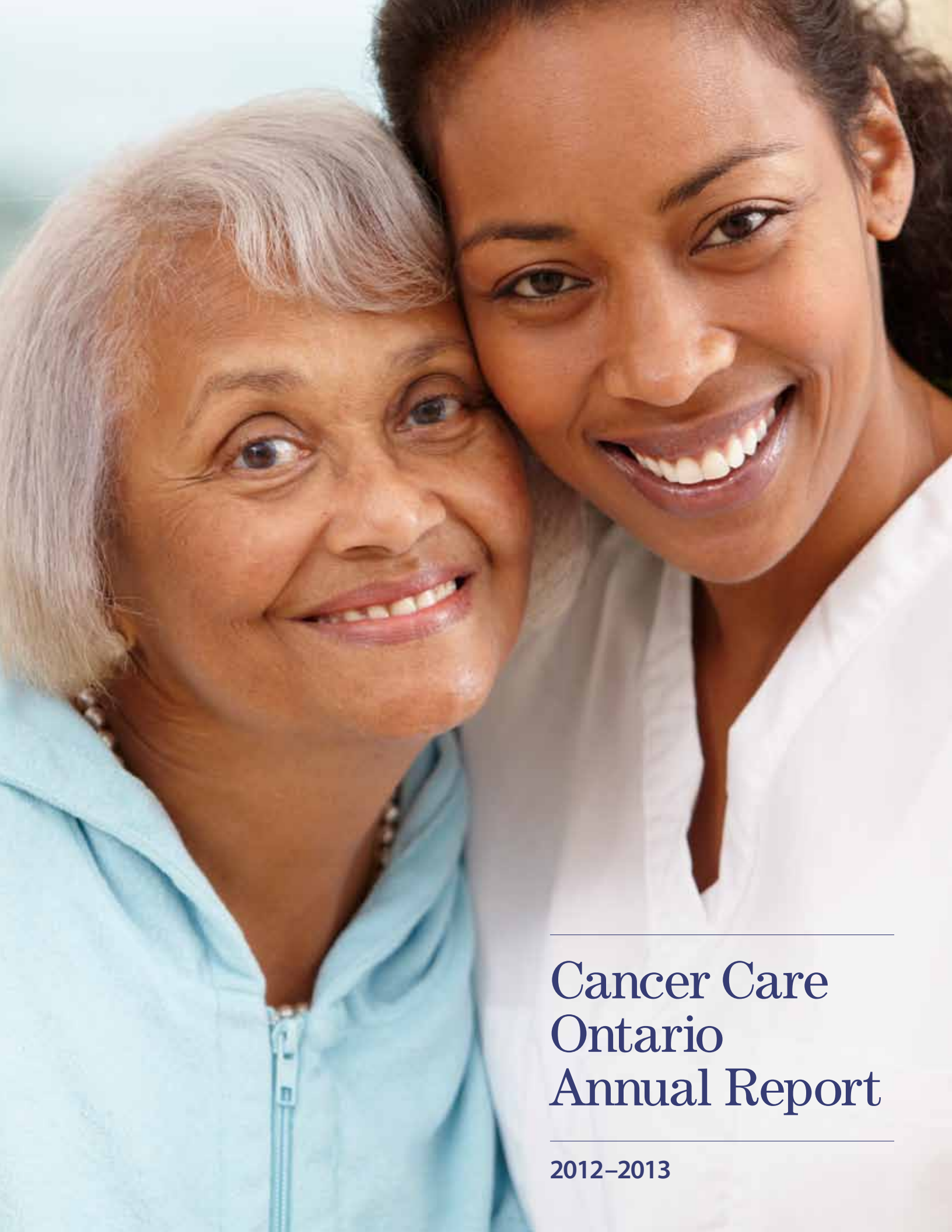




Cancer Care Ontario Annual Report

2012–2013

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Letter from the President and the Chairman of Cancer Care Ontario

The past year was one of significant progress as Cancer Care Ontario continued to help shape the future of healthcare in cancer, chronic kidney disease and access to care for the people of Ontario.

This progress was made in the face of a serious fiscal and demographic environment that challenges the province's ability to meet the healthcare needs of Ontarians.

Ontario's Action Plan for Healthcare addresses the reality that baby boomers – the largest generation in Canadian history – are reaching an age when they will need more healthcare. Chronic diseases – like cancer and chronic kidney disease – are associated with aging. They are the major causes of disability, the main reasons people seek healthcare and the cause of 79 percent of all Ontario deaths.

This, combined with a growing population and a constrained economic environment, is placing ever-greater pressure on our healthcare resources and their costs and has tremendous implications for our health system.

If we didn't change anything, kept the age-specific costs as they are today and applied them to the 2030 population, our health costs would rise by \$24 billion – a 50 percent increase from changing demographics alone.

In future, those demographics will play an increasing role. The reality is that 45 percent of men and 40 percent of women in Canada will face cancer in their lifetimes. In Ontario in 2013, nearly 28,000 people will die of cancer and almost 70,000 new cases will be diagnosed.

In renal care, the prevalence of chronic kidney disease continues to increase. Today, an estimated 1.5 million Ontarians have – or are at increased risk of developing – kidney disease.

These factors have made transformation of our healthcare system even more of a necessity, and in the past year Cancer Care Ontario continued to play an important role in helping bring about needed changes.

We are doing this by driving quality and continuous improvement in disease prevention and screening, the delivery of care and the patient experience for cancer and chronic kidney disease and in access to care for key health services.

We are guided by an overarching Corporate Strategy and system strategic plans – the Ontario Cancer Plan III, 2011–2015 and the first Ontario Renal Plan, 2012–2015.

Created in 2011–2012, our Corporate Strategy guides our efforts to improve the performance of health systems for cancer, chronic kidney disease and access to care across Ontario.

It encompasses five areas of focus – supporting patient-centred care, preventing chronic disease, integrating care, ensuring value for money and sharing knowledge. Together, these address Ontario's most critical healthcare challenges and will be instrumental in improving quality, transforming our healthcare system and framing the next chapter in CCO's work.

Under this overarching corporate strategy, our system strategies for cancer, chronic kidney disease and access to care serve as roadmaps, detailing the ways in which CCO will work with health professionals and organizations, government and disease experts to prevent and fight cancer and chronic kidney disease while improving access and the quality of care.

Together, these plans are addressing the challenges facing healthcare in Ontario and in the past year have guided our actions and driven our accomplishments. Among them:

CANCER

This past year, we:

- Introduced new cervical cancer screening guidelines for the province that clarify the age when screening should start and the optimum screening interval. Annually in Ontario, about 550 women are diagnosed with cancer of the cervix and about 160 women die from the disease.
- Launched the 2012–2015 Aboriginal Cancer Strategy II, which sets out a clear plan for reducing risk and preventing cancer in Aboriginal communities. As part of the strategy, CCO appointed Aboriginal Patient Navigators and Regional Aboriginal Cancer Leads in four key regions of the province that are home to significant First Nations, Inuit and Métis populations. The Leads and Navigators work to promote better access to timely cancer diagnosis and treatment and seamless, coordinated care.
- Improved the quality and consistency of physical and emotional symptom management by responding to what patients themselves identify as most concerning to them. Using our Interactive Symptom Assessment and Collection (ISAAC) electronic screening platform, 53 percent of patients seen in the 14 Regional Cancer Centres in 2012–2013 were routinely screened for symptoms. This compares with 50.5 percent in 2011–2012. Enabling patients to drive improvements in symptom management allows the cancer system to ensure a higher quality of life for patients and families throughout their care journey.
- Increased the proportion of patients receiving radiation, chemotherapy and surgery within recommended time targets for treatment. In radiation, 89 percent of patients were treated within the 14-day target in 2012, an increase of 5 percent from 2011. In chemotherapy, wait times for consult to treatment remained stable between 2011 and 2012, with 73 percent of patients being treated within the 28-day target, despite increased volumes. In cancer surgery, overall 81 percent of patients received their surgery within the recommended wait time in 2012, an increase of three percentage points from 2011, despite increasing demand.
- Ensured more patients can receive care closer to home by opening the Niagara Health System's Walker Family Cancer Centre in St. Catharines and expanding the Simcoe Muskoka Regional Cancer Centre in Barrie.
- Leveraged our strategy of investing in a portable bunker in Ottawa and equipment in Barrie to redeploy these assets – with the opening of new facilities in those two cities – to Peterborough to ensure patients there can receive care closer to home and not have to travel to another cancer centre for treatment.
- Increased the number of Multidisciplinary Cancer Conferences (MCCs) in hospitals. During the year, approximately 32,000 patients were the focus of multidisciplinary discussions, up from 26,000 in 2011–2012. MCCs provide an opportunity for health professionals to discuss diagnosis and treatment options with the goal of providing optimal patient management.
- Implemented new models of follow-up care for colorectal cancer (piloted in three sites) and breast cancer (all sites) patients with our Regional Cancer Programs. The initiative optimized how care is provided to patients once their active treatment is complete. Results from the measurement of patient and provider experiences with the new models of care delivery suggested that patients now are transitioned from cancer centres with appropriate tools and knowledge regarding their ongoing follow-up care, and providers now have evidence-based guidelines outlining a standardized approach to delivering care after patients leave the cancer centre. In 2012, approximately 600 colorectal cancer patients were transitioned to new models of follow-up care, which will contribute to overall system sustainability.

ONTARIO RENAL NETWORK

This past year, we:

- Launched the Ontario Renal Plan, the province's first comprehensive strategy for improved care of Chronic Kidney Disease (CKD) patients. With the patient at its centre, the plan addresses the detection, diagnosis and treatment of CKD in a systematic way for the first time in Ontario's history.
- Launched the Independent Dialysis (ID) and Body Access Coordinator Collaborative to support front-line healthcare providers in sharing best practices for home dialysis and vascular access. This project aligns with the ORN target of having 40 percent of all new dialysis patients on the independent dialysis (ID) option within six months of initiating dialysis by 2015. Independent, or home dialysis enhances a patient's quality of life and reduces costs to the healthcare system. In 2012–2013, 32.9 percent of new patients were on ID. The collaborative also supports ORN's target of decreasing prevalent hemodialysis catheter use by 2 percent annually. Today, arteriovenous (AV) fistulas are considered the optimal access for hemodialysis. AV fistulas last a long time and have lower complication rates than other types of access, such as catheters. Provincially, the catheter rate for vascular access remained stable in 2012–2013 at 56.2 percent.
- Launched a Mentorship Pilot Project to build stronger relationships between nephrologists and primary care practitioners, with the goal of enhancing early screening and detection practices for patients at risk for CKD, better managing the disease and clarifying the criteria for patients being appropriately referred to nephrology. Year one of this program saw seven nephrologists linked with 154 primary care practitioners.
- Implemented a CKD patient-based funding framework to align hospital funding with the number of patients they see, the services they deliver and the quality of those services. In 2012–2013, 26 regional programs, which include 31 providers, were involved in the ORN's phase 1 implementation.

- Rolled out a Vascular/Independent Dialysis Assessment Tracker to all 26 Regional CKD programs. This tool documents and communicates key decision points and milestones in a patient's continuum of care and identifies barriers to use of AV fistula access and the uptake of ID. The tool supports ORN's targets of having 100% of patients seen in a pre-dialysis clinic for at least one year assessed for appropriate body access and for ID suitability before starting dialysis.

ACCESS TO CARE

CCO's Access to Care (ATC) program supports Ontario's Wait Time and Emergency Room/Alternate Level of Care Strategies. ATC provides high-quality information products and services to healthcare organizations across the province. They, in turn, use them to reduce wait times and improve patient access to healthcare services.

This past year, we:

- Deployed four additional Alternate Level of Care data elements to 122 facilities. These additional data elements provide a more comprehensive picture of those patients not accessing the right level of care and highlight barriers to patients being discharged to the appropriate level of care. As a result, hospitals are provided with more robust data that can be used to improve patient outcomes.
- Continued to expand our reporting of emergency room (ER) wait-time data to help measure and ultimately reduce how long patients spend in the ER by 1.2 hours, a 13 percent reduction compared with the April 2008 baseline. Hospitals are able to use this information to improve patient flow and capacity planning.
- Provided operating room performance data from our Surgical Efficiency Targets Program (SETP) to hospitals so they could improve efficiency and surgical capacity to handle ongoing growth in demand at reduced cost while maintaining high-quality patient care. Seventy-seven hospitals submitted SETP data last year.

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- Conducted an operational reporting review with the ministry, hospitals, LHINs and CCACs to better understand their reporting requirements. The review resulted in ATC providing new and enhanced reports that enable its stakeholders to make more informed decisions.

While we made important gains in the fight against cancer and chronic kidney disease, and in access to healthcare in the past year, the need continues to grow, and we have much more work to do.

We project that by 2015, the number of people in Ontario diagnosed with cancer will have increased by 50 percent from 1999 figures. And in the 10 years to 2021, the number of people living with or beyond cancer in Ontario will increase by more than one third. That equates to more than 400,000 Ontarians, compared with 300,000 in 2007.

And today, more than 10,000 Ontarians with chronic kidney disease require dialysis to stay alive, at a cost of about \$500 million a year, and more than 1,000 people are waiting for a kidney transplant.

Thus, while Ontario's health system has recorded many gains and has many strengths, it continues to face growing challenges.

CCO is fully invested in meeting these challenges, and in the years ahead we will continue to play a leadership role in supporting and advancing the transformation of Ontario's healthcare system.

Toronto, July 2013



Ratan Ralliar, Chair



Michael Sherar, PhD, President and CEO

About Cancer Care Ontario (CCO)

Cancer Care Ontario – an Ontario government agency – drives quality and continuous improvement in disease prevention and screening, the delivery of care and the patient experience for cancer and chronic kidney disease, as well as access to care for key health services.

Known for its innovation and evidence-based approaches, CCO leads multi-year system planning, contracts for services with hospitals and providers, develops and deploys information systems, establishes guidelines and standards and tracks performance targets to ensure system-wide improvements in cancer, chronic kidney disease – through the Ontario Renal Network – and access to care.

CCO began life in April 1943 as the Ontario Cancer Treatment and Research Foundation. More than a half century later, in 1997, it was formally launched and funded as an Ontario government agency. CCO is governed by The Cancer Act and is accountable to the Ministry of Health and Long-Term Care (MOHLTC). Details of this relationship with the MOHLTC are laid out in a formal Memorandum of Understanding (MOU) signed in December 2009.

As the government's cancer advisor, CCO:

- Directs and oversees more than \$1 billion in funding for hospitals and other cancer care providers, enabling them to deliver high-quality, timely cancer services and improved access to care.
- Implements provincial cancer prevention and screening programs.
- Works with cancer care professionals and organizations to develop and implement quality improvements and standards.

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

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

ONTARIO RENAL NETWORK (ORN)

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

The ORN's goal is to improve CKD management by preventing or delaying the need for dialysis, broadening appropriate CKD patient-care options, improving the quality of all stages of CKD care and building a world-class system for delivering care to Ontarians living with CKD.

ACCESS TO CARE (ATC)

In 2004, Canada's First Ministers made a national commitment to reduce wait times for key healthcare services. In Ontario, this commitment resulted in the MOHLTC's Wait Time Strategy and its subsequent Emergency Room/Alternate Level of Care (ER/ALC) Strategy.

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

As the service delivery agent for the Wait Times Strategy and ER/ALC Information Strategy, ATC enables improvements in the access, quality and efficiency of healthcare services. It also helps to reduce wait times by implementing and using IM/IT solutions, and by tracking patients as they move across the continuum of care.

In addition, CCO manages special access programs, such as Positron Emission Tomography for uninsured indications. Activities such as these are mandated through separate accountability agreements between CCO and the MOHLTC.

The Ontario Cancer Plan (OCP)

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

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

In 2011, CCO launched its third Ontario Cancer Plan (OCP III), covering the years 2011 to 2015.

OCP III continues the transformation of cancer services across Ontario, including the development of new patient-centred models of care delivery. The development of OCP III focused on measurable outcomes and consultation with patients. The patient experience is central to OCP III and recognizes that patients need:

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

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



2012–2013 Highlights and Achievements Cancer Services

Prevention and Cancer Control

CCO's Prevention and Cancer Control (P&CC) portfolio comprises a Cancer Screening Program (made up of four units), five other units and a Centre of Practice. Four of the five units not part of Cancer Screening work on research, prevention, surveillance, occupational health research and Aboriginal initiatives to ease the burden of cancer. The fifth non-screening unit provides business operations, planning and performance management support to the whole portfolio. P&CC also has a Primary Care Centre of Practice which provides guidance and expertise for Primary Care work across the full cancer journey and in support of CCO's work on other chronic diseases.

The portfolio aligns with CCO's corporate strategy and supports all six priorities of the Ontario Cancer Plan III (OCP III). The portfolio is particularly focused on the delivery of initiatives within the strategic priority areas of cancer risk reduction (Strategic Priority 1) and cancer screening and early detection (Strategic Priority 2) and contributes to other OCP III priorities.

To support OCP III, P&CC has three portfolio-level strategic priorities: (1) Prevention (2) Screening and (3) Cancer Care and Disease Management. Some of P&CC's units have, or are in the process of creating detailed strategic plans for their specific areas.

The P&CC Portfolio

RESEARCH

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

The Research Unit's goals are to increase knowledge of the distribution, causes and determinants of cancer. It explores issues such as the willingness to change, which is relevant to interventions designed to reduce cancer risk. Furthermore, it links the generation of new knowledge with policy and practice to strengthen and expand the Research Centre of Excellence within P&CC.

Within the unit, Clinical and Translational Research oversees administration for CCO's Research Chairs Program, its Applied Cancer Research Units (ACRU) and its four research networks.

Clinical and Translational Research also provides funding to researchers across the province in four important areas: cancer imaging, health services, population studies and experimental therapeutics. Funding is provided to CCO Research Chairs, Networks and ACRUs.

Highlights

In 2012–2013, we:

- Developed a research agenda focused on interventions to improve prevention of chronic disease.
- Increased our capacity to conduct geospatial analyses mapping cancer and to support public health units across Ontario.
- Fostered research in gene environment interactions.
- Continued our involvement in the International Cancer Benchmarking Partnership (ICBP), which strives to understand how and why cancer survival rates vary between participants in Australia, Canada, Denmark, Norway, Sweden and the UK.
- Identified community partners and developed population-specific research programs to increase cancer screening in hard-to-reach and under/never-screened populations in Ontario.

Looking Ahead

In 2013–2014, we will:

- Develop and implement a multi-year strategy to consolidate research at CCO focusing on key strategic priorities.
- Conduct research to explore possible associations between cancers and risk factors, including obesity, environmental contaminants and occupational exposures.
- Support the development of the Ontario Cancer Study (OCS).
- Undertake the implementation of changes to the Research Networks program and plan the external review of ACRUs.
- Conduct a pilot study of the OPT-IN procedure for patient contact studies.

PREVENTION AND SURVEILLANCE

Prevention and Surveillance is organized as one unit, but it comprises different initiatives. The Prevention group leads development of the Online Cancer Risk Tool, which is part of the first pillar of Ontario's Action Plan for Health Care, and the Prevention Performance Measurement Framework, both of which are deliverables under OCP III. Prevention and Surveillance also helps Ontarians reduce their risk of developing cancer through a wide range of prevention strategies and actions. These are based on strong evidence about the kinds of behaviours or exposures that increase or decrease a person's risk of developing cancer. The Surveillance Group within Prevention and Surveillance turns raw data into meaningful information using sophisticated analytic techniques and interpretation. It develops indicators for – and analyzes – risk factors and cancer burden and develops screening strategies for monitoring specific groups such as Aboriginal populations. The Provincial Training and Consultation Centre (PTCC), the third program within Prevention and Surveillance, focuses on tobacco control.

PREVENTION

While there is much to be learned about the causes of cancer, there is evidence that a number of modifiable behaviours and exposures can affect an individual's risk. These include tobacco use, alcohol consumption, physical inactivity and unhealthy eating. A goal of the OCP III is to help Ontarians lessen their risk of developing cancer. One strategic priority under this is to develop and implement a focused approach to cancer risk reduction. To accomplish this, CCO engages in a number of prevention activities.

The PTCC plays a leading role in providing training, consultation and other capacity-building services to Ontario health intermediaries working in tobacco control. The program also facilitates the coordination of services among other Smoke-Free Ontario resource centres and acts as a knowledge broker between local public health departments, the research community and government.

Highlights

In 2012–2013, we:

- Completed an environmental scan, finalized requirements for a prototype Online Cancer Risk Assessment Tool (OCRAT), developed prototype for two cancers (breast and lung) for testing and research and created a project plan as per the FY2012-2013 Integrated Cancer Screening funding letter.
- Initiated and supported the Smoking Cessation Steering Committee, which developed a framework for smoking cessation activities among ambulatory cancer patients in the Regional Cancer Programs.
- Developed a business case and preliminary framework for measuring performance of cancer prevention. The business case was supported by a comprehensive scan of other successful approaches to accurately depict measures of our collective ability to prevent cancer.
- Advanced action by the government and other stakeholders on the recommendations in the *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario* report. We shared our expertise and insights from this report with Ontario's Healthy Kids Panel, which incorporated many of our recommendations in its final report.
- Conducted a community-based intervention research project to support smoking cessation among young adult retail workers.
- Continued to support the MOHLTC's renewal of the Smoke-Free Ontario Strategy through training development, delivery and system-level planning and coordination.

Looking Ahead

In 2013–2014, we will:

- Continue development of the Online Cancer Risk Assessment Tool for release to the public in December 2014.
- Initiate a comprehensive strategic plan for cancer and chronic disease prevention, articulating gaps in the system that CCO can address.
- Develop a workplace prevention strategy within CCO to create an office environment that is a model workplace for cancer risk reduction and prevention.

- Continue to build the capacity of Ontario's 36 public health departments to plan and implement evidence-informed tobacco-control programs through training, technical assistance and other capacity-building programs.
- Develop new practice-based research initiatives that align with the PTCC's applied research agenda.

SURVEILLANCE

Highlights

In 2012–2013, we:

- Published *Cancer Risk Factors in Ontario: Evidence Summary*, a resource for prevention programming. It summarizes the scientific evidence linking a broad range of risk factors and exposures to specific cancers.
- Provided a detailed analysis of lung cancer in Ontario for the Cancer Quality Council of Ontario's Cancer System Quality Index.

Looking Ahead

In 2013–2014, we will:

- Continue our series of *Cancer in Ontario* publications with a report on tobacco use and cancer in Ontario.
- Continue to enhance our surveillance of specific populations, with a special focus on cancer and risk factors in Ontario First Nations, Inuit and Métis, and the production and dissemination of information on cancer incidence, mortality, survival and prevalence in Ontario. This information assists Ontario and CCO in planning, funding and evaluating our cancer services.

CANCER SCREENING PROGRAM (formerly Integrated Cancer Screening)

Cancer screening improves early detection and saves lives. In 2007, Ontario committed to increasing prevention and early detection of cancer, with a focus on improving screening rates for colorectal, breast and cervical cancers. In 2012, the MOHLTC, in its Action Plan for Health Care, committed to expand Ontario's screening programs for cervical, breast and colorectal cancer. To accomplish this, CCO and MOHLTC are implementing the Integrated Cancer Screening (ICS) strategy, with the mandate to speed reduction in cancer mortality by implementing coordinated, organized cancer screening programs across Ontario.

Managed by CCO's newly reorganized Cancer Screening Program, the ICS strategy is focused on increasing public participation in screening, improving provider performance and establishing a high-quality screening system supported by a common information management and technology infrastructure. Organized, population-based cancer screening programs have been shown to increase screening rates, improve access, reduce cancer treatment costs and, ultimately, reduce mortality.

The Cancer Screening Program leads the planning and operation of colorectal, breast and cervical cancer screening at the provincial and regional level. This includes policy development and advice, education, clinical practice guidelines and standards development, clinical engagement, stakeholder engagement functions, program design, program funding, program management, contract management and screening performance management.

Colorectal, breast and cervical cancers together account for nearly 30 percent of all newly diagnosed cancer cases. The Cancer Screening Program oversees three distinct screening programs for these cancers: ColonCancerCheck, the Ontario Breast Screening Program and the Ontario Cervical Screening Program.

Several units that provide crucial support to CCO's cancer screening initiatives were absorbed formally into the Program. For example, a new dedicated Evaluation and Reporting unit will evaluate the effectiveness and impact of our cancer screening programs. It will monitor progress in cancer control and develop and conduct formal evaluations on screening interventions. Each screening program has a Scientific Lead that supports the development of performance indicators and the analysis of performance data and that assists in identifying, validating and evaluating initiatives to improve cancer screening.

Highlights

In 2012–2013, we:

- Began a pilot to assess the effectiveness and feasibility of the Fecal Immunochemical Test in the Ontario context as recommended by the Program in Evidence-based Care.
- Developed recommendations for an organized follow-up service delivery model to ensure timely and appropriate follow-up for people who have abnormal screening test results.
- Implemented a secure messaging technology platform for primary care physicians to access their ColonCancerCheck Screening Activity Reports electronically and securely.
- Outfitted two new cancer screening mobile coaches in Thunder Bay and Hamilton regions with nurses who will provide mammography and pap tests and distribute FOBT kits to Ontarians in 2013–2014.

Looking Ahead

In 2013–2014, we will:

- Accelerate the reduction in cancer mortality by implementing an integrated, organized cancer-screening program across Ontario to increase screening participation, improve follow-up rates for participants with abnormal results and improve the timeliness of follow-up and the quality and appropriateness of screening. CCO will be working with all of our stakeholders to reach these goals.
- Develop and implement patient decision-making aids and public education materials, and follow-up research for Cancer Screening Public Awareness. An evaluation of this public awareness program was completed and shared with the Ministry.
- Assess options to collect and manage data identifying preferred language, ethnicity and cultural data for people eligible for cancer screening.
- Develop methodology and tools for integrated Primary Care Screening Activity Report to Patient Enrolment Model physicians across the province.

ColonCancerCheck

While colorectal cancer is the third most common cancer in Ontario, there is a 90 percent chance those with this cancer can be cured if it is caught early.

ColonCancerCheck (CCC) is instrumental in early detection. It is an organized, population-based screening program that CCO and the MOHLTC established in 2008 to reduce colorectal cancer mortality.

The program recommends the guaiac fecal occult blood test (gFOBT or just FOBT) for people of average risk and recommends colonoscopy for those testing positive with FOBT or those at increased risk.

Highlights

In 2012–2013, we:

- Expanded correspondence (invitations, recalls, reminders and/or results letters) for colorectal cancer screening to increase participation.
- Developed a successful grass-roots Early Bird Special campaign that resulted in more than 12,000 Ontarians taking the pledge to get screened for colorectal cancer.
- Published and disseminated worldwide *ColonCancerCheck: 2010 Program Report*, providing a comprehensive picture of Ontario's performance in colorectal cancer screening and identifying areas for further improvement.
- Began including Out-of-Hospital Premises in the CCC program through two colonoscopy pilot projects.
- Initiated a clinical expert panel to support the development of a robust quality assurance program for endoscopy services.
- Began the development of a new patient-based funding model for gastrointestinal endoscopy procedures.
- Planned to expand the number of qualified nurses and sites where Registered Nurse Flexible Sigmoidoscopy can be performed.

Looking Ahead

In 2013–2014, we will:

- Develop and begin implementing a colonoscopy quality assurance program and specialist reporting.

- Publish updated evidence-based colorectal cancer screening guidelines and supporting knowledge products to increase uptake and awareness.
- Expand access to colorectal cancer screening tests through non-primary care provider settings (including mailing of FOBT kits, OBSP sites, cancer screening mobile coaches, pharmacies, nurses, etc.).
- Implement a patient-based funding model for endoscopy services across Ontario.

Ontario Breast Screening Program

Breast cancer is the most frequently diagnosed cancer in Ontario women and is second only to lung cancer as a cause of cancer deaths. Early detection through organized breast cancer screening combined with effective treatment currently is the best approach available to reduce the number of deaths.

The Ontario Breast Screening Program (OBSP) is operated by CCO with the goal of reducing mortality from breast cancer through high-quality screening. Studies show that regular screening detects cancers earlier when they are small and less likely to have spread, resulting in increased chance of survival, less invasive treatments and, ultimately, improved health outcomes for women.

Although the breast cancer incidence rate in Ontario remained stable from 1990 to 2007, mortality dropped by 35 percent for women aged 50–69 years during this period. This decrease is attributed both to improved breast cancer treatments and to increased participation in breast cancer screening.

Highlights

In 2012–2013, we:

- Transformed the OBSP Hub structures and accountabilities to align with each of the 14 Regional Cancer Programs and related hospital site Diagnostic Imaging Departments.
- Discontinued Clinical Breast Exams as an adjunct or alternative to mammography for average-risk breast screening, based on updated evidence.
- Developed requirements for a new breast screening data-collection tool.
- Formally evaluated the first year of the OBSP High Risk Program introduced in July 2011. This program achieved its first full year of operation in July 2012. It is the first organized high-risk breast screening program of its kind in Canada.

Looking Ahead

In 2013–2014, we will:

- Complete the CCO-recommended transition of all mammography units using the less effective digital computed radiography (CR) technology (103 mammography units in 97 sites) to the more effective digital direct radiography (DR). The entire project is expected to be completed by November 2013.
- Publish updated evidence-based breast cancer screening guidelines and supporting knowledge products to increase uptake and awareness.
- Introduce updated provincial quality standards for mammography and supporting knowledge products to increase uptake and awareness.
- Pilot a new data collection tool for breast cancer screening and assessment data.

ONTARIO CERVICAL SCREENING PROGRAM

Cervical cancer is preventable. Yet year after year, about 550 women in Ontario are diagnosed with cancer of the cervix, and about 160 women die from this disease. Regular screening is an essential defence against cervical cancer. Cervical cancer screening can detect early cell changes on the cervix caused by persistent human papillomavirus (HPV) infection. These changes seldom cause any symptoms, but can progress to cancer if not found and, if necessary, treated.

Highlights

In 2012–2013, we:

- Introduced new cervical cancer screening guidelines to women and their healthcare providers across Ontario.
- Initiated planning to introduce Human Papillomavirus (HPV) tests as a pilot only as the primary cervical cancer screening test, as recommended by PEBC.

Looking Ahead

In 2013–2014, we will:

- Introduce direct correspondence to patients for cervical cancer screening.
- Develop a colposcopy data collection plan and begin a pilot to collect data from colposcopy providers.

THE ABORIGINAL CANCER CONTROL UNIT

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

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

Highlights

In 2012–2013, we:

- Successfully launched ACSII.
- Introduced Aboriginal Patient Navigator and Regional Aboriginal Cancer Leads in four regions.
- Partnered with Science Travels to expand reach of youth education and awareness initiatives to FNIM communities in Ontario.
- Engaged 10 Regional Cancer Programs to develop plans to build regional capacity to sustain priorities and objectives.
- Established cross-jurisdictional and organization partnerships through the Aboriginal Tobacco Partnership Table to streamline efforts and improve reach and programming to FNIM communities.

Looking Ahead

In 2013–2014, we will:

- Develop and implement a Relationship Building E-module, to educate primary care providers on cultural sensitivity when working with FNIM cancer patients and families.
- Launch a pilot initiative for pain and symptom management (ESAS) using mobile technology.
- Complete a needs assessment to develop FNIM-specific tools to support palliative care mentorship among healthcare providers (help build capacity to improve symptom management in primary care).

- Develop a plan to establish FNIM identifiers for InScreen to support province-wide cancer screening across FNIM communities.
- Develop and implement a lay health education program for FNIM cancer patients and their respective families.
- Initiate discussions with FN communities to develop and implement community-led smoke-free by-laws or policies

OCCUPATIONAL CANCER RESEARCH CENTRE

The Occupational Cancer Research Centre (OCRC) historically has been funded by CCO, the Workplace Safety and Insurance Board (WSIB) and the Canadian Cancer Society (CCS), Ontario Division. The OCRC was developed with the support of the United Steelworkers Union. In 2013, this is changing. The WSIB is being replaced by the Ministry of Labour and the CCS Research Institute is replacing the CCS. We are seeking additional funds for specific projects through grant competitions.

The OCRC's objectives align with the OCP III goal of helping Ontarians lessen their risk of developing cancer and the strategic priority of developing and implementing a focused approach to cancer risk reduction. These goals will be achieved through a focused approach to occupational cancer risk reduction by conducting research on: (1) the causes of occupational cancer; (2) the surveillance of occupational cancer; and (3) the prevention of occupational cancer.

Occupational cancer is caused wholly or in part by exposure to a carcinogen in the workplace. The OCRC was established to fill knowledge gaps around occupation-related cancers and to translate these findings into preventive programs to control workplace carcinogenic exposures and improve the health of workers.

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

Highlights

In 2012–2013, we:

- Received a very favourable external review of the OCRC's accomplishments during its first three years of operation. The review was conducted by the WSIB in co-operation with the Ontario Division of the CCS and CCO (OCRC's three core funding organizations).
- Brought in approximately \$1.6 million in external research funding from the CCS Research Institute, the WSIB, the Canadian Nuclear Safety Commission (CNSC) and the Canadian Institutes for Health Research.
- Held several very successful public events; a symposium on interventions to mitigate the adverse effects of shift work, co-sponsored with the Institute for Work and Health, and a workshop on the classification of carcinogens. Educational modules, based on the classification of carcinogens workshop, can now be found on YouTube. OCRC continued to meet its mandate to expand research capacity in occupational cancer in Ontario through hiring four new staff, attracting four new students and recruiting two new affiliated scientists from other institutions.

Looking Ahead

In 2013–2014, we will:

- Launch, with major funding from the CCS Research Institute, a four-year study to assess the human and economic costs of occupational cancer in Ontario and the rest of Canada. OCRC is leading a national team of researchers and working in close co-operation with the Ontario Division of the CCS on this project.
- Greatly expand our efforts in occupational cancer surveillance with funding from the WSIB.
- Initiate a new research program focused on Ontario's mining industry. With some initial funding from the WSIB, we are collecting data on potential exposure to carcinogens across the industry. In collaboration with the CNSC, we are examining the risk of lung cancer among Ontario uranium miners.

PRIMARY CARE CENTRE OF PRACTICE

The Primary Care Centre of Practice is in early development and will operate as a consultation hub for CCO initiatives that have goals dependent upon primary care. Centre of Practice facilitators, using primary care-related tools and supports, will work with CCO programs to provide primary care providers with the best practices, strategies, research and policies to engage them in providing quality cancer care across the cancer journey. The Centre also will provide stakeholder management support through its relationship with key stakeholders, including the Ontario Medical Association, the Ontario Chapter of the College of Family Physicians, the Canadian Institute for Health Information (CIHI), OntarioMD, eHealth Ontario and Health Quality Ontario (HQO).

Highlights

In 2012–2013, we:

- Appointed a new Provincial Clinical Lead, Dr. Suzanne Strasberg.
- Provided first-year funding for a second day of Regional Primary Care Lead work to focus beyond screening to cancer care.
- Facilitated the work of the Diagnostic Assessment Programs and the Survivorship Program and Disease Pathway Management (DPM) program.
- Undertook Palliative Care and Primary Care provincial and regional partnering and planning groundwork to develop a strategic focus for primary palliative care across Ontario.
- Published the Primary Care Prostate Referral Guideline on the CCO website.
- Developed a Quality Improvement Plans toolkit for Family Health Teams that decide to include cancer screening as part of their QIP.

Looking Ahead

In 2013–2014, we will:

- Continue to advance the work of Survivorship, Palliative Care and Diagnostic Assessment Programs to improve well follow-up, build symptom management capacity and raise program awareness, respectively.

- Develop a CCO e-repository housing all primary care-related tools and supports that inform Centre of Practice facilitators in their work with CCO programs to provide best practices, strategies, research and policies specific to providing high-quality cancer care along the cancer journey.
- Implement in partnership with the Disease Pathway Management team a Knowledge Translation and Exchange (KTE) plan for primary care referral guidelines for colorectal, lung cancer and prostate cancer.
- Document, design and package a standard approach to Primary Care (PC) KTE in a toolkit to ensure a comprehensive view of PC KTE options. This toolkit will be a resource for CCO's programs and will ensure methods, approaches and ideas that work for one program can be used by others, and will include a strategy for Primary Care Referral Guidelines as a case study.
- Continue participation in the Provincial Primary Care Performance Measurement Committee (co-chaired by CIHI and HQO).
- Review cancer screening primary care work to ensure knowledge transfer to rest of CCO.

Diagnosis

DIAGNOSTIC ASSESSMENT PROGRAMS

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

To improve the diagnostic phase of the cancer journey, CCO supported the development and implementation of Diagnostic Assessment Programs (DAPs) throughout Ontario. These programs significantly improve the patient experience during the diagnostic process for individuals with suspected cancer, as shown by the high satisfaction rates with the DAP nurse navigator and reported on the 2013 Cancer System Quality Index (CSQI).

DAPs are composed of multidisciplinary healthcare teams that manage and coordinate care for patients from testing to a definitive diagnosis leading up to their first treatment, which leads to improved access to care. DAPs also provide the necessary support and information about cancer to patients and their families. Through DAPs, CCO is helping decrease diagnostic wait times, optimize the patient experience, improve integration of care amongst providers and, where possible, minimize disease progression.

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

Highlights

In 2012–2013, we:

- Continued with provincial DAP implementation and development. There now exist 15 lung DAPs, 10 colorectal DAPs and four prostate DAPs.
- Created increased accountability for regional DAP performance by introducing a diagnostic wait times target indicator for lung DAPs on the regional performance scorecard of 28 days from date of referral (to DAP) to date of definitive diagnosis (or rule-out). DAPs for all disease sites also began public reporting in the area of patient experience through the CSQI under the dimension of responsiveness. The role of the nurse navigator and the DAP program's ability to better address fear and anxiety in the diagnostic phase is highlighted.
- Piloted experienced-based design in the Hamilton Niagara Haldimand Brant Lung DAP. This was done using a combination of observations and interviews with staff and patients, and a co-design session which brought together patients, hospital administration, nurse navigators, physicians and caregivers. The goal of this event was to openly discuss and prioritize issues to improve the DAP experience for all stakeholders.

- Completed an evaluation project that demonstrated the value of conducting symptom assessment for patients in the diagnostic phase. The use of the Edmonton Symptom Assessment System was validated through this work.
- Continued Phase 2 of the DAP-EPS development. This included:
 - Implementing the DAP-EPS in three additional Regional Cancer Programs, which manage five different DAP programs.
 - Integrating with the Ontario Laboratory Information System to directly share lab results within the DAP-EPS for providers.
 - Enhancing functionality within the DAP-EPS to improve workflow and communications between the care team.
 - Enabling and supporting the development of the first patient-friendly disease pathway map for lung cancer diagnosis. A clickable version is embedded in the DAP-EPS as an educational tool for lung patients. Paper versions are being used by nurse navigators in lung DAPs.

Looking Ahead

In 2013–2014, we will:

- Complete DAP strategic planning, which will include short- and long-term goals, refreshed objectives for the program, key performance indicators for evaluating outcomes and a plan which leverages leading practices and emerging trends in diagnosis.
- Develop and execute a communications plan to raise the profile of DAPs and the DAP-EPS amongst providers and patients to improve access to DAPs.
- Introduce a wait time measure for the diagnostic phase for public reporting on the CSQI.
- Complete Phase 2 of the DAP-EPS, which includes:
 - Allowing primary care providers to submit e-referrals for patients to DAPs.
 - Providing patients, their caregivers and providers with online access to results.
 - Enabling patients to send messages to their care team online through the DAP-EPS.
 - Evaluation of the DAP-EPS, including adoption, usability and system impact.

STAGE CAPTURE/PATHOLOGY

Pathology and Laboratory Medicine Program

The Pathology and Laboratory Medicine Program (PLMP) focuses on the screening, diagnostic and prognostic/predictive components of cancer care. The PLMP's goal is to establish a province-wide system that will allow pathology and laboratory medicine providers and professionals to accurately analyze samples and provide relevant consultation reports. The PLMP continues to develop and promote quality initiatives that improve patient care by facilitating timely, accurate and complete diagnosis and cancer staging information. Key initiatives include Stage Capture and Pathology Reporting.

Stage Capture

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

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

Pathology Reporting

Pathology reporting is critical in the diagnosis and treatment of cancer. The aim of the Pathology Reporting initiative is to make cancer pathology reports more complete and consistent by helping hospitals change to a standardized electronic format. The goal was to have all hospitals that electronically submit reports to Cancer Care Ontario use evidence-based cancer checklists and capture the data in discrete data field format. By March 2012, 97 percent of (116 of 119) Ontario hospitals achieved Level 6, the highest level of standardized cancer pathology reporting.

Highlights

In 2012–2013, we:

- Appointed regional leads to foster quality pathology and laboratory medicine services throughout Ontario's 14 LHINs.

- Implemented a turnaround-time measure for colorectal cancer to measure time from surgical resection to receipt of the pathology report at CCO.
- Started developing a turnaround-time measure for all cancers for implementation in 2013–2014.
- Monitored compliance to synoptic reporting and completeness to ensure ongoing high performance; worked closely with hospitals to implement updates to new mandated reporting requirements.
- Expanded stage data collection to include melanoma of the skin and gynecologic disease sites.

Looking ahead

In 2013–2014, we will:

- Monitor and improve turnaround-time performance for pathology reporting.
- Continue to work with regional leads to build, foster and advance CCO's quality agenda.
- Finalize secondary review best-practice guidelines and implement them across Ontario.
- Collaborate with relevant standards-setting organizations to finalize bio-marker testing cancer protocols for colorectal, breast and lung and develop a plan to implement them across Ontario.
- Further expand stage data capture to include thyroid cancer.

Treatment

DISEASE PATHWAY MANAGEMENT

Disease Pathway Management (DPM) is a unifying approach to the way in which we set priorities for cancer control, plan cancer services and improve the quality of care in Ontario.

DPM applies a framework for examining the performance of the entire system across the cancer journey – from prevention to recovery and end-of-life care – and identifies any gaps and bottlenecks along the way. DPM addresses the unique issues faced by patients with a specific type of cancer through the development and maintenance of disease pathway maps that set out best practice, and are used to:

- Identify opportunities to embed best practice into care-delivery processes.
- Monitor performance against the disease pathway.
- Catalyze action to address any quality and measurement gaps.

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

Highlights

In 2012–2013, we:

- Published on the CCO website pathways for:
 - Lung cancer treatment.
 - Prostate cancer diagnosis and treatment.
- Released the first patient-friendly version of the lung cancer diagnosis pathway. It is available as a printable pathway and as a clickable and interactive pathway on the CCO website, and is also embedded in the Cancer Care Ontario Diagnostic Assessment Program – Electronic Pathway Solution.
- Invested in projects to improve the quality of prostate cancer care based on priority goals identified by the prostate disease pathway management team:
 - 1) Enhancing our ability to capture data about the risk status of prostate cancer patients to enable quality monitoring, improvement initiatives and better system planning for this high-incidence cancer.
 - 2) Exploring mechanisms to increase access to appropriate multidisciplinary pre-treatment consultations to support informed decision-making by patients.
- Continued efforts on colorectal and lung cancer priorities for action; regional cancer centres continue to participate in – and deliver on – quality improvement projects aligned with these priority action areas.

Looking Ahead

In 2013–2014, we will:

- Launch standardized pathways for colorectal, breast and gynecological cancers and begin assessing performance against the pathways.
- Publish the patient-friendly versions of the colorectal screening and diagnosis pathways and evaluate their effectiveness.
- Initiate prostate cancer regional engagement sessions with all Regional Cancer Programs. These will include:
 - Meeting with local prostate cancer site groups.
 - Discussing local progress towards the improvement priorities within the local context.
 - Discussing performance on the region's prostate-specific quality measures.
 - Understanding how provincial resources and experts can be leveraged to advance improvement in each region.
- Strengthen the palliative care and psychosocial oncology components of the published pathways.
- Continue measuring and evaluating quality improvement progress within the lung and colorectal pathways against selected priorities for action.

MODELS OF CARE

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

As a result, it is imperative we receive even greater performance and value from every healthcare dollar we spend and that we optimize the use of health human resources (HHR).

To achieve these goals, CCO has launched the Models of Care Initiative, which is designed to change how Ontario provides and pays for care, engages patients and reliably plans for the HHR we will need in the future.

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

Highlights

In 2012–2013, we:

- Continued supporting the implementation of a new model of care for patients who have completed their cancer treatment. The new model of care optimizes the roles of specialists and primary care providers, while providing best care for patients. The focus this year included:
 - Colorectal cancer – established demonstration projects in three Regional Cancer Programs.
 - Breast cancer – implemented new models of care in all 14 Regional Cancer Programs.
- Continued work to optimize advanced-practice roles in the treatment phase, including:
 - Clinical Specialist Radiation Therapist (CSRT) sustainability project – 10 new CSRTs recruited.
 - Supported the development of a guideline on the effective use of Advanced Practice Nurses.
- Supported building primary care capacity to improve access to palliative care and work towards the right mix of primary and specialist care.
- Developed a framework to measure the impact of the new models on patients, providers and the healthcare system.
- Further enhanced CCO's ability to accurately predict HHR demand.

Looking Ahead

In 2013–2014, we will:

- Continue advancing models that optimize use of HHR, settings and technology to drive improved value for money.
- Integrate best-practice “well follow-up” models into ambulatory chemotherapy funding reform.
- Assess the impact on patients, providers and the cancer system of models of care changes.
- Continue to enhance HHR planning by using models of care impact assumptions to forecast the demand for specialist oncologists.

MULTIDISCIPLINARY CANCER CONFERENCES

Multidisciplinary Cancer Conferences (MCCs) bring clinicians with various areas of expertise together in regularly scheduled meetings to discuss the diagnosis and treatment of individual cancer patients.

Participants represent medical oncology, radiation oncology, surgical oncology, pathology, diagnostic radiology and nursing. Other healthcare providers involved in a patient's care – such as dietitians, rehabilitation specialists and pharmacists – may also attend.

MCCs ensure that all appropriate diagnostic tests, all suitable treatment options and the most appropriate treatment recommendations are generated for each cancer patient discussed.

There is evidence that cases reviewed at MCCs are more likely to result in patients:

- Receiving evidence-based care.
- Having all their treatment options considered.
- Enjoying better outcomes.

MCCs are a mechanism for peer review and quality assurance, fostering the development of a multidisciplinary culture and encouraging hospitals across regions to work together.

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

Highlights

In 2012–2013, we:

- Implemented more stringent MCC quality and access criteria. Now, all hospitals annually treating more than 35 unique patients with a given cancer will ensure appropriate patients have access to a high-quality MCC discussion.
 - Progress has been steady and significant. Ontario hospitals were compliant with 56 percent of the minimum MCC quality criteria, surpassing the annual compliance target of 55 percent. This is up from 38 percent compliance in 2010–2011 and 44 percent in 2011–2012.
- There are more MCCs in more hospitals than ever before. In 2012–2013, approximately 32,000 patients were the focus of multidisciplinary discussions, up from 26,000 in 2011–2012.

Looking Ahead

In 2013–2014, we will:

- Strive to reach the 2015 provincial goal of Ontario hospitals being 80 percent compliant with MCC quality criteria.
- Ensure more patients are the focus of multidisciplinary discussions.
- Use the findings of the seven-site pilot to collect patient-related indicators to inform a provincial measurement plan.
- Share best practices and tools with the provincial network of MCC Coordinators to optimize practices and access across the province.

PATIENT EXPERIENCE

Cancer Care Ontario's mission, to create the best cancer system in the world, requires that we go beyond safe, effective treatment; it requires us to understand and improve the patient experience – the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across a continuum of care.

This commitment to the patient experience is reflected in the Ontario Cancer Plan III, strategic priority 4: *To continue to assess and improve the patient experience*. This strategic priority is being addressed through a number of initiatives and programs, including, but not limited to, improving patient navigation, providing the opportunity for patients to provide feedback and be represented in a patient and family advisory council, improved symptom management, expanded psychosocial and patient-education programs and improved integration of palliative and primary care services.

One important strategy for improving the patient experience is meaningful patient engagement. Thus, patient engagement is a common theme across all the initiatives and programs in this area. To achieve meaningful patient engagement, we are working with patients, family members, professionals and community groups to plan, deliver and evaluate health services. This involves building strong, sustainable partnerships and relationships and actively engaging stakeholders in a dialogue to drive system change.

Highlights

In 2012–2013, we:

- Developed a broader strategy for patient engagement, which includes increasing representation on the Patient and Family Advisory Council to 28 advisors, representing all 14 cancer regions.
- Improved the quality of psychosocial oncology services – with the aim of addressing the unmet need of emotional support for patients – through the appointment of local leaders who direct, and are accountable for, quality improvement agendas. Having leaders in psychosocial oncology embedded in cancer centres across the province enables us to drive change and thus improve quality at the front line.
- Increased the number of certified specialized oncology nurses across the cancer system. Specialized oncology nurses have expert knowledge and the clinical skills required to meet the complex needs of cancer patients, and thus they are able to ensure that safe, high-quality, patient-centred care is provided.
- Collaborated with primary care to shift the culture of palliative care earlier in the journey. This will help to improve the overall access to palliative care for people across the journey, and result in people getting the care they need when they need it.
- Continued to help clinicians improve symptom management by implementing guides-for-practice on loss of appetite, oral care, bowel care and fatigue – areas identified by patients as a concern throughout their cancer journey.
- Further improved symptom management by successfully implementing an upgrade of our interactive symptom management software. This upgrade will provide caregivers with the ability to add new patient-reported outcome tools that expand measurement and further improve the patient experience.

Looking Ahead

In 2013–2014, we will:

- Increase access to psychosocial services and quality patient education by developing and implementing quality indicators. Measuring the quality of psychosocial and patient education services enables us to identify gaps, implement changes in areas that need improvement and, ultimately, increase access to quality services.

- Pilot a tool to measure patient experience in real time in the treatment phase of the cancer journey and to expand opportunities for patient feedback to other phases, such as screening and palliative care.
- Embed patient input and feedback into system-level priorities and programs by expanding the patient and family advisor registry and seeking new opportunities for advisors on various committees.
- Facilitate earlier identification of palliative care patients through collaboration between palliative and primary care providers and improve the management of these patients and the continuity of their care through the use of tools that promote optimal palliative care, such as just-in-time support and coaching.
- Improve the delivery and quality of palliative care through the development of system-level palliative care indicators, enabling us to measure areas of strength and those that need improvement to ensure the optimal delivery of equitable palliative care across the province.
- Improve symptom management by implementing new patient-reported outcome measures that will focus on:
 - Core symptoms (anxiety and depression) currently screened using the Edmonton Symptom Assessment System (EASAS), which assesses common symptoms experienced by cancer patients.
 - New disease-specific measures (prostate and breast cancers).
 - The patient's physical functioning.

Allowing patients further opportunities to self-screen for symptoms gives them greater input into the care they receive and clinicians more information on which to respond.

CANCER SURGERY

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

CCO has evaluated the impact of the new CSA methodology and its effect on funding, patient volumes and wait times by:

- Reviewing CSA hospitals for trends over time.
- Conducting stakeholder interviews.

The results will be incorporated into the 2013–2014 CSA methodology.

Thoracic Cancer Surgery Standards

Thoracic cancer surgery is a high-complexity operation. There is a proven relationship between thoracic surgeries performed in a designated thoracic cancer surgery centre and improved patient outcomes. There are 15 designated thoracic surgery centres in Ontario.

Highlights

In 2012–2013, we:

- Consolidated thoracic cancer surgery in designated centres to optimize patient outcomes.
- Measured seven quality indicators for lung surgery and pathology performance and brought together 32 thoracic surgery and pathology representatives to review and analyze the seven quality indicator results. They identified invasive mediastinal staging and lymph-node assessment as quality initiatives to be addressed. The event fostered communication between the two disciplines – a key to standardizing processes from specimen resection to reporting.

Hepato-Pancreatic-Biliary Cancer Surgery Standards

Hospitals that perform high volumes of pancreatic surgery have better patient outcomes. CCO released Hepato-Pancreatic-Biliary (HPB) Cancer Surgery Standards in 2006 and designated nine centres to perform HPB surgery.

Highlights

In 2012–2013, we:

- Surpassed our target of having more than 90 percent of HPB surgeries performed at a designated centre.

-
- Released the guideline *The Role of Liver Resection in Colorectal Cancer Metastases*. This guideline will result in clinicians understanding that more colorectal cancer patients with metastases are liver surgical candidates than previously believed. A comprehensive implementation plan accompanying the guideline included:
 - A live videocast during which more than 300 participants across 35 hospitals watched an expert panel discuss representative cases of colorectal metastases.
 - A listserv discussion with more than 250 participants.
 - Development by each region of a plan to ensure that all patients with CRC metastases to the liver have timely access to multidisciplinary assessment, including assessment by a HPB surgeon to determine if they are candidates for liver resection.

Looking Ahead

In 2013–2014, we will:

- Improve patient access to high-quality, coordinated head and neck cancer services by implementing *The Management of Head and Neck Cancer in Ontario: Organization and Clinical Practice Guideline Recommendations*.
- Release and implement an organizational guideline for gynecologic oncology services in Ontario. The guideline investigates the optimal organization of care based on expert consensus and a systematic literature review. Its goal is to ensure quality patient care. Review findings were interpreted by a multidisciplinary expert panel and translated into recommendations appropriate for Ontario. The panel comprised clinicians from gynecology oncology, medical oncology, radiation oncology, pathology and regional service management.

Cancer Surgery Wait Times

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

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

Highlights

In 2012–2013, we:

- Saw 81 percent of cancer surgeries completed within their target times, an improvement from 79 percent in 2011–2012 and 74 percent in 2010–2011.

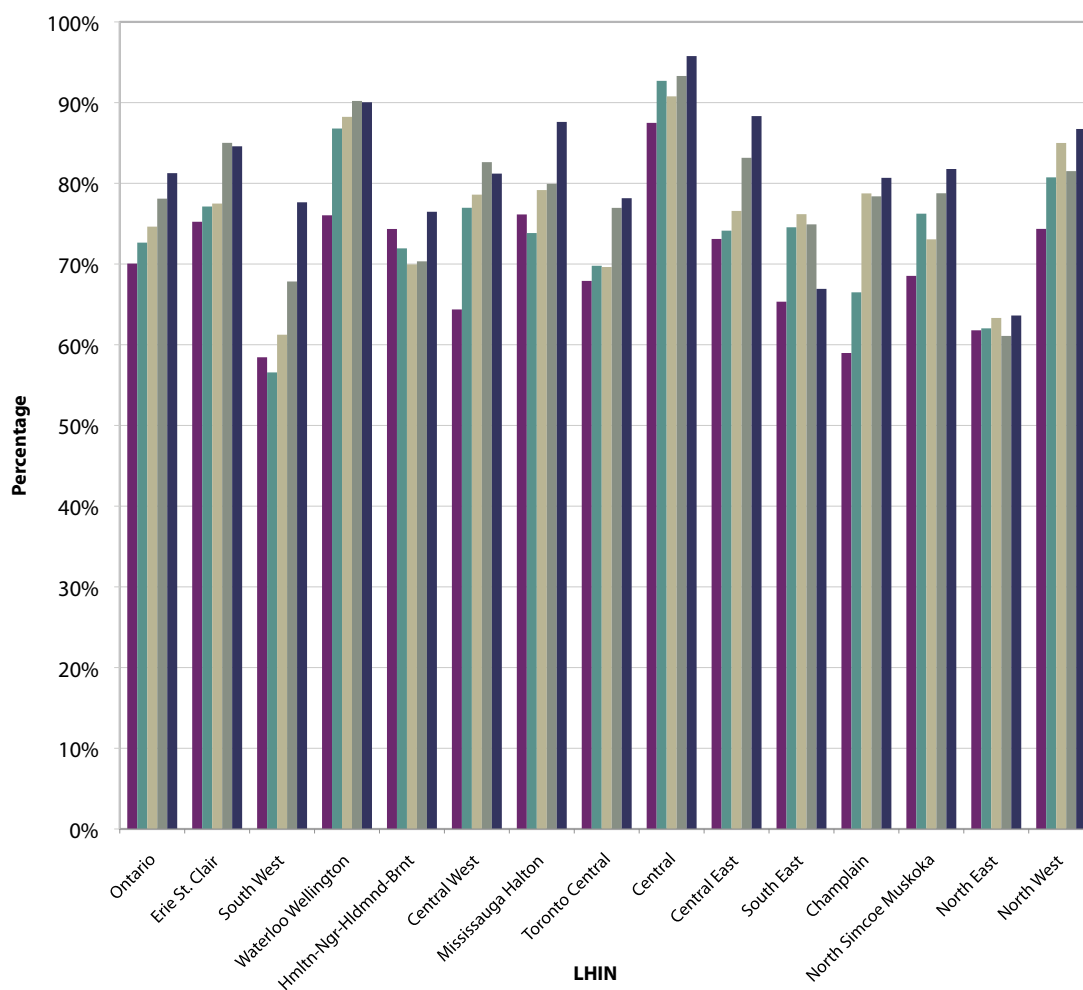
There is variation between disease sites and priority levels. Endocrine, prostate and gynecological cancers have the lowest wait time performance for Priority 2 cases (patients with highly aggressive malignancies — 14-day wait time target), with 54 percent, 42 percent, and 54 percent, respectively, completed within their targets. Lung and sarcoma cancers, in contrast, have the highest performance for Priority 2 cases, with 92 percent and 96 percent, respectively, completed within their Priority 2 wait time targets.

Looking Ahead

In 2013–2014, we will:

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

Wait Times for Cancer Surgery – Percentage of cases completed within priority access targets 2, 3 and 4, decision-to-treat to operation, Ontario, 2010, 2011, 2012, by LHIN



RADIATION TREATMENT

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

IMPROVING TREATMENT WAIT TIMES

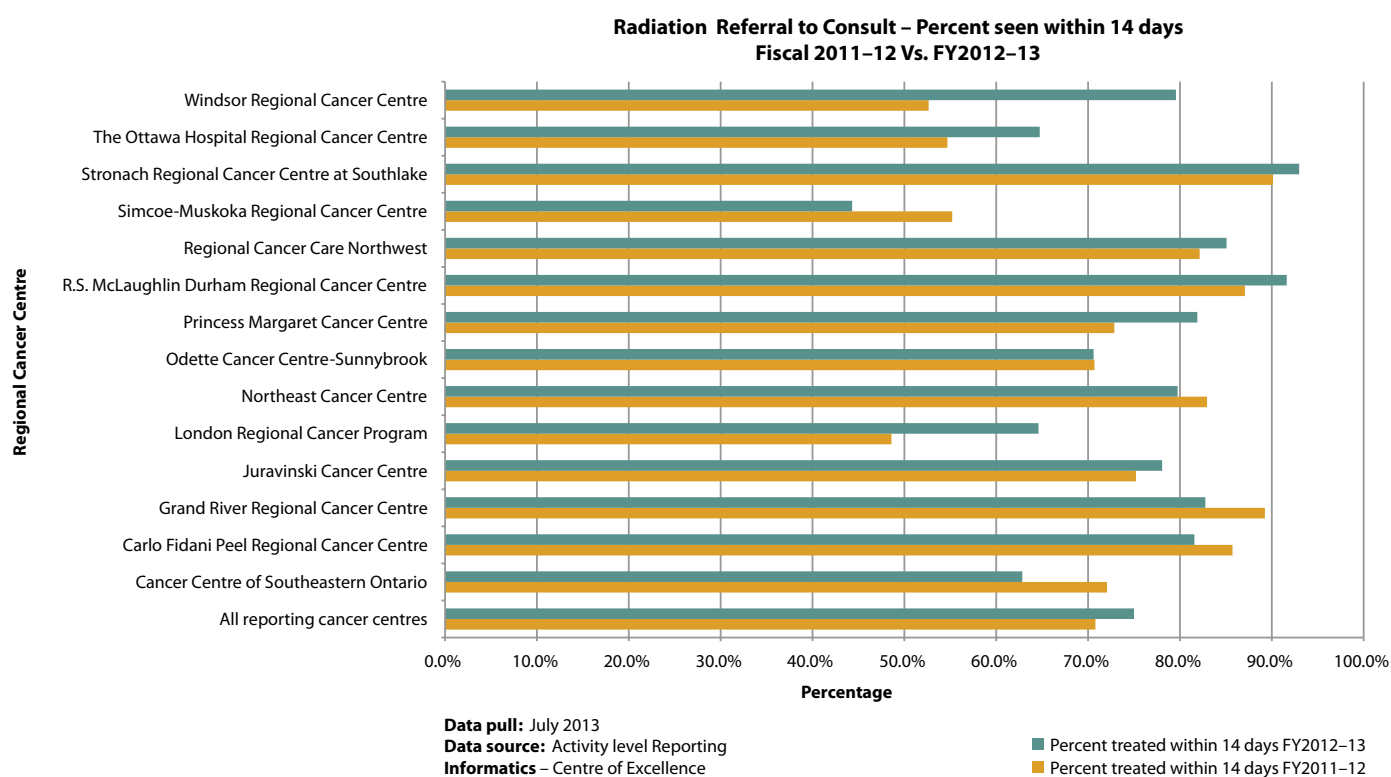
CCO's Radiation Treatment Program works to ensure timely access to coordinated, safe, evidence-based, technologically innovative treatment. Ongoing reductions in wait times reflect, in large part, the investments made by the province based on advice from CCO. In the past six years, government investments in radiation infrastructure and equipment have increased the availability of and access to cancer treatments across Ontario. These include the opening of new cancer centres

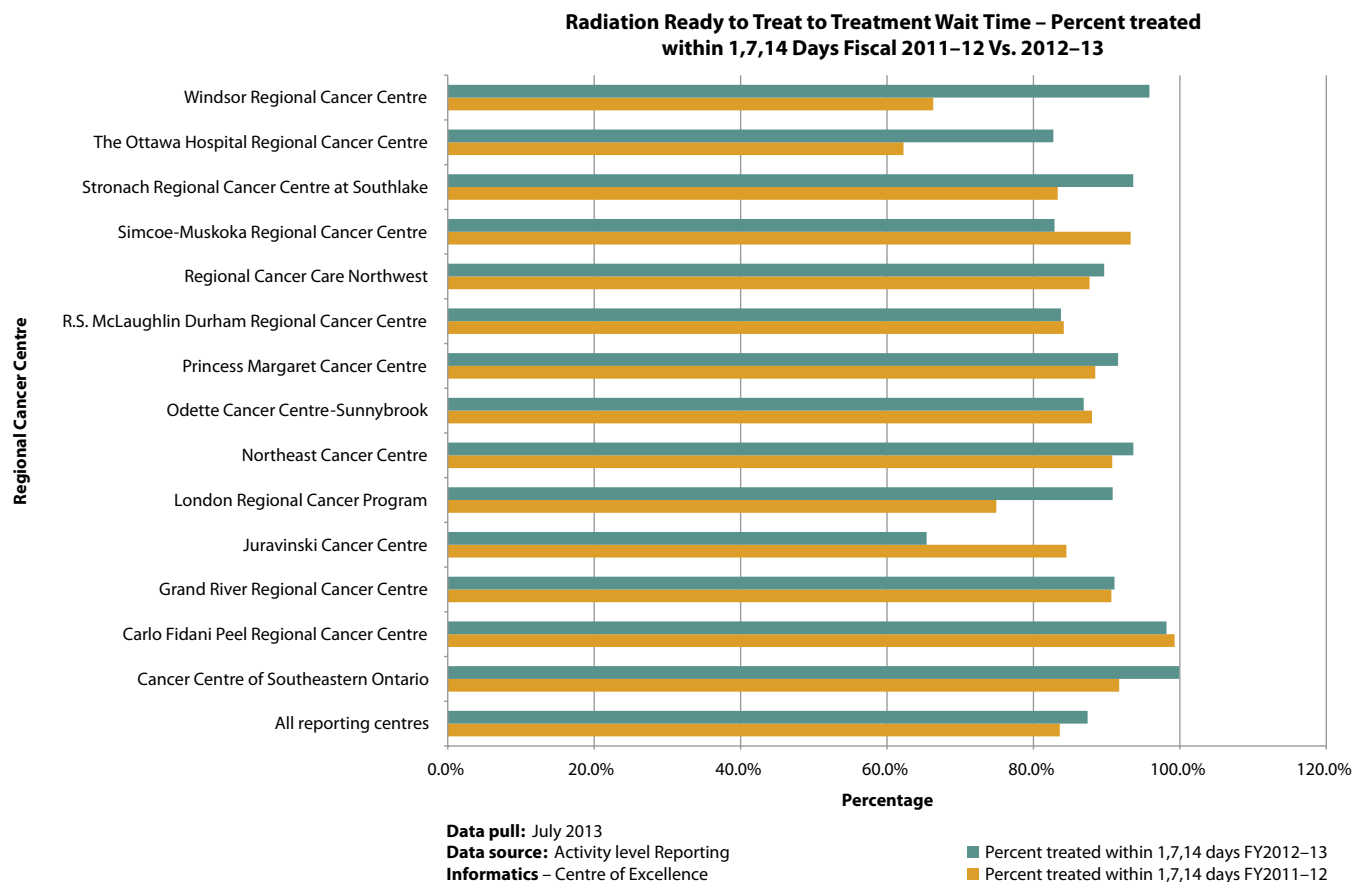
in Newmarket (Southlake) and Durham, as well as facilities expansions in Ottawa, Kingston and Niagara and two new satellite centres in Ottawa and Sault Ste. Marie. Since July 1, 2007, 18 new treatment units have been added across Ontario.

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

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

The target wait time for Referral to Consult is 14 days. Wait time targets for the Ready to Treat to Start of Treatment interval vary from one to 14 days depending on the patient's condition.





Highlights

In 2012–2013, we:

- Saw the Referral to Consult interval improve by 4.1 percent – from 70.7 percent of patients being seen by a radiation oncologist within 14 days from April 2011 to March 2012 to 74.8 percent from April 2012 to March 2013.
- Saw the Ready to Treat to Start of Treatment interval improve by 5.2 percent – from 83.6 percent of patients being treated within the 1-, 7-, and 14-day targets from April 2011 to March 2012 to 88.8 percent from April to March 2013, despite the deployment of a new, higher-complexity treatment technique: intensity-modulated radiation therapy technology.
- Facilitated the opening of the Niagara Health System Walker Family Cancer Centre in March 2013, with three linear accelerators.
- Added two additional linear accelerators in July 2012 as part of the Simcoe Muskoka Regional Cancer Centre expansion in Barrie.

The new and expanded cancer centres ensure more patients can receive care closer to home.

Looking Ahead

In 2013–2014, we will:

- Introduce availability for radiation treatment closer to home for patients in the Peterborough area as that treatment site becomes operational.
- Continue to further refine the model for capacity requirements to the year 2020 to ensure we have the capacity to meet increasing demand.

PEER REVIEW QUALITY ASSURANCE PROGRAM

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

Highlights

In 2012–13, we:

- Began the initial work of the PR QA program, by:
 - Conducting site visits to the Regional Cancer Centres to promote PR QA.
 - Developing a guidance document on the structure and function of PR QA activities in Ontario's cancer centres.
 - Evaluating key performance indicators, including the proportion of patients whose treatment plan is peer reviewed.
 - Setting a provincial target of 50 percent for fiscal year 2013–2014 of treatment plans for patients undergoing curative treatment under the PR QA process.

Looking Ahead

In 2013–2014, we will:

- Continue to conduct site visits to the Regional Cancer Centres to promote PR QA.
- Continue to develop and refine performance indicators (including the target for the proportion of peer-reviewed cases stratified by treatment intent, timing and scope of peer review), data collection methods and reporting mechanisms.
- Investigate the feasibility of establishing inter-hospital QA rounds to exchange best practices between Regional Cancer Centres.
- Report the peer review data through CSQI and other vehicles.

RADIATION UTILIZATION

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

Radiation utilization does not change drastically year over year, but the trend shows that appropriate care is being provided to Ontario patients. However, there is still room for improvement, with radiation utilization across LHINs still below the recommended 48 percent rate. Overall, 38% of Ontario cancer patients received radiation treatment at some point during their illness in 2012–2013, up 1.5% over the previous year.

Highlights

In 2012–2013, we:

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

Looking Ahead

In 2013–2014, we will:

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

INTENSITY MODULATED RADIATION TREATMENT (IMRT)

Intensity Modulated Radiation Treatment (IMRT) is the current standard of care in radiation treatment for specific clinical circumstances – a precise method of delivering high doses of radiation to a tumour while significantly reducing radiation to the surrounding healthy tissues. This increases local control, reduces treatment-related morbidity and increases cure rates and patient quality of life. IMRT is used to treat patients with breast, prostate, head and neck cancers, brain tumours, sarcomas and paediatric cancers.

IMRT utilization for the following disease sites has increased without affecting wait times or safety between fiscal year 2008–2009 and 2012–2013. Absolute change for the following disease sites: prostate 48 percent (from 53 percent to 98 percent), thyroid 36 percent (from 60 percent to 96 percent), head and neck 28 percent (from 67 percent to 95 percent), sarcoma 31 percent (from 47 percent to 78 percent) and CNS 29 percent (from 47 percent to 76 percent). Breast IMRT from Q1 April 2011 (71 percent) to Q3 December 2012 (96 percent) saw an absolute change of 25 percent (See chart below for more details).

Highlights

In 2012–2013, we:

- Continued to monitor and report the disease-specific performance targets for prostate, thyroid, head and neck, central nervous system, sarcoma and breast. As of November 2012, five of the six disease sites have hit their targets (see chart below).

- Continued to improve IMRT by fostering an environment of:
 - Knowledge exchange, quality assurance and best-practice sharing among the cancer centres.
 - Improved access to specialized courses and symposiums.

To date, an additional 12,000 eligible patients now have access to IMRT.

- We continued to support the provincial IMRT external (CQA), established in 2009 and operated by Princess Margaret Cancer Centre. The program ensures a high-quality standard for IMRT planning and delivery province-wide by assessing the IMRT planning and delivery performance of all radiotherapy centres in Ontario. The CQA program allows participating institutions to compare performance among a homogenous group of participants – the first step toward identifying areas for improvement. The provincial IMRT CQA program supports CCO's mandate to implement safe, accessible and high-quality IMRT across Ontario.
- The Radiation Treatment Program worked closely with CCO's Pharmacoeconomics group to assess value for money and ensure the publication of two Cost-Effectiveness Analyses (CEA). CEA allows payers to assess the value for money of new technologies. The two CEAs, *Cost-effectiveness of Intensity-modulated*

Radiotherapy in Oropharyngeal Cancer and *Cost-effectiveness of Intensity-modulated Radiotherapy in Prostate Cancer*, compare the costs and effectiveness of IMRT with three-dimensional conformal radiotherapy (3DCRT) for the radical treatment of localized prostate cancer at elevated doses and the treatment of locally advanced oropharyngeal cancer. Both CEAs concluded that IMRT is cost-effective when compared with 3DCRT for both prostate and locally advanced oropharyngeal cancer.

The articles can be accessed at:

<http://www.ncbi.nlm.nih.gov/pubmed/22739256>

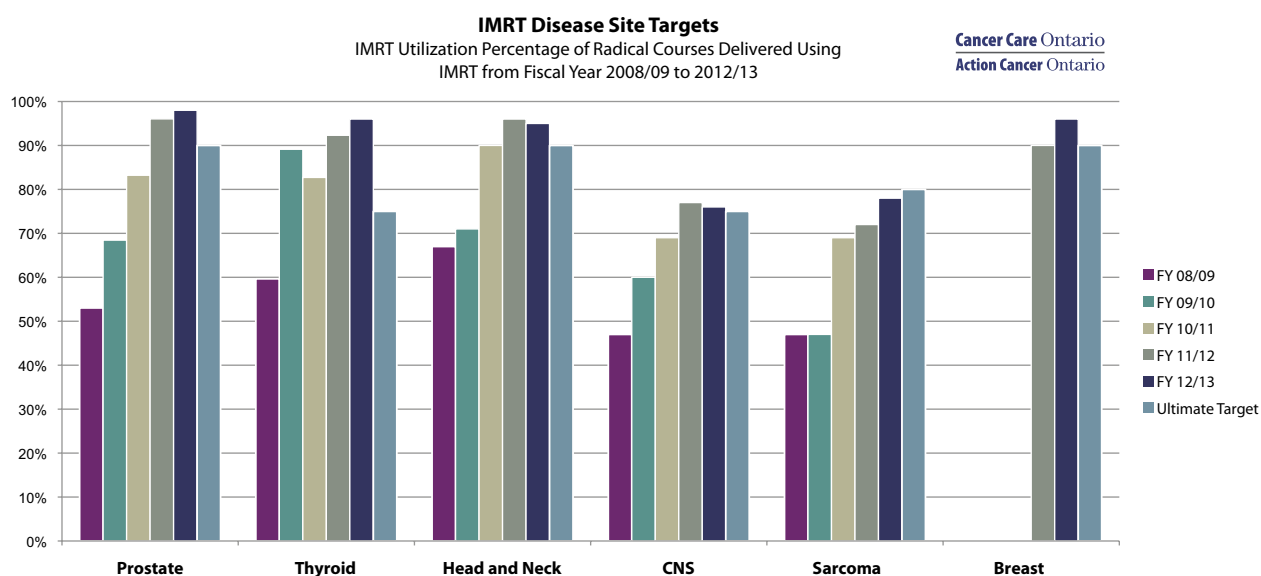
and

<http://www.ncbi.nlm.nih.gov/pubmed/23040143>

Looking Ahead

In 2013–2014, we will:

- Continue to monitor and report the disease-specific IMRT performance targets for the six specific disease sites – prostate, thyroid, head and neck, CNS, sarcoma and breast – for which CCO continues to monitor IMRT availability across Ontario. These indicators have strengthened CCO's ability to monitor the appropriateness of care.
- Continue to promote and support the external CQA program to address variations in IMRT treatment and ensure eligible patients continue to receive safe, accessible and high-quality care across Ontario.



OUTCOMES COLLECTION AND EVALUATION FOR HEAD AND NECK CANCER PATIENTS

Highlights

In 2012–2013, we:

- Partnered with Princess Margaret Cancer Centre to develop an application, eOutcomes – head and neck (H&N), to collect and evaluate outcomes data for H&N cancer patients in Ontario in a prospective way.
- Piloted the application in two Regional Cancer Centres and drafted an evaluation template to inform broader provincial deployment of the application.

Looking Ahead

In 2013–2014, we will:

- Implement the eOutcomes – H&N application in the remaining eight cancer centres that treat H&N cancer patients.
- Continue to collect, monitor and evaluate outcomes data received through the application to drive quality improvement initiatives focused on providing appropriate and high-quality radiation treatment to H&N patients provincially.
- Use the experience gained from this project to inform the collection of outcomes for other disease sites.

MEDICAL PHYSICS RESIDENCY PROGRAM

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

Highlights

In 2012–2013, we:

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

Looking Ahead

In 2013–2014, we will:

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

PROTON BEAM THERAPY

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

Highlights

In 2012–2013, we:

- Created a multidisciplinary advisory panel to comprehensively review available literature in order to determine appropriate next steps. This will inform CCO on which patient populations would benefit from the use of proton therapy in Ontario.

Looking Ahead

In 2013–2014, we will:

- Review the results of the advice document to determine whether CCO should create a business case recommending the implementation of proton beam therapy in Ontario.

SYSTEMIC TREATMENT

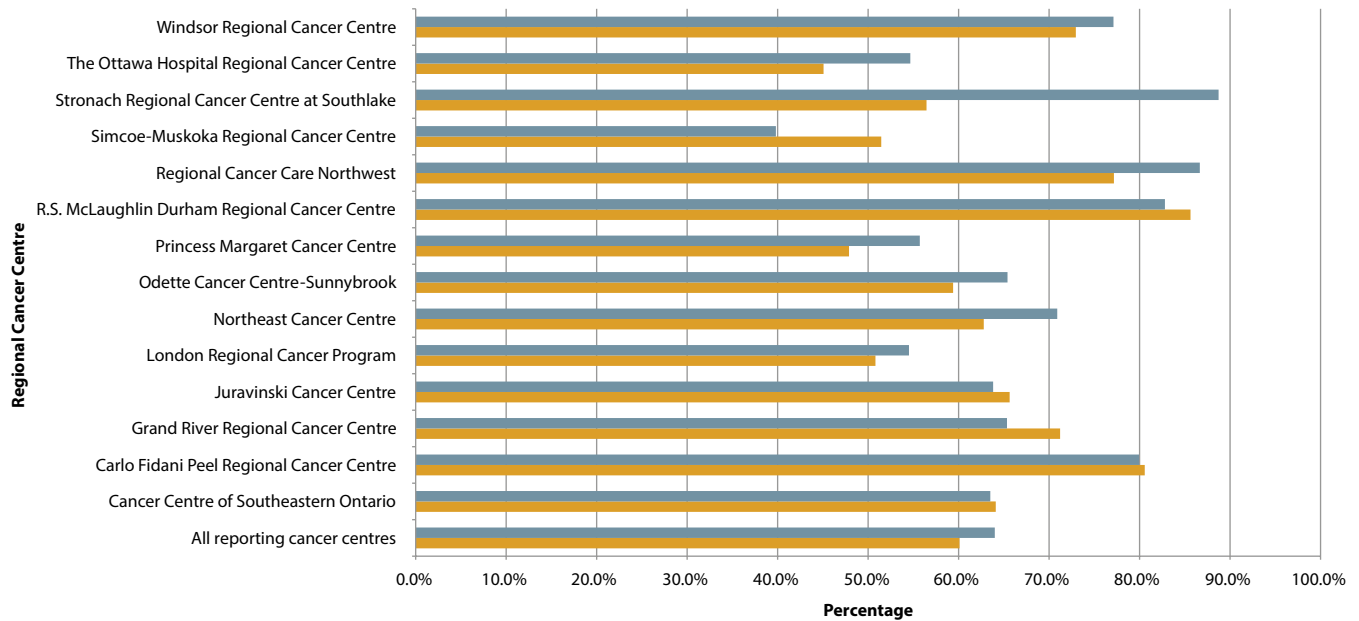
Systemic treatment – or chemotherapy – uses drugs to slow or stop cancer cells from multiplying or spreading. The sooner chemotherapy is given, the better the likely outcome for the patient.

Improving Treatment Wait Times

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

- 1. Wait times by target for Referral to Consult** – the time between a referral to a specialist to the time that specialist consults with the patient. In February 2013, 66 percent of patients in Ontario were seen within the 14-day target.
- 2. Wait times by target for Consult to Treatment** – the time between when a specialist consults with the patient and the time the patient receives his or her first chemotherapy treatment. In February 2013, 74 percent of patients were treated within the 28-day target.

**Systemic Referral to Consult – Percent seen within 14 days
Fiscal 2011–12 Vs. FY2012–13**



Data pull: July 2013

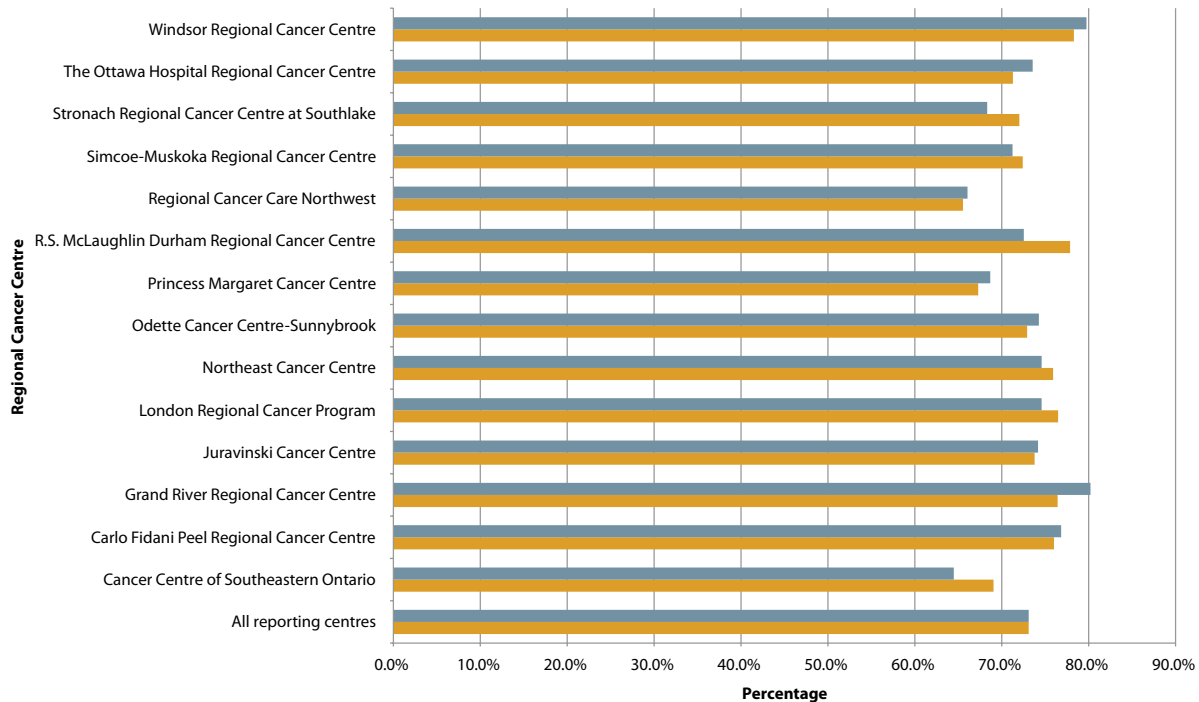
Data source: Activity level Reporting

Informatics – Centre of Excellence

■ Percent treated within 14 days FY2012–13

■ Percent treated within 14 days FY2011–12

**Systemic Consult to Treatment Wait Time – Percent treated within 28 days
Fiscal 2011–12 Vs. 2012–13**



Data pull: July 2013

Data source: Activity level Reporting

Informatics – Centre of Excellence

■ Percent treated within 28 days FY2012–13

■ Percent treated within 28 days FY2011–12

Computerized Physician Order Entry (CPOE)

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

- Expanding OPIS, CCO's chemotherapy medication ordering software, to 19 additional sites.
- Developing and disseminating Best Practice Guidelines for ST CPOE systems.
- Enhancing CCO's Drug Formulary clinical information tool to improve access at the point of care.

Regional Systemic Treatment Program

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

CCO's evaluation of the implementation of the RSTP Provincial Plan now is informing next steps in service delivery plans for other clinical programs. The RSTP also is developing a new patient-based funding model.

Highlights

In 2012–2013, we:

- Worked with the Canadian Institute for Health Information to enhance the National System for Incident Reporting system to collect systemic treatment data and implemented a communication and adoption strategy.
- Held the first Systemic Treatment Safety Symposium. A total of 93 participants discussed local quality initiatives in each region of Ontario, incident reporting for systemic treatment and the expanding role of oral chemotherapy.
- Launched the Regional Quality and Safety Network to support ongoing, locally driven quality improvement for systemic treatment.

- Provided incremental systemic treatment funding to community hospitals so they can expand capacity and deliver care close to home. CCO also is collecting wait-times information from community hospitals to support ongoing planning, monitoring, evaluation and improvement in systemic treatment delivery.

Looking Ahead

In 2013–2014, we will:

- Begin implementing a new funding model for systemic treatment as part of Ontario's Health System Funding Reform, to strengthen the link between the delivery of high-quality care and funding for services.
- Continue to focus on safety with the introduction of new and updated guidelines for the safe handling of cytotoxics and the implementation of the ST CPOE Best Practice Guideline.
- Conduct the Ambulatory Toxicity Management Pilot to identify a systematic and proactive approach to the assessment and management of chemotherapy-related toxicities.
- Support high-quality delivery of oral chemotherapy through coordinated local and provincial initiatives.

PROVINCIAL DRUG REIMBURSEMENT PROGRAMS

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

The Evidence Building Program

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

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

Highlights

In 2012–2013, we:

- Considered eight drugs for funding under EBP, out of which three were funded through other public drug programs, and three were selected for further review under EBP. Out of the three selected for further review, one drug was rejected, one was selected for further development, and one drug was approved for funding.
- Initiated the evaluation of the first drug-indication approved under the EBP (trastuzumab for adjuvant treatment of node-negative, HER2-positive tumours less than or equal to 1 cm) with an external analytics group.
- Integrated the enrolment and treatment claim processing for EBP-funded drugs into CCO eClaims, a new, web-based claims adjudication application. The program Privacy Impact Assessment was revised to enable this change from manual to automated processing.
- Developed an evaluation and reporting framework to measure key performance indicators for the program. Indicators were developed to support program operations. These are reviewed on a monthly basis with Ontario Public Drug Programs (OPDP).

Looking Ahead

In 2013–2014, we will:

- Continue to coordinate and act as the secretariat with the MOHLTC for the Ontario Steering Committee for Cancer Drug Programs to review proposals for funding consideration under the EBP.
- Conduct analysis and report on the first approved EBP drug (trastuzumab)
- Appoint disease-site-specific physicians accountable for:
 - Ensuring the currency of existing guidelines.
 - Continuing to work with the Program in Evidence-Based Care on ongoing horizon-scanning to mitigate risks associated with out-of-date guidance.
- Continue to support CCO's Disease Site Groups in the development of proposals for funding consideration under the EBP.
- Work with the MOHLTC to assess expanding the scope of the EBP to consider non-hospital (i.e., community-based) cancer drug therapies.
- Maintain timely and transparent communications with key stakeholders.

The Case-by-Case Review Program

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

Highlights

In 2012–2013, we:

- Evaluated the policy criteria against the overall program intent and revised accordingly.
- Reviewed and revised program processes and forms based on feedback from physicians, expert reviewers and the Executive Officer of the OPDP.
- Worked with the MOHLTC to explore additional ways of streamlining the application and adjudication processes, including Out-of-Country cancer drug requests.
- Developed key performance indicators to evaluate and report on the program to ensure reviews are timely, efficient, consistent and transparent, and to ensure that appropriate resources are in place to sustain operations.

Looking Ahead

In 2013–2014, we will:

- Continue to evaluate and revise the program policy and communicate changes to relevant stakeholders.
- Work with expert reviewers and the Ontario Steering Committee for Cancer Drug Programs to identify potential funding gaps that need to be addressed by the MOHLTC's expert committees.
- Evaluate the CBCRP against set performance indicators.

The New Drug Funding Program

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

Highlights

In 2012–2013, we:

- Worked closely with the MOHLTC, CCO's Disease Site Groups and the pan-Canadian Oncology Drug Review (pCODR) to provide comprehensive and timely feedback on the clinical and pharmacoeconomic reviews of the national drug review process. This resulted in three drugs being approved for three different cancer indications. We are also developing an evaluation process for drug-test pairs in conjunction with the MOHLTC and CCO's Pathology and Laboratory Medicine Program.
- Worked with the Systemic Treatment Program to collaborate and communicate with the MOHLTC, Group Purchasing Organizations, Regional Cancer Programs, and hospital pharmacies during the Sandoz drug shortage. An online collaboration site with more than 400 invited users will continue as a provincial resource for managing future shortages.
- Improved tracking of manufacturer drug pipelines and Disease Site Group submissions to inform a consistent pan-Canadian approach to injectable and oral cancer drug pipeline management. This responsibility is being transitioned to the pCODR.
- Drafted a policy on funding NDFP drugs for patients undergoing clinical trials to ensure providers are aware of the downstream funding policy implications for patients who agree to participate in a clinical trial.
- Developed an improved systematic drug funding forecast model which enables CCO and the MOHLTC to collaborate on drug-funding forecast assumptions.
- Began the development of a web-based reimbursement and claims-adjudication solution which will interface with CCO's Systemic Treatment databases and improve the efficiency of the NDFP in implementing and administering funding policies, adjudicating claims and reimbursing hospitals. The solution also will improve the end-user experience by providing decision-support tools when chemotherapy is ordered.

Looking Ahead

In 2013–2014, we will:

- Seek feedback from hospitals on the CCO eClaims solution.
- Expand reporting capabilities on the new data being captured through CCO eClaims.
- Continue to provide decision support to the pCODR process.
- Provide support to the Disease Site Group submission process.
- Continue to improve and enhance program policies with the support of the Ontario Steering Committee for Cancer Drug Programs.
- Ensure appropriate resources are in place to maintain internal and external audits and claim review.

CANCER IMAGING

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

Imaging is a critical component of care throughout a cancer patient's journey, with imaging technology used to screen for risk and to diagnose, stage, determine prognoses, predict, deliver and monitor response to treatment, and monitor for recurrence of cancer.

Imaging technologies contribute significantly to the cost of a patient's care and may also involve some risk for the patient through radiation exposure. Thus, the appropriate use of imaging is paramount in containing system resources and ensuring patients receive high-quality care at a minimum cost, optimizing value for money and patient safety.

Highlights

In 2012–2013, we:

- Finalized recommendations for imaging in lung cancer diagnosis and staging. The report consolidated guidance on evidence-based practice aligned with the patient journey. It was developed with extensive stakeholder feedback, and its format is being leveraged for other disease sites (e.g., colorectal cancer). The program also sponsored the development of evidence-based clinical guidelines to determine the current applications of prostate MRI in diagnosis and staging.
- Reported on wait times for priority interventional radiology procedures for oncology collected from participating institutions using ongoing, standardized methods. Recommended targets for these procedures were proposed, based on clinical requirements and informed by the wait time data.
- Distributed provincially a synoptic (standardized) report developed for rectal cancer staging with MRI. This report was leveraged to inform the implementation strategy for synoptic radiology reporting and assess barriers and enablers to its uptake. We convened a multidisciplinary clinical Advisory Panel to define minimum content for reports, and we identified partners for standards development.

Looking Ahead

In 2013–2014, we will:

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

Positron Emission Tomography Program

The Cancer Imaging program is accountable for CCO's Evidence-Based Positron Emission Tomography (PET) Program. The PET Program manages the evidence-building component of provincial PET imaging, including the expert advisory group (PET Steering Committee), evidence review and patient access to, and evaluation of, emerging PET indications to ensure appropriate access to PET scans in the province.

Highlights

In 2012–2013, we:

- Recommended the use of PET for selected head-and-neck and colorectal cancer indications as insured services.
- Completed a recommendation report on the use of PET in lymphoma. As a result of this review, we identified two new emerging indications (PET for lymphoma staging) for inclusion in the evidence-building portion of the provincial program.
- Initiated a systematic evidence review on the clinical utility of PET in epilepsy.

Looking Ahead

In 2013–2014, we will:

- Expand access to emerging indications for PET.
- Maintain our transparency in processes and decisions related to PET scanning.

MOLECULAR ONCOLOGY

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

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

Highlights

In 2012–2013, we:

- Took over the administration and oversight of two genetic tests from the MOHLTC and expanded the number of centres performing gastric HER2/Neu testing.
- Established the Hereditary Cancer Screening Subcommittee to provide expert clinical advice and recommendations aimed at strengthening clinical services for hereditary cancer syndromes.
- Undertook planning to inform CCO's strategic planning for personalized medicine.
- Conducted horizon-scanning and completed advice documents to inform system planning and the introduction of new tests.
- Worked with stakeholders to align and integrate strategies related to system planning and service delivery.

Looking Ahead

In 2013–2014, we will:

- Work with stakeholders to develop a governance structure and strategy for personalized medicine as it relates to oncology, in line with the Ontario Cancer Plan III, 2011–2015 strategic priority on personalized medicine.
- Work with stakeholders to implement new genetic tests.
- Continue activities related to horizon-scanning and the development of advice documents.
- Develop strategies for knowledge translation to facilitate uptake of evidence-based standards and guidelines.

ONTARIO CANCER SYMPTOM MANAGEMENT COLLABORATIVE

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

The collaborative actively engages all Regional Cancer Programs in implementing standardized assessment and care management tools.

Patients self-report their symptoms using the Edmonton Symptom Assessment System (ESAS).

The majority of patients do this electronically using the Interactive Symptom Assessment and Collection (ISAAC) tool. This allows them to see their progress over time and gives clinicians an idea of how their patients are feeling from one visit to the next.

Highlights

In 2012–2013, we:

- Saw the proportion of cancer patients routinely undergoing monthly symptom assessments at Regional Cancer Programs increase steadily from 30 percent in 2009 to 51 percent in 2011. In 2011–2012, approximately 112,500 patients self-reported their symptoms. At present, a total of 31 hospitals offer patients electronic assessment capabilities. This is an increase of seven hospitals.
- Undertook knowledge transfer and exchange (KTE) activities in all regions to support the broad diffusion and application of the symptom management guides published in 2010. We evaluated clinician uptake and concordance with the guides through chart audits and patient-satisfaction surveys. Survey results will be reported publicly in the Cancer System Quality Index; early evidence indicates that ESAS is a tool patients greatly value.
- Redeveloped ISAAC to provide the technical platform to add other patient-reported outcome measures beyond ESAS.

Looking Ahead

In 2013–2014, we will:

- Continue measuring and reporting on symptom assessment and offer ISAAC to additional regional partners.
- Publish four new symptom management guides; regions will be expected to conduct related KTE and application evaluation activities.
- Begin implementing the new ISAAC tool and adding other patient-reported outcome measures.
- Continue to work with the Regional Cancer Programs to ensure all patients receive appropriate symptom management and a better patient experience across their cancer journey.

SURVIVORSHIP PROGRAM

The Program is committed to better understanding the strategies required to address the identified needs and experiences of this population.

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

Highlights

In 2012–2013, we:

- Implemented breast cancer survivorship models and follow-up care projects in all 14 regions to optimize how care is provided to cancer survivors and to measure the impact of their experiences with new models of care.
- Completed – in collaboration with the Program in Evidence-Based Care – an evidence-based Guideline on Models of Care for Cancer Survivorship to provide guidance on appropriate models of care that could be considered for implementation and sustainability.
- Completed a patient and family-friendly pathway for colorectal cancer follow-up care to provide patients and their families with appropriate information on how to navigate colorectal cancer follow-up care after leaving the cancer centre.

See also: Models of Care

Looking Ahead

In 2013–2014, we will:

- Assess the impact of the breast cancer survivorship and follow-up care projects to measure the number of patients transitioned from specialist oncologists to primary care settings, as well as patient and provider experiences with new models.
- Implement new models for colorectal cancer well follow-up care in the remaining 12 regions to optimize how follow-up care is delivered and create sustainable changes in practice.
- Conduct knowledge and exchange activities with Primary Care Providers to facilitate the awareness of survivorship priorities and system needs to assist them in providing follow-up care for survivors of cancer and promote adherence to guidelines.
- Develop additional evidence-based consensus guidelines in conjunction with the Program in Evidence-Based Care to provide guidance and standard practices for follow-up care for lung and prostate cancers.

SPECIALIZED SERVICES OVERSIGHT

One of the strategies of OCP III is to provide oversight (including planning and quality management) of specialized services, such as stem-cell transplantation and neuroendocrine, acute leukemia and sarcoma services.

Such services tend to be low-volume, high-complexity, high-cost and offered in provincial centres of excellence, as opposed to every LHIN region. Though the nature of each program varies, a common approach is needed, including:

- Provincial coordination regarding clinical guidelines.
- Quality standards, data standards.
- System planning and the introduction of new techniques and technology.

Highlights

In 2012–2013, we:

- Saw the stem cell transplant oversight program focus on capacity management and planning for expected growth. The six transplant centres in Ontario – Toronto, Hamilton, London, Kingston, Ottawa and Sudbury – worked together to understand future demand and service availability and to improve referral patterns.

Funding continues for stem-cell transplants. We are now collecting and analyzing quality and access measures, including wait times, to ensure all Ontarians have equitable access to high-quality services.

- Developed – following pressures in the Greater Toronto Area – a plan to:
 - Ensure adequate access to – and capacity and sustainability for – acute leukemia services throughout the patient treatment journey.
 - Advance the quality and safety of acute leukemia services.
- Began implementing a service delivery plan for acute leukemia patients in the Greater Toronto Area. This supports care closer to home and reduces some patient needs to travel outside their community for frequent outpatient visits and hospitalizations. Acute leukemia is a rapidly progressive disease requiring timely, intensive and complex treatment.
- Ontario is putting in place a structure for the use of radiopharmaceuticals for neuroendocrine tumours that aligns with recommendations from the Ontario Neuroendocrine Tumour Expert Panel that are supported by new evidence-based guidelines. During the year, centres submitted proposals that met defined service, safety and clinical criteria. The new service-delivery structure will coordinate multiple treatment sites through a provincial Multidisciplinary Cancer Conference (MCC) and Clinical Trials Agreements with Health Canada.
- Initiated funding for specific care services in identified sarcoma centres. CCO is working with regional stakeholders to develop a provincial plan to ensure all patients have coordinated access to these services.
- Developed an application to enhance the capture and analysis of data to support the access, quality and funding goals of all specialty oversight programs. Once fully operational in 2013–2014, this system will accommodate future growth in each program and additional programs as they are implemented.

Looking Ahead

In 2013–2014, we will:

- Continue focusing on quality and access issues in the stem-cell transplant program by developing additional clinical practice guidelines and analyzing access and quality indicators to identify areas for improvement. We also will convene a provincial MCC to ensure all Ontarians have access to appropriate transplant services.
- Implement a plan for leukemia services in the Greater Toronto Area. This work will be leveraged to provide a platform to expand the services across Ontario in the future.
- Have newly established treatment sites begin delivering radionuclide therapy to patients with neuroendocrine tumours. We will establish a provincial MCC to assist with treatment decisions and put Clinical Trials Agreements in place to help ensure the best possible care for patients and a sustainable regulatory framework going forward. Additionally, we will begin provincial data collection to inform program developments in future years.
- Enhance the sarcoma program through implementation of an oversight program to address quality and access issues.

Infrastructure

CAPITAL PROJECTS

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

Highlights

In 2012 we:

- Began implementing our Capital Investment Strategy, including updated approaches to the Radiation Equipment Replacement Grant deployment and the prioritization of capital investments to ensure additional treatment capacity is available in regions where demand for treatment will exceed existing capacity.
- Secured an additional \$31.5 million in funding for 2012–2013, bringing the total investments in equipment replacements to \$61 million. CCO's management of this grant ensures equitable access to quality tools for the delivery of radiation treatment across Ontario. The \$61 million was allocated to 12 centres to upgrade radiation equipment with more advanced technology.
- Opened new cancer treatment facilities in Barrie and Niagara. When these centres are operating at capacity, each will support more than 80,000 patient visits per year.
- Relocated both the Ottawa Portable Radiation Treatment Facility and the Barrie treatment machine to Peterborough. As a result, approximately 400 patients a year will not have to travel from Peterborough to Oshawa for treatment.
- Updated Vendor of Record arrangements for Linacs and CT Simulators to ensure provincial procurement arrangements for radiation capital equipment represent the most current technologies and ensure competitive pricing.

Looking Ahead

In 2013–2014, we will:

- Develop a plan to secure funding to equip 16 existing – but vacant – radiation treatment rooms in regions where demand exceeds treatment capacity.
- Develop plans to secure capital approvals for investments in additional radiation treatment facilities based on capacity planning priorities established through the implementation of the Capital Investment Strategy.
- Manage the Radiation Replacement Grant process to distribute funding based on provincial priorities; continue work to secure additional funding to better address the need to replace aging radiation equipment.
- Update equipment ownership and procurement approaches to leverage opportunities to further improve the deployment of our capital resources.

The Ontario Renal Network (ORN)

As Ontario's population continues to grow and age and the prevalence of diabetes and vascular disease increases, the prevalence of chronic kidney disease (CKD) is also expected to increase. The Ontario Renal Network (ORN) is implementing a provincial CKD strategy (Ontario Renal Plan 2012–2015) that will lead to a measurable and sustained improvement in care for CKD patients across the province. Through the expanded Ontario Renal Reporting System (ORRS), we have been able to leverage timely data for health-system performance and patient outcomes, by using monthly measurement of key performance and quality indicators to support ORN's provincial priorities. In 2012–2013, we completed planning for the launch of the technical project, ORRS Expose with upload. Additionally, our capacity planning activity has served as a critical decision aid to ensure that Ontario's renal system has the infrastructure in place to meet the needs of people with CKD.

Highlights:

In 2012–2013, we:

- Built stronger relationships with more than 150 primary care practitioners in a shared care pilot model with their CKD patients to increase screening (early detection), facilitate better management (delaying the need for dialysis) and enhance overall CKD education among primary care providers to support more appropriate and timely referrals to nephrologists.
- Launched an Electronic Medical Record (EMR) research pilot with four Family Health Teams from various areas of the province to test whether modifications, such as CKD screening prompts and Chronic Disease Management flow sheets, make an impact on primary care behavior and patient outcomes.
- Collected vascular surgery data to better understand the barriers to improving the timely and appropriate delivery of vascular access.
- Established and reported a new Independent Dialysis (ID) metric – six-month incident ID. This metric is critical for monitoring and evaluating the performance of our CKD system to promote and increase the uptake of ID.

-
- Launched the Body Access and ID Collaborative, a quality improvement initiative that is building a provincial network of local healthcare leaders to achieve appropriate body access for all patients and increase ID uptake. The initiative is led by the ORN-funded Body Access and Independent Dialysis Coordinators in each Regional CKD Program.
 - Implemented patient-based funding within all CKD programs by implementing home dialysis patient-based funding bundles, revised reimbursement rates and increased funding flow through the ORN. All 31 CKD providers and related stakeholders were engaged through technical and strategic educational forums. We also developed a funding policy monitoring and evaluation framework.

Looking Ahead

In 2013–2014, we will:

- Continue to focus on reaching the goals and targets of the seven strategic priorities in the Ontario Renal Plan by implementing work plans and continuing to build the network.
- Evaluate the EMR pilot and continue to monitor its success.
- Continue to work with the five nephrologists and primary care practitioners in the mentorship project.
- Develop a strategy for implementing the patient-based funding framework in Community Care Access Centres and Long-Term Care Facilities, as well as expand the framework to include additional Vascular Access services.
- Throughout the year we will continue working to ensure that we have the required capacity in place for patients to receive care closer to home.

Access to Care

Access to Care (ATC) is the service delivery agency for the Ontario Wait Time Strategy and Emergency Room/Alternate Level of Care Information Strategy. ATC uses clinician leadership and engagement, along with state-of-the-art project management methodologies, to develop information solutions and deploy them to healthcare organizations across the province. They, in turn, use them to reduce wait times and improve patient access to healthcare services. ATC provides high-quality IM/IT products that enable performance improvement for:

- Alternate Level of Care (ALC)
- Emergency Room (ER) Information
- Surgery and Diagnostic Imaging Wait Times (Surgery and DI)
- Surgical Efficiency Targets Program (SETP)
- Wait Times Information System (WTIS) – Cardiac Care Network (CCN)

In 2012–2013, ATC conducted an operational reporting review across the ALC, ER, Surgery and Diagnostic Imaging Wait Times and SETP areas of focus. This major initiative included meeting with stakeholders to identify how ATC can best meet their reporting needs. The result is a refresh of the reports generated by ATC for its stakeholders. In 2013–2014, ATC will communicate these reporting changes and enhancements with its stakeholders as they are introduced.

ALTERNATE LEVEL OF CARE INFORMATION

In 2008–2009, the province expanded the WTIS to include ALC information in near real-time in both acute and post-acute care. ALC is the designation given by a physician to a patient who is occupying a bed in a hospital but does not require the hospital-level intensity of resources or services.

Highlights

In 2012–2013, we:

- Deployed four additional ALC data elements:
 1. Most Appropriate Discharge Destination Type.
 2. Most Appropriate Discharge Destination Detail.
 3. Specialized Needs and Supports Indicator.
 4. Specialized Needs and Supports (as a need/ as a barrier).

These additional data elements provide a more comprehensive picture of those patients not accessing the right level of care and highlight barriers to patients being discharged to the appropriate level of care, thereby providing more robust data that can be used to improve patient outcomes.

- Supported six existing facilities to change their data submission integration level.
- Deployed the WTIS application to collect and report all ALC data in near real-time for 10 new facilities.
- Maintained IT technology and infrastructure services and provided daily operational services to support ALC facilities.
- Supported reporting functionality through iPort™ Access (a business intelligence tool) for hospitals, Local Health Integration Networks and the MOHLTC which included introducing or enhancing ALC reports.

Looking Ahead

In 2013–2014, we will:

- Provide information management reporting and analytics to hospitals, LHINs and the MOHLTC.
- Begin the reporting of the four new data elements deployed during 2012–2013 starting in the fall of 2013. All are available in manual informatics reporting.
- Continue to support reporting functionality through iPort™ Access for hospitals, LHINs and the Ministry.

EMERGENCY ROOM INFORMATION

The goals of the ER/ALC Information Strategy are to reduce the time spent in the ER and improve patient satisfaction.

To address these strategy elements, ATC partnered with the Canadian Institute for Health Information (CIHI) to leverage the National Ambulatory Care Reporting System (NACRS) for the timely collection of ER wait-time data. We introduced the Emergency Room National Ambulatory Initiative in 2009 to help measure and report how long patients were spending in the ER. Ninety-two facilities across the province now are collecting and submitting a dataset of 38 ER data elements that capture the patient journey through the ER. This data is publicly reported on the MOHLTC's Wait Times website.

Highlights

In 2012–2013, we:

- Provided data quality monitoring, reporting services and operational support to 92 facilities.
- Provided ER performance reports to hospitals, LHINs and the MOHLTC.
- Provided and supported reporting functionality through the iPort™ Access to hospitals, LHINs and the MOHLTC.
- Engaged ER clinical experts and stakeholders to develop data-collection guidelines, data quality initiatives, reporting services and future directions of the program.
- Engaged ER clinical experts and stakeholders to evaluate and develop proposed additional NACRS data elements for implementation in 2013–2014.

Looking Ahead

In 2013–2014, we will:

- Release new ER Segment Dashboard and ER Consult data in iPort™ Access.
- Deploy ER Consult data to one additional hospital.
- Continue to provide data quality monitoring, reporting services and operational support to 92 facilities.
- Continue to provide ER performance reports to hospitals, LHINs and the MOHLTC.
- Continue to engage ER clinical experts and stakeholders to develop data collection guidelines, data-quality initiatives, reporting services and future directions of the program.

SURGERY AND DIAGNOSTIC IMAGING WAIT TIMES

The WTIS tracks, measures and reports on surgical and diagnostic wait times province-wide. More than 3,100 clinicians and 2,200 end users in 96 wait-time-funded hospitals submit information on 2.3 million adult and paediatric surgeries and MRI/CT scans each year.

Highlights

In 2012–2013, we:

- Maintained technology and infrastructure services and provided daily operational services to support 96 hospitals and 3,100 clinicians with wait list entries and 2,200 end users.
- Engaged hospitals to ensure WTIS data is fully reportable and compliant based on CCO's data-quality framework.
- Worked with seven Independent Health Facilities (IHF's) to begin manual reporting of diagnostic imaging (DI) wait times at these sites.
- Supported reporting functionality through iPort™ Access for hospitals, LHINs and the MOHLTC.

Looking Ahead

In 2013–2014, we will:

- Continue to engage hospitals to ensure WTIS data is fully reportable and compliant based on CCO's data-quality framework.
- Automate DI data collection from seven IHFs by deploying the WTIS to these facilities by March 31, 2014.
- Deploy our integration migration initiative to qualified hospitals reporting surgery and/or DI data.

MRI EFFICIENCY PROJECT

The MRI Efficiency Project is part of the Ontario Wait Time Strategy to improve patient access to MRI services. The initial concept for this project was developed by University Health Network (UHN) as an extension of the MRI Process Improvement Project, and has focused on creating sustainable improvements in MRI processes by optimizing the use of existing resources to increase capacity and decrease wait times. As of October 1, 2013, operational support of this project will be transferred to ATC.

In 2013–2014, we will:

- Transition the MRI Efficiency Project from UHN and establish an operational program to support ongoing management and data collection.
- Conduct all activities to support data collection, data quality, analytics and reporting for 63 MRI sites as of October 1, 2013.
- Develop a reporting and analytics plan for MRI data.

SURGICAL EFFICIENCY TARGETS PROGRAM

SETP uses operating-room data to identify areas where performance opportunities and issues exist in the perioperative portion of patient care (the duration of a patient's surgical procedure, from admission to discharge).

SETP:

- Measures and reports on surgical management Key Performance Indicators.
- Benchmarks the performance of comparable hospitals.
- Establishes provincial performance targets to support process improvements.

Highlights

In 2012–2013, we:

- Provided SETP data collection and reporting services to 77 hospitals and more than 230 users.
- Provided information management reporting and analytics to hospitals, LHINs and the MOHLTC.

Looking Ahead

In 2013–2014, we will:

- Continue providing SETP data collection and reporting services to hospitals and users.
- Continue providing information management reporting and analytics to hospitals, LHINs and the MOHLTC.
- Engage with our vendor to request product changes to the Operating Room Benchmarks Collaborative that will benefit the Ministry, LHINs, SETP hospitals and/or strategic SETP objectives.

CARDIAC CARE NETWORK

CCO works with the CCN to develop and enhance the functionality of its application that supports clinicians in caring for their cardiac patients. Each year, CCO delivers two key application releases in support of the ATC strategy for cardiac disease. The ability to track this information is vital to the clinical teams and the Cardiac Care Network in delivering quality care.

Highlights

In 2012–2013, we:

- Provided operational support for infrastructure hosting for the WTIS-CCN production and test systems, and application support for WTIS-CCN.
- Achieved 99 percent or higher availability of the CCN WTIS Application for the fiscal year.
- Provided a near real-time transmission of the WTIS-CCN data to the CCN for wait-time reporting purposes.
- Successfully released new functionalities for CCN.

Looking Ahead

In 2013–2014, we will:

- Continue to provide operational support for infrastructure hosting of the WTIS-CCN production and test systems, and application support for WTIS-CCN.
- Develop, test and deploy prioritized enhancements based on direction from CCN and cardiac care clinicians.

Human Resources

In today's competitive and knowledge-driven environment, Human Resources (HR) is a critical element in the success of an organization.

At Cancer Care Ontario, HR supports the flexibility, speed and performance of our business through contributions in strategic areas, including talent management, succession planning, engagement, recruitment and retention.

Highlights

In 2012–2013, we:

- Delivered initiatives against our three-year Human Resources Strategic Plan focused on four key areas: Continuing to Build HR Infrastructure, Attracting and Retaining Talent, Building Capability and Capacity and Building the Desired Culture. The four areas encompass:
 - Continuing to build HR infrastructure.
 - Ensuring consistency of HR standards and practices.
 - Documenting processes and policies.
 - Utilizing HR metrics to drive business decisions.
 - Automating HR systems.
 - Attracting and retaining top talent.
 - Refining our recruitment strategy.
 - Focusing on resourcing.
 - Developing a differentiating value proposition.
 - Establishing standards of practice.
 - Building capability and capacity.
 - Expanding succession planning.
 - Accelerating leadership development.
 - Enhancing employee career development.
 - Building the desired culture.
 - Emphasizing quality, accountability and innovation.
 - Fostering collaboration.
 - Enhancing communication.
 - Supporting diversity in the workplace.
 - Fostering respect in the workplace.
- Saw the growth of CCO's staff complement to a full-time equivalent (FTE) workforce of 846.9 as a result of an expansion of our scope and mandate, in particular in the areas of Integrated Cancer Screening and Clinical and Quality Care Programs.

Looking Ahead

In 2013–2014, we will:

- Continue our work to:
- Couple HR's technical knowledge and people skills with a deeper focus on challenges and business issues facing our organization, closely mapping HR strategy to our business strategy.
- Develop and continually improve the HR systems and programs that enable CCO to attract, engage, develop and retain talented people who take pride in improving the healthcare system.
- Build programs that support and reinforce a culture of quality, accountability and innovation.
- Make CCO an employer of choice by using the information from the Employee Engagement Survey completed in November 2012.
- Develop our leaders by building skills and capacity to support our employees.

Financial Reports

Cancer Care Ontario Action Cancer Ontario

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June 20, 2013

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, 2013, 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, CA
Vice President & Chief Financial Officer





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

Independent Auditor's Report

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

I have audited the accompanying financial statements of Cancer Care Ontario, which comprise the statements of financial position as at March 31, 2013, March 31, 2012 and April 1, 2011 and the statements of operations, changes in fund balances, and cash flows for the years ended March 31, 2013 and March 31, 2012 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 audits. I conducted my audits 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 in my audits 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, 2013, March 31, 2012 and April 1, 2011 and its financial performance and its cash flows for the years ended March 31, 2013 and March 31, 2012 in accordance with Canadian public sector accounting standards.

Toronto, Ontario
June 20, 2013

Susan Klein, CPA, CA, LPA
Acting Deputy Auditor General

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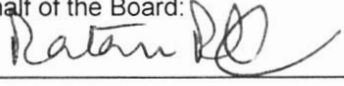
Cancer Care Ontario

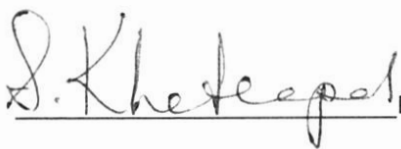
Statements of financial position

(In thousands of dollars)

	March 31, 2013	March 31, 2012	April 1, 2011
Assets			
Current			
Cash and cash equivalents (Note 3)	\$ 91,164	\$ 117,484	\$ 155,804
Short-term investments (Note 4)	102,921	122,111	80,982
Receivables and prepaids (Note 5)	54,989	28,878	20,253
	<u>249,074</u>	<u>268,473</u>	<u>257,039</u>
Capital assets (Note 6)	<u>160,147</u>	<u>134,148</u>	<u>103,488</u>
	<u>\$ 409,221</u>	<u>\$ 402,621</u>	<u>\$ 360,527</u>
Liabilities			
Current			
Accounts payable and accrued liabilities (Note 7)	\$ 185,070	\$ 208,573	\$ 190,280
Deferred operating grants (Note 8(a))	4,554	4,861	6,546
	<u>189,624</u>	<u>213,434</u>	<u>196,826</u>
Deferred contributions related to capital assets (Note 8(b))	169,278	140,464	115,930
Post-employment benefits other than pension plan (Note 9(b))	2,380	2,512	2,611
	<u>361,282</u>	<u>356,410</u>	<u>315,367</u>
Fund balances			
Endowment (Note 1)	1,288	1,288	2,317
Internally restricted (Note 1)	1,550	2,009	1,641
Externally restricted (Note 1)	2,469	2,476	8,364
General – unrestricted (Note 1)	37,543	36,819	27,372
Investment in capital assets (Note 10)	5,089	3,619	5,466
	<u>47,939</u>	<u>46,211</u>	<u>45,160</u>
	<u>\$ 409,221</u>	<u>\$ 402,621</u>	<u>\$ 360,527</u>
Commitments (Note 15)			
Contingencies (Note 16)			
Guarantees (Note 17)			

On behalf of the Board:

 Director

 Director

See accompanying notes to the financial statements.

Cancer Care Ontario

Statements of operations

(In thousands of dollars)

Years ended March 31, 2013 and 2012

	Restricted		General		Total	
	2013	2012	2013	2012	2013	2012
Revenue						
Ministry of Health and Long-Term Care	\$ -	\$ -	\$ 959,244	\$ 844,437	\$ 959,244	\$ 844,437
Ministry of Health and Long-Term Care capital funding for Integrated Cancer Programs	-	-	8,125	9,597	8,125	9,597
Net investment income (Note 11)	17	31	2,626	4,200	2,643	4,231
Amortization of deferred contributions related to capital assets (Note 8(b))	-	-	34,687	23,957	34,687	23,957
Other (Note 12)	2,293	3,465	8,611	9,419	10,904	12,884
	<u>2,310</u>	<u>3,496</u>	<u>1,013,293</u>	<u>891,610</u>	<u>1,015,603</u>	<u>895,106</u>
Expenses						
Integrated Cancer Programs						
Services	7	3,694	300,191	312,417	300,198	316,111
Drugs	-	-	232,323	219,309	232,323	219,309
Chronic kidney disease services	-	-	174,861	51,643	174,861	51,643
Surgical services – hospitals	-	-	70,955	66,675	70,955	66,675
Salaries and benefits	1,772	1,762	68,124	63,174	69,896	64,936
Amortization of capital assets	-	-	36,037	25,715	36,037	25,715
Medical services	6	24	28,232	25,662	28,238	25,686
Purchased services	937	1,212	22,642	21,099	23,579	22,311
Hospital systemic therapy services	-	-	17,761	15,344	17,761	15,344
Screening services	-	-	17,588	50,369	17,588	50,369
Capital contributions to Integrated Cancer Programs	-	-	13,712	11,737	13,712	11,737
Other operating (Note 13)	194	216	12,641	11,734	12,835	11,950
Pension (Note 9(a))	-	-	5,679	5,102	5,679	5,102
Consulting services	17	12	4,893	2,780	4,910	2,792
Occupancy costs	-	5	4,554	3,893	4,554	3,898
Professional fees	-	1	608	324	608	325
Post-employment benefits other than pension plan (Note 9(b))	-	-	141	141	141	141
Loss on disposal of capital assets	-	-	-	11	-	11
	<u>2,933</u>	<u>6,926</u>	<u>1,010,942</u>	<u>887,129</u>	<u>1,013,875</u>	<u>894,055</u>
Excess (deficiency) of revenue over expenses	\$ (623)	\$ (3,430)	\$ 2,351	\$ 4,481	\$ 1,728	\$ 1,051

See accompanying notes to the financial statements.

Cancer Care Ontario

Statements of changes in fund balances

(In thousands of dollars)

Years ended March 31, 2013 and 2012

	<u>Restricted</u>			<u>General –</u>	<u>Invested</u>	
	<u>Endowment</u>	<u>Internally</u>	<u>Externally</u>	<u>unrestricted</u>	<u>in capital</u>	<u>Total</u>
					<u>assets</u>	
Fund balances, April 1, 2011	\$ 2,317	\$ 1,641	\$ 8,364	\$ 27,372	\$ 5,466	\$ 45,160
Excess (deficiency) of revenue over expenses	-	(225)	(3,205)	4,481	-	1,051
Net change in investment in capital assets (Note 10)	-	555	-	1,292	(1,847)	-
Interfund transfers (Note 14)	<u>(1,029)</u>	<u>38</u>	<u>(2,683)</u>	<u>3,674</u>	<u>-</u>	<u>-</u>
Fund balances, March 31, 2012	1,288	2,009	2,476	36,819	3,619	46,211
Excess (deficiency) of revenue over expenses	-	(592)	(31)	2,351	-	1,728
Net change in investment in capital assets (Note 10)	-	-	-	(1,470)	1,470	-
Interfund transfers (Note 14)	<u>-</u>	<u>133</u>	<u>24</u>	<u>(157)</u>	<u>-</u>	<u>-</u>
Fund balances, March 31, 2013	<u>\$ 1,288</u>	<u>\$ 1,550</u>	<u>\$ 2,469</u>	<u>\$ 37,543</u>	<u>\$ 5,089</u>	<u>\$ 47,939</u>

See accompanying notes to the financial statements.

Cancer Care Ontario

Statements of cash flows

(In thousands of dollars)

Years ended March 31

2013

2012

Increase (decrease) in cash and cash equivalents

Operating

Excess of revenue over expenses	\$ 1,728	\$ 1,051
Amortization of capital assets	36,037	25,715
Amortization of deferred contributions related to capital assets	(34,687)	(23,957)
Loss on disposal of capital assets	-	11
Post-employment benefits expense other than pension plan	141	141
Post-employment benefits paid other than pension plan	(273)	(240)
	<u>2,946</u>	<u>2,721</u>
Change in non-cash operating working capital		
Receivables and prepaids	(26,111)	(8,625)
Accounts payable and accrued liabilities	(23,503)	18,293
Deferred operating grants	(307)	(1,685)
	<u>(49,921)</u>	<u>7,983</u>
	<u>(46,975)</u>	<u>10,704</u>

Capital

Purchase of capital assets	(62,036)	(56,393)
Proceeds on disposal of capital assets	-	7
	<u>(62,036)</u>	<u>(56,386)</u>

Investing

Proceeds from maturity of investments	91,428	83,422
Purchase of investments	(72,238)	(124,551)
	<u>19,190</u>	<u>(41,129)</u>

Financing

Amounts received related to capital assets	<u>63,501</u>	<u>48,491</u>
--	---------------	---------------

Decrease in cash and cash equivalents (26,320) (38,320)

Cash and cash equivalents, beginning of year 117,484 155,804

Cash and cash equivalents, end of year \$ 91,164 \$ 117,484

See accompanying notes to the financial statements.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

Nature of operations

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

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

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

The Organization is a registered charity under the Income Tax Act (Canada) and accordingly is exempt from income taxes, provided certain requirements of the Income Tax Act are met. Members of the Board of Directors and Board Committees are volunteers who service without remuneration. The Organization and the Ministry of Health and Long-Term Care ("MOHLTC") entered into a Memorandum of Understanding, effective December 31, 2009. The Organization is primarily funded by the Province of Ontario through the MOHLTC.

1. 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 ("PSA-GNPO") as issued by the Public Sector Accounting Board (PSAB). This is the first time that the Organization has prepared its financial statements in accordance with PSA-GNPO, having previously prepared its financial statements in accordance with Not-For-Profit accounting standards in Part V of the Canadian Institute of Chartered Accountants (CICA) Handbook.

Details of how the transition has affected the financial position, financial performance and cash flows are disclosed in Note 2.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

1. Significant accounting policies (continued)

Fund accounting

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

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

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

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

Contributions

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

Unrestricted contributions are recognized as revenue of the General Fund when the amount is reasonably estimated 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.

See accompanying notes to the financial statements.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

1. Significant accounting policies (continued)

Financial Instruments

Financial instruments are measured at fair value when acquired or issued. In subsequent periods, financial instruments (including short-term 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 short-term investments that is other than a temporary decline, the investment is written down and the loss is recorded in the statements of operations. For receivables, when a loss is considered probable, the receivable is reflected at its estimated written down amount to the lower of its cost and its estimated net recoverable amount, with the loss reported on the statements of operations. Transaction costs on the acquisition, sale or issue of financial instruments are expensed for those items subsequently measured at fair value and charged to the financial instrument for those measured at amortized cost.

Capital assets

Capital assets are recorded at cost less amortization and impairment. 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 is amortized over periods ranging from 4 years to 9 years; office furniture, equipment is 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 5 years.

Land and buildings for four lodges donated by the Canadian Cancer Society – Ontario Division are recorded at nominal value, as the 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 statements 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 multiemployer 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 contribution are accounted for as if the plan were a defined contribution plan with the Organization's contribution being expensed in the period they come due.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

1. Significant accounting policies (continued)

Pension benefits and post-employment benefits other than pension plan (continued)

(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 prorated 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 to income over the estimated average remaining service life of the employee groups on a straight line basis.

Use of estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Items subject to such estimates and assumptions include the impairment assessment in the carrying amount of capital assets, accruals for drug expenditures and post-employment benefits other than pension plan. Actual results could differ from those estimates.

2. Transition to Public Sector Accounting Standards

The Organization has adopted PSA-GNPO effective April 1, 2011 ("the transition date") and has prepared its opening PSA-GNPO statement of financial position as at that date. Prior to the adoption of PSA-GNPO the Organization prepared its financial statements in accordance with Not-For-Profit accounting standards in Part V of the Canadian Institute of Chartered Accountants (CICA) Handbook ("Canadian GAAP").

The financial statements of the Organization have been prepared using policies specified by PSA-GNPO that are in effect at the end of the reporting period ended March 31, 2013. The significant accounting policies that have been applied in the preparation of these financial statements are summarized in Note 1. These accounting policies have been used throughout all periods presented in the financial statements, except where the Organization has applied certain accounting policy exemptions to full retrospective application upon transition to PSA-GNPO.

Public Sector ("PS") 2125, *First-time adoption by Government Organizations* requires that comparative financial information be provided and that the PSA-GNPO be applied retrospectively; however, PS 2125 provides for certain optional exemptions and mandatory exemptions for first time adopters.

The PS 2125 exemptions applied in the conversion from Canadian GAAP to PSA-GNPO are as follows:

Post-employment benefits other than pension plan

The Organization has elected to recognize all cumulative actuarial gains and losses at the date of transition directly into general – unrestricted fund balance at the date of transition of April 1, 2011. This election resulted in an increase in fund balances of \$458 at the date of transition.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

2. Transition to Public Sector Accounting Standards (continued)

These accounting changes have been applied retroactively with restatement of prior periods except for the accounting standards contained in PS 2601 – *Foreign currency translation* and PS 3450 – *Financial instruments* as these standards specifically prohibit retroactive application. The following changes have been implemented to comply with PSA-GNPO:

<u>March 31, 2012</u>	<u>Previously Reported</u>	<u>Adjustments</u>	<u>Revised</u>
a) Statement of financial position			
Financial liabilities:			
Post-retirement benefits other than pension plan (i) (ii)	\$ 3,195	\$ (683)	\$ 2,512
Fund balances:			
General – unrestricted (i) (ii)	\$ 36,136	\$ 683	\$ 36,819
Statement of operations			
Post-retirement benefits other than pension Plan (i)	\$ 121	\$ 20	\$ 141

<u>April 1, 2011</u>	<u>Previously Reported</u>	<u>Adjustments</u>	<u>Revised</u>
b) Statement of financial position			
Financial liabilities:			
Post-retirement benefits other than pension plan (i) (ii)	\$ 3,314	\$ (703)	\$ 2,611
Fund balances:			
General – unrestricted (i) (ii)	\$ 26,669	\$ 703	\$ 27,372

c) Statement of Cash Flow

PS 1201 *Financial Statement Presentation*, includes an additional "capital" activities category. The Organization has moved all capital asset activity from the "investing" category to the "capital" activities category in the statements of cash flows.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

2. Transition to Public Sector Accounting Standards (continued)

Notes to the reconciliations:

- (i) As a result of adopting PS 3250 *Retirement Benefits*, the Organization was required to use a different discount rate to calculate the accrued liability. The discount rate is now based on the Organization's own borrowing rate. In addition, the Organization is required to amortize the actuarial gains and losses on a different basis than under pre-changeover GAAP. As a result of these differences, there was a decrease in the accrued benefit liability and an increase of general – unrestricted fund balances of \$245 at the date of transition, April 1, 2011 (March 31, 2012 - \$235).
- (ii) These adjustments are a result of the exemption elected under PS 2125, *First-Time Adoption* as described earlier in Note 2. This election resulted in a decrease in the accrued benefit liability and an increase of general – unrestricted fund balances of \$458 at the date of transition, April 1, 2011 (March 31, 2012 - \$448).

Effective April 1, 2012, the Organization adopted PS 2601 – *Foreign currency translation* and PS 3450 – *Financial instruments*. There were no accounting adjustments required upon adoption of these standards. These sections have been applied prospectively; as a result, comparative amounts are presented in accordance with the accounting policies applied by the Organization immediately preceding its adoption of PSA-GNPO.

3. Cash and cash equivalents – restricted

Cash and cash equivalents includes \$412 (2012 - \$407; April 1, 2011 - \$404) 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

	March 31, 2013	March 31, 2012	April 1, 2011
Guaranteed Investment Certificates as follows:			
- interest at 1.50%, maturing September 5, 2013	\$ 42,516	\$ -	\$ -
- interest at 1.89%, redeemable on demand, maturing September 5, 2013	30,041	60,082	-
- interest at 1.75%, maturing October 2, 2013	10,262	-	-
- interest at 1.35%, maturing May 9, 2013	10,053	-	-
- interest at 1.75%, redeemable on demand, maturing June 23, 2014	10,049	-	-
- interest at 1.85%, maturing September 5, 2012	-	41,820	-
- interest at 1.60%, maturing December 21, 2012	-	10,125	-
- interest at 1.75%, maturing April 2, 2012	-	10,084	-
- interest at 2.10%, maturing March 3, 2012	-	-	10,226
- interest at 2.26%, maturing March 5, 2012	-	-	30,693
- interest at 2.05%, maturing March 5, 2012	-	-	40,063
	<u>\$ 102,921</u>	<u>\$ 122,111</u>	<u>\$ 80,982</u>

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

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

5. Receivables and prepaids	March 31, 2013	March 31, 2012	April 1, 2011
Accounts receivable	\$ 12,639	\$ 5,838	\$ 4,225
Due from MOHLTC	39,817	21,305	14,818
Prepaids	<u>2,533</u>	<u>1,735</u>	<u>1,210</u>
	<u>\$ 54,989</u>	<u>\$ 28,878</u>	<u>\$ 20,253</u>

6. Capital assets

	March 31, 2013		
	Cost	Accumulated Amortization	Net Book Value
Therapeutic and other technical equipment	\$ 322,480	\$ 189,761	\$ 132,719
Office furniture, equipment	6,097	3,630	2,467
Leasehold improvements	4,284	3,802	482
Land and buildings	1	-	1
Software	<u>44,990</u>	<u>20,512</u>	<u>24,478</u>
	<u>\$ 377,852</u>	<u>\$ 217,705</u>	<u>\$ 160,147</u>

	March 31, 2012		
	Cost	Accumulated Amortization	Net Book Value
Therapeutic and other technical equipment	\$ 279,430	\$ 174,531	\$ 104,899
Office furniture, equipment	4,935	2,380	2,555
Leasehold improvements	4,056	3,069	987
Land and buildings	1	-	1
Software	<u>32,942</u>	<u>7,236</u>	<u>25,706</u>
	<u>\$ 321,364</u>	<u>\$ 187,216</u>	<u>\$ 134,148</u>

	April 1, 2011		
	Cost	Accumulated Amortization	Net Book Value
Therapeutic and other technical equipment	\$ 272,034	\$ 181,885	\$ 90,149
Office furniture, equipment	2,985	1,287	1,698
Leasehold improvements	4,056	2,248	1,808
Land and buildings	1	-	1
Software	<u>11,507</u>	<u>1,675</u>	<u>9,832</u>
	<u>\$ 290,583</u>	<u>\$ 187,095</u>	<u>\$ 103,488</u>

The cost of capital assets include software under development of \$3,112 (2012 - \$9,547, April 1, 2011 - \$1,718) and deposits for therapeutic equipment of \$36,526 (2012 - \$23,487, April 1, 2011 - \$18,855). Amortization of these amounts will commence when the asset is available for use.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

7. Accounts payable and accrued liabilities

	March 31, 2013	March 31, 2012	April 1, 2011
Trade payables	\$ 125,340	\$ 138,672	\$ 63,980
Accrued liabilities	46,208	39,341	63,955
Payable to MOHLTC	13,110	30,153	61,941
Pension escrow	412	407	404
	<u>\$ 185,070</u>	<u>\$ 208,573</u>	<u>\$ 190,280</u>

8. Deferred contributions

a) Deferred operating grants

Deferred operating grants represent unspent resources related to MOHLTC and other funded programs. Unspent amounts are held for use in subsequent periods or settlement with the respective Ministry. Changes in the deferred operating grant balance are as follows:

	March 31, 2013	March 31, 2012
Balance, beginning of year	\$ 4,861	\$ 6,546
Amounts received during the year	52,759	99,389
Amounts recognized as revenue	(9,189)	(5,068)
Amounts returned to MOHLTC	(30,767)	(65,853)
Amounts reclassified to accounts payable and accrued liabilities	<u>(13,110)</u>	<u>(30,153)</u>
Balance, end of year	<u>\$ 4,554</u>	<u>\$ 4,861</u>

b) 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:

	March 31, 2013	March 31, 2012
Balance, beginning of year	\$ 140,464	\$ 115,930
Amounts received related to capital assets	63,501	48,491
Amounts recognized as revenue	<u>(34,687)</u>	<u>(23,957)</u>
Balance, end of year	<u>\$ 169,278</u>	<u>\$ 140,464</u>

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

8. Deferred contributions (continued)

b) Deferred contributions related to capital assets (continued)

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

	March 31, 2013	March 31, 2012	April 1, 2011
Unamortized capital contributions used to purchase capital assets	\$ 155,058	\$ 130,529	\$ 98,022
Unspent contributions	<u>14,220</u>	<u>9,935</u>	<u>17,908</u>
Balance, end of year	<u>\$ 169,278</u>	<u>\$ 140,464</u>	<u>\$ 115,930</u>

9. Pension benefits and post-employment benefits

a) Pension Plan

Employees of the Organization are members of HOOPP, which is a multiemployer 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 \$5,679 (2012 - \$5,102) and are included in the pension expense in the statements of operations. The most recent actuarial valuation filed with pension regulators as of December 31, 2010 indicated an actuarial surplus of \$176 million. The next valuation will be completed as of December 31, 2013.

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 \$273 (2012 - \$240). The actuarial valuation for the post-employment benefits other than pension plan is dated March 31, 2010 and has been extrapolated to March 31, 2013.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

9. Pension benefits and post-employment benefits (continued)

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

	March 31, 2013	March 31, 2012	April 1, 2011
Accrued benefit obligation, end of year	\$ 2,754	\$ 2,709	\$ 2,611
Plan assets	<u>-</u>	<u>-</u>	<u>-</u>
Plan deficit	2,754	2,709	2,611
Unamortized net actuarial loss	374	197	-
Accrued liability, end of year	\$ 2,380	\$ 2,512	\$ 2,611

	March 31, 2013	March 31, 2012
Interest cost	\$ 122	\$ 141
Amortization of experience losses	19	-
Total benefit expense	\$ 141	\$ 141

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

	March 31, 2013	March 31, 2012
Discount rate	3.94%	4.69%
Drug cost trend rate	7.5% in 2013 to 5% in 2018 and after	8% in 2012 to 5% in 2018 and after
Hospital, dental and other medical costs trend rate	4% per annum	4% per annum
Employee average remaining lifetime (years)	10.21	11.21

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

10. Investment in capital assets

	March 31, 2013	March 31, 2012	April 1, 2011
Capital assets	\$ 160,147	\$ 134,148	\$ 103,488
Amounts financed by deferred capital contributions (Note 8 b))	<u>(155,058)</u>	<u>(130,529)</u>	<u>(98,022)</u>
	\$ 5,089	\$ 3,619	\$ 5,466

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

Purchase of capital assets	\$ 62,036	\$ 56,393	\$ 38,936
Increase in deferred contributions related to capital assets	(59,216)	(56,464)	(33,193)
Amortization of deferred contributions related to capital assets	34,687	23,957	30,981
Amortization of capital assets	(36,037)	(25,715)	(32,402)
Disposal of capital assets	<u>-</u>	<u>(18)</u>	<u>(588)</u>
	\$ 1,470	\$ (1,847)	\$ 3,734

11. Net investment income

Net investment income earned on the Endowment Fund resources in the amount of \$17 (2012 - \$31) is included in the Restricted Fund.

12. Other revenue

	March 31, 2013	March 31, 2012
General Fund		
eHealth Ontario	\$ 4,080	\$ 3,290
Public Health Ontario	2,319	2,333
Salary recovery	171	143
Canadian Partnership Against Cancer	-	3,122
Other income	<u>2,041</u>	<u>531</u>
	\$ 8,611	\$ 9,419
Restricted Fund		
Grants	\$ 2,293	\$ 3,465

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

13. Other operating expenses	March 31, 2013	March 31, 2012
Restricted Fund		
Travel	\$ 71	\$ 79
General office	44	69
Education and publications	42	32
Equipment	37	31
Other expenses	-	5
	<u>\$ 194</u>	<u>\$ 216</u>
General Fund		
Equipment	\$ 6,095	\$ 5,322
Education and publications	2,465	2,095
General office	2,077	2,261
Travel	948	751
Patient service	800	800
Other expenses	256	505
	<u>\$ 12,641</u>	<u>\$ 11,734</u>
14. Interfund transfers	March 31, 2013	March 31, 2012
Transfer to the General Fund from Endowment Fund	\$ -	\$ 1,029
Transfer from the General Fund to the Internally Restricted Fund	(133)	(38)
Transfer (from) to the General Fund (to) from the Externally Restricted Fund	(24)	2,683
	<u>\$ (157)</u>	<u>\$ 3,674</u>

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

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

15. Commitments

- a) The Organization leases space, and computer and office equipment. Under the terms of the leases, future repayments in aggregate and over each of the next five years are estimated as follows for the years ending March 31:

2014	\$	4,259
2015		3,852
2016		3,616
2017		3,518
2018		<u>1,007</u>
	\$	<u>16,252</u>

- b) The Organization has committed \$6,180 (2012 - \$4,796; April 1, 2011 - \$24,101) for the purchase of equipment, which is net of deposits disclosed in Note 6.
-

16. Contingencies

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

Since the inception, HIROC has accumulated an unappropriated surplus, which is the total of premiums paid by all subscribers plus investment income less the obligation for claims reserves and expenses and operating expenses. Each subscriber which has an excess of premium plus investment income over the obligation for their allocation of claims reserves and expenses and operating expenses may be entitled to receive distributions of their share of the unappropriated surplus at the time such distributions are declared by the Board of Directors of HIROC. There are no distributions declared by HIROC as of March 31, 2013.

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.

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

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

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

	<u>Total</u>	<u>0 to 30</u> <u>days</u>	<u>31 to 60</u> <u>days</u>	<u>61 to 90</u> <u>days</u>	<u>91 to 120</u> <u>days</u>	<u>120</u> <u>days +</u>
Accounts receivables	\$ 12,639	\$12,584	\$ 23	\$ 7	\$ 25	\$ -
Due from MOHLTC	<u>39,817</u>	<u>39,481</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>336</u>
Net amount receivable	<u>\$ 52,456</u>	<u>\$ 52,065</u>	<u>\$ 23</u>	<u>\$ 7</u>	<u>\$ 25</u>	<u>\$ 336</u>

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

Cancer Care Ontario

Notes to the financial statements

(In thousands of dollars)

Years ended March 31, 2013 and March 31, 2012

18. Financial instruments (continued)

Interest rate risk

Interest rate risk is the risk that 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.

At March 31, 2013, a 1% fluctuation in interest rates, with all other variables held constant, will have an estimated impact on the value of investment of (\$650) to \$809.

Liquidity risk

Liquidity risk is the risk that the Organization will not be able to meet its cash flow obligations as they fall due. The Organization mitigates this risk by maintaining no debt and monitoring cash activities and expected outflows through budgeting and maintaining investments that may be converted to cash in the near-term if unexpected cash outflows arise. The following table sets out the contractual maturities (representing undiscounted contractual cash-flows) of financial liabilities:

	<u>Total</u>	<u>0 to 30</u> <u>days</u>	<u>31 to 60</u> <u>days</u>	<u>61 to 90</u> <u>days</u>	<u>91 to 120</u> <u>days</u>	<u>120</u> <u>days +</u>
Trade payables	\$ 125,340	\$ 125,327	\$ 8	\$ 3	\$ -	\$ 2
Accrued liabilities	46,208	46,058	-	-	-	150
Payable to MOHLTC	13,110	13,110	-	-	-	-
Pension Escrow	<u>412</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>412</u>
Net amount payable	<u>\$ 185,070</u>	<u>\$ 184,495</u>	<u>\$ 8</u>	<u>\$ 3</u>	<u>\$ -</u>	<u>\$ 564</u>

Appendices

BOARD OF DIRECTORS

Neil Stuart, Chair

(June 1, 2010 – May 31, 2013)

Ratan Ralliar, Vice-Chair

(November 15, 2006 – November 14, 2015)

Kevin Conley

(June 27, 2007 – June 26, 2014)

Michael Cooper

(August 12, 2009 – August 11, 2012)

Malcolm Heins

(February 25, 2009 – February 24, 2015)

Shoba Khetrapal

(December 21, 2006 – December 20, 2013)

Marilyn Knox

(March 23, 2011 – March 22, 2014)

Patricia Lang

(June 20, 2007 – June 19, 2014)

Dr. Andreas Laupacis

(March 23, 2011 – March 22, 2014)

Dr. Wendy Levinson

(February 13, 2008 – November 9, 2012 – member resigned)

Stephen Roche

(September 20, 2006 – June 30, 2015)

Dr. Walter Rosser

(June 27, 2007 – June 26, 2014)

Dianne Salt

(April 7, 2010 – April 6, 2013)

Dr. Mamdouh Shoukri

(September 24, 2008 – September 23, 2015)

Betty-Lou Souter

(June 20, 2007 – June 19, 2013)

David Williams

(April 18, 2011 – April 17, 2014)

EXECUTIVE LEADERSHIP

Michael Sherar, PhD

President and CEO

Rebecca Harvey

Vice-President, Ontario Renal Network, CCO
(since October 2012)

Paula Knight

Vice-President, Communications
(since January 2012)

Garth Matheson

Vice-President, Planning and Regional Programs

Rick Skinner

Vice-President, Chief Information Officer

Dr. Linda Rabeneck

Vice-President, Prevention and Cancer Control

Elham Roushani

Vice-President, Finance and Chief Financial Officer (CFO)

Dr. Carol Sawka

Vice-President, Clinical Programs and Quality Initiatives

Pamela Spencer

Vice-President, Corporate Services, General Counsel, Chief Privacy Officer

Helen Angus

Vice-President, Ontario Renal Network, CCO (until May 2012)

CLINICAL LEADERSHIP

Dr. Julian Dobranowski

Provincial Head, Cancer Imaging Program

Dr. José Pereira

Provincial Head, Palliative Care Program

Audrey Friedman

Provincial Head, Patient Education Program

Esther Green

Provincial Head, Nursing and Psychosocial Oncology Programs

Dr. Jonathan Irish

Provincial Head, Surgical Oncology Program

Dr. Leonard Kaizer

Provincial Head, Systemic Treatment Program

Dr. John Srigley

Provincial Head, Pathology and Laboratory Medicine Program

Dr. Suzanne Strasberg

Clinical Lead, Provincial Primary Care Cancer Network

Dr. Padraig Warde

Provincial Head, Radiation Treatment Program

Dr. Michael Gould

Clinical Lead, ColonCancerCheck Program

Dr. Joan Murphy

Clinical Lead, Ontario Cervical Screening Program

Dr. Derek Muradali

Radiologist-in-Chief, Ontario Breast Screening Program

PROVINCIAL LEADERSHIP

Claudia den Boer Grima

Regional Vice-President, Erie St. Clair

Dr. Louis Balogh

Regional Vice-President, Central

Brenda Carter

Regional Vice-President, South East

Tom McHugh

Regional Vice-President, Central East

Paula Doering

Regional Vice-President, Champlain

Dr. Bill Evans

Regional Vice-President, Hamilton Niagara Haldimand Brant

Dr. Craig McFadyen

Regional Vice-President, Peel Regional Cancer Centre, Central West and Mississauga Halton

Dr. Mary Gospodarowicz

Regional Vice-President, Toronto Central (PMH)

Lindsey Crawford

Regional Vice-President, North Simcoe Muskoka

Mark Berry

Acting Regional Vice-President, Waterloo Wellington

Neil Johnson

Regional Vice-President, South West

Mark Hartman

(I) Regional Vice-President, North East

Dr. Mark Henderson

Regional Vice-President, North West

Dr. Andy Smith

Regional Vice-President, Toronto Central (Odette)

ORN LEADERSHIP

Helen Angus

Vice-President, Ontario Renal Network
(until May 2012)

Judy Burns

Acting Vice-President, Ontario Renal Network
(May 2012 – Oct. 2012)

Rebecca Harvey

Vice-President, Ontario Renal Network
(since October 2012)

Dr. Judith Miller (until September 2013)

Provincial Medical Director and Ontario Renal
Network Provincial Lead, Early Identification and
Prevention

Dr. Peter Magner

Interim Provincial Medical Director and Ontario
Renal Network (since October 2013) Provincial
Lead, Chronic Kidney Disease Funding

Dr. Allan Grill

Provincial Lead, Early Identification and Prevention

Dr. Louise Moist

Provincial Lead, Vascular Access

Dr. Andreas Pierratos

Provincial Lead, Independent Dialysis

Dr. David Mendelssohn

Provincial Lead, Research and Innovation

ORN PROVINCIAL LEADERSHIP

Janice Dawson

Regional Director, Erie St. Clair

Janice McCallum

Regional Director, South West

Peter Varga

Regional Director, Waterloo Wellington

Rick Badzioch

Regional Director, Hamilton Niagara Haldimand
Brant

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Regional Director, Central West

Nancy Webster

Regional Director, Mississauga Halton

Jill Campbell

Regional Director, Toronto Central

Melanie Tremblay

Regional Director, Central

Jay Wilson

Regional Director, Central East

Julie A. Gordon

Regional Director, South East

Connie Twolan

Regional Director, Champlain

Marni Van Kessel

Regional Director, North Simcoe Muskoka

Brenda Lynn

Regional Director, North East

Julia Salomon

Regional Director, North West