developed and measurement began on the impact of new models of followup for patients with cancer once they are well on the cost of care and oncologist workload. The impact of new models was used to adjust the planning of future requirements for medical and radiation oncologists in the HHR plan.

- An initiative was launched to identify and implement new **ambulatory models of care** in active treatment that optimize the nursing scope of practice.

- The first iteration of the **gynecologic oncology HHR planning model** was used to inform the request to MOHLTC for additional oncologist positions.

- An evidence-based guideline on the effective use of **Advanced Practice Nurses** in cancer control was completed and a knowledge translation strategy is being developed to facilitate uptake of the recommendations in the cancer centres.

- Seven additional **clinical specialist radiation therapist positions**—an advanced-practice radiation treatment role—were implemented, bringing the provincial total to 23 active positions in 2014/15 (with one additional position on maternity leave) and further improving Ontarians' access to safe, high-quality radiation treatment.

Strategic Priority 6

EXPAND OUR EFFORT IN PERSONALIZED MEDICINE
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—an area of personalized medicine—is the study of the 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.

While personalized medicine holds the potential to dramatically improve the diagnosis and treatment of cancer, it is still in the relatively early stages of development. As a strategic priority of OCP III, Cancer Care Ontario has been working to ensure that personalized medicine is introduced in accordance with best clinical evidence and value for money.

2014/15 Highlights

- New electronic cancer checklist **biomarker templates** were introduced. These templates by the College of American Pathologists will improve data collection for genetic tests funded by Cancer Care Ontario.
- Two **genetic tests** (anaplastic lymphoma kinase and epidermal growth factor receptor) were added to those for which Cancer Care Ontario provides funding and oversight.
- The **Personalized Medicine Steering Committee** was formed and began development of a provincial strategy for Personalized Medicine.

Cancer Care Ontario has been working to ensure that personalized medicine is introduced in accordance with best clinical evidence and value for money

Looking Ahead: Ontario Cancer Plan IV 2015–2019

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

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

Stemming from extensive environmental scanning and consultation, six key themes emerged and have become the goals of OCP IV. These goals focus on:

- Quality of life and patient experience
- Safety
- Equity
- Integrated care
- Sustainability
- Effectiveness

The identified goals cut across the cancer care continuum so that no matter what stage a person is at with regards to prevention, screening, diagnosis, treatment, recovery, survivorship or end-of-life, their needs will be addressed by the goals and initiatives of this plan. The goals are supported by strategic objectives and several initiatives that are included in the implementation plan. To support the newly released OCP IV, Cancer Care Ontario is developing a robust measurement and evaluation strategy to track progress against the plan and support our vision of creating the best cancer system in the world.

Ontario Cancer Plan IV Report Cover

Vision

Working together to create the best health systems in the world.

Mission

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

OCP IV Goals

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

Strategic Objectives

Initiatives

Guiding Principles

- The people of Ontario are at the core of everything we do and every decision we make.
- We will be transparent in sharing performance-related information, and foster a culture of open communication with colleagues, partners and the public.
- 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.

The goals are supported by strategic objectives and several initiatives that are included in the implementation plan

Goal

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

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

Goal

ENSURE THE SAFETY OF PATIENTS AND CAREGIVERS IN ALL CARE SETTINGS

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

Goal

ENSURE HEALTH EQUITY FOR ALL ONTARIANS ACROSS THE CANCER SYSTEM

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

Goal

ENSURE THE DELIVERY OF INTEGRATED CARE ACROSS THE CANCER CARE CONTINUUM

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

Goal

ENSURE A SUSTAINABLE CANCER SYSTEM FOR FUTURE GENERATIONS

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

Goal

ENSURE THE PROVISION OF EFFECTIVE CANCER CARE BASED ON BEST EVIDENCE

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

CCO Ontario Renal Network

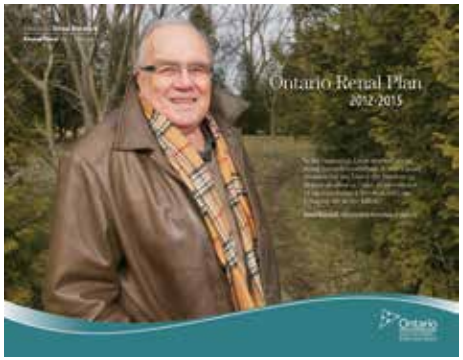
Ontario Renal Plan

The prevalence of chronic kidney disease (CKD) has been gradually rising for more than a decade and is expected to continue climbing in the foreseeable future. This trend is largely driven by changing demographics and the increasing prevalence of risk factors associated with CKD (e.g., aging, diabetes, hypertension). As the government's CKD advisor, the Ontario Renal Network provides leadership and strategic direction to effectively organize, manage and fund the delivery of kidney care services in Ontario in a consistent and coordinated manner. The Ontario Renal Network consists of a large array of partners who work collaboratively to achieve a common goal of creating a safe, sustainable, efficient and effective kidney care system in Ontario.

This past year, the Ontario Renal Network completed the province's first comprehensive strategy, the Ontario Renal Plan 2012-2015 (ORP I). This first plan outlined a set of strategic priorities to improve the quality of care and treatment for current and future patients with CKD. Working together with our partners on these priorities, we established a solid foundation on which to build future improvements.

Ontario Renal Plan, 2012–2015

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



Ontario Renal Plan I
Report Cover

Our Core Values

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

Vision

Working together to improve the life of every person with kidney disease

Mission

By 2015, the Ontario Renal Network will:

- fund patient-based care to drive equity and access to CKD care across Ontario;
- support excellent evidence based CKD patient care across Ontario; and
- enable leading CKD knowledge generation, research and innovation.

Strategic Priorities

The plan outlines several priorities designed to simultaneously improve health, increase system accountability and provide value for money

Enablers

- Regional Leadership
- Performance Improvement Cycle
- Data Management, Analysis and Reporting
- Information Technology
- Research and Innovation

1	2	3	4	5	6	7
Strengthen accountability to patients.	Reduce the impact of CKD by improving early detection and prevention of progresstion.	Improve peritoneal and vascular access for dialysis patients.	Improve uptake of independent dialysis.	Ensure Ontario has the necessary infrastructure to care for CKD patients.	Strengthen Ontario CKD care through research and innovation.	Align funding to quality patient-focused care.

Strategic Priority

STRENGTHEN ACCOUNTABILITY TO PATIENTS

As a priority of ORP I, we sought to increase patient engagement with their healthcare providers and the kidney care system. After assessing the current state of patient and family engagement within renal programs across Ontario, we worked with our partners to set new expectations. All Regional Renal Programs now have a comprehensive plan for how to advance person-centred care through engagement with patients and families within their programs. New resources to support patient involvement have also been developed.

2014/15 Highlights

- Patients, their families and caregivers were involved as key partners in a variety of Ontario Renal Network activities, including strategic planning, development of educational materials, and CKD research projects.
- A library of patient and provider educational materials was established and is available on the web and in print.
- In partnership with patients and families, a training video for healthcare providers on decision coaching and navigating decisional conflict was developed. This project was undertaken with support from The Ottawa Hospital and a grant from the Canadian Foundation for Healthcare Improvement.

Strategic Priority

REDUCE THE IMPACT OF CKD BY IMPROVING EARLY DETECTION AND PREVENTION OF PROGRESSION

Early detection and management of CKD increases the likelihood that kidney function can be preserved and progression of the disease delayed. To improve early detection and management of CKD, the Ontario Renal Network is developing new clinical tools for primary care providers.

2014/15 Highlights

- The primary care providers' KidneyWise Clinical Toolkit, which includes a CKD clinical algorithm (an evidence summary and an outpatient nephrology referral form), was developed in both an application and paper format. This resource provides guidance to primary care providers on which patients are at high risk of developing CKD, and recommendations on how to properly diagnose and best manage the patient to reduce the risk for further disease progression.

Strategic Priority

IMPROVE PERITONEAL AND VASCULAR ACCESS FOR DIALYSIS PATIENTS

Initiatives to reduce barriers to peritoneal dialysis and hemodialysis access through Regional CKD Program engagement, evaluation, reporting and collaboration were developed.

A pilot project was launched to study regional centres of practice as a model of care to help ensure patients have timely access to the creation of body access for both hemodialysis and peritoneal dialysis.

2014/15 Highlights

- A standardized cannulation education program for renal nurses in Ontario was developed to help improve outcomes for patients and lead to an increase in patients' willingness to have an arteriovenous (AV) fistula or AV graft created.
- The Interventional Radiology Wait Times Initiative (for hemodialysis) was implemented to measure, and report on, access to interventional radiology for vascular access-related procedures.

Strategic Priority

IMPROVE UPTAKE OF INDEPENDENT DIALYSIS

Independent dialysis includes both peritoneal and home hemodialysis in the patient's place of residence. With these dialysis modality options available in the home, patients can choose to dialyze longer and more frequently, an option that has been shown to provide the best clinical outcomes at home, while reducing the use of costly in-facility-based dialysis.

2014/15 Highlights

- The prevalent home dialysis rate continued to improve, with an additional 117 patients receiving care at home in the 2014/15 fiscal year, compared to the same period of time in 2013/14.
- A study was launched into the feasibility of implementing the personal support worker-assisted home hemodialysis model on a large scale and across multiple hospital sites.

Strategic Priority

ENSURE ONTARIO HAS THE NECESSARY INFRASTRUCTURE TO CARE FOR CKD PATIENTS

The Ontario Renal Network's mandate is to ensure our kidney care system has the resources required to meet the province's growing demands for CKD care. As part of our work under ORP I, we have been improving processes to monitor and forecast CKD system resource requirements across Ontario.

2014/15 Highlights

- A capacity planning tool was refined, improving the ability to forecast patient numbers and hemodialysis station requirements across the province. The tool allows the Ontario Renal Network to identify capacity shortages and make transparent, evidence-based investments to ensure the necessary resources and infrastructure for kidney care are available.
- Ontario's CKD infrastructure needs were funded by investing in 28 new in-facility hemodialysis stations, 41 new home hemodialysis machines and 137 replacement hemodialysis machines.

The Ontario Renal Network's mandate is to ensure our kidney care system has the resources required to meet the province's growing demands for CKD care

Strategic Priority

STRENGTHEN ONTARIO'S CKD CARE THROUGH RESEARCH AND INNOVATION

The Ontario Renal Network focused on collaboration with research institutions to translate research into innovation in the field, and made both direct and indirect contributions towards ORP priorities.

2014/15 Highlights

- Policy and planning was informed through research partnerships with the Institute for Clinical Evaluative Sciences (ICES), Toronto Health Economics and Technology Assessment (THETA) and the Ivey Centre for Health Innovation.
- Participation in the Dialysis Outcomes and Practice Patterns Study (DOPPS) was expanded to 20 facilities in Ontario. Field studies were initiated to examine the use of Personal Service Workers (PSWs) for home hemodialysis and the use of bedside ultrasound to improve cannulation.
- Initiatives focused on improving CKD management by primary care were evaluated.

Strategic Priority

ALIGN FUNDING TO HIGH-QUALITY PATIENT-FOCUSED FUNDING

As part of the provincial government's Health System Funding Reform, the Chronic Kidney Disease Patient-Based Funding Framework was implemented in all hospital CKD programs beginning in 2012/13. This funding framework promotes person-centred and evidence-based care, links funding to patients and best care practices, and ensures funding equity across service providers. Recent work expanded this funding framework.

2014/15 Highlights

- The CKD patient-based funding framework expanded to incorporate funding for assisted peritoneal services provided by Community Care Access Centres and in long-term care homes. This expanded framework increases the opportunity for patients to receive care at home or in the long-term care home where they live.

Looking Ahead: Ontario Renal Plan 2015–2019

In 2015, the Ontario Renal Network will launch its second provincial kidney care strategy, Ontario Renal Plan II (ORP II). This strategy will build on the foundational achievements, experiences and lessons of the first plan. The development of ORP II relied on extensive collaboration and meaningful consultation with key stakeholders, including healthcare professionals, Regional Renal Program administrators, regional and provincial partners, and, for the first time, people with CKD and their families. These consultations outlined several key themes that became the basis of the three goals identified in the new plan.

Ontario Renal Plan II
Report Cover

Vision

Working together to create the best health systems in the world.

Mission

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

ORP II Goals

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

Strategic Objectives

Initiatives

Guiding Principles

- The people of Ontario will be at the core of everything we do and every decision we make.
- We will be transparent in sharing performance-related information, and foster a culture of open communication with colleagues, partners and the public.
- 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.

Better integration of care means that patients will experience well-organized care from a multidisciplinary team

ORP II Goal

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

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

ORP II Goal

INTEGRATE PATIENT CARE THROUGHOUT THE KIDNEY CARE JOURNEY

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

ORP II Goal

IMPROVE PATIENTS' ACCESS TO CARE

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

Financial Statements
2014/15

Cancer Care Ontario
Action Cancer Ontario

620 University Avenue, Toronto ON, M5G 2L7
tel: 416.971.9800 **fax:** 416.971.6888 www.cancercare.on.ca

June 18, 2015

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, 2015, 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

Ontario
Cancer Care Ontario
Action Cancer Ontario

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

Independent Auditor's Report

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

I have audited the accompanying financial statements of Cancer Care Ontario, which comprise the statement of financial position as at March 31, 2015 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.

Box 105, 15th Floor
20 Dundas Street West
Toronto, Ontario
M5G 2C2
416-327-2381
fax 416-326-3812

B.P. 105, 15e étage
20, rue Dundas ouest
Toronto (Ontario)
M5G 2C2
416-327-2381
télécopieur 416-326-3812

www.auditor.on.ca

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of Cancer Care Ontario as at March 31, 2015 and the results of its operations, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Toronto, Ontario
June 18, 2015

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

Cancer Care Ontario

Financial Statements
March 31, 2015

Cancer Care Ontario

Statement of Financial Position
As at March 31, 2015

(in thousands of dollars)

	2015 $	2014 $
Assets		
Current assets		
Cash and cash equivalents (note 3)	73,769	75,124
Investments (note 4)	95,388	93,962
Receivables and prepaid expenses (note 5)	10,932	31,171
	180,089	200,257
Capital assets (note 6)	6,825	152,437
	186,914	352,694
Liabilities		
Current liabilities		
Accounts payable and accrued liabilities (note 7)	126,813	144,931
Non-current liabilities		
Deferred contributions related to capital assets (note 8)	6,049	153,393
Post-employment benefits other than pension plan (note 9(b))	2,438	2,371
	8,487	155,764
Fund Balances		
Endowment (note 2)	1,088	1,288
Internally restricted (note 2)	670	1,012
Externally restricted (note 2)	1,731	1,749
General - unrestricted (note 2)	45,097	44,666
Invested in capital assets (note 10)	3,028	3,284
	51,614	51,999
	186,914	352,694

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, 2015

(in thousands of dollars)

	Restricted		General		Total	
	2015 $	2014 $	2015 $	2014 $	2015 $	2014 $
Revenue						
Ministry of Health and Long-Term Care	-	-	1,720,943	1,479,491	1,720,943	1,479,491
Ministry of Health and Long-Term Care capital funding for Integrated Cancer Programs	-	-	33,181	7,569	33,181	7,569
Amortization of deferred contributions related to capital assets (note 8)	-	-	13,476	39,115	13,476	39,115
Other revenue (note 12)	2,665	1,915	4,567	5,634	7,232	7,549
Investment income (note 11)	17	18	2,584	2,730	2,601	2,748
	2,682	1,933	1,774,751	1,534,539	1,777,433	1,536,472
Expenses						
Chronic kidney disease services	-	-	612,557	577,497	612,557	577,497
Cancer and prevention related services	8	32	507,768	444,624	507,776	444,656
Provincial drug reimbursement program	-	-	319,171	280,682	319,171	280,682
Screening services	-	-	147,993	48,132	147,993	48,132
Salaries and benefits (note 9)	2,003	1,902	98,329	86,524	100,332	88,426
Capital contributions to cancer related services	-	-	32,904	12,897	32,904	12,897
Other operating expenses (note 13)	190	328	28,113	22,688	28,303	23,016
Amortization of capital assets	-	-	15,364	41,064	15,364	41,064
Purchased services	985	858	9,015	10,667	10,000	11,525
Clinical translational research	-	-	3,344	4,102	3,344	4,102
Net loss on disposal of capital assets	-	-	74	415	74	415
	3,186	3,120	1,774,632	1,529,292	1,777,818	1,532,412
Excess (deficiency) of revenue over expenses	(504)	(1,187)	119	5,247	(385)	4,060

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, 2015

(in thousands of dollars)

	Restricted						
						2015	2014
	Endowment $	Internally $	Externally $	General unrestricted $	Invested in capital assets $	Total $	Total $
Fund balances - March 31, 2014	1,288	1,012	1,749	44,666	3,284	51,999	47,939
Excess (deficiency) of revenue over expenses	(200)	(282)	(22)	119	-	(385)	4,060
Net change in invested in capital assets (note 10)	-	-	-	256	(256)	-	-
Interfund transfers (note 14)	-	(60)	4	56	-	-	-
Fund balances - March 31, 2015	1,088	670	1,731	45,097	3,028	51,614	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, 2015

(in thousands of dollars)

	2015 $	2014 $
Cash provided by (used in)		
Operating activities		
Excess (deficiency) of revenue over expenses	(385)	4,060
Amortization of capital assets	15,364	41,064
Amortization of deferred contributions related to capital assets	(13,476)	(39,115)
Net loss on disposal of capital assets	74	415
Post-employment benefits expense other than pension plan	243	221
Post-employment benefits paid other than pension plan	(176)	(230)
Change in non-cash operating working capital		
Receivables and prepaid expenses	20,239	23,818
Accounts payable and accrued liabilities	(18,118)	(44,693)
	3,765	(14,460)
Capital activities		
Purchase of capital assets	(6,517)	(33,857)
Proceeds on disposal of capital assets	-	88
	(6,517)	(33,769)
Investing activities		
Proceeds from maturity of investments	93,078	102,096
Purchase of investments	(94,504)	(93,137)
	(1,426)	8,959
Financing activities		
Amounts received related to capital assets	2,823	23,230
Decrease in cash and cash equivalents during the year	(1,355)	(16,040)
Cash and cash equivalents - Beginning of year	75,124	91,164
Cash and cash equivalents - End of year	73,769	75,124

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

Cancer Care Ontario

Notes to Financial Statements

March 31, 2015

(in thousands of dollars)

1 Nature of operations

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

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

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

The Organization is primarily funded by the Province of Ontario through the Ministry of Health and Long-Term Care (MOHLTC). The Organization and the MOHLTC entered into a Memorandum of Understanding (MOU), effective December 2, 2009. It is mandated by the Agencies and Appointments Directive for all agencies to have a MOU as a mode of operation with the MOHLTC.

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

2 Significant accounting policies

Basis of presentation

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

Fund accounting

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

(in thousands of dollars)

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

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

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

Contributions

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

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

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

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

Cash and cash equivalents

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

Financial instruments

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

Cancer Care Ontario
Notes to Financial Statements
March 31, 2015

(in thousands of dollars)

Capital assets

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

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

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

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

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

Expenses

Expenses are recorded on an accrual basis.

Pension benefits and post-employment benefits other than pension plan

i) Pension costs

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

ii) Post-employment benefits other than pension plan

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

(in thousands of dollars)

Use of estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Items subject to such estimates and assumptions include 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 $417 (2014 - $416), 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

	2015 $	2014 $
Guaranteed investment certificates		
Interest at 1.85%, maturing September 5, 2015	23,870	-
Interest at 1.77%, redeemable on demand, maturing March 17, 2016	20,191	-
Interest at 1.80%, redeemable on demand, maturing September 5, 2015	10,103	-
Interest at 1.80%, redeemable on demand, maturing September 5, 2015	10,103	-
Interest at 1.90%, maturing October 2, 2015	10,636	-
Interest at 1.89%, maturing November 3, 2015	10,261	-
Interest at 1.90%, maturing January 7, 2016	10,224	-
Interest at 1.95%, maturing September 5, 2014	-	43,259
Interest at 1.70%, redeemed on May 7, 2014	-	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
	95,388	93,962

5 Receivables and prepaid expenses

	2015 $	2014 $
Accounts receivable	7,990	13,138
Due from MOHLTC	1,140	16,100
Prepaid expenses	1,802	1,933
	10,932	31,171

Cancer Care Ontario
Notes to Financial Statements
March 31, 2015

(in thousands of dollars)

6 Capital assets

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

	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 buildings	1	-	1
Software	51,352	35,603	15,749
	370,434	217,997	152,437

During the 2014/15 fiscal year, the Organization transferred ownership of the radiation treatment equipment and related software to the Integrated Cancer Program (ICP) Hospitals, where the equipment had been installed. The equipment was fully funded through a deferred capital grant, and thus the transfer of ownership was completed at net book value, with no proceeds being exchanged on transfer, resulting in no gain or loss being recorded by the Organization. The equipment had a cost of $326,889, and $190,198 in accumulated amortization at the time of transfer.

The cost of capital assets includes software under development of $746 (2014 - $997) and deposits for equipment and leasehold improvements of $766 (2014 - $24,281). Amortization of these amounts will commence when the asset is available for use.

(in thousands of dollars)

7 Accounts payable and accrued liabilities

	2015 $	2014 $
Trade payables	50,102	69,182
Accrued liabilities	68,160	53,724
Payable to MOHLTC	8,134	21,609
Pension escrow (note 3)	417	416
	126,813	144,931

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:

	2015 $	2014 $
Balance - beginning of year	153,393	169,278
Amounts received related to capital assets	2,823	23,230
Amounts transferred to hospitals	(136,691)	-
Amounts recognized as revenue	(13,476)	(39,115)
Balance - end of year	6,049	153,393

The amounts transferred to hospitals relate to the transfer in ownerships of the radiation treatment equipment (note 6).

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

	2015 $	2014 $
Unamortized capital contributions used to purchase capital assets	3,797	149,153
Unspent contributions	2,252	4,240
	6,049	153,393

Cancer Care Ontario
Notes to Financial Statements
March 31, 2015

(in thousands of dollars)

9 Pension benefits and post-employment benefits

a) Pension plan

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

Contributions to HOOPP made during the year by the Organization on behalf of its employees amounted to $7,264 (2014 - $6,403) 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 $176 (2014 - $230). The actuarial valuation for the post-employment benefits other than pension plan is dated April 1, 2013 and has been extrapolated to March 31, 2015.

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

	2015 $	2014 $
Accrued benefit obligation	3,635	3,388
Unamortized actuarial losses	(1,197)	(1,017)
Post-employment benefits other than pension plan	2,438	2,371

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

	2015 $	2014 $
Post-employment benefits other than pension plan - April 1, 2014	2,371	2,380
Expense related to post-retirement benefits	243	221
Funding contributions	(176)	(230)
Post-employment benefits other than pension plan - March 31, 2015	2,438	2,371

(in thousands of dollars)

	2015 $	2014 $
Interest cost	144	122
Amortization of experience losses	99	99
Total benefit expense	243	221

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:

	2015	2014
Discount rate	3.31%	4.36%
Drug cost trend rate	7.0% in 2015 to 5% in 2018 and after	7.5% in 2014 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)	10.22	11.22

10 Invested in capital assets

	2015 $	2014 $
Capital assets	6,825	152,437
Amounts financed by deferred capital contributions (note 8)	(3,797)	(149,153)
	3,028	3,284

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

	2015 $	2014 $
Purchase of capital assets	6,517	33,857
Capital funding	(4,811)	(33,210)
Amortization of deferred contributions related to capital assets	13,476	39,115
Amortization of capital assets	(15,364)	(41,064)
Net book value of equipment transferred to hospitals	(136,691)	-
Deferred contributions transferred to hospitals	136,691	-
Disposal of capital assets	(74)	(503)
	(256)	(1,805)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2015

(in thousands of dollars)

11 Net investment income

Net investment income earned on the Endowment Fund resources in the amount of $17 (2014 - $18) is included in the Restricted Fund.

12 Other revenue

	2015 $	2014 $
General Fund		
Public Health Ontario	2,351	2,366
Canadian Partnership Against Cancer	1,056	95
Salary recovery	163	131
eHealth Ontario	3	1,355
Other income	994	1,687
	4,567	5,634
Restricted Fund		
Grants	2,665	1,915

13 Other operating expenses

	2015 $	2014 $
Restricted Fund		
Travel	80	119
Education and publications	35	71
General office	32	61
Equipment	31	49
Consulting services	12	27
Other expenses	-	1
	190	328
General Fund		
Equipment	6,383	5,537
General office	5,666	4,089
Occupancy costs	5,177	4,352
Consulting services	4,544	3,898
Education and publications	4,232	2,607
Travel	1,360	1,210
Professional fees	505	797
Other expenses	246	198
	28,113	22,688

(in thousands of dollars)

14 Interfund transfers

	2015 $	2014 $
Transfer to the General Fund from the Internally Restricted Fund	60	54
Transfer (from) to the General Fund (to) from the Externally Restricted Fund	(4)	17
	56	71

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:

	$
2016	7,033
2017	5,808
2018	3,046
2019	232
2020	9
	16,128

b) The Organization has committed $3,031 (2014 - $5,087) for the purchase of equipment, which is net of deposits disclosed in note 6.

16 Contingencies

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

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

Cancer Care Ontario
Notes to Financial Statements
March 31, 2015

(in thousands of dollars)

17 Guarantees

a) Director/officer indemnification

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

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

b) Other indemnification agreements

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

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

18 Financial instruments

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

(in thousands of dollars)

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.

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	7,475	182	29	304	7,990
Due from MOHLTC	1,140	-	-	-	1,140
Amount receivable	8,615	182	29	304	9,130

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, 2015, a 1% fluctuation in interest rates, with all other variables held constant, will approximately increase/decrease the value of investments by $482.

Liquidity risk

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

(in thousands of dollars)

	0 to 30 days $	31 to 60 days $	61 to 90 days $	91 + days $	Total $
Trade payables	50,095	49	(107)	65	50,102
Accrued liabilities	68,087	-	-	73	68,160
Payable to MOHLTC	8,134	-	-	-	8,134
Pension escrow	-	-	-	417	417
Amount payable	126,316	49	(107)	555	126,813

19 Comparative figures

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

Appendices

Board of Directors

Ratan Ralliaram
Chair (January 5, 2015 – January 4, 2018)
Acting Chair (November 15, 2006 – January 4, 2015)

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

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

Kevin Conley
(June 27, 2007 – June 26, 2014)

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

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

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

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

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

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

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

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

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
President and CEO

Jason Garay
Vice-President, Analytics and Informatics

Rebecca Harvey
Vice-President, Ontario Renal Network

Paula Knight
Vice-President, People, Strategy and Communications

Garth Matheson
Vice-President, Planning and Regional Programs

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

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

Elham Roushani
Vice-President, Finance, and Chief Financial Officer

Ken Sutcliffe
Chief Technology Officer

Working together to create the best health systems in the world

620 University Avenue
Toronto, ON M5G 2L7
416.971.9800
publicaffairs@cancercare.on.ca
cancercare.on.ca

information@renalnetwork.on.ca
renalnetwork.on.ca

Ontario
Cancer Care Ontario