

Annual Report

2016/17



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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

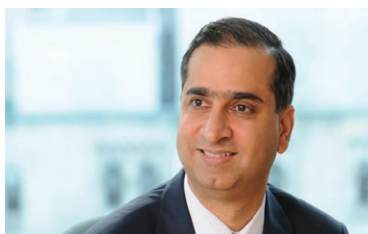
- The people of Ontario are at the core of everything we do.
- We will be transparent and foster a culture of open communication.
- We will ensure fairness across regions in the development of strong provincial health systems.
- We will make decisions and provide advice based on the best available evidence.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

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



Michael Sherar

Michael Sherar
President and CEO



Ratan Ralliam

Ratan Ralliam
Board Chair

As the Ontario government's principal advisor on cancer and chronic kidney disease (CKD) care as well as access to care for key health services, CCO has an important role to play in shaping the future of healthcare in this province. We continue to work closely with our many partners—including the Ministry of Health and Long-Term Care (MOHLTC), healthcare providers and administrators, regional cancer and renal programs, other provincial health agencies, and patients and their families—to ensure the quality and sustainability of our health systems for all Ontarians. CCO recognizes that this is becoming increasingly important as there are now more Ontarians over the age of 65 than under 15. This aging of our population, combined with its increasing size, will impact our healthcare system, as the incidence of many chronic illnesses, including cancer and CKD, increase with age.

The Ontario Cancer Plan IV (OCP IV) and Ontario Renal Plan II (ORP II), launched in 2015, continue to guide the work we do with our many partners to reduce the risk of Ontarians developing cancer and advanced CKD, while improving the quality of care for current and future patients. Both plans reflect the following themes that were identified through extensive consultations with our partners and stakeholders, including patients and their families, and which became the goals for each system plan. For OCP IV: quality of life and patient experience; safety; equity; integrated care; sustainability; and effectiveness. For ORP II: patient and family empowerment; integrated care; and improved access to care. Now midway through the term of both system plans, we reflect on the steady progress being made toward these goals. This annual report includes highlights on how:

- The integration of smoking cessation programs into regional cancer centres is leading to more cancer patients being screened for tobacco use and an increase in patients accepting a referral for counselling to stop smoking.
- More patients in need of complex malignant hematology services (including acute leukemia and stem cell transplant) are able to access timely transplants in Ontario and through MOHLTC's Out-of-Country program.
- The Ontario Renal Network continues to empower CKD patients to access their choice of kidney care services as close to home as possible with initiatives underway to broaden community and home care options, which is reflected in the steady rise of home dialysis rates.
- *Path to Prevention: Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis* provides evidence-based policy recommendations to reduce exposure to the four key risk factors for chronic diseases, including cancer, in these communities (commercial tobacco use, alcohol consumption, inactivity and unhealthy eating).
- Patients are being increasingly empowered to report on their experiences of cancer, which provides CCO and the Regional Cancer Programs with better information, which is needed to make continued improvements to the cancer system at the local, regional and provincial levels.

In addition to our work in the cancer and kidney care systems, CCO continues to support and actively participate in initiatives that address opportunities across Ontario's health systems, with a particular focus on the five key priorities identified in our corporate strategy, namely patient-centred care; prevention of chronic disease; integrated care; value for money; and knowledge sharing and support. For example:

- As a key partner in the Ontario Palliative Care Network (OPCN), CCO provided comprehensive provincial and regional data to the Regional Palliative Care Networks to enable them to gain a clearer picture of how and where palliative care services are delivered in Ontario. This data will better inform OPCN's capacity planning to improve access to high-quality, high-value hospice palliative care for all patients in Ontario.
- CCO developed tools that show where dementia programs currently exist in Ontario and predict the impact of specific initiatives on demands for capacity. The resulting insights led to an increased allocation of beds and improved access to care for patients with dementia.
- The development and implementation of an electronic standardized approach to triaging patients in emergency rooms is improving the quality, efficiency and safety of care for patients across the province.

This annual report describes CCO's work in collaborating with our partners and stakeholders to improve the performance of the health systems by driving quality, accountability, innovation and value. As we look to the future, we will continue to work closely together to enable the delivery of high-quality, sustainable and person-centred care.

CCO continues to work closely with our many partners to ensure the quality and sustainability of our health systems for all Ontarians.

About CCO

CCO is the Ontario government's principal advisor on the cancer and kidney care systems, as well as on access to care for key health services. Our mission is to work together with our many partners to improve the performance of our health systems, by driving quality, accountability, innovation and value. CCO is governed by *The Cancer Act* and is accountable to the Ministry of Health and Long-Term Care (MOHLTC).

Encompassing Cancer Care Ontario and the Ontario Renal Network, CCO drives continuous improvement in disease prevention and screening, the delivery of care and the patient experience for chronic diseases. We provide tools, resources and evidence-based data to help our healthcare partners improve the delivery of care.

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 and access to care.

CCO directs and oversees approximately \$1.9 billion in funding for hospitals and other cancer and kidney care providers, enabling them to deliver high-quality, timely services and improved access to care.

Although our work takes place at a system level and we do not provide direct patient care, we seek every opportunity to address the needs of the people of Ontario in the healthcare system. CCO currently partners with more than 100 volunteer Patient and Family Advisors and public advisors from across the province. The CCO Community of Patient and Family Advisors consists of patients and caregivers who have had personal experience with cancer or chronic kidney disease, as well as members of the public who advise the Cancer Screening program. Patient and Family Advisors work closely with CCO's program areas to help improve care provided across the province.

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

Cancer Care Ontario

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

Ontario Renal Network

The Ontario Renal Network, the government's principal advisor on chronic kidney disease (CKD), leads a provincewide effort to reduce the burden of CKD on Ontarians and the kidney care system through the effective management and funding of CKD services in Ontario. Working through 14 Integrated Renal Regional Program Councils and 26 Regional Renal Programs, the Ontario Renal Network's goal is to improve CKD management by preventing or delaying the need for dialysis, broadening appropriate care options for people with CKD, improving the quality of all stages of kidney care, and working with patients, families and healthcare providers to build a world-class system for delivering care to Ontarians living with CKD.

Access to Care

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

As a result, CCO's Access to Care (ATC) program was established to understand, analyze and report on health system performance, centred on the patient. Data analysis provides meaningful information to provincial health system stakeholders to improve access, performance, efficiency and quality of care. ATC focuses on the design, implementation and management of provincial Information Management/Information Technology (IM/IT) initiatives.



Cancer Care Ontario



Ontario Cancer Plan IV 2015-19

Cancer Care Ontario launched the Ontario Cancer Plan IV (OCP IV) in March 2015. OCP IV serves as a guide to move forward together through to 2019 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, the scope of work broadens 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 the efforts to create a comprehensive plan.

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

Cancer Care Ontario has developed a robust measurement and evaluation framework and governance structure for the implementation of OCP IV that includes a comprehensive performance scorecard. The OCP IV performance scorecard provides a measure of progress against the strategic objectives and “by 2019” commitments for each of the six goals by combining both quantitative and qualitative measures and identifying gaps in the work to achieve the goals. The scorecard is updated twice a year, at the end of the second and fourth quarters.

In addition, Cancer Care Ontario has evaluated the process used to develop OCP IV from the perspective of the stakeholders who were involved. This was done via a broad-based stakeholder engagement survey and a series of interviews held with the Patient and Family Advisors who were involved. This evaluation is an important step in ensuring Cancer Care Ontario is continually enhancing its ability to develop future system plans.



Ontario Cancer Plan IV Report Cover

OCP IV Goals

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

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

Under earlier cancer plans, significant strides were made in terms of measuring and understanding care needs from the patient's perspective. OCP IV further advances 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. In addition, patient and family engagement at the care, organization and system levels continues to be promoted.

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

2016/17 Highlights

- In the past year, Cancer Care Ontario's ability to collect patient-reported experience measures improved significantly. Patients are systematically able to report on their experience in real time using an electronic survey tool called "Your Voice Matters" in regional cancer centres across Ontario. "Your Voice Matters" is one of a suite of products housed on an electronic platform that supports the use of various patient questionnaires aimed at consistent assessment and reporting of patient experiences and their symptoms at the time of their appointments. Real-time linked patient experience data is made available to the regions to inform quality improvement.
- Cancer Care Ontario's Psychosocial Oncology program continued to work closely with Regional Cancer Programs throughout Ontario to collect and report access information (volumes) and wait times from referral to consult for seven psychosocial oncology disciplines (dietitian, social work, psychiatry, psychology, occupational therapy, physiotherapy and speech language pathology). The purpose of this reporting is to measure, monitor and improve patients' quality of life through access to high-quality, timely psychosocial oncology services. In addition, a Regional Cancer Program service delivery framework was developed for psychosocial oncology services in Ontario.
- A patient-reported outcome questionnaire, specific to the prostate cancer population, progressed from the pilot phase to being rolled out across all regional cancer centres, and planning work for implementation in urologist offices is underway.
- Patients and families now have access to 10 patient symptom management guides that are available online and in print in the cancer clinics. The aim of the Patient Symptom Management Guides is to provide patients with strategies on how to reduce physical symptoms and emotional distress. These education materials cover fatigue, nausea, pain, depression, fever and other common patient symptoms, are provided in multiple languages, and include critical safety information for patients receiving parenteral or oral chemotherapy treatment at home.
- Cancer Care Ontario conducted preliminary scoping for the development of symptom management education modules for primary care providers and is exploring potential partnerships with the Ontario College of Family Physicians, Ontario Palliative Care Network and Ontario Medical Association on the development, delivery and promotion of these modules.

Goal

ENSURE THE SAFETY OF PATIENTS AND CAREGIVERS IN ALL CARE SETTING

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 Ontario's cancer system. Moving forward, Cancer Care Ontario will focus on understanding the gaps that still exist in safety and work toward addressing them by setting performance benchmarks, promoting the use of safety guidelines and resources, and supporting safety training to both healthcare providers and patients. Cancer Care Ontario will also continue working with its partners to strengthen the culture of safety that exists, and establish stronger governance and accountability around safety for cancer services.

2016/17 Highlights

- Peer review of care plans ensures concordance with evidence-informed practice and appropriateness of care that will lead to improved patient safety and clinical effectiveness.
 - The Multidisciplinary Case Conference (MCC) Concordance score exceeded the provincial target of 80% in the first quarter of 2016/17 for the first time since measurement was put in place. From the first quarter of 2014/15 to the third quarter of 2016/17, the provincial MCC concordance score increased from 73% to 89%.
 - Peer review of curative radiation treatment plans by a second radiation oncologist or multidisciplinary team to prevent treatment errors has been an area of focus since 2011, and improvements continued in 2016/17. In the first quarter of 2014/15, the percentage of peer-reviewed curative radiation treatment cases was 63% for the province, whereas at the third quarter of 2016/17 the rate was 88%, well above the 80% target.
 - Highlighting the significant commitment and buy-in from the radiation community, five centres began doing palliative case peer review on their own and three of these are already reaching the 2017/18 target.
- Ontario's Radiation Program has had a history of incident reporting and consistent quality improvement for many years. However, the incident reporting has, until recently, been internal to Cancer Care Ontario. Through a new reporting initiative, 13 of the 14 regional cancer centres in Ontario actively participated in the pilot of the new National System for Incident Reporting for Radiation Treatment (NSIR-RT). Full implementation is scheduled for Fall 2017. Regional cancer centres will continue to submit their incident data to Cancer Care Ontario in parallel until the transition is completed.
- An in-depth review of the impact of adopting the National Association of Pharmacy Regulatory Authorities' (NAPRA) model standards for pharmacy compounding of hazardous sterile preparations (e.g., Beyond Use Dates, biosafety cabinets, closed system transfer devices and physical requirements) was completed. This work included significant engagement with national and provincial bodies and the Regional Cancer Programs, and an assessment of NAPRA standards and Cancer Care Ontario's Safe Handling Guideline to determine areas of gaps and discordance.

- 94% of Regional Cancer Programs completed their parenteral and oral chemotherapy regimen review work that was started in 2015/16 to ensure that regimens were developed as intended within their Computerized Physician Order Entry (CPOE) systems. As part of this initiative, a guidance document on the regimen review process was developed.
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- As chemotherapy treatments move to the community or home, an assessment of the education and safety measures was necessary to ensure the same safe, high-quality care could be delivered outside of the hospital setting. As a result of this assessment:
 - A new oncology curriculum was developed in collaboration with the University of Toronto targeting community pharmacists and pharmacists new to oncology, ensuring they have the information they need to provide safe, high-quality care within the community. In 2016/17, 150 pharmacists completed the “Essentials of Oncology” program, and 35 pharmacists completed the “Advanced Oncology” program.
 - The take-home chemotherapy checklist was developed to standardize dispensing practice in community pharmacies.
 - A Pan-Canadian Consensus Guideline for the Safe Use and Handling of Oral Anti-Cancer Drugs (OACDs) in Community Pharmacies was published on the Canadian Association of Provincial Cancer Agencies and Cancer Care Ontario Drug Formulary websites. This document was further disseminated to the Ontario College of Pharmacists, Ontario Pharmacists Association, Canadian Pharmacists Association and other national organizations.
 - An online course on providing oral chemotherapy teaching was developed in partnership with the Anna de Souza Institute. The course uses the MASCC (Multinational Association of Supportive Care in Cancer) Oral Agent Teaching Tool, which assists healthcare providers in the assessment and education of patients receiving oral agents as treatment for their cancer. The goal is to ensure that patients know and understand their treatment as well as the importance of taking their medication as prescribed.

With OCP IV, the scope of work broadens to more fully encompass all stages of the cancer care continuum and advance a person-centred approach.

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, income, sexual orientation, immigration status or education. In recent years, improvements to health equity have been made, but this work is just the beginning. OCP IV seeks to improve understanding of the barriers that contribute to health disparities across the cancer care continuum.

In addition, Cancer Care Ontario will raise awareness among traditionally underserved populations about what services are available, how to access those services and why it is important to do so.

2016/17 Highlights

- Equitable access to Complex Malignant Hematology (CMH), including Stem Cell Transplant (SCT) services, improved through the collective efforts of multiple working groups. Highlights include:
 - Capacity demand models and health human resources planning, including new patient-centred and sustainable models of care, have identified the resources required to deliver high-quality care for CMH patients within clinically acceptable wait times.
- A capital expansion plan was developed and is in progress to ensure optimal physical space at existing transplant facilities and to develop one new program in Ontario at Sunnybrook Health Sciences Centre.
- A newly developed funding model and funding agreements ensure that funding follows the patient and that hospitals are compensated appropriately.
- The provincial median wait time for auto-transplant patients with multiple myeloma, from last apheresis to transplant, dropped from 31 days at the beginning of 2014/15 to 21 days at the end of 2015/16 (most recent data available).
- A key component of the Aboriginal Cancer Strategy III, *Path to Prevention: Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis*, was released. This report provides evidence-based policy recommendations to reduce exposure to the four key chronic disease risk factors in Aboriginal communities: commercial tobacco use, alcohol consumption, inactivity and unhealthy eating. Implementation of the 22 recommendations is underway. *Path to Prevention* is a companion report to *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario*.
- The Cancer Surveillance, Population Health, and Cancer Screening groups at Cancer Care Ontario combined expertise and data sets to release the new Ontario Cancer Profiles, an online, interactive dashboard of population-level cancer data. Through this new tool, users can find statistics on cancer incidence and mortality, modifiable risk factors, demographics, social determinants of health and Cancer Screening program participation gaps, at both the provincial and Local Health Integration Network (LHIN) levels. This tool will support the Regional Cancer Programs in identifying disparities that exist in prevention, care and outcomes.
- Radiation utilization rates are a measure of access to radiation treatment services and can be used to show, among other things, inequities across regions. Radiation utilization continues to improve in Ontario. The lifetime utilization increased from 38.4% in 2014/15 to 39% in 2015/16 (most recent data available). This overall improvement represents both increasing cancer incidence (3%) and utilization rates (1.8%).
- “Aboriginal Relationship and Cultural Competency Courses” were developed and released free of charge to anyone who wishes to take them. To date, there have been 3,944 course enrolments.

Goal

ENSURE THE DELIVERY OF INTEGRATED CARE ACROSS THE CANCER CARE CONTINUUM

As people transition through the different stages of the cancer care continuum, they will encounter many different care providers in many different settings. Under OCP IV, Cancer Care Ontario will work to ensure that care is person-centred, coordinated and continuous throughout the system and across care settings. Integrated care will be facilitated by standardizing care and optimizing relationships and information sharing among care providers, patients and families. In addition, Cancer Care Ontario 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.

2016/17 Highlights

- A large, multi-program quality improvement initiative to address patient toxicity and symptom management was launched to ensure that patients will experience the best possible symptom management while on cancer treatment. All regional cancer centres are participating in a two-year initiative to explore new approaches to care, moving toward the long-term goal that all cancer patients receiving chemotherapy will have access to an oncology provider for urgent advice.
- To ensure patients transition smoothly in care post-treatment from oncology specialists to primary care, standard elements of survivorship transition plans were developed and validated, and implementation planning is underway.
- An Integrated Care Planning framework/model focusing on complex cancer patients was developed and finalized.
- A draft Provincial Pediatric Oncology Plan 2017-22 was developed with participation from Cancer Care Ontario's Survivorship Clinical Leadership and others. The plan includes recommendations to improve transitions for adult survivors of pediatric cancers.

Goal

ENSURE A SUSTAINABLE CANCER SYSTEM FOR FUTURE GENERATIONS

Ontarians want to know that, should they or their loved ones ever face a diagnosis of cancer, high-quality cancer care services will be available for them. Several strides have been made over the years to build a sustainable cancer system. Moving forward, Cancer Care Ontario will be bolder in its approach to building a sustainable cancer system, using resources wisely and ensuring patients receive appropriate care in the right setting. This will be achieved by expanding 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, Cancer Care Ontario 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.

2016/17 Highlights

- Based on recommendations from a 2015 Cancer Quality Council of Ontario's Programmatic Review on cancer drug funding, all new drugs approved for funding became subject to the collection and evaluation of real-world evidence to support the evaluation on benefit to patients and value for money.

- Four new drugs and indications implemented in 2016/17 were evaluated for potential real-world evidence analyses; data fields in support of real-world evidence were included in New Drug Funding Program enrolment forms; and two proof-of-concept studies to identify opportunities and barriers with regard to data linkages to support future real-world evidence analysis efforts were conducted.

- An evaluation of the online cancer risk assessment tool, My CancerIQ, was completed, and a knowledge transfer, education and communications strategy to promote My Cancer IQ is being implemented. The tool currently includes risk assessments of breast, cervical, colorectal, kidney and lung cancer, and melanoma. As of March 2017, over 900,000 people have visited the site and 300,000 risk assessments have been completed.

- Smoking cessation is integrated into all Regional Cancer Programs, and uptake of screening for tobacco use and cessation referrals is increasing. At the provincial level, the percentage of new ambulatory cancer patients who were screened for tobacco use at a regional cancer centre in the past six months improved from 44% in the first quarter of 2015/16 to 65% in the third quarter of 2016/17. In the same period, the percentage of patients using tobacco who accepted a referral for cessation counselling improved from 16% to 21%.

- CCO's Program Training and Consultation Centre developed and delivered evidence-based tobacco control training and capacity-building programs to Ontario's 36 public health departments and community partner agencies.

- A 2016 update to the 2015 Prevention System Quality Index (PSQI), which measures the impact of population-based programs and healthy public policies, was released in 2016. The 2017/18 PSQI, with a focus on health equity, is underway.

- The fifth report in the *Cancer Risk Factors in Ontario* series was released in August. The *Environmental Burden of Cancer in Ontario* report, which was produced jointly with Public Health Ontario, focuses on environmental carcinogens and estimates how many new cancer cases each year in the province are the result of exposure to 23 carcinogens that exist in the environment.

- The Aboriginal Tobacco Program (ATP) continued to provide commercial tobacco prevention, cessation and protection programming with and for First Nations, Inuit and Métis communities and organizations to enhance knowledge, skills, capacity and behaviour to address the high smoking rates among these populations. In 2016/17, prevention workshops were held in more than 50 communities reaching over 4,500 community members; cessation workshops were held in more than 40 communities, reaching over 1,000 community members and health staff.

- The Gastrointestinal (GI) Endoscopy Data Submission Portal was implemented at 103 hospitals (130 hospital sites), establishing a common GI endoscopy data collection system that will support ColonCancerCheck, the GI Endoscopy Quality Based Procedure and the Quality Management Partnership.
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- The transition of all screen-eligible mammography into the Ontario Breast Screening Program (OBSP) ensures that eligible women experience the full benefits of an organized screening program, including correspondence, navigation and quality assurance processes. Twenty-three mammography sites were integrated into the OBSP in 2016/17 for a total of 107 hospitals and 105 independent health facilities participating in the OBSP. This leaves approximately 25 non-OBSP sites in Ontario to be on-boarded in 2017/18.
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- Preparations continued for the implementation of the fecal immunochemical test (FIT) as the primary screening test for average-risk colorectal cancer. This included preparing for the procurement of the test and lab services, development of a stakeholder engagement and communication plan, and development of detailed requirements for technical changes to Cancer Care Ontario infrastructure to support the change.
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- A Systemic Treatment Management tool was developed and shared with Regional Cancer Programs. This tool helps regions manage resources and identify areas of inefficiencies by comparing funding to utilization.
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- Cancer Care Ontario continued to develop and refine capacity planning models to allocate key health human, infrastructure and financial resources for all cancer services. As a result of utilizing data-driven models, 10 complex malignant hematology, 11 medical, six radiation and two gynecological oncologist positions were awarded to regions. In addition to these new positions, 88 medical oncology positions were converted from fee-for-service to the alternative payment plan. In diagnostic services, a PET (positron emission tomography) scan siting model was developed, including recommendations to ensure patients receive timely access to care closer to home while supporting sustainable, high-quality services, and an analysis for MRI (magnetic resonance imaging) access was completed.
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- Capacity for radiation services in the Central LHIN was expanded with an additional radiation treatment machine at Southlake Regional Health Centre, and in the Waterloo-Wellington LHIN through an additional unit installed at Grand River Regional Cancer Centre. When operating at capacity, each of these treatment units will serve approximately 400 patients a year.

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. OCP IV will strengthen the understanding of whether outcomes are improving based on the care provided. Cancer Care Ontario will ensure that new evidence is promptly evaluated and that best practice guidelines are consistently used in practice to optimize patient outcomes. Collaboration with partners will continue in order to align efforts in the area of molecular oncology (i.e., personalized medicine).

2016/17 Highlights

- Cancer Care Ontario's funding model work continued to be refined, and a Cancer Surgery Quality Based Procedure (QBP) for breast and thyroid I cancers was introduced (this builds on previous work for colorectal and prostate cancers). Funding model refinements for colonoscopy and gastroscopy have been submitted to MOHLTC. In addition, a process was established to ensure that only prophylactic mastectomies identified as clinically appropriate are funded within the Cancer Surgery QBP. The Systemic Treatment QBP was improved through the development of a definition of "evidence-informed" to ensure that all funded regimens have sufficient evidence for funding. All new regimens in 2016/17 were reviewed with this definition.
- Cancer Care Ontario continued to develop evidence-based pathway maps that lay out evidence-based best practice across the continuum of care. In 2016/17, a High Risk Lung Cancer Screening pathway was completed and pilot sites identified. Also, a new methodology for measuring pathway concordance for patients with Stage II or III colorectal cancer was developed.
- The Clinical Utility of Multigene Profiling Assays in Invasive Early-Stage Breast Cancer clinical guideline was developed by the Program in Evidence-Based Care and the Molecular Oncology Advisory Committee, and was published on the Cancer Care Ontario website. An environmental scan on genetic discrimination was conducted to understand the current landscape and how other jurisdictions have dealt with genetic discrimination issues. In addition, the BRCA 1 and 2 testing criteria were updated.
- To support patient-reported outcomes in First Nations, Inuit and Métis communities, planning and implementation of a mobile Interactive Symptom Assessment and Collection tool (mISAAC) and overall expansion and use of the Edmonton Symptom Assessment System (via mISAAC) for these communities began.
- A Complex Malignant Hematology long-term measurement framework and strategy for system-level performance management was completed.
- An algorithm was developed to identify breast cancer recurrence from administrative data sets. Two regional cancer centre sites are assisting Cancer Care Ontario in validating the model by using chart reviews to extract breast cancer recurrence information as a comparator to recurrences identified by the algorithm.



Ontario Renal Network

Ontario Renal Plan II 2015-19

Entering the third year of the Ontario Renal Plan II (ORP II), the Ontario Renal Network continues to focus on quality, value for money and access to care, with the ultimate goal of creating a person-centred kidney care system. The network continues to drive forward initiatives that ensure the experiences and perspectives of patients and their families from across the province are used to help guide the policies that directly impact the way kidney care is provided. In addition, the Ontario Renal Network has collected baseline data, addressed barriers to kidney care, and developed strategic frameworks that will be crucial to the success of this network's strategic objectives.

By translating strategic goals into actionable initiatives to support the priorities laid out in ORP II, the Ontario Renal Network will continue to provide overarching leadership to successfully organize, manage and fund the delivery of kidney care services in Ontario.

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



Ontario Renal Plan II Report Cover

ORP II Goals

Empower and support patients and family members to be active in their care.

Integrate patient care throughout the kidney care journey.

Improve patients' access to kidney care.

Goal

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

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

2016/17 Highlights

- The Ontario Renal Network developed its first Person-Centred Care indicator survey to measure the proportion of Regional Renal Programs that have structures or standardized tools in place (e.g., patient passport and/or patient portal) to regularly document a plan of care (including modality choice, access choice and goals of care). The results of the survey showed that most Regional Renal Programs have a structure or standardized tool in place to document patients' goals and choices related to their kidney care, with a normalized score of 82% in the first quarter of 2016/17.
- In June 2016, the Your Symptoms Matter project was launched, with the goal of improving symptom awareness for people living with chronic kidney disease (CKD) and their care team by providing an organized approach to symptom assessment and management. Eight Regional Renal Programs were selected to participate in the pilot and have worked with the Ontario Renal Network to develop a future state workflow, patient education materials, symptom management resources for healthcare providers, and an evaluation framework.
- Shared decision-making (SDM) is a collaborative process that allows patients, families and their healthcare providers to make healthcare decisions together, taking into account the best scientific evidence available as well as the patient's values and preferences. In partnership with The Ottawa Hospital, the Ontario Renal Network developed SDM tools and hosted a skill-building workshop in March 2016 with representation from 17 Regional Renal Programs. Programs that have adopted the tools are supported through monthly collaborative calls to help strengthen SDM practices and share successes and challenges. With increased knowledge about the SDM process and tools to facilitate its practice, healthcare providers are better equipped to support patients and families to make decisions about their kidney care, ultimately leading to an improved patient experience.
- The Ontario Renal Network's Provincial Patient and Family Advisory Council developed five patient and family experience videos. The videos capture various aspects of living with kidney disease from patients and family members with lived experience. All videos are now available on the Ontario Renal Network website and are being used in many forums as a key tool to communicate the patient and family member perspective.
- Consultations with patients and family members affected by CKD reveal that there is a need to connect with and receive support from others who have lived experience with the disease. The Ontario Renal Network and The Kidney Foundation of Canada (KFOC) partnered to evaluate the awareness of, access to and use of KFOC's Peer Support Program. A survey, completed by 1,940 patients, caregivers and kidney transplant donors, revealed that there are opportunities to increase awareness of peer support programs and utilize marketing initiatives to strengthen peer support program branding. Posters and brochures have been developed and circulated to all Regional Renal Programs to share the results of the survey with patients and program staff. The Ontario Renal Network and KFOC are working collaboratively to strengthen and broaden the use of peer-to-peer support, highlighting the importance of this type of support to Regional Renal Programs and the availability of programming to patients, caregivers and transplant donors.

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. The focus is on three areas that stakeholders, including patients and families, identified as offering the greatest potential impact for improved integration of care: early detection and prevention of progression of kidney disease; palliative care; and kidney transplant.

2016/17 Highlights

- The Primary Care Strategic Framework was established to guide work to ensure that primary care providers have timely access to tools and supports to manage care for people with CKD, and that patients transitioning from primary care to nephrology will have timely access to appropriate pre-dialysis care. The framework focuses on building regional engagement and accountability, patient and provider education, establishing provincial partnerships, and leveraging data to monitor outcomes.
- The ORP II Primary Care Engagement Provincial Scorecard Indicator was developed and operationalized to identify whether Regional Renal Programs are actively engaging primary care in their regions. The Provincial Scorecard tracks progress against all categories within the Regional Renal Program's Primary Care Engagement Plans (i.e., priority setting, accessibility and relationships, education and awareness, and the KidneyWise Toolkit). Most Regional Renal Programs have been successful in either planning or implementing activities based on their Primary Care Engagement Plans, with an overall score of 76% in the first quarter of 2016/17.
- In July 2016, a regional Primary Care Engagement Dashboard was made available to all Regional Renal Programs to enable knowledge sharing across programs. The dashboard is updated biannually and enables Programs to view the activities and progress other Regional Renal Programs have made in regard to primary care engagement, and to learn from these experiences.
- In March 2017, the Ontario Renal Network completed a current state assessment of Multi-Care Kidney Clinics (MCKC) in all 26 Regional Renal Programs. The results identified wide variation in practice and structure of MCKCs across the province. The current state assessment, in combination with literature and clinical expertise, will inform a best practice guidelines document to be developed in the upcoming year.
- In April 2016, the Ontario Renal Network implemented revised eligibility criteria for MCKC patients, based on a patient's two-year risk of kidney failure. The evidence-based criteria were developed with the intention of ensuring that this complex multidisciplinary care was delivered to those patients who would benefit most from it. Monthly patient management reports are provided to Regional Renal Programs to support them in managing their clinics.
- "Learning Essential Approaches to Palliative (LEAP) Care Renal," an interdisciplinary palliative care education program, was implemented in all 26 Regional Renal Programs in 2016/17 with strong community participation. The LEAP Care Renal program provides an introduction to the essential practical knowledge, attitudes and skills needed to provide a palliative care approach to kidney care, from early in the illness to the end of life.
- In April 2016, the Ontario Renal Network circulated a current state survey to understand current attitudes about, awareness of and comfort with palliative care by CKD providers. Results were used at the provincial level to identify opportunities and inform improvement planning for the portfolio, and were shared with leadership at Regional Renal Programs to drive local improvement.
- In order to support the palliative care needs of people living with CKD, partnerships between the Regional Renal Programs and the Regional Palliative Care Networks were established by connecting local nephrology champions with Regional Palliative Care Network leads. Through this partnership, a shared resource list is being developed to increase awareness of and access to local palliative resources available to people living with CKD.

- The Ontario Renal Network—Trillium Gift of Life Network Executive partnership developed an Access to Kidney Transplantation and Living Donation Provincial Framework, with the objective of enhancing access to, and improving patients' experiences of, kidney transplantation, with a focus on living kidney donation. This framework guides ORP II work in the area of transplant.
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- A provincial transplant education needs assessment was conducted to inform the development of transplant education toolkits for patients, families, potential living donors and healthcare providers at Regional Renal and Transplant Programs. Preliminary results of the assessment indicated that the majority of both the Regional Renal and Transplant Programs believe that kidney transplant education materials need to be improved, and agree that there is a role for provincial organizations in the development and dissemination of education materials and in providing guidance on the approach and content of materials. Based on these results, the Ontario Renal Network is developing Transplant Education Toolkits to ensure providers and patients are well informed about kidney transplantation and living donation.
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- In March 2017, 13 of 26 Regional Renal Programs were randomly selected to participate in the provincial Access to Kidney Transplantation and Living Donation strategy as part of a cluster-randomized trial. Each Program was asked to develop a local transplant quality improvement team, which will champion and drive quality improvement initiatives to improve transplant education and access to transplantation. The Ontario Renal Network hosted a quality improvement collaborative to train implementation teams in preparation for the launch of the Transplant Quality Improvement Collaborative in the upcoming year.
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- Regional Renal Models of Care were developed to define the relationship between hubs and satellites and detail criteria for in-facility dialysis, acute dialysis and associated costing models. The Models of Care clarify and define sets of services, roles and accountabilities for hubs and satellites, ensuring a transparent approach to service level agreements, and enable leadership to conduct more effective planning, implementation and management of kidney care services.

Goal

IMPROVE PATIENTS' ACCESS TO KIDNEY CARE

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

2016/17 Highlights

- Progress continued in the Home First Strategy as the Ontario Renal Network continued to approach its provincial home dialysis target of 28% by 2019, with a home dialysis rate of 26.1% as of the third quarter of 2016/17, up from 24.8% as of the third quarter of 2015/16. The increase in the home dialysis cohort was achieved even as the total chronic dialysis population grew by over 1.6% during the same time period. As of the third quarter of 2016/17, nearly 11,300 people in Ontario required chronic dialysis.

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- Personal Support Worker (PSW) Assisted Home Hemodialysis is now an available service in eight Regional Renal Programs as part of a provincial pilot. As of March 2017, 44 patients were enrolled in the pilot, and 31 patients had received home hemodialysis with a PSW. Interim evaluation indicated a positive impact on quality of life and patient confidence and competence to dialyze at home.
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- An expression of Interest was issued with the goal of selecting early adopters for the Integrated Dialysis Care (IDC) service model. In IDC, the Regional Renal Program will become the single fund holder overseeing the service delivery of all dialysis care from hospital to home. The IDC will promote a more effective accountability and funding structure, resulting in seamless, consistent and accessible dialysis care for patients wherever they receive their service.
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- The Ministry of Health and Long-Term Care (MOHLTC) approved an evidence-formed provincial policy proposal to address the patient-borne costs associated with home hemodialysis, which have been cited as barriers to patients opting to dialyze at home. The goal of this policy is to enable more patients to choose home modalities over in-facility treatments, contributing to improved patient quality of life with equivalent clinical outcomes, and generating overall savings for the health system.
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- The Ontario Renal Network, Thunder Bay Regional Health Sciences Centre and Big Trout Lake First Nation worked together to support a patient from the community to successfully transition to home hemodialysis. This is the first patient in Ontario to do home dialysis in a remote, fly-in community. An evaluation of this cluster care model indicated that it is safe and feasible to provide this service, and expansion is planned in other communities.
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- The Ontario Renal Network provided overall guidance and management of the Wikwemikong CKD Screening initiative. This screening model seeks to capture risk factors of developing CKD, and help connect patients with measures and healthcare to prevent disease progression. As of March 31, 2017, 504 community members had been screened. Of these members, 323 were referred for diabetes management, and 28 were referred for primary care management of early-stage CKD.
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- Tools were developed to support patients with glomerulonephritis. These tools include patient-friendly fact sheets to inform on seven commonly prescribed immunosuppressive medications, and a Drug Access Process Map to support healthcare providers in navigating the complex application process to obtain funding for glomerulonephritis drugs.
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- To address several challenges that exist in optimizing patients' dialysis access, an Optimal Dialysis Access Strategic Framework was established. This strategy aims to ensure that all patients receiving dialysis experience as few complications as possible, for safe, individualized and timely dialysis access.
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- Provincially, the proportion of Priority 2 Cases meeting targeted wait times for vascular access surgeries (target of 75% of cases completed within 14 days) was 73.0% in the third quarter of 2016/17. This was an 11.7% increase compared to 61.3% in the third quarter of 2015/16. The proportion of Priority 3 Cases meeting targeted wait times for vascular access surgeries (80% of cases completed within 28 days) was 76.8% in the third quarter of 2016/17. This was a 4.9% increase compared to 71.9% in the third quarter of 2015/16. Overall, Regional Renal Programs are trending up in both Priority 2 and Priority 3.
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- As part of the Centres of Practice Pilot Project, eight hospitals across Ontario were accepting patient referrals for peritoneal dialysis catheter insertions and vascular access creations to enable more timely access to dialysis-related care and support centres with specialized and regional expertise. This resulted in an incremental increase in the number of referrals for vascular access creations, more patient options and the creation of new practice relationships.
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Our future health built with care

Access to Care

CCO's Access to Care (ATC) 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 (IM/IT) solutions, and by tracking patients as they move across the continuum of care. Areas of focus include: surgical and diagnostic imaging wait times; emergency room wait times; and patients designated as requiring an alternate level of care. New areas of focus for 2016/17 included the launch of the Electronic Canadian Triage and Acuity Scale, and development of a comprehensive provincial approach to improving access to care for mental health and addiction services.

Information Management Programs

SURGICAL INFORMATION PROGRAM

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

2016/17 Highlights

- The ATC Surgeon Wait Time Dashboard enabled more than 3,200 Ontario surgeons to review their data and compare to peer surgeons in order to identify opportunities for practice improvements. Through wait time data evaluation, it was demonstrated that 32% to 52% of surgeons (ranged by service area) improved their wait for surgery (Wait 2) by at least 5%. Building on the original dashboard, the LHIN-level ATC Surgeon Wait Time Dashboard was developed to provide aggregated provider-level data for systemic monitoring and performance evaluation.

- The new ATC Executive Performance Report offered healthcare site CEOs data analysis of key wait time performance indicators for their facility in the following four clinical areas: surgery, diagnostic imaging, emergency room and alternate level of care. The report has the ability to identify potential areas for improvement with the end goal of improving patient access to the system.
- The Surgical Efficiency Targets Program (SETP) Outreach Pilot was developed and implemented to provide opportunities to improve performance through hospital engagement, awareness and action planning. The key SETP performance indicator is *Percentage (%) First Case Start On-Time or Early*. The results of the pilot demonstrated 10% or greater improvement in performance in 83% of participating facilities.

DIAGNOSTIC IMAGING INFORMATION PROGRAM

ATC maintains the infrastructure and daily operational services to collect and report near real-time diagnostic imaging wait time data, using WTIS, for magnetic resonance imaging (MRI) and computerized tomography (CT) services for more than 170 healthcare sites across Ontario. Expansion of the data collection to capture efficiency data for MRI (2013) and CT (2015) enhances ATC performance reporting capabilities and supports MOHLTC in identifying opportunities to improve operational efficiency of service delivery, capacity planning and patient access to these critical diagnostic tools.

2016/17 Highlights

- All 14 LHINs received operational support and education on the use of the MRI Allocation Tool. This tool supports facility-level resource planning with the goal of optimizing resources to reduce MRI wait times at the regional level.

- The methodology for a new MRI Scheduling Accuracy Key Performance Indicator was developed to enable facilities to understand patient flow and drive a performance management culture.
- ATC collaborated with more than 80 facilities to support data stabilization and compliance activities on the collection of near real-time MRI and CT wait times and efficiency data to monitor, evaluate and report on provincial and systematic access to diagnostic imaging services.
- The percentage of MRI scanning time actually used to scan outpatients (as a percentage of the total available outpatient operating hours) increased to 76% in 2016/17 (April – December), up from an average of 74% in 2015/16. This surpassed the provincial benchmark of $\geq 70\%$, indicating that MRI machines were being used more efficiently.

EMERGENCY ROOM INFORMATION

ATC partners with the Canadian Institute for Health Information to leverage the National Ambulatory Care Reporting System (NACRS) for the timely collection of emergency room (ER) wait time data. More than 125 sites collect a dataset of 38 ER data elements that capture the patient journey from the time a patient is triaged/registered until the time the patient leaves the ER.

2016/17 Highlights

- Reporting products were developed and distributed to hospitals to support the Emergency Department Return Visit Quality Initiative and assist with audits focused on improving quality of care.
- Data distributed by time of day was incorporated into NACRS. This enhanced reporting facilitates greater understanding of variations in emergency rooms throughout the day and assists with planning.

ALTERNATE LEVEL OF CARE

ATC maintains the infrastructure and daily operational services to collect and report near real-time wait time data through the WTIS. More than 180 healthcare sites across Ontario collect and report over 190 data elements on patients designated as requiring an alternate level of care (ALC). ATC further supports and works collaboratively with MOHLTC to drive ongoing improvement in performance management with hospital, LHIN and Community Care Access Centre (CCAC) partners.

2016/17 Highlights

- Engagement sessions with LHIN, hospital and CCAC stakeholders were conducted; these sessions focused on providing education on ALC access issues for the province as well as identification of performance improvement opportunities.
- The mandate of the ALC Advisory Committee was expanded to include responsibility for developing recommendations for ALC improvement practices to support sites and LHINs as they work to achieve the provincial ALC target of 12.7%.

WAIT TIME INFORMATION SYSTEM– CARDIAC CARE NETWORK

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

2016/17 Highlights

- Aspects of the WTIS-CCN system and its administrative tools were modernized; these enhancements were made to improve the sustainability and reliability of the WTIS-CCN system. Enhancements supporting the capture of new/modified information to meet CCN's business needs were implemented.

ELECTRONIC CANADIAN TRIAGE AND ACUITY SCALE SOLUTION

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

2016/17 Highlights

- The 90-member provincial eCTAS Clinical Working Group was consulted and engaged to design, develop and test the eCTAS application.
- First early adopter hospitals began triaging patients with eCTAS in February 2017.
- More than 100 hospitals are participating in the initiative, surpassing the expected 73 pay-for-results hospitals mandated to participate. Over 80% of participating hospitals will use CCO's clinically designed web application to implement eCTAS (versus incorporating eCTAS into their own system).
- Pre-implementation triage time and reliability research studies were completed to provide a baseline for evaluating the post-implementation impact of the new tool.

ACCESS TO CARE PROVINCIAL SUPPORT MODEL

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

2016/17 Highlights

- eCTAS Phase 1 (early adopters) was successfully implemented in three hospitals, increasing standard application of the CTAS at point of care. Implementation expanded across the province, engaging another 113 hospitals to begin eCTAS implementation with a target completion date of March 2018.
- More than 190 stakeholder hospitals were supported with daily operational business/clinical and data compliance support as well as technical support services. ATC responded to more than 7,500 hospital, independent health facility and other stakeholder requests in 2016/17.
- ATC Business Intelligence Tool (iPort™ Access) login access and identity management transitioned to leverage eHealth's ONE ID system, improving the interface for over 750 users.

MENTAL HEALTH AND ADDICTIONS WAIT TIMES

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

2016/17 Highlights

- ATC, in collaboration with the four MH&A partner organizations, created comprehensive resource manuals to support standardized data submission and associated clinical guidance. Additionally, ATC provided data collection expertise in the establishment of an MH&A data quality framework, data quality indicators and implementation of a monthly review process.
- Standardized data collection and reporting on MH&A wait times and priority indicators were operationalized across the four partner organizations.

CCO's Access to Care program enables improvements in the access, quality and efficiency of healthcare services.

Strategic Initiatives

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

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

Following extensive consultation with stakeholders and partners, CCO developed *Strategic Direction 2012–2018*, an action plan that identifies how we can support health system improvements through a set of specific goals, aligning work in pursuit of those goals, and creating a platform that enables greater improvements in the cancer and chronic kidney disease health systems and in access to care.

Beyond these current areas of focus, CCO will also be active in enabling broader health system improvement by sharing and supporting the use of approaches that have demonstrated success in driving quality, accountability, innovation and value.

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

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

Quality Management Partnership

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

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

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

2016/17 Highlights

- The Partnership made significant strides in establishing its clinical leadership structure. As of March 31, 2017, 100% of the provincial leads and mammography and colonoscopy regional leads were in place, and 73% of the pathology regional leads had been recruited and on-boarded. The Partnership successfully recruited 99% of facility leads and 100% of administrative contacts across all three health services. This network of clinical leadership will strengthen accountability for quality at all levels and will promote consistency and transparency in the three health service areas.
- The Partnership launched the Provincial Quality Committees for the three health service areas. These provincial committees advise on program priorities, refinements of recommendations and future areas of expansion; provide recommendations for quality improvement opportunities; and support change management and knowledge translation exchange across the province.
- The Partnership released provincial, regional and facility-level reports on quality for mammography, colonoscopy and pathology. These reports provide a current state overview of quality based on recommended facility standards and quality indicators. The development and design of these quality reports used a collaborative and iterative process driven by a diverse and dedicated stakeholder group. To support the uptake of these quality reports, the Partnership hosted provincial webcasts, technical briefings and regional events.
- The Partnership launched the Citizens Advisory Committee. The committee provides guidance from the patient/service user's perspective on the overall design and implementation of the QMPs as well as guidance on patient engagement, patient experience indicators and public reporting.
- The Partnership began a multi-phase, mixed-methods evaluation. Phase one of the evaluation focuses on the use and effectiveness of the QMP reports. Results will be presented in Spring 2017 and will be used to inform future reports and engagements.

Health System Funding Reform

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

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

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

2016/17 Highlights

- The chronic kidney disease, gastrointestinal endoscopy and systemic treatment QBPs were refined.
- The cancer surgery QBP for breast and thyroid cancers was implemented. Additional development for the cancer surgery QBP is in progress for future implementation for additional cancers including hysterectomy (co-led with Health Quality Ontario), non-prostate genitourinary surgery and neurosurgery (in collaboration with Provincial Neurosurgery Ontario). Planning continues for the remaining cancers in future years.
- The QBP Evaluation Framework, completed in 2015/16, is helping CCO and MOHLTC understand whether the funding models are achieving intended results, ensuring value for money, enhancing quality and monitoring for unintended consequences. The intended goal for this framework will also include informing design and evaluation of new QBPs and funding models, as well as informing potential redesign of current QBPs. In 2016/17, a pilot was completed to evaluate both the framework and the chronic kidney disease QBP.
- Capacity building within CCO to measure and report on healthcare costs is ongoing; in 2016/17, this included final recruitment for building the Funding Unit team and the on-boarding of a Provincial Lead – Health System Funding as well as ongoing additional data availability.

Ontario Palliative Care Network

The Ontario Palliative Care Network (OPCN) is a provincewide network of healthcare providers and organizations, health system planners, patients, families and caregivers, working together to ensure the provision of coordinated, high-quality hospice palliative care for everyone in Ontario, regardless of their age, illness or where they live.

OPCN has introduced a governance structure, accountable to MOHLTC, under the leadership of four partners: the Local Health Integration Networks (LHINs), CCO, Health Quality Ontario and a coalition of hospice palliative care organizations. This new structure has established a solid foundation that sets OPCN on the path to transforming palliative care in the province.

OPCN was launched in March 2016. It is guided by the report *Advancing High Quality, High Value Palliative Care in Ontario: The Declaration of Partnership and Commitment to Action* and is funded by MOHLTC. OPCN works closely with MOHLTC to ensure its work supports and aligns with *Patients First: A Roadmap to Strengthen Home and Community Care* and Parliamentary Assistant John Fraser's *Palliative and End-of-Life Care Provincial Roundtable Report* (March 2016), both of which highlight a commitment to improved access to and equity in palliative and end-of-life care at home and in the community.

As a lead partner in OPCN, CCO is committed to improving palliative care for all patients—regardless of their age or disease. CCO hosts the OPCN Secretariat and performance reporting infrastructure. CCO is also advancing the commitments of its corporate strategy to share CCO assets and expertise to support improvements beyond cancer and kidney care to other priority areas such as hospice palliative care.

2016/17 Highlights

- The provincial governance structure of OPCN was enhanced with the establishment of a Data and Information Advisory Council and the formalization of the Terms of Reference for all four advisory councils (Clinical Advisory Council, Data and Information Advisory Council, Implementation Advisory Council and Partnership Advisory Council) and the Executive Oversight.
- With CCO's Analytics and Informatics and Infrastructure Planning team, OPCN undertook an initiative to understand the current state, future needs and gaps in palliative care services in Ontario for people with a life-limiting illness who are in their last year of life and are receiving care in the community, home, long-term care, hospice or hospital settings. As a result of this work, an interactive regional profile tool was developed to help each LHIN better understand and plan for the services needed in each region.
- A clinical advisory subgroup was formed to support changes to prescribing high-strength opioids through several functions, including negotiating access of high-strength opioids for Palliative Care Facilitated Access (PCFA) prescribers, developing recommendations to delist other PCFA listed drugs, and creating a revised PCFA applicant process.
- OPCN launched its website, ontariopalliativecare.network.ca, and a newsletter, to promote ongoing awareness of and engagement with the network.

Dementia Capacity Planning

Enhancing and improving dementia care is a key priority identified in MOHLTC's *Patients First: Action Plan for Health Care*. People living with dementia represent a growing population with complex health and social needs within Ontario, and a segment of the population for whom policy makers and healthcare system planners are focusing their attention as part of future system sustainability.

To address the needs of people living with dementia and their care partners, the Dementia Capacity Planning project was established in 2015 to begin work toward a dementia capacity planning framework. This project—which is delivered in partnership with MOHLTC, CCO, the Ontario Brain Institute and the Institute for Clinical Evaluative Sciences—supports Ontario's Dementia Strategy and informs population-based capacity planning within MOHLTC. The scope of the first two years of the project was to develop tools to support community-dwelling persons living with dementia, including a predictive model for dementia care to support strategic and regional planning; and a regional profile tool to provide MOHLTC and other planners access to extensive data on the current state of dementia and the associated health system use in Ontario.

2016/17 Highlights

- A scoping review was developed to synthesize evidence from peer-reviewed literature with the aim of identifying potential candidate scenarios or interventions that would be likely to improve outcomes for people living with dementia, their care partners and the health system.
- Focus groups, which included people living with dementia and/or care partners, were conducted in the Champlain and North East LHINs to better understand the needs of this population and inform strategic planning and analytical modelling.
- An analytical, data-driven model was developed for health system planners and policy makers to estimate the effects of implementing programs on demand for long-term care and capacity requirements at a provincial and LHIN level. Two interventions—care partner education and adult day programs—were incorporated into the model. This work was informed by the best available evidence and through work by the Provincial Medical Lead for Dementia Capacity Planning.
- A regional profile tool for planning, which includes current state and future state dementia planning-relevant information provincially and by LHIN, was developed and shared with the LHINs for feedback.
- A clinical advisory committee, which included people living with dementia and/or care partners, was established to identify strengths and opportunities for improvements with current dementia-related services and provide expert clinical advice on promising local practices and innovations.
- A knowledge transfer plan was developed and executed to ensure project knowledge across all partner organizations was appropriately transferred and maintained for successful continuation and replication of the dementia capacity planning process within MOHLTC.

Financial Statements

2016/17



June 29, 2017

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, 2017, Cancer Care Ontario's Board of Directors, through the Audit Finance Committee, was responsible for ensuring that management fulfilled its responsibilities for financial reporting and internal controls. The Committee meets regularly with management, the internal auditor and the Auditor General to satisfy itself that each group had properly discharged its respective responsibility, and to review the financial statements before recommending approval by the Board of Directors. The Auditor General had direct and full access to the Audit Finance Committee, with and without the presence of management, to discuss their audit and their findings as to the integrity of Cancer Care Ontario's financial reporting and the effectiveness of the system of internal controls.

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

On behalf of Cancer Care Ontario Management,

Michael Sherar, PhD
President and CEO

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

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Office of the Auditor General of Ontario
Bureau de la vérificatrice générale 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, 2017 and the statements of operations, changes in fund balances, and cash flows for the year then ended and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of Cancer Care Ontario as at March 31, 2017 and the results of its operations, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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Toronto, Ontario
June 29, 2017

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

www.auditor.on.ca

Cancer Care Ontario

Statement of Financial Position

As at March 31, 2017

(in thousands of dollars)

	2017 \$	2016 \$
Assets		
Current assets		
Cash (note 3)	64,745	55,500
Investments (note 4)	76,226	66,141
Receivables and prepaid expenses (note 5)	5,069	49,094
	146,040	170,735
Capital assets (note 6)	6,867	6,047
	152,907	176,782
Liabilities		
Current liabilities		
Accounts payable and accrued liabilities (note 7)	98,161	119,196
Non-current liabilities		
Deferred contributions related to capital assets (note 8)	5,989	4,277
Post-employment benefits other than pension plan (note 9(b))	2,428	2,511
	8,417	6,788
Fund Balances		
Endowment (note 19)	88	1,088
Internally restricted	86	99
Externally restricted	1,577	1,867
General - unrestricted (note 20)	43,700	45,974
Invested in capital assets (note 10)	878	1,770
	46,329	50,798
	152,907	176,782
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.

(1)

Cancer Care Ontario

Statement of Operations

For the year ended March 31, 2017

(in thousands of dollars)

	Restricted		General		Total	
	2017 \$	2016 \$	2017 \$	2016 \$	2017 \$	2016 \$
Revenue						
Ministry of Health and Long-Term Care	-	-	2,023,038	1,923,965	2,023,038	1,923,965
Amortization of deferred contributions related to capital assets (note 8)	-	-	1,268	2,092	1,268	2,092
Other revenue (note 12)	1,396	2,968	5,297	4,298	6,693	7,266
Investment income (note 11)	1	12	2,201	2,441	2,202	2,453
	1,397	2,980	2,031,804	1,932,796	2,033,201	1,935,776
Expenses						
Cancer and prevention related services	9	10	754,123	634,123	754,132	634,133
Chronic kidney disease services	-	-	634,118	621,421	634,118	621,421
Provincial drug reimbursement program	-	-	319,262	349,879	319,262	349,879
Screening services	-	-	159,986	158,324	159,986	158,324
Salaries and benefits (note 9)	1,953	2,322	105,845	100,703	107,798	103,025
Capital contributions to cancer related services	-	-	34,730	35,699	34,730	35,699
Other operating expenses (note 13)	237	233	20,365	22,415	20,602	22,648
Purchased services	496	673	2,882	4,974	3,378	5,647
Amortization of capital assets	-	-	2,279	3,667	2,279	3,667
Clinical translational research	-	-	1,385	2,149	1,385	2,149
	2,695	3,238	2,034,975	1,933,354	2,037,670	1,936,592
(Deficiency) of revenue over expenses	(1,298)	(258)	(3,171)	(558)	(4,469)	(816)

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

(2)

Cancer Care Ontario
Statement of Changes in Fund Balances
For the year ended March 31, 2017

(in thousands of dollars)

	2017					
	Restricted			General unrestricted \$	Invested in capital assets \$	Total \$
	Endowment \$	Internally \$	Externally \$			
Fund balances - March 31, 2016	1,088	99	1,867	45,974	1,770	50,798
(Deficiency) of revenue over expenses	(1,000)	(8)	(290)	(3,171)	-	(4,469)
Net change in invested in capital assets (note 10)	-	-	-	892	(892)	-
Interfund transfers (note 14)	-	(5)	-	5	-	-
Fund balances - March 31, 2017	88	86	1,577	43,700	878	46,329

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

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

(3)

Cancer Care Ontario
Statement of Cash Flows
For the year ended March 31, 2017

(in thousands of dollars)

	2017 \$	2016 \$
Cash provided by (used in)		
Operating activities		
(Deficiency) of revenue over expenses	(4,469)	(816)
Amortization of capital assets	2,279	3,667
Amortization of deferred contributions related to capital assets	(1,268)	(2,092)
Post-employment benefits expense other than pension plan	141	244
Post-employment benefits paid other than pension plan	(224)	(171)
Change in non-cash operating working capital		
Receivables and prepaid expenses	44,025	(38,162)
Accounts payable and accrued liabilities	(21,035)	(7,617)
	19,449	(44,947)
Capital activities		
Purchase of capital assets	(3,099)	(2,889)
Investing activities		
Proceeds from maturity of investments	-	94,777
Purchase of investments	(10,085)	(65,530)
	(10,085)	29,247
Financing activities		
Amounts received related to capital assets	2,980	320
Increase (decrease) in cash during the year	9,245	(18,269)
Cash - Beginning of year	55,500	73,769
Cash - End of year	64,745	55,500

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

(4)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

1 Nature of operations

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

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

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

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

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

2 Significant accounting policies

Basis of presentation

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

Fund accounting

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

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

(5)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

2 Significant accounting policies - continued

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 charged to the financial instrument.

(6)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2017

(in thousands of dollars)

2 Significant accounting policies - continued

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.

(7)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2017

(in thousands of dollars)

2 Significant accounting policies - continued

Use of estimates

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

3 Cash - restricted

Cash includes \$330 (2016 - \$420), 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

	2017 \$	2016 \$
Guaranteed investment certificates, as follows:		
Redeemable on demand:		
Interest at 1.75%, maturing September 5, 2017	44,861	44,861
Interest at 1.75%, maturing October 2, 2017	10,830	10,830
Interest at 1.75%, maturing November 3, 2017	10,450	10,450
Non-Redeemable on demand:		
Interest at 1.60%, maturing March 19, 2018	10,085	-
	<u>76,226</u>	<u>66,141</u>

5 Receivables and prepaid expenses

	2017 \$	2016 \$
Accounts receivable	2,606	16,644
Due from MOHLTC	350	30,765
Prepaid expenses	<u>2,113</u>	<u>1,685</u>
	<u>5,069</u>	<u>49,094</u>

(8)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

6 Capital assets

	2017		
	Cost \$	Accumulated amortization \$	Net book value \$
Therapeutic and other technical equipment	2,996	2,955	41
Office furniture and equipment	7,417	6,798	619
Leasehold improvements	5,058	4,972	86
Land and building	1	-	1
Software	34,633	28,513	6,120
	<u>50,105</u>	<u>43,238</u>	<u>6,867</u>
	2016		
	Cost \$	Accumulated amortization \$	Net book value \$
Therapeutic and other technical equipment	4,242	4,100	142
Office furniture and equipment	7,426	6,319	1,107
Leasehold improvements	5,056	4,583	473
Land and building	1	-	1
Software	34,411	30,087	4,324
	<u>51,136</u>	<u>45,089</u>	<u>6,047</u>

The cost of capital assets includes software under development of \$3,464 (2016 - \$3,319). Amortization of these amounts will commence when the asset is available for use. During the year, there were disposals of fully depreciated capital assets of \$4,130 (2016 - \$Nil). The values represent the original cost.

7 Accounts payable and accrued liabilities

	2017 \$	2016 \$
Trade payables	38,738	58,927
Accrued liabilities	48,783	49,207
Payable to MOHLTC	10,206	10,284
Payable to other funders	104	358
Pension escrow (note 3)	330	420
	<u>98,161</u>	<u>119,196</u>

(9)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

8 Deferred contributions related to capital assets

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

	2017 \$	2016 \$
Balance - beginning of year	4,277	6,049
Amounts received related to capital assets	2,980	320
Amounts recognized as revenue	<u>(1,268)</u>	<u>(2,092)</u>
Balance - end of year	<u>5,989</u>	<u>4,277</u>

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

	2017 \$	2016 \$
Unamortized capital contributions used to purchase capital assets	5,989	4,277
Unspent contributions	<u>-</u>	<u>-</u>
	<u>5,989</u>	<u>4,277</u>

9 Pension benefits and post-employment benefits

a) Pension plan

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

Contributions to HOOPP made during the year by the Organization on behalf of its employees amounted to \$8,724 (2016 - \$7,817) and are included in the pension expenses, which reflect all amounts owing for the year, in the statement of operations.

(10)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2017

(in thousands of dollars)

9 Pension benefits and post-employment benefits - continued

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 \$224 (2016 - \$171). The actuarial valuation for the post-employment benefits other than pension plan is dated March 31, 2016 and has been extrapolated to March 31, 2017.

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

	2017 \$	2016 \$
Accrued benefit obligation	2,795	2,935
Unamortized actuarial losses	(367)	(424)
Post-employment benefits other than pension plan	2,428	2,511

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

	2017 \$	2016 \$
Post-employment benefits other than pension plan - opening balance	2,511	2,438
Expense related to post-retirement benefits	141	244
Funding contributions	(224)	(171)
Post-employment benefits other than pension plan - ending balance	2,428	2,511
	2017 \$	2016 \$
Interest cost	84	117
Amortization of experience losses	57	127
Total expense related to post-retirement benefits	141	244

(11)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2017

(in thousands of dollars)

9 Pension benefits and post-employment benefits - continued

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:

	2017	2016
Discount rate	3.00%	3.00%
Extended health care trend rate	6.00% in 2017 to 4.5% in 2023 and after	6.25% in 2016 to 4.5% in 2023 and after
Dental cost trend rates	3%	3%
Employee average remaining lifetime (years)	9.5	9.22

10 Invested in capital assets

	2017 \$	2016 \$
Capital assets	6,867	6,047
Amounts financed by deferred capital contributions (note 8)	(5,989)	(4,277)
	878	1,770

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

	2017 \$	2016 \$
Purchase of capital assets	3,099	2,889
Capital funding	(2,980)	(2,572)
Amortization of deferred contributions related to capital assets	1,268	2,092
Amortization of capital assets	(2,279)	(3,667)
	(892)	(1,258)

11 Investment income

Investment income earned on the Endowment Fund resources in the amount of \$1 (2016 - \$12) is included in the Restricted Fund.

(12)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

12 Other revenue

	2017 \$	2016 \$
General Fund		
Public Health Ontario	2,353	2,313
Canadian Partnership Against Cancer	1,231	898
Other income	1,713	1,087
	<u>5,297</u>	<u>4,298</u>
Restricted Fund		
Grants	<u>1,396</u>	<u>2,968</u>

13 Other operating expenses

	2017 \$	2016 \$
Restricted Fund	<u>237</u>	<u>233</u>
General Fund		
Equipment	7,492	6,849
General office	1,385	1,513
Occupancy costs	5,213	5,176
Education and publications	2,209	3,600
Consulting services	1,968	2,712
Travel	1,610	1,481
Professional fees	176	278
Other expenses	312	806
	<u>20,365</u>	<u>22,415</u>

14 Interfund transfers

	2017 \$	2016 \$
Transfer to the General Fund from the Internally Restricted Fund	5	175
Transfer to the General Fund from the Externally Restricted Fund	-	2
	<u>5</u>	<u>177</u>

(13)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

15 Commitments

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

	\$
2018	9,199
2019	9,083
2020	8,528
2021	7,082
2022	5,937
	<u>39,829</u>

16 Contingencies

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

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

17 Guarantees

a) Director/officer indemnification

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

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

(14)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2017

(in thousands of dollars)

17 Guarantees - continued

b) Other indemnification agreements

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

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

18 Financial instruments

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

Credit risk

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

(15)

Cancer Care Ontario
Notes to Financial Statements
March 31, 2017

(in thousands of dollars)

18 Financial instruments - continued

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	2,018	548	32	8	2,606
Due from MOHLTC	-	-	350	-	350
Amount receivable	2,018	548	382	8	2,956

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.

Liquidity risk

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

	0 to 30 days \$	31 to 60 days \$	61 to 90 days \$	91 + days \$	Total \$
Trade payables	38,738	-	-	-	38,738
Accrued liabilities	48,780	3	-	-	48,783
Payable to MOHLTC	10,206	-	-	-	10,206
Payable to other funders	104	-	-	-	104
Pension escrow	-	-	-	330	330
Amount payable	97,828	3	-	330	98,161

(16)

Cancer Care Ontario

Notes to Financial Statements

March 31, 2017

(in thousands of dollars)

19 Fund Balances – Endowment

Contributions held by CCO in the amount of \$1,000 plus interest of \$181 earned since 1996, were transferred, at the request of the donor, to Western University through mutual agreement between CCO, London Heath Sciences Centre and Western University.

20 Subsequent Event – General Unrestricted Fund Balance

Subsequent to March 31, 2017, CCO received direction from the MOHLTC that it would need to pay \$15 million from its General – Unrestricted Fund Balance to the MOHLTC during fiscal 2017-18 and a reduction of \$5 million to its annual MOHLTC base funding.

21 Comparative figures

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

(17)

Appendices

Board of Directors

Ratan Ralliar

(November 15, 2006 – January 4, 2018; Chair: January 5, 2015 – January 4, 2018)

Bonnie Jean Adamson

(May 27, 2015 – May 26, 2018)

D. Scott Campbell

(April 18, 2012 – April 17, 2018)

Dr. Euan Carlisle

(January 5, 2015 – January 4, 2018)

Catherine Caule

(March 8, 2017 – March 7, 2020)

Malcolm Heins

(February 25, 2009 – February 24, 2018)

Shoba Khetrpal

(December 21, 2006 – December 20, 2016)

Marilyn Knox

(March 23, 2011 – March 22, 2020)

Patricia Lang

(June 20, 2007 – June 19, 2017)

Dr. Andreas Laupacis

(March 23, 2011 – March 22, 2017)

Patrick Madahbee

(March 1, 2017 – February 29, 2020)

Carol Poulsen

(December 10, 2014 – December 9, 2017)

David Ross

(May 29, 2013 – May 28, 2019)

Betty-Lou Souter

(June 20, 2007 – June 19, 2016)

Harvey Thomson

(April 18, 2012 – April 17, 2018)

David Wexler

(February 10, 2016 – February 9, 2019)

David Williams

(April 18, 2011 – April 17, 2020)

Executive Leadership

Michael Sherar

President and CEO

Elizabeth Carson

Vice-President, Technology Services

Jason Garay

Vice-President, Analytics and Informatics

Rebecca Harvey

Vice-President, Ontario Renal Network

Paula Knight

Vice-President, People, Strategy and Communications

Garth Matheson

Vice-President, Planning and Regional Programs

Dr. Robin McLeod

Vice-President, Clinical Programs and Quality Initiatives

Dr. Linda Rabeneck

Vice-President, Prevention and Cancer Control

Elham Roushani

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

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create the best health
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