



Cancer Care Ontario

Ontario Cancer Plan IV

2015-2019

together we will



Ontario
Cancer Care Ontario



In one way or another, cancer inevitably touches everyone's life at some point. In whatever way that cancer affects us, we can feel confident that Ontario's cancer system is working to take care of us.

As the cancer advisor to the government of Ontario, Cancer Care Ontario is committed to improving the performance of the cancer system by driving quality, accountability, innovation and value.

This Ontario Cancer Plan IV provides a comprehensive road map for the way Cancer Care Ontario, healthcare professionals and organizations, cancer experts and the provincial government will work together to develop and deliver cancer services over the next four years. This is a plan for all Ontarians, developed in consultation with our vast network of partners—including patients and their families—and built on the solid foundation set by the first three plans. Working together, we will use this plan to reduce the risk of Ontarians developing cancer, while improving the quality of care for current and future patients.

commitment



Quality of life & patient experience

GOAL

Ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum

STRATEGIC OBJECTIVES

- Drive excellence in the development of policies, programs, strategies and evaluation by partnering with patients and their families to ensure services and care reflect their needs and preferences.
- Expand and integrate access to palliative, psychosocial and rehabilitation services to improve quality of life and patient experience in cancer centres and the community.
- Capture a range of real-time patient-reported information that is meaningful to patients to improve the quality of care.
- Increase understanding of wait times from the patient's perspective and identify opportunities to improve the patient experience.
- Support healthcare providers, patients and families with training, tools and resources to improve communication, decision-making, self-management and quality of life.

Safety

GOAL

Ensure the safety of patients and caregivers in all care settings

STRATEGIC OBJECTIVES

- Expand the use of technologies and tools for providers that drive adherence to evidence-based guidelines across care settings, including the home.
- Develop and implement patient safety tools in collaboration with patients and families that enable safer care in settings outside the hospital, including the home.
- Identify opportunities for system-level oversight for safety related to cancer services.
- Advance peer review of care plans to ensure concordance with evidence-informed practice and appropriateness of care that will lead to improved patient safety and clinical effectiveness.
- Describe cancer-specific requirements for regulated healthcare providers delivering cancer care.

Equity

GOAL

Ensure health equity for all Ontarians across the cancer system

STRATEGIC OBJECTIVES

- Develop and implement the third Aboriginal (FNIM) Cancer Strategy, building on successes of previous FNIM cancer strategies as well as the established relationship protocol agreements between Cancer Care Ontario and FNIM communities.
- Assess, expand, enhance and utilize data to better understand and improve equity issues in the regions.
- Develop locally relevant policies and programs in partnership with community service providers to improve access to services for specific populations and support healthcare providers with training, data and tools to deliver equitable services.
- Advise governments in the development of provincial policies and programs to improve access to services for specific populations, including equitable access to specialized services.

2015 - 2019

ocp.cancercare.on.ca

Integrated care

GOAL

Ensure the delivery of integrated care across the cancer care continuum

STRATEGIC OBJECTIVES

- Stratify patients by risk, based on clinical factors, comorbid conditions and social determinants of health, to determine the supports that patients and families require to navigate their care pathway.
- Ensure that standardized care plans are developed and communicated to all members of the care team, across the cancer care continuum, to facilitate an integrated approach to care that is centred on the patient.
- Enhance communication among all providers across the cancer care continuum and care settings to facilitate smoother care transitions.
- Increase the availability of relevant patient clinical information to patients and providers across care settings to support informed decision-making.
- Determine opportunities for improving the transition of adolescents and young adults, when appropriate, from the pediatric to adult cancer system.

Sustainability

GOAL

Ensure a sustainable cancer system for future generations

STRATEGIC OBJECTIVES

- Develop and execute on a chronic disease prevention strategy that focuses on reducing the incidence of the major chronic disease modifiable risk factors and exposures.
- Continue to implement organized cancer screening programs for breast, cervical and colorectal cancer.
- Assess value from a patient experience, population health and cost perspective to inform decision-making across the cancer system.
- Optimize the model of care delivery to achieve the greatest benefit for patients and the cancer system.
- Strengthen and expand system capacity planning to ensure resources are most optimally allocated and utilized.

Effectiveness

GOAL

Ensure the provision of effective cancer care based on best evidence

STRATEGIC OBJECTIVES

- Expand measurement of clinical and patient-reported outcomes to enable effective, high-quality care.
- Expand our performance management model to include non-hospital healthcare organizations and performance at the provider level in order to be more effective with our quality and access programs across the system.
- Leverage and expand the use of evidence-based guidance to improve the appropriateness of care.
- Develop a unifying strategy for personalized medicine for cancer care including personal and tumour genetics, and incorporate recommendations into clinical practice.



Quality of life & patient experience

BY 2019...

- Patients will report that cancer care was delivered in a manner that recognized their needs and preferences.
- Patient needs for palliative care and advance care planning will be addressed early in the cancer care continuum. Patients will have timely access to psychosocial and palliative care as appropriate.
- Patients will have opportunities to report on their symptoms for specific disease sites in real time and will have their symptoms addressed.
- There will be improved information and communication, resulting in a better experience for those waiting for care.
- Patients and their families will have access to the resources, tools, knowledge and support they need to help them manage their care.
- Patients will have discussions with their provider about advance care planning and will have the information they need to make informed decisions.

Safety

BY 2019...

- Concordance and compliance with evidence-based safety guidelines will be increased.
- Patients and providers will be partners in designing how chemotherapy is delivered safely in the home.
- All care partners, including patients and families, will have access to the resources that are needed to ensure a safe care environment, in all settings.
- Following review of reported near-miss and actual incident data, Cancer Care Ontario and our partners will have identified targeted improvement initiatives.
- An accountability framework and performance management structure will be in place to drive improvement in quality and safety in colonoscopy, mammography and pathology.
- In radiation, pathology and mammography, provider peer reviews will be consistently conducted as part of clinical practice.
- Healthcare providers involved in the delivery of chemotherapy, including in the community, will be appropriately trained in oncology care.

Equity

BY 2019...

- The relationships among FNIM, Cancer Care Ontario and Regional Cancer Programs will be firmly established and formalized through protocols. This will ensure and sustain ongoing dialogue and implementation of the Aboriginal (FNIM) Cancer Strategy through customized regional Aboriginal cancer plans, an achievement that will allow for increased service awareness and equitable access that honours the Aboriginal path of well-being.
- FNIM identifiers will be incorporated into data sets that will be used to detect and quantify equity gaps.
- Data to identify equity gaps will be available beyond FNIM populations, including “cancer risk profiles” for communities.
- Cancer Care Ontario will provide the information and tools that will support the Regional Cancer Programs in reducing disparities that exist in prevention, care and outcomes.
- Equity assessments will be applied to program design to ensure that access and utilization of services by FNIM and other underserved, high-risk communities are improved.

2015 - 2019

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Integrated care

BY 2019...

- Patients will have appropriate supports throughout their care pathway, and providers will have the necessary tools to assist their patients with navigation.
- Standardized care plans will be available for selected disease sites, treatments and patient populations, across care settings. These plans will be used to improve communication of goals of care and expected outcomes among patients, families and providers.
- Use of technology will be expanded to improve communication among providers across the cancer care continuum and care settings.
- Patient care information will be made available to patients and providers to support joint decision-making (e.g., Diagnostic Assessment Program – Electronic Pathway Solution and Interactive Symptom Assessment and Collection).
- A strategy will be developed with provincial partners to improve transitions for adolescents and young adults.

Sustainability

BY 2019...

- We will have begun implementation of the chronic disease prevention strategy and have developed the evaluation framework.
- Participation in breast, cervical and colorectal cancer screening programs will be increased and followup for those with an abnormal screening result will be improved.
- Drugs funded through the Provincial Drug Reimbursement Program will be evaluated for the greatest benefit to patients and impact on healthcare resources.
- Innovative, person-centred models of care will enable the right provider to deliver the right care, at the right time, in the right place.
- Data-driven, system-level plans will be used to allocate key health human, infrastructure and financial resources for all cancer services.
- Radiation, gynecology and medical oncologist positions will be expanded consistent with capacity planning models.

Effectiveness

BY 2019...

- Standards, guidelines and programming for patient care will be informed and developed using enhanced measures of clinical and patient-reported outcomes for colorectal and breast cancers.
- We will use system-level indicators to compare the performance of Ontario's cancer system against international benchmarks.
- Our performance management and evaluation system will be expanded beyond the hospital setting to healthcare providers, the community sector and the home.
- Individual healthcare providers and facilities will have access to performance data to drive improvements in care.
- Our funding levers will be used to align care with evidence-based guidelines for mammography, upper gastrointestinal endoscopy, colonoscopy, colposcopy, systemic treatment, cancer surgery, radiation, diagnostics and other specialized services.
- In conjunction with our partners, we will begin the implementation of the personalized medicine strategy for cancer care in Ontario.

Together we will... transform cancer care in Ontario

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Ontario Cancer Plan IV

- Ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum
 - Ensure the safety of patients and caregivers in all care settings
 - Ensure health equity for all Ontarians across the cancer system
-

- Ensure the delivery of integrated care across the cancer care continuum
 - Ensure a sustainable cancer system for future generations
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A call to action

Together we will... make a difference



leadership

Together we will... create the best health systems in the world

I am pleased to present the Ontario Cancer Plan IV 2015-2019 (OCP IV), a road map for how Cancer Care Ontario, the Regional Cancer Programs, our many partners and the Ministry of Health and Long-Term Care will work together to continue to improve the performance of the cancer system in this province.

Provincial health system plans are an integrating force in a complex healthcare system. They help drive continuous system improvement by setting clear goals, priorities and objectives. They guide our work at all levels, and are endorsed by the government. The plans help direct major initiatives and funding decisions, and ensure key gaps are addressed at the system level. At the same time, they promote sustainability by focusing efforts where they are most needed.

This Ontario Cancer Plan is our fourth strategic plan for the province, and it builds on the significant accomplishments of its three predecessors. With our first two plans, we focused on building system capacity, reducing wait times and improving the quality of care. Our most recent cancer plan (Ontario Cancer Plan III 2011-2015) called for realistic investments in prevention, early detection, care closer to home and research-informed ways to manage growth in costs. With our OCP IV, we now broaden our scope of work to more fully encompass

“The strength of our partnerships—current and new—is more critical than ever before. Only through working together can we create a sustainable health system for Ontarians.”

all stages of the cancer care continuum and advance our person-centred approach.

This plan reflects the collective expertise and experiences of our many partners. Our Regional Cancer Programs, clinicians and care providers from across the province, healthcare agencies at the provincial and local levels, the Ministry of Health and Long-Term Care and especially patients and their families all played a vital role in shaping OCP IV. Their shared commitment and active participation will be crucial in realizing its successful implementation.

At CCO, we are leading a transformation in healthcare, one that is driving quality, accountability, innovation and value throughout the system. By leveraging each other's strengths and working towards our common goals, together we will create the best health systems in the world.



Michael Sherar
President & CEO of CCO



Together we will... put patients at the centre of cancer care

A conversation with the co-chairs of the OCP IV Executive Sponsor Group: Garth Matheson, Vice-President, Planning and Regional Programs; and Joanne MacPhail, Co-Chair, Patient and Family Advisory Council

Garth Matheson: Ever since Cancer Care Ontario undertook the development of Canada's first comprehensive provincial cancer strategy in 2005 and through the next two iterations of the Ontario Cancer Plan (OCP), our goal has been to improve the quality of care for current and future patients. With OCP IV, we are taking a transformational leap forward in engaging patients and families throughout the development process as Cancer Care Ontario commits to partnering with them in the truest sense of the word.

Joanne MacPhail: Those of us who have personally experienced cancer have a very different perspective of the cancer system than healthcare providers or administrators. We have lived through the treatments, cared for loved ones through their illness and contended with all the physical and emotional ups and downs that cancer entails. We each have a story to tell, and collectively our stories can help create a better health system.

“Through my experience working on OCP IV, I now know there is a strategic plan to ensure that my outcome is the very best. I no longer feel alone when I walk into the cancer centre because I know there are a lot of people working very hard on behalf of all cancer patients in Ontario.” –**Joanne MacPhail**

Garth Matheson: There is increasing recognition that high-quality healthcare requires a shift from a provider-centred approach towards one that is centred on patients and their families. To that end, Cancer Care Ontario launched the Patient and Family Advisory Council (PFAC) in 2011. Patient and family advisors have been embedded in the development of OCP IV right from the very beginning, fully engaged in meaningful discussions that will shape the way cancer care is delivered in this province.

Joanne MacPhail: I know from my personal experiences with two rounds of cancer and from speaking with many other cancer survivors that patients fare better physically and psychologically when they have access to the information they need to actively participate in their care (if they are able and choose to do so). On a system level, there are clear benefits to involving us in planning and implementing strategies and initiatives that will directly impact us.

Garth Matheson: Patients are, after all, our biggest stakeholders. Their insights were invaluable in helping us to identify our key priorities for OCP IV. They shared the issues that are most meaningful to them, advocating for care that improves their quality of life and is safe, effective and accessible, no matter where they live in Ontario. Some told

us about the challenges of moving from one stage of care to another. Others expressed concerns about the sustainability of the cancer system for future generations.

Joanne MacPhail: Our experiences helped shape the themes in OCP IV that will guide the cancer system over the next four years—Quality of Life and Patient Experience, Safety, Equity, Effectiveness, Integrated Care and Sustainability. Importantly, these themes cut across the cancer care continuum. No matter where people are in their cancer experience—from prevention to screening, diagnosis and treatment through to recovery and survivorship or end-of-life—their needs will be addressed by the goals and initiatives outlined in this plan.

Garth Matheson: Given that the lifetime risk of developing cancer is greater than 40 per cent, everyone involved in the development of OCP IV is very aware that any one of us might need the cancer system one day. This is a plan for all Ontarians.

Joanne MacPhail: On behalf of all the patients and families who participated in the development of OCP IV, I want to thank everyone at Cancer Care Ontario for their commitment and leadership in the area of patient engagement. As patients, family

“OCP IV is Ontario’s cancer plan. It is a workbook that will guide the way cancer care is delivered in this province over the next four years.”

–**Garth Matheson**

members and potential future patients, we now have a responsibility to do what we can to help this plan succeed by being active participants in our healthcare.

Garth Matheson: The development and implementation of such a comprehensive cancer strategy relies on many stakeholders. Cancer Care Ontario is grateful for the active involvement and support of all those who have provided input into the development of OCP IV, including PFAC members; clinical, research and administrative leaders; Regional Cancer Programs; healthcare professionals; provincial health agencies; the Ministry of Health and Long-Term Care; and other external stakeholders. Working with our valued partners brings us ever closer to achieving our vision of creating the best cancer system in the world.

future



The impact of cancer

Together we will...
reduce the burden of cancer
on patients, caregivers and
the healthcare system

A lot of progress has been made in cancer care in recent years. Policies related to prevention, such as smoking restrictions, are in place. Screening programs allow colorectal, breast and cervical cancers to be found at an earlier, more treatable stage (or even prevented in some cases). And new, more effective treatments continue to be developed. Yet the fact remains that cancer continues to place a tremendous burden on individuals, caregivers and the healthcare system.

Forty-five per cent of men and 41 per cent of women in Ontario will develop cancer in their lifetime. The number of new cases of cancer is rising and is expected to continue to rise into the foreseeable future. Our aging population is a significant factor in this growth in new cancer cases, as cancer is largely a disease of aging. Seniors aged 65 years and older now represent almost 15 per cent of this province's population; by 2036, they will constitute

nearly one-quarter of Ontario's projected 17.4 million people.

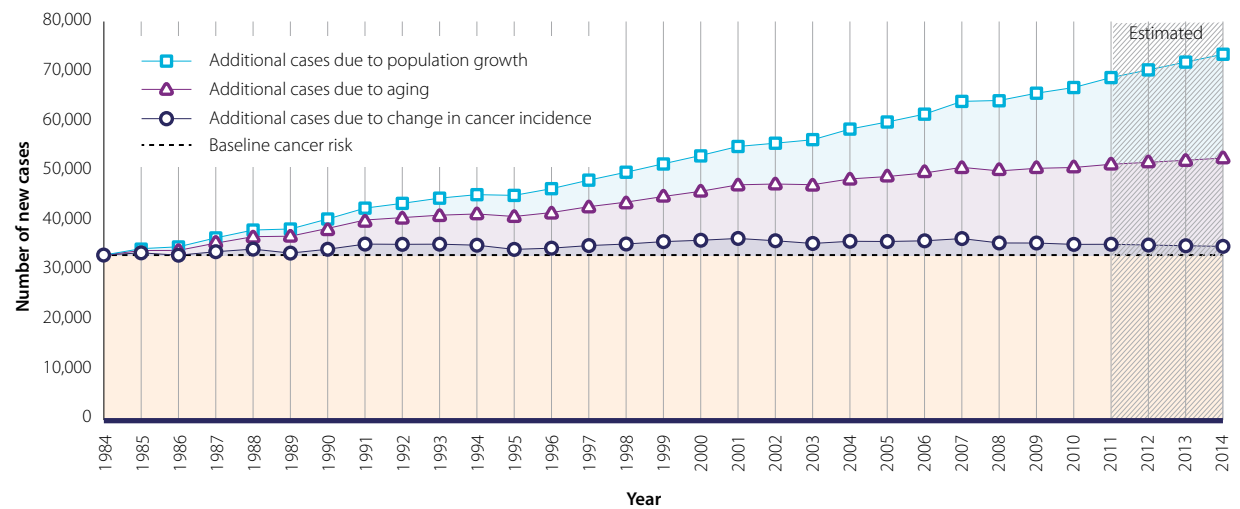
In high-income countries similar to Canada, an estimated 40 to 50 per cent of cancers are associated with behavioural, occupational and environmental risk factors, and could be prevented. (See *Cancer Risk Factors in Ontario*, www.cancercare.on.ca/riskfactor.) In light of our growing and aging population, initiatives that target modifiable risk factors take on added importance. We must take steps today to reduce the future incidence of cancer to promote a sustainable healthcare system for generations to come.

Most common cancers

While there are more than 200 different types of cancer, four body sites account for more than half of all cancers. In men, these are prostate, lung and colorectal cancer. In women, the most common

FIGURE 1 CANCER INCIDENCE

Growth in new cases of cancer in Ontario, 1984-2014



Data source: Cancer Care Ontario (Ontario Cancer Registry, 2013)

Cancer in Aboriginal populations: A unique burden

Until recently, First Nations people in Ontario had lower cancer rates than other Ontarians. Now cancer rates are increasing, and they will likely continue to increase more for First Nations Ontarians than for the general population. The rising burden of cancer among Aboriginal peoples has been attributed at least in part to the higher prevalence of several modifiable risk factors such as smoking, poor diet and obesity.

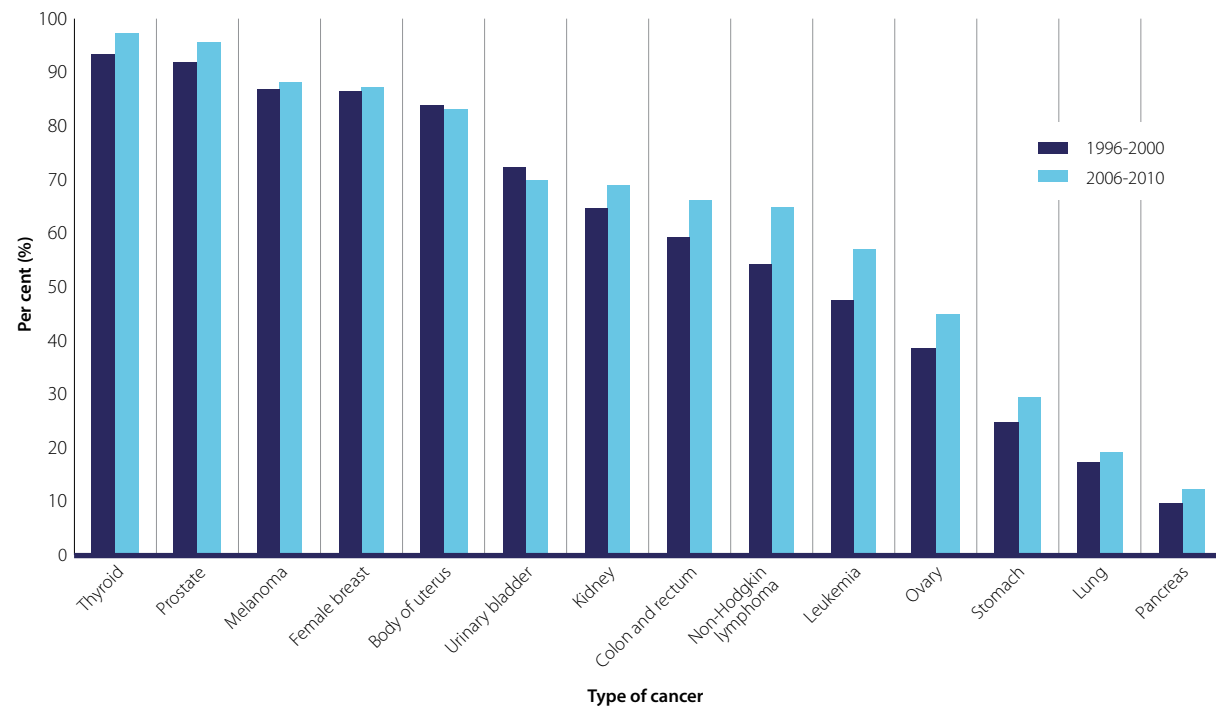
Most strikingly, while colorectal cancer incidence rates have been essentially stable over time in the general Ontario population, rates more than quadrupled among First Nations people from the late 1960s to 2001, attaining or exceeding rates in the non-First Nations population. In addition, survival following a cancer diagnosis is poorer in First Nations people compared to other Ontarians.

cancers are breast, lung and colorectal. These types of cancer are also the leading causes of cancer death, although their rankings differ between men and women.

Due to a variety of factors—including advances in detection (e.g., organized screening) and treatment—we are seeing improved five-year relative survival ratios for most cancers in Ontario.* Most significantly, the greatest relative improvements in survival have occurred for cancer of the pancreas, leukemia and

FIGURE 2 CANCER SURVIVAL

Age-standardized five-year relative survival ratio for 14 common cancers, Ontario, 1996-2000 vs. 2006-2010



Data source: Cancer Care Ontario (Ontario Cancer Registry, 2013)

non-Hodgkin lymphoma. Despite these gains, five-year relative survival ratios for some cancers remain consistently low, notably pancreas, lung and stomach cancers.

As survival rates improve, prevalence (i.e., the number of people living with cancer) is rising. By 2019, more than 253,900 Ontarians will have received a diagnosis of cancer in the past five years, compared to 196,300 in 2009. Because cancer care does not end at the completion of treatment,

patients, families, caregivers and the health system will face new challenges as more and more people move from active treatment to survivorship.

At the same time, more Ontarians who live with cancer are also dealing with chronic conditions, such as diabetes, heart disease and arthritis. Comorbidities complicate treatment and have a strong negative impact on survivorship. On a system level, the more health conditions a person has, the more complex and therefore more expensive the care.

Cancer surveillance data come primarily from the Ontario Cancer Registry, which compiles information about all newly diagnosed cancer cases in Ontario, and from provincial and national population-based surveys. For links to the registry and other sources as well as notes about methodology, see www.cancercare.on.ca/surv.

* Relative survival is a ratio that compares the survival experience of individuals with cancer to that of the general population of the same age and sex. It shows the extent to which cancer shortens life and is often age-adjusted to account for the fact that the risk of death increases as we age, and the current population is older.

In Ontario, healthcare already consumes more than 40 per cent of every dollar spent on provincial programs. This figure will grow unless we use our resources wisely and take effective preventive measures to slow the rate of cancer growth.

Behind the numbers

Of course, behind these statistics are human lives: patients, families and friends who love them, colleagues who work with them, and healthcare professionals who care for them—all bearing, in some way, the tremendous toll that cancer demands. Patients and their families must deal with both the physical and emotional effects of the disease and its treatment, from pain, nausea and fatigue to anxiety and depression.

As the prevalence of cancer rises, and as people live longer with cancer, we must look at ways to reduce these burdens—on individuals and the healthcare system—while improving patients' and families' experiences.



Kendall C.

“Brandy was extremely sick after the stem cell transplant. Even though we both have a really positive attitude, it was a solid year of misery, with one complication after another after another after another. We started to wonder what normal would even look like for us.”

Kendall C.'s then-fiancée, Brandy, was diagnosed with acute myeloid leukemia at the age of 28 in 2012. After three rounds of intensive chemotherapy, she received a stem cell transplant in July 2013. Now married, the couple looks forward to focusing on their careers, their passion for sailing and “something fun and different” for a few years before possibly starting a family when they feel secure that “all of this is in the past.”



integrity

About us: Cancer Care Ontario

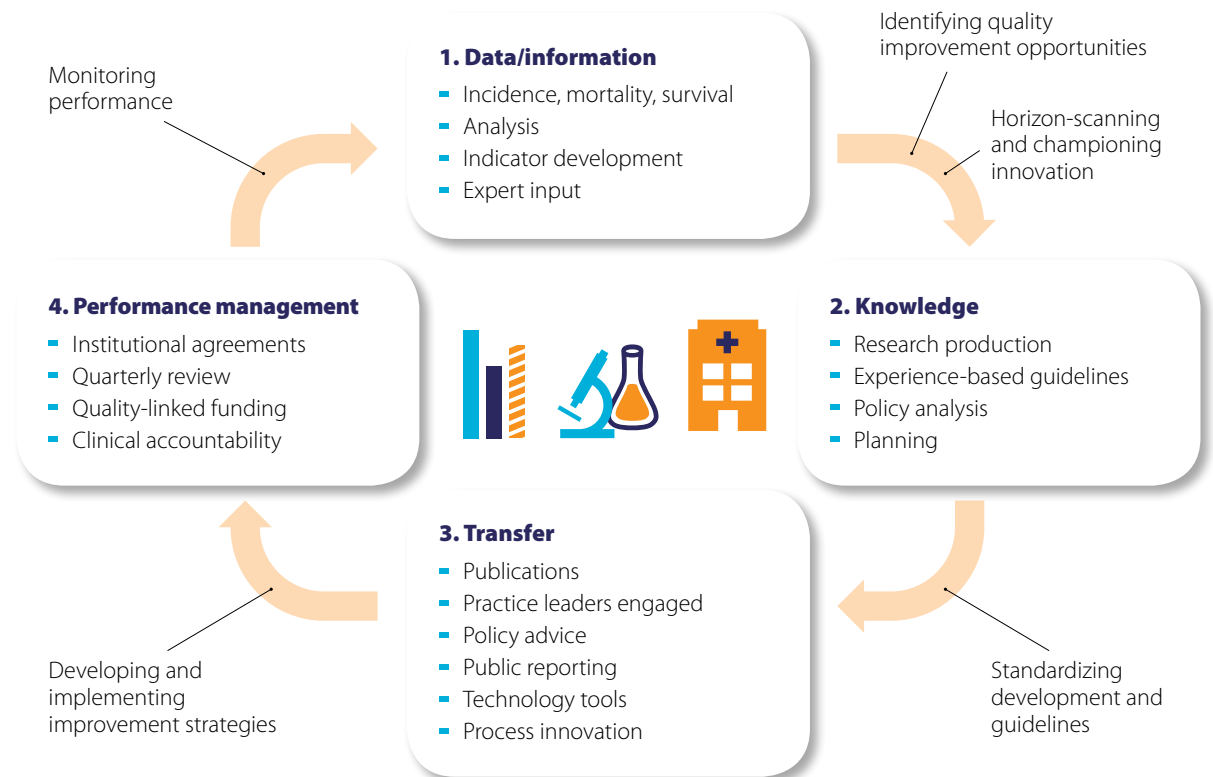
Together we will...
make Ontario's cancer
system the best in the world

Ontario is in a period of significant demographic change. As our population grows and ages, more people will require healthcare services, and we need to find a way to deliver these services in a manner that provides the highest benefits for both individuals and the healthcare system.

For Cancer Care Ontario, this challenging reality is an opportunity to transform the future of cancer care in Ontario. As the government's advisor on the cancer system, we work to continually improve the performance of our system by driving quality, accountability, innovation and value. Cancer Care Ontario directs and oversees approximately \$1.1 billion in funding for hospitals and other cancer care providers, enabling them to deliver high-quality, timely services.

More than 1,000 professionals at CCO are dedicated to supporting the delivery of integrated, accessible, person-centred care for all Ontarians, and we rely on the experience, expertise and networks of our many stakeholders and partners to help achieve our common goals.

CANCER CARE ONTARIO'S PERFORMANCE IMPROVEMENT CYCLE



Continuously improving cancer services

Cancer Care Ontario plays a critical role in equipping health professionals, organizations and policy-makers with the most up-to-date cancer knowledge and tools to prevent cancer and deliver unsurpassed patient care. We use a number of strategies and levers to continually improve the quality and performance of cancer services.

We collect and analyze a vast amount of data about cancer services and combine it with best evidence and research. We then disseminate this information in the form of guidelines and standards. We also monitor and manage performance to ensure that

these standards are being met, and through ongoing data collection, we continuously improve services. In addition, Cancer Care Ontario's funding and governance model ties funding to performance, thereby making providers more accountable, and reinvesting the saved money in the healthcare system.

Responsive, accountable leadership

The delivery of cancer services in Ontario is organized into Regional Cancer Programs (RCPs), which are aligned with the province's Local Health Integration Networks (LHINs). The RCPs are Cancer Care Ontario's networks of local stakeholders,

healthcare professionals and organizations involved in cancer prevention, screening and care. Each RCP is led by a Regional Vice-President (RVP) of Cancer Services, who provides oversight to the region's cancer services and implementation of quality initiatives, and who directs the operations of the Regional Cancer Centre. Our RVPs are the keystone to the successful design and implementation of improved cancer services. Through the development of regional cancer plans aligned to the Ontario Cancer Plan, RVPs ensure that the system is responsive to local needs so that Ontarians can consistently access high-quality cancer care as close to their homes as possible.

Cancer Care Ontario's provincial and regional leadership models provide clear accountability, both administratively and clinically. In addition to holding senior management appointments at their local hospitals, RVPs report directly to Cancer Care Ontario on the performance of cancer services in their regions. They also advise on funding allocation for local cancer services and the needs of their populations. They meet regularly through Cancer Care Ontario's Provincial Leadership Council, which sets the vision and priorities for the provincial cancer system and shares best practices. Our Clinical Council, which includes provincial leaders representing each clinical discipline and cancer control, provides guidance and expertise to ensure optimal delivery of cancer services.

Patients and their families also play a vital role in the continuous improvement of cancer services in Ontario. More than 80 patient and family advisors provide their insights and recommendations to Cancer Care Ontario to enhance the patient experience and to influence the future direction of our cancer system.

As we strive to make our cancer system the best in the world, we participate in international

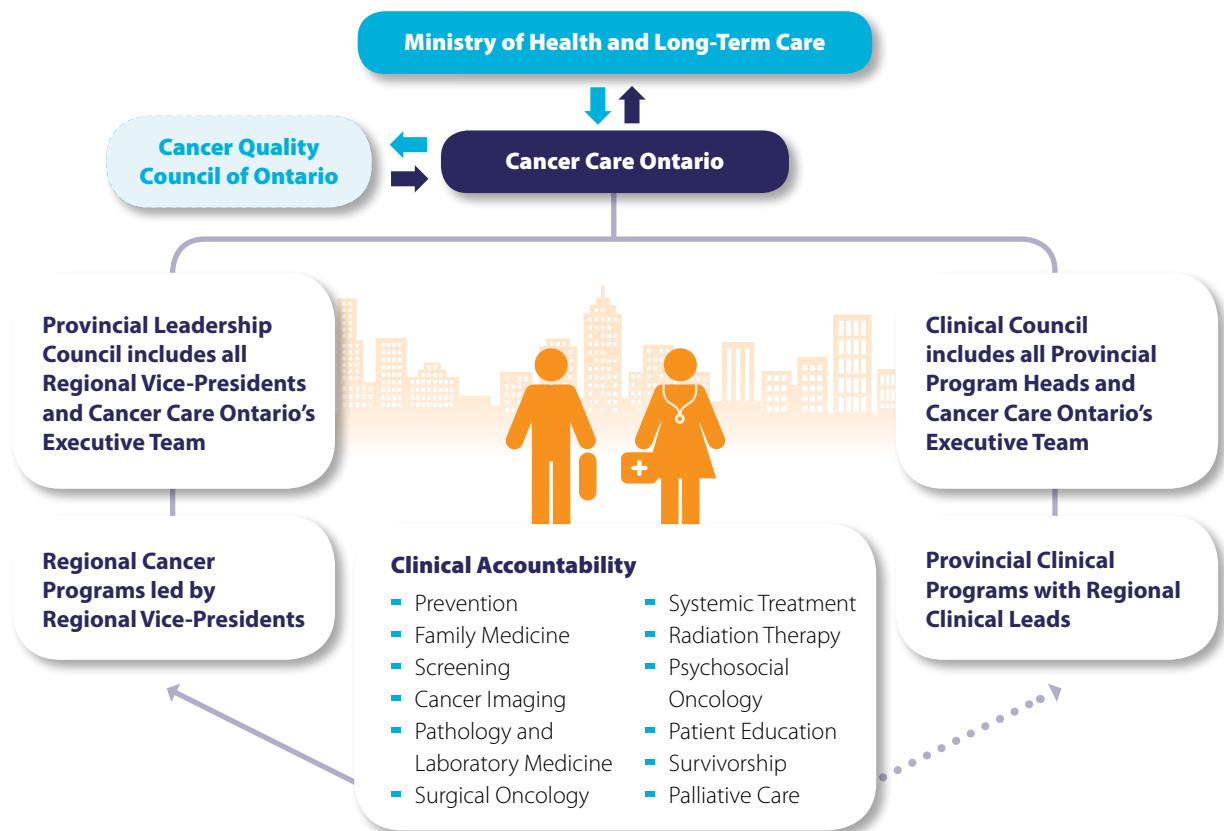
benchmarking. Cancer Care Ontario participates in the International Cancer Benchmarking Partnership (ICBP), a leader in international comparisons of cancer survival. ICBP results published in *The Lancet* identified Ontario as one of the top performers in cancer survival rates among 12 jurisdictions across six countries.* If you live in Ontario and get cancer, you have one of the best chances of survival compared to anyone in the world.

Cancer Quality Council of Ontario

The Cancer Quality Council of Ontario (CQCO) is an

arms-length multidisciplinary group that consists of cancer care providers, survivors and other experts. Reporting to CCO's Board of Directors and to the Ministry of Health and Long-Term Care, CQCO identifies and assesses gaps in cancer system performance and quality, and advises on planning and strategic priorities. Each year, CQCO publishes the Cancer System Quality Index, holds a "Signature" event to bring together stakeholders and experts to address a particular quality gap in Ontario, and reviews existing or emerging cancer system programs. For more information about CQCO, visit www.cqco.ca.

PROVINCIAL AND REGIONAL LEADERSHIP ACCOUNTABILITY



“We are proud to partner with Cancer Care Ontario to reduce the burden of cancer in Canada. The power of partnership has already improved access to lifesaving screening and prevention programs, and allowed Canada’s cancer community to react more quickly and collaboratively to new evidence. Working with partners like Cancer Care Ontario will ultimately help prevent new cases of cancer while improving the experience of cancer patients and their families today.” –**Shelly Jamieson, CEO, Canadian Partnership Against Cancer**

CCO’s vision for the future

In addition to advising the Ontario government about cancer services, CCO also leads provincewide efforts to improve kidney care services and access to care for key health services. In 2012, CCO introduced its corporate strategy, which describes how we see our role and the opportunity we have to help shape the future of healthcare in Ontario. The plan unifies CCO’s cancer, kidney disease and access to care work and ensures that, together with our partners, we will create sustainable health systems for all Ontarians.

VISION

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

MISSION

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

GUIDING PRINCIPLES

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

A decade of progress

January 2004 marked the launch of a new era for cancer care in Ontario when 11 hospital boards voluntarily signed a Cancer Program Integration Agreement with Cancer Care Ontario. Under the agreement, Cancer Care Ontario’s role radically shifted, moving away from the day-to-day management of cancer centres to planning and managing the quality, access and performance of the cancer system provincewide.

This transformation came in response to the serious challenges cancer services faced in the early years of this century. Patient care was fragmented, quality varied across the province, and Ontario was lagging significantly in access to care. With a rigorous focus on quality and performance, and working in partnership with our stakeholders, Cancer Care Ontario has changed the face and future of cancer care in Ontario.

“I think the most dramatic change over the past decade has been one of perspective,” says Mark Hartman, Regional Vice-President for the North East Regional Cancer Program. “We’ve broadened our view, moving from a narrow focus on cancer centre-based treatment to now working on improvements in all stages of care. This broader perspective requires us to work in partnerships across the entire healthcare system so that we improve how the system works for cancer patients and their families.”



Our record so far

Together we will...
build on the accomplishments
of our first three cancer plans

Cancer Care Ontario has been creating multi-year cancer plans for the province for the past 10 years, with each plan building on the achievements of its predecessor. The Ontario Cancer Plan I (2005-2008) set us on the path to providing higher-quality care by focusing on building system capacity to meet the growing needs of cancer patients. Our second plan, which covered 2008-2011, tackled wait times and quality of care, expanded prevention and screening efforts, strengthened system quality improvement and performance management, and increased our focus on the patient experience.

The landscape for cancer services across Ontario continued to be transformed with OCP III (2011-2015). Listed here are some of the key accomplishments under that plan, demonstrating that, working together, we can all make a significant difference in our health system and in the lives of Ontarians.*

- Twenty-nine members joined Cancer Care Ontario's **Patient and Family Advisory Council**, with representatives from all Regional Cancer Programs. The broader community of patient and family advisors has more than 80 members working with us to improve the patient experience along every step of the cancer care continuum.

* Unless otherwise specified, statistics provided here are current as of November 2014.

- **MyCancerIQ** launched in February 2015. This online cancer risk assessment tool will help to motivate Ontarians to reduce their risk of developing cancer and increase their participation in cancer screening.
- All Regional Cancer Centres developed programs to screen patients for smoking status and refer smokers to **smoking cessation programs**.
- More than five million Ontarians received direct correspondence to encourage participation in **breast, cervical and colorectal cancer screening** (2013/14). More than 5,000 primary care physicians and more than 1,000 physician delegates registered to receive a **Screening Activity Report**, which helps primary care providers understand and manage their patients' screening activity and appropriate followup.
- Thirty-four Diagnostic Assessment Programs (DAPs) now have **patient navigators**, which 80% of patients strongly agreed helped them cope with the diagnostic process.
- The **Diagnostic Assessment Program – Electronic Pathway Solution (DAP-EPS)** rolled out across five regions. More than 12,000 patients are able to access their appointments, test results and educational resources, and care providers can use the online tool to help streamline patient care. Interactive lung and colorectal cancer diagnosis pathways are now embedded in DAP-EPS.
- **Disease Pathway Maps** were created. Pathways, which depict evidence-based care to improve quality, access, appropriateness and coordination across the cancer care continuum, have been published for colon, rectal, lung and prostate cancers.
- **Capital infrastructure** was provided to support the opening of two new cancer centres in Niagara and Barrie and expanded radiation treatment across the province (103 treatment units in 2013, up from 95 in 2011). Furthermore, since 2011, an investment of \$154.5 million has been made to replace radiation equipment and systems so the province stays current with state-of-the-art technology.
- Working towards the implementation of the **Aboriginal Cancer Strategy II**, Cancer Care Ontario signed relationship protocols with five Aboriginal groups: the Union of Ontario Indians, Grand Council Treaty #3, Nishnawbe Aski Nation, Big Trout Lake First Nation and Ontario Federation of Indigenous Friendship Centres. These protocols outline how we will work together to address increasing cancer incidence and mortality rates among the province's First Nations, Inuit and Métis (FNIM) communities in a way that honours the Aboriginal path to well-being.
- **Wait times for diagnosis, treatment and pathology reporting** improved. Some examples of improvements seen in 2013/14 include:
 - **The wait time** from referral for suspicion of lung cancer to diagnosis was 20% shorter compared to 2010.
 - **In cancer surgery**, 85% of patients received surgery within their wait time target versus 76% in 2010/11.
 - **In systemic treatment**, 75% of patients were seen for consultation within 14 days of referral, compared to 66% in 2012/13.
 - **For radiation treatment**, 83% of patients consulted with a radiation oncologist within 14 days of referral, compared to 75% in 2012/13. In addition, in the second quarter of 2014/15, 90% of patients started their treatment within set targets (1, 7 or 14 days), compared to 87% in 2012/13. This improvement in wait times occurred despite the deployment of higher-complexity treatment techniques.
 - **90% of post-surgical pathology reports** were completed within the 14-day target time for colorectal cancers.
- The risk of chemotherapy errors was reduced through the implementation of Canada's first **cancer-specific computerized prescriber order entry system**, which now supports approximately 93% of intravenous chemotherapy prescriptions in Ontario.
- Cancer Care Ontario's Provincial Drug Reimbursement Program (PDRP) launched two new programs to improve access to necessary cancer treatments across the province: The **Evidence Building Program** facilitated funding for treatment to 345 patients while collecting real-world data on each medication's clinical and cost-effectiveness; and the **Case-by-Case Review Program** helped approximately 50 cancer patients with immediately life-threatening circumstances receive treatments with drugs that would otherwise be unfunded. Funding for the PDRP increased to approximately \$320 million from \$218 million (a 46% increase) since 2011.
- The number of **advance practice radiation therapists** increased to 24 in 10 cancer centres (2014/15), up from seven therapists in three cancer centres (2011/12). This innovative role and model of care has been shown to be effective in reducing treatment wait times and improving quality of care.
- The introduction of the rectal cancer **MRI synoptic report** improved the completeness and clarity of reporting between radiologists and referring physicians. This diagnostic imaging template and accompanying clinical guide improves the consistency of reporting, ensuring referring physicians get the information required to provide optimal patient care.
- **Access to PET imaging** increased to include five new clinical indications. In addition, the **Pediatric PET Registry** was launched, providing streamlined access to PET while building evidence on the impact of PET scans on patient care.

Celebrating regional success

From 2011 to the beginning of 2015, Ontario's Regional Cancer Programs brought the initiatives of our third cancer plan (OCP III) to life at the regional level. More patients participated in screening programs, waited less time for radiation, and accessed high-quality care closer to home thanks to the commitment and hard work of our regional partners. Here, we celebrate just a few of their achievements in making positive improvements in the patient experience and the provision of high-quality cancer services across this province.

1

ERIE ST. CLAIR

Windsor Regional Hospital aggressively reduced radiation wait times with the aid of the Treatment Planning Tracker, a locally developed workflow and wait time management system, and daily treatment planning huddles. More than 95% of patients now receive their radiation treatment within provincially mandated wait time targets, compared to less than 85% in 2011.



2

SOUTH WEST

The "Pink and Blue Notes for Primary Care" resource guides assist primary care providers in managing their well breast and colorectal cancer patients in the followup phase. These innovative toolkits allow patients to be confident in their care. The notes received very positive responses from primary care providers across the region, and have been adopted by several other regions.

3

WATERLOO WELLINGTON

The unique and creative campaign called "Build a Butt" increased public awareness of the ColonCancerCheck program. More than 76,000 views on the campaign's Facebook page and an increase of more than 200 additional FOBT kits processed (compared to the same three-month period in the previous year) demonstrated that people were interested in participating in their community to raise awareness and start talking about colorectal cancer screening.



4

HAMILTON NIAGARA HALDIMAND BRANT

The regional Radiation Treatment Program is a fully integrated model that enables the optimal use of physicians to deliver care for their residents. Person-centred care closer to home is being facilitated by: specialized services at the Juravinski Cancer Centre; additional radiation facilities and services at the newly opened Walker Family Cancer Centre; as well as increased capacity for radiation referral and followup clinics in Burlington and Brantford.

5



6

MISSISSAUGA HALTON/CENTRAL WEST

The new Gynecological Oncology Program at Credit Valley Hospital provides improved access and quality services to patients. In 2013/14, 80% of women living in the Mississauga Halton/Central West regions who needed gynecological oncology surgery received it in their own region (compared to 27% in 2010/11).

7

TORONTO CENTRAL

At Sunnybrook's Odette Cancer Centre, symptom screening rates increased by 61% over the first few months of their "How Are You Feeling" campaign (started in February 2014), thanks to the collaborative efforts of volunteers, unit coordinators, clinic coordinators, nurses and radiation therapists.

As part of its world-class personalized cancer medicine strategy, the Princess Margaret Cancer Centre has implemented new programs such as IMPACT/COMPACT molecular profiling and therapy, molecular imaging, image-guided/robotic-assisted interventions, immunotherapy and personalized support interventions, such as its Adolescent and Young Adults Program. These programs and others ensure that the right patients receive the right treatment at the right time.

8

CENTRAL

Every patient who receives radiation treatment at the Stronach Regional Cancer Centre undergoes a multidisciplinary peer quality review. More than 98% of patients treated at the centre have benefited from these radiation oncology reviews, in which collaborative discussion among healthcare providers has led to improved patient safety and quality of care.

14



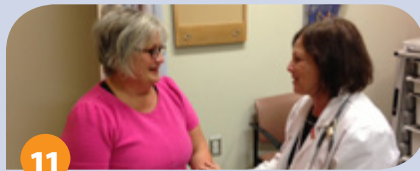
CENTRAL EAST

The Durham Regional Cancer Centre in Oshawa opened a satellite radiation treatment unit in Peterborough. Radiation staff and radiation oncologists travel to Peterborough daily to ensure that patients receive the same high-quality standard of care that they would otherwise get in the Regional Cancer Centre.



SOUTH EAST

Kingston General Hospital nearly doubled the size of its cancer care facilities, allowing for new outpatient clinics, a new pediatric unit, increased space for chemotherapy and radiation treatment, state-of-the-art technologies and equipment, and a 24% increase in the number of treated cases.



CHAMPLAIN

The Wellness Beyond Cancer Program ensures breast and colorectal cancer patients, upon treatment completion, receive appropriate followup care and resources. More than 2,500 patients have been referred since spring 2012. More than half were discharged with a survivorship care plan to their primary care provider; the remainder are cared for by a cancer centre nurse practitioner.



NORTH SIMCOE MUSKOKA

The first comprehensive Regional Cancer Centre in the region opened in 2012, providing care closer to home for the area's residents. The 73,000-square-foot facility located at the Royal Victoria Regional Health Centre in Barrie provides a full range of cancer services. Since its opening, the cancer centre has provided almost 203,000 patient visits (July 2012-September 2014) and consultation to more than 8,200 patients.

NORTH EAST

Oral chemotherapy processes were improved, including an electronically generated order, and revised tools for nursing documentation, telephone monitoring, and patient education and adherence. The streamlined processes, which were developed in partnership with patients and private pharmacies, ensure maximum patient safety.



NORTH WEST

Patients who must travel from outlying communities can now access the Rapid Assessment Clinic and receive compressed two- to three-day lung assessment services from a multidisciplinary team of experts. Patients are able to stay at the patient lodge free of charge while accessing supportive care services.



About this plan

Together we will...
develop a plan to work
towards our goals

Much has been accomplished under the first three Ontario Cancer Plans, but there is still more to do in order to meet the challenges ahead and seize the opportunities of today's changing healthcare environment. The Ontario Cancer Plan IV (OCP IV) serves as our guide as we move forward together over the next four years and continue to improve the cancer system in this province.

OCP IV is truly Ontario's cancer plan. We engaged with an unprecedented number of our cancer partners and stakeholders in identifying and validating areas in which to prioritize our work through to 2019. In all, more than 560 participants from every region across the province offered their insights about the gaps and opportunities that exist in our current system. Participants included staff of the Regional Cancer Programs, external health organizations and medical associations, and CCO leadership. For the first time, patients and families were at the planning table at every stage of developing OCP IV, offering keen observations that can come only from first-hand experience.

We gained insights from across Canada and around the world, reviewing cancer plans and reports from other provinces and countries. For the first time, we

also consulted with an international panel of cancer and health system experts. Our extensive environmental scan included several reports on our performance, such as the Cancer System Quality Index. Furthermore, the Cancer Quality Council of Ontario hosted a day to review and provide recommendations on OCP IV's strategic direction.

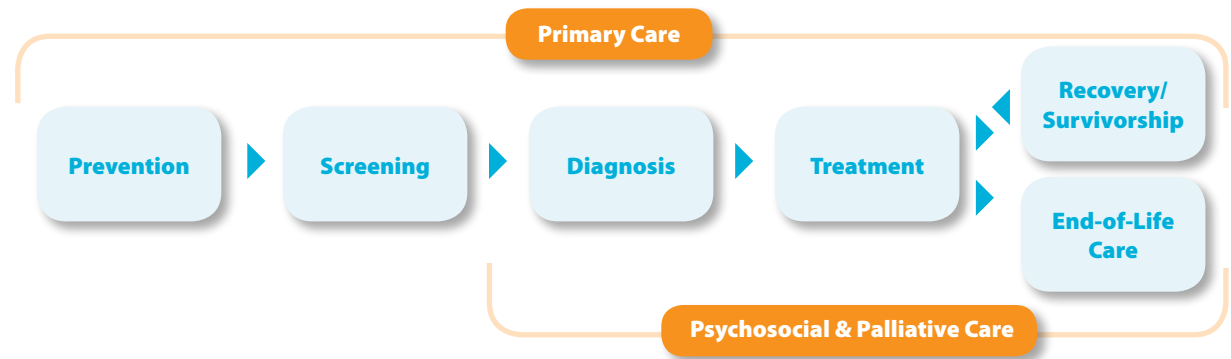
Six key themes emerged, and they have become the goals of this cancer plan: Quality of Life and Patient Experience, Safety, Equity, Integrated Care, Sustainability and Effectiveness. These themes cut across the cancer care continuum so that no matter what stage a person is at with regards to prevention, screening, diagnosis, treatment, recovery, survivorship or end-of-life, their needs will be addressed by the goals and initiatives of this plan.

Execution and evaluation

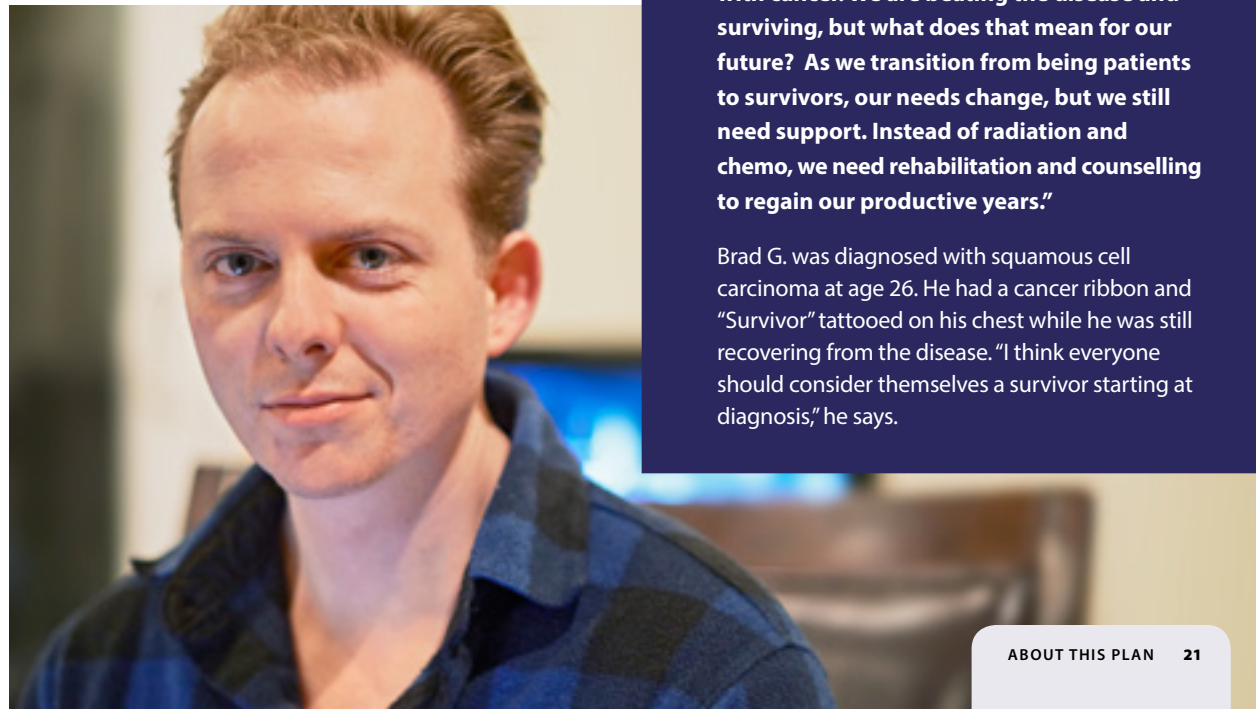
OCP IV is a strategic document, and as such will be supported by a detailed operating plan and annual business plans, as well as a measurement and evaluation plan. Evaluation of OCP IV will focus on three areas: how well we captured the priorities of the system; what part of the process worked well and what could be improved; and what is the system impact of OCP IV over time. Cancer Care Ontario is developing a separate scorecard with performance indicators and targets to measure progress against this plan. The "By 2019" statements included in this document reflect our commitment to the plan's overall impact. These statements will form the basis of some key performance indicators that we will use to chart the impact of our work. The evaluation will also have built-in mechanisms to allow us to adjust our approach to achieving the goals and respond to the changing environment in which the cancer system operates.

Cancer Care Ontario is accountable to the Ministry of Health and Long-Term Care, our partners and the people of Ontario for the fulfilment of OCP IV.

THE CANCER CARE CONTINUUM



Our progress is reported through several mechanisms, including annual reports, quarterly reports on our accountability and funding agreements, CCO special program reports (e.g., ColonCancerCheck report) and the Cancer System Quality Index, which tracks Ontario's progress towards better outcomes in cancer care and highlights opportunities for improvement.



Brad G.

"More young people are being diagnosed with cancer. We are beating the disease and surviving, but what does that mean for our future? As we transition from being patients to survivors, our needs change, but we still need support. Instead of radiation and chemo, we need rehabilitation and counselling to regain our productive years."

Brad G. was diagnosed with squamous cell carcinoma at age 26. He had a cancer ribbon and "Survivor" tattooed on his chest while he was still recovering from the disease. "I think everyone should consider themselves a survivor starting at diagnosis," he says.

Goal

Ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum

Having cancer is an intensely personal experience. Ultimately, it is the patient's subjective perception of their experience and quality of life, in addition to the clinical outcome, that defines excellence in care. Optimal care ensures that patients' and families' needs and preferences are respected at every stage of the cancer care continuum. This person-centric model of care requires excellent communication and supportive partnerships between patients and their care providers. It also addresses not only their physical health but their psychological, social and cultural concerns as well. Sensitivity to these issues is particularly important in discussing treatment options and especially in advance care planning.

Under the Ontario Cancer Plan III (OCP III), significant strides were made in terms of measuring and understanding care needs from the patient's perspective. Two examples include the Ambulatory Oncology Patient Satisfaction Survey and the Interactive Symptom Assessment and Collection

(ISAAC). ISAAC is now used by 168,000 patients annually, enabling them to report their symptoms directly to their care team in real time. With this information, patients and providers are able to make better-informed care decisions.

While this work has laid a strong foundation, there is an opportunity for further improvements to be made, which we will focus on in OCP IV. Patients tell us that balancing outcomes and survival with their preferences and quality of life is important to them. We need to work towards this by advancing person-centred care, enabling providers and patients to better engage in quality-of-life discussions, and improving access to resources to assist patients in fully participating in their own care. We also need to continue to promote patient and family engagement at the system level. As our experience has already demonstrated, there is clear benefit to involving them in designing healthcare improvements that will directly impact their care.

Strategic objectives

Drive excellence in the development of policies, programs, strategies and evaluation by partnering with patients and their families to ensure services and care reflect their needs and preferences.

Expand and integrate access to palliative, psychosocial and rehabilitation services to improve quality of life and patient experience in cancer centres and the community.

Capture a range of real-time patient-reported information that is meaningful to patients to improve the quality of care.

Increase understanding of wait times from the patient's perspective and identify opportunities to improve the patient experience.

Support healthcare providers, patients and families with training, tools and resources to improve communication, decision-making, self-management and quality of life.

Examples of initiatives*

Provide support, training, tools and mechanisms for primary care providers to better identify and support patients in the palliative care and survivorship phases of the cancer care continuum.

Develop training and tools to help care providers better address patient psychosocial needs.

Complete implementation of real-time patient experience measures, expand the electronic reporting of symptoms and develop symptom management tools for clinician and patient use.

* Our Operating Plan details all initiatives that we will undertake to deliver on OCPIV strategic objectives.



Anya H.

"I am sure it is hard for doctors and nurses to face their patients' death. And I don't expect them all to have the expertise to deal with palliative issues. But there should be someone who can help us through this bewildering and terribly difficult time, and they should start talking to us about palliative care as soon as a life-threatening diagnosis is made."

Anya H. lost her husband, Fred, to colon cancer six years ago. Her son, Ted, died of testicular cancer just four years later, at age 35. As a retired psychotherapist who volunteers as a patient and family advisor with Cancer Care Ontario, she would like to see better methods of measuring and evaluating whether people are having their emotional needs met by the healthcare system.

By 2019...

Patients will report that cancer care was delivered in a manner that recognized their needs and preferences.

Patient needs for palliative care and advance care planning will be addressed early in the cancer care continuum. Patients will have timely access to psychosocial and palliative care as appropriate.

Patients will have opportunities to report on their symptoms for specific disease sites in real time and will have their symptoms addressed.

There will be improved information and communication, resulting in a better experience for those waiting for care.

Patients and their families will have access to the resources, tools, knowledge and support they need to help them manage their care.

Patients will have discussions with their provider about advance care planning and will have the information they need to make informed decisions.

Goal

Ensure the safety of patients and caregivers in all care settings

Patients, families and care providers expect the care received and delivered by our health system to be safe. Indeed, safety is intrinsic to high-quality healthcare.

Many steps have been taken to improve safety and reduce avoidable harm in our cancer system. A Regional Quality and Safety Network was established, which offers care providers a forum to share best practices in systemic treatment. Through the de Souza Institute, more than 80 per cent of all registered nurses in Ontario's chemotherapy clinics have participated in training programs to ensure the safe and standardized delivery of chemotherapy and biotherapy throughout the province. We also began a new partnership with the College of Physicians and Surgeons of Ontario to develop provincial quality-management programs for mammography, colonoscopy and pathology. These programs set standards, and measure and report

on quality at the individual physician, facility, regional and provincial levels. Quality improvement will be a key component of these programs. The goals of these programs are to improve quality of care while also building public confidence by increasing transparency and accountability.

Moving forward, we need to be more proactive in reducing avoidable harm at every step of the cancer care continuum and in all care settings. We need to understand the gaps that still exist in safety and work towards addressing them by setting performance benchmarks, promoting the use of safety guidelines and resources, and supporting safety training. There is also an opportunity to strengthen the culture of safety that exists, and to establish stronger governance and accountability around safety for cancer services.

Strategic objectives

Expand the use of technologies and tools for providers that drive adherence to evidence-based guidelines across care settings, including the home.

Develop and implement patient safety tools in collaboration with patients and families that enable safer care in settings outside the hospital, including the home.

Identify opportunities for system-level oversight for safety related to cancer services.

Advance peer review of care plans to ensure concordance with evidence-informed practice and appropriateness of care that will lead to improved patient safety and clinical effectiveness.

Describe cancer-specific requirements for regulated healthcare providers delivering cancer care.

Examples of initiatives*

Implement plans for comprehensive quality management programs for colonoscopy, mammography and pathology.

Implement the *Systemic Treatment Provincial Plan, 2014-2019* (see page 34).

Through partnerships, increase specialized oncology training of care providers (oncology provider education, training and certification) across the cancer system.

*Our Operating Plan details all initiatives that we will undertake to deliver on OCP IV strategic objectives.



Lillian C.

“As patients, we trust healthcare providers with our safety. We need to know that proper protocols for our care are in place and, more importantly, are being followed. We should receive clear, written instructions well in advance of our procedures, have our questions answered and our concerns addressed.”

Lillian C. was worried about her family’s safety when she was told to spend five days at home (but to not go out in public) following her radioactive iodine capsule treatment for thyroid cancer in 2008. The self-described “soccer mom” joined Cancer Care Ontario’s Patient and Family Advisory Council in order to raise awareness of the challenges, stresses and confusion that patients and their families can face with take-home cancer therapies.

By 2019...

Concordance and compliance with evidence-based safety guidelines will be increased.

Patients and providers will be partners in designing how chemotherapy is delivered safely in the home.

All care partners, including patients and families, will have access to the resources that are needed to ensure a safe care environment, in all settings.

Following review of reported near-miss and actual incident data, Cancer Care Ontario and our partners will have identified targeted improvement initiatives.

An accountability framework and performance management structure will be in place to drive improvement in quality and safety in colonoscopy, mammography and pathology.

In radiation, pathology and mammography, provider peer reviews will be consistently conducted as part of clinical practice.

Healthcare providers involved in the delivery of chemotherapy, including in the community, will be appropriately trained in oncology care.

Goal

Ensure health equity for all Ontarians across the cancer system

Ontario's population is diverse and geographically dispersed. Patients' access to care and their health outcomes should not depend on demographic characteristics or where they live. Yet some Ontarians face significant, and often multiple, barriers in finding and accessing cancer services based on geography, race, culture, gender, age, sexual orientation, immigration status and education.

In recent years, Cancer Care Ontario has been instrumental in improving health for specific populations. For example, we worked with First Nations, Inuit and Métis (FNIM) groups to develop the Aboriginal Cancer Strategy II and, through successful partnerships, have implemented initiatives outlined in the strategy. Recommendations for the organization and delivery of specialized cancer services have been developed, particularly for stem cell transplant, acute leukemia and sarcoma; these programs look

at the role of emerging technologies, capacity management and planning for expected growth to support equitable access to high-quality care for these patient populations. Furthermore, investments in infrastructure and expanded services are helping to bring cancer care closer to home for many Ontarians.

Despite all that has been accomplished so far, this work is just the beginning. We need to better understand the barriers that contribute to health disparities across the cancer care continuum, including barriers between health and community services to address social determinants of health. We need to raise awareness among traditionally underserved populations about what services are available, how to access them and why it is important to do so. FNIM groups and other groups mentioned previously may face unique challenges that require targeted solutions.

Strategic objectives

Develop and implement the third Aboriginal (FNIM) Cancer Strategy, building on successes of previous FNIM cancer strategies as well as the established relationship protocol agreements between Cancer Care Ontario and FNIM communities.

Assess, expand, enhance and utilize data to better understand and improve equity issues in the regions.

Develop locally relevant policies and programs in partnership with community service providers to improve access to services for specific populations and support healthcare providers with training, data and tools to deliver equitable services.

Advise governments in the development of provincial policies and programs to improve access to services for specific populations, including equitable access to specialized services.

Examples of initiatives*

Implement a health equity impact assessment tool in program design and planning.

Expand efforts to address inequities in screening behaviours and modifiable risk factors or exposures for cancer and other chronic diseases.

Design and implement provincial models for the delivery of specialized services such as focal tumour ablation, neuroendocrine tumours and sarcoma.

Expand the reach of provider-level cancer screening reporting to providers serving FNIM populations (Screening Activity Reports for Aboriginal Health Access Centres).

* Our Operating Plan details all initiatives that we will undertake to deliver on OCP IV strategic objectives.



Gail S.

“I had to drive an hour and a half each way for my radiation treatment. As stressful as that was, I realize I was incredibly lucky. I think about all the people who have to drive three, four or five hours to get to a treatment centre. What about people who don’t have cars, or can’t afford the gas and parking, or don’t have jobs that give them paid sick leave? We have one of the best healthcare systems in the world, but not everyone has equal access to it.”

Gail S. is a retired teacher and school administrator who says surviving two bouts of cancer (breast and uterine) has made her more appreciative of life and more compassionate towards others. She is very active in her community, belongs to numerous clubs and swims half a mile almost every day.

By 2019...

The relationships among FNIM, Cancer Care Ontario and Regional Cancer Programs will be firmly established and formalized through protocols. This will ensure and sustain ongoing dialogue and implementation of the Aboriginal (FNIM) Cancer Strategy through customized regional Aboriginal cancer plans, an achievement that will allow for increased service awareness and equitable access that honours the Aboriginal path of well-being.

FNIM identifiers will be incorporated into data sets that will be used to detect and quantify equity gaps.

Data to identify equity gaps will be available beyond FNIM populations, including “cancer risk profiles” for communities.

Cancer Care Ontario will provide the information and tools that will support the Regional Cancer Programs in reducing disparities that exist in prevention, care and outcomes.

Equity assessments will be applied to program design to ensure that access and utilization of services by FNIM and other underserved, high-risk communities are improved.

Goal

Ensure the delivery of integrated care across the cancer care continuum

Ontario's cancer system is large and complex. As people transition through the different stages of the cancer care continuum and into and out of the cancer system, they will see many different care providers in many different settings. This is especially true for cancer patients who have multiple comorbidities. Patients may be confused by the variations in care practice they experience or the lack of clarity with regards to the role of care providers and how to access various services. Care providers may also not fully understand their role in helping patients transition and how to coordinate with other members of the multidisciplinary care team.

Under OCP III, we started to lay the foundation for a more integrated person-centred model of care, particularly through improved communications. Diagnostic Assessment Programs were expanded, providing patients with a single point of access for all diagnostic services, the testing they require, and support with transitions and navigation. In addition, the Provincial Primary Care and Cancer Network is helping to strengthen connections

between family medicine and the cancer system, aided by new educational programs and provider tools such as referral guidelines and disease pathway maps. Communication among care providers has also improved with the use of synoptic pathology reporting, which standardizes pathology reporting and makes it easier for care providers to find clear, concise information required for clinical decision-making.

Moving forward with OCP IV, we need to ensure that care is person-centred, coordinated and continuous through the cancer system and across settings. In particular, we have identified palliative care as one facet of care that benefits from an integrated care approach. We can facilitate integrated care by standardizing care and optimizing relationships and information-sharing among care providers, patients and families. In addition, patients should have a clear understanding of their care plan, how to navigate through the system and who they can turn to for help at every stage of the cancer care continuum.

Strategic objectives

Stratify patients by risk, based on clinical factors, comorbid conditions and social determinants of health, to determine the supports that patients and families require to navigate their care pathway.

Ensure that standardized care plans are developed and communicated to all members of the care team, across the cancer care continuum, to facilitate an integrated approach to care that is centred on the patient.

Enhance communication among all providers across the cancer care continuum and care settings to facilitate smoother care transitions.

Increase the availability of relevant patient clinical information to patients and providers across care settings to support informed decision-making.

Determine opportunities for improving the transition of adolescent and young adults, when appropriate, from the pediatric to adult cancer system.

Examples of initiatives*

Design and implement a risk assessment tool to determine supports for complex cancer patients (e.g., multi-morbidity, mental health) and other high-need populations.

Work with primary care providers to develop supports for providing ongoing followup care to cancer survivors.

Implement *Navigating the Diagnostic Phase of Cancer: Ontario's Strategic Directions 2014-2018* (see page 35), and expand the Diagnostic Assessment Program – Electronic Pathway Solution (DAP-EPS) road map across the province.

Collaborate with partners to broaden linkages to electronic medical records and facilitate comprehensive and complete electronic health records in Ontario.

Expand synoptic reporting to facilitate sharing of information.

* Our Operating Plan details all initiatives that we will undertake to deliver on OCP IV strategic objectives.

By 2019...

Patients will have appropriate supports throughout their care pathway, and providers will have the necessary tools to assist their patients with navigation.

Standardized care plans will be available for selected disease sites, treatments and patient populations, across care settings. These plans will be used to improve communication of goals of care and expected outcomes among patients, families and providers.

Use of technology will be expanded to improve communication among providers across the cancer care continuum and care settings.

Patient care information will be made available to patients and providers to support joint decision-making (e.g., Diagnostic Assessment Program – Electronic Pathway Solution and Interactive Symptom Assessment and Collection).

A strategy will be developed with provincial partners to improve transitions for adolescents and young adults.



Carly G.

“When someone starts treatment, they and their families have so many questions: What’s going to happen, what will it be like, where do we go next? Having a plan in place gives them a better idea of what to expect, lets them prepare and helps them feel confident about their care. I think having navigators or care consultants to help patients—and their information—move through the system is a great idea.”

Carly G.'s father passed away from colon cancer in 2000 and her stepfather is being treated for refractory lymphoma. Motivated by her father's spirit, she pursued a degree in biochemistry, and is now a post-doctoral fellow at the University of Toronto.

Goal

Ensure a sustainable cancer system for future generations

Ontarians want to know that, should they ever face a diagnosis of cancer, high-quality care will be available to them. Even more, they want to know that these cancer services will be there for their loved ones in the future. In order to ensure the sustainability of our cancer system, we must slow the growing need for services while simultaneously ensuring we make the best use of our human, infrastructure and financial resources.

Successful strides with several strategies under OCP III have been made. For example, prevention initiatives, such as smoking cessation programs and sun safety messaging, aim to reduce the incidence of cancer. The release of *Cancer Risk Factors in Ontario* reports will form the basis for future policy advice and prevention initiatives. In addition, highly successful breast, cervical and colorectal screening programs are helping to prevent and detect cancers at earlier, more treatable stages. New and innovative models of

care are ensuring breast and colorectal cancer survivors receive standardized high-quality followup care by their primary care providers. We are also increasing our capacity to evaluate programs in order to determine which healthcare investments are having the most significant impact.

Over the next four years we need to be bolder in our approach to building a sustainable cancer system, using our resources wisely and ensuring patients receive appropriate care in the right setting. There is an opportunity to do this by expanding our prevention and screening efforts and developing innovative solutions to deliver high-quality services while ensuring the greatest benefit to patients and the cancer system.

At the same time, we need to measure and respond to patient-, provider- and system-related outcomes as well as conduct robust system planning and ongoing evaluation to inform future decisions.

Strategic objectives

Develop and execute on a chronic disease prevention strategy that focuses on reducing the incidence of the major chronic disease modifiable risk factors and exposures.

Continue to implement organized cancer screening programs for breast, cervical and colorectal cancer.

Assess value from a patient experience, population health and cost perspective to inform decision-making across the cancer system.

Optimize the model of care delivery to achieve the greatest benefit for patients and the cancer system.

Strengthen and expand system capacity planning to ensure resources are most optimally allocated and utilized.

Examples of initiatives*

Pilot initiatives and models of care that use technology to enable patients to manage their treatment symptoms, and facilitate communication with care providers from the home.

Develop our capacity for health technology assessment and economic evaluation at the system level.

Implement continuous review of the processes, roles and locations of care delivery, with an initial focus on ambulatory services.

Enable secure, online access to screening invitations and results for the provincial cancer screening programs (breast, cervical and colorectal) as a replacement for current paper-based processes.

Implement systematic screening for tobacco use among all new ambulatory care patients attending Regional Cancer Centres and ensure that smoking cessation is integrated into the care plan.

Transition colorectal cancer screening from the fecal occult blood test (FOBT) to the fecal immunochemical test (FIT) and pilot the human papillomavirus (HPV) test as the primary screening mechanism for the Ontario Cervical Screening Program.

* Our Operating Plan details all initiatives that we will undertake to deliver on OCP IV strategic objectives.

By 2019...

We will have begun implementation of the chronic disease prevention strategy and have developed the evaluation framework.

Participation in breast, cervical and colorectal cancer screening programs will be increased and followup for those with an abnormal screening result will be improved.

Drugs funded through the Provincial Drug Reimbursement Program will be evaluated for the greatest benefit to patients and impact on healthcare resources.

Innovative, person-centred models of care will enable the right provider to deliver the right care, at the right time, in the right place.

Data-driven, system-level plans will be used to allocate key health human, infrastructure and financial resources for all cancer services.

Radiation, gynecology and medical oncologist positions will be expanded consistent with capacity planning models.

A portrait of Rhonel B., a young Black woman with braided hair, wearing a black leather jacket over a light blue top. She is looking slightly to the right of the camera with a neutral expression.

Rhonel B.

“My sister Monica died of breast cancer at the age of 36, so cancer is always at the forefront of my mind—not only for me but also for her three daughters (now aged 18, 25 and 30). Prevention and early detection are so important because we know we are at high risk. I want clear direction about best practices for mammography, ultrasound, genetic testing, maybe even prophylactic surgery.”

Rhonel B. decided to study health information management at school after watching healthcare providers access her sister’s medical records. “Better access to information goes hand in hand with sustainability because it reduces redundant tests and improves decision-making,” she says.

Goal

Ensure the provision of effective cancer care based on best evidence

Effective cancer care means that patients receive appropriate, timely care, based on the best evidence. This will ensure the best possible clinical outcomes are achieved and that patients' goals of care are met. In order to achieve this, clinical guidance and new knowledge need to be implemented into practice as quickly as possible to reduce the gap between best evidence and the care provided.

Over the last four years, notable progress has been made in ensuring that patients receive care based on the best available evidence; for example, we published best practice pathway maps that link evidence-based guidelines and help us identify where more guidance is needed (see "Our record so far," page 16). In 2013-14, approximately 36,000 patients were discussed at multidisciplinary case conferences (MCCs), in which inter-professional oncology teams review individual cases and collectively determine treatment plans. Patients whose cases are reviewed at an MCC are more likely to receive treatment according to clinical

guidelines. In regards to molecular oncology, funding oversight to six biomarker laboratory tests was expanded. This helps to ensure that patients receive the right treatments for their specific cancer and allows the necessary monitoring of the treatment's effectiveness. In addition, we started to implement the Quality-Based Procedures/Programs (QBPs) for Systemic Treatment and Gastrointestinal Endoscopy, which is tied to evidence-informed practice and ensures that funding follows the patient.

With OCP IV, we need to improve our understanding about whether we are improving outcomes based on the care we are providing. We need to ensure that new evidence is promptly evaluated, and that best practice guidelines are consistently used in practice to optimize patient outcomes. We need to drive adherence to the use of evidence-based guidelines and to work with our partners to align efforts in the area of molecular oncology (i.e., personalized medicine).

Strategic objectives

Expand measurement of clinical and patient-reported outcomes to enable effective, high-quality care.

Expand our performance management model to include non-hospital healthcare organizations and performance at the provider level in order to be more effective with our quality and access programs across the system.

Leverage and expand the use of evidence-based guidance to improve the appropriateness of care.

Develop a unifying strategy for personalized medicine for cancer care including personal and tumour genetics, and incorporate recommendations into clinical practice.

Examples of initiatives*

Implement new funding models for systemic treatment, upper gastrointestinal endoscopy, colonoscopy, colposcopy, cancer surgery and radiation, and further develop our leadership in funding model methodologies.

Promote imaging appropriateness by endorsing guidelines, measuring guideline concordance and implementing technical imaging standards.

Expand the use of pathway maps with a focus on measuring system performance and patient outcomes by disease site.

* Our Operating Plan details all initiatives that we will undertake to deliver on OCP IV strategic objectives.

By 2019...

Standards, guidelines and programming for patient care will be informed and developed using enhanced measures of clinical and patient-reported outcomes for colorectal and breast cancers.

We will use system-level indicators to compare the performance of Ontario's cancer system against international benchmarks.

Our performance management and evaluation system will be expanded beyond the hospital setting to healthcare providers, the community sector and the home.

Individual healthcare providers and facilities will have access to performance data to drive improvements in care.

Our funding levers will be used to align care with evidence-based guidelines for mammography, upper gastrointestinal endoscopy, colonoscopy, colposcopy, systemic treatment, cancer surgery, radiation, diagnostics and other specialized services.

In conjunction with our partners, we will begin the implementation of the personalized medicine strategy for cancer care in Ontario.



Lianne D.

"For patients, our symptoms define our illness. We just want to feel better, to be able to get back to our lives. I had to blindly trust a doctor I had never met before to look after me, to believe in what he told me would be the most effective treatment for me. I am incredibly lucky to be alive today, but I still have lingering side effects from that treatment."

Lianne D. was treated for acute promyelocytic leukemia in 2000 when she was just 27 years old. Cancer-free but struggling with ongoing memory loss, "brain fog" and fatigue that she attributes to intensive chemotherapy, she devotes her time to her family and being a "professional volunteer" with a wide range of organizations, including Cancer Care Ontario's Patient and Family Advisory Council.



Shared directions

Together we will...
align our program priorities

The Ontario Cancer Plan IV (OCP IV) does not exist in isolation. In developing and implementing OCP IV, Cancer Care Ontario takes direction from the Ministry of Health and Long-Term Care, while at the same time providing direction to the Regional Cancer Programs. Our shared priority is the well-being of all Ontarians.

In order to put OCP IV into action, some of our programs develop program-level strategic plans highlighting more specific areas of focus. The first two examples below (*The Systemic Treatment Provincial Plan, 2014-2019* and *Navigating the Diagnostic Phase of Cancer: Ontario's Strategic Directions 2014-2018*) are recently launched plans aligned with OCP IV's goals. The third, the palliative care program plan, is in early development and showcases the breadth of alignment with OCP IV goals and broader provincial priorities.

The Systemic Treatment Provincial Plan, 2014-2019

(see www.cancercare.on.ca/systemicplan) will be implemented in order to improve the safety, quality and accessibility of systemic treatment in Ontario.

This plan has several goals that enable the success of OCP IV:

- Develop and implement a standardized and proactive approach for preventing and managing systemic treatment-related toxicity;

- Develop recommendations related to prescribing, monitoring, adherence and education for oral chemotherapy;
- Improve the culture of safety through increased medication incident reporting and dissemination; and
- Create and implement a standardized home care model that will enable the safe delivery of chemotherapy in the home for patients, their families and community providers.

Similarly, ***Navigating the Diagnostic Phase of Cancer: Ontario's Strategic Directions 2014-2018***

(see www.cancercare.on.ca/diagnosticstrategy) will be implemented to enable OCP IV's goals of improving the integration of care, optimizing quality of life and ensuring the sustainability of the cancer system.

This plan focuses on four priority areas:

- Refine and align the scope of the Diagnostic Assessment Programs (DAPs);
- Develop models of navigation for patients during the diagnostic phase;
- Improve patient transitions along the care pathway, from suspicion to diagnosis, leading to treatment; and
- Drive continuous quality improvement during the diagnostic phase.

The work of **CCO's Palliative Care Program** is broad in scope, aligning to OCP IV and with provincial efforts in this area. As a leader and facilitator of systems change, CCO is working closely with the Local Health Integration Networks and other provincial partners to leverage our assets to support transformational improvements in the delivery of palliative care. This program spans across all OCP IV goals, touches patients at many stages of the care continuum and

will be relevant to diseases beyond cancer.

While the Palliative Care Program is in evolution, its mandate is to develop and identify best practices for the system as a whole while also supporting regional applications. The program's vision, which aligns with that of the Ministry of Health and Long-Term Care, is that every Ontarian faced with a serious illness should have the opportunity to receive optimal symptom management and be supported with dignity and respect throughout the course of his or her illness.

The goals of CCO's Palliative Care Program are to:

- Promote a societal culture change around palliative care;
- Ensure a seamless patient experience with the right care at the right time in the right place;
- Ensure equitable access to palliative care for all Ontarians, including vulnerable populations; and
- Increase the health system's capacity to deliver palliative care.

The following initiatives will help us to meet these palliative care goals:

- Increase the capacity for primary level providers to deliver high-quality palliative care through education, coaching and support mechanisms;
- Enable earlier identification of people who would benefit from a palliative approach, and facilitate advance care planning and goals of care discussions through best practice tools and education;
- Endorse tools for standardized functional, frailty and/or complexity assessment that allow for integrated care across care settings;
- Measure regional variations in access to palliative care;
- Work with underserved populations, including

What is palliative care?

Palliative care is a holistic person-centred approach to caring for patients who are facing a life-limiting illness and their families who are caring for them. The aim is to prevent and ease suffering, while promoting quality of life from the time of diagnosis, through survivorship, right up until the end of life.

Palliative care can be provided at any stage of the illness, although advance care planning and goals of care discussions should begin early rather than at the end of life, and should be ongoing as the person's needs and preferences change.

Palliative care should be a standard part of care that is integrated throughout the care continuum. It should be available across all care settings, provided by an inter-professional team of healthcare professionals, and include family, informal caregivers and the community as part of the circle of care.

Aboriginal communities, to understand and address gaps in palliative care; and

- Measure the patient and family experience across the care continuum to drive improvements in palliative care and patient well-being.

For more information about CCO's Palliative Care Program, visit www.cancercare.on.ca/pallcare.



strength

Enablers of success

Together we will...
successfully
implement this plan

If the Ontario Cancer Plan IV is the road map guiding the way we develop and deliver cancer services over the next four years, enablers are the vehicles that will help get us to our destination. We rely on the enablers below—the capabilities, conditions, concepts and especially the people—to successfully implement the initiatives that will make Ontario's cancer system the best in the world.

Planning

We will continue to enhance our corporate and provincial planning to ensure the availability of timely, high-quality, high-value services that offer the greatest benefit to patients and the cancer system. We will strengthen our planning tools and methodologies with a focus on health human resources and incorporating new models of care.

Information management and technology (IM/IT)

We will implement systems, processes and tools to capture, organize and retrieve reliable, high-quality data. Using innovative approaches, we will identify new data requirements and sources, facilitate data acquisition, conduct data analysis and complex modelling, and provide sophisticated interpretation of analytic results. This work will support quality improvement across the cancer care continuum and in multiple care settings, and will inform clinical decision-making. CCO's IM/IT work will be guided by our IM/IT strategic plan.

Partnerships and engagement

We will continue to foster strong partnerships with our many stakeholders, especially patients and families, while also building new connections. We will seek opportunities to combine our competencies and assets with our partners to achieve common goals and priorities.

Evidence and knowledge generation

We will conduct and enable research, surveillance and evidence-based reviews to better understand and close critical knowledge gaps. We will translate knowledge and evidence into planning, policy and program design recommendations for our stakeholders to shape action across the cancer care continuum.

As well, we will build on CCO's long history with respect to research. We are undertaking an initiative to make research more closely aligned to the organization's priorities and to be guided by a clearly defined strategy.

Value assessments

We will improve how we use resources by assessing the impact of initiatives on patient outcomes and patient experience against the required investment. We will evaluate the relative value of a wider range of programs across the cancer system.

Quality and performance improvement

We will develop and implement accountability models (which include funding levers, clinical leadership, standards and guidelines) that enable care to be delivered in the most appropriate setting to realize the best outcomes for patients and maximize the return on health system resources.

Knowledge transfer and exchange

We will work collaboratively with all our partners to facilitate, enable and support the appropriate use of our quality and performance improvement approaches, and to enable action on policy, planning and program design recommendations. We will deliver the right knowledge to the right people at the right time by using multiple formats and media to communicate in ways that are creative, timely, audience-specific and dynamic.



fulfill

A call to action

Together we will...
make a difference

The development of the Ontario Cancer Plan IV (OCP IV) required input from hundreds of people, working diligently for more than 18 months. Teamwork has been critical throughout this process. We wish to express our appreciation to everyone who shared their experiences, expertise and insights to help create this plan, including all of our partners in the Regional Cancer Programs, our partner organizations, the Ministry of Health and Long-Term Care, the OCP IV panel of international advisors, our Patient and Family Advisory Council, and the staff and leadership at Cancer Care Ontario, particularly the OCP IV working groups, which were led and supported by Elaine Meertens, Junell D'Souza, Goran Klaric and Rebecca Ho. We would especially like to thank the patients and families who lent their voices and faces to this document. Patients and the public are at the centre of everything we do at CCO. This plan is our commitment to create a cancer system that continually improves to address their needs.

Now the work of implementing this plan begins.

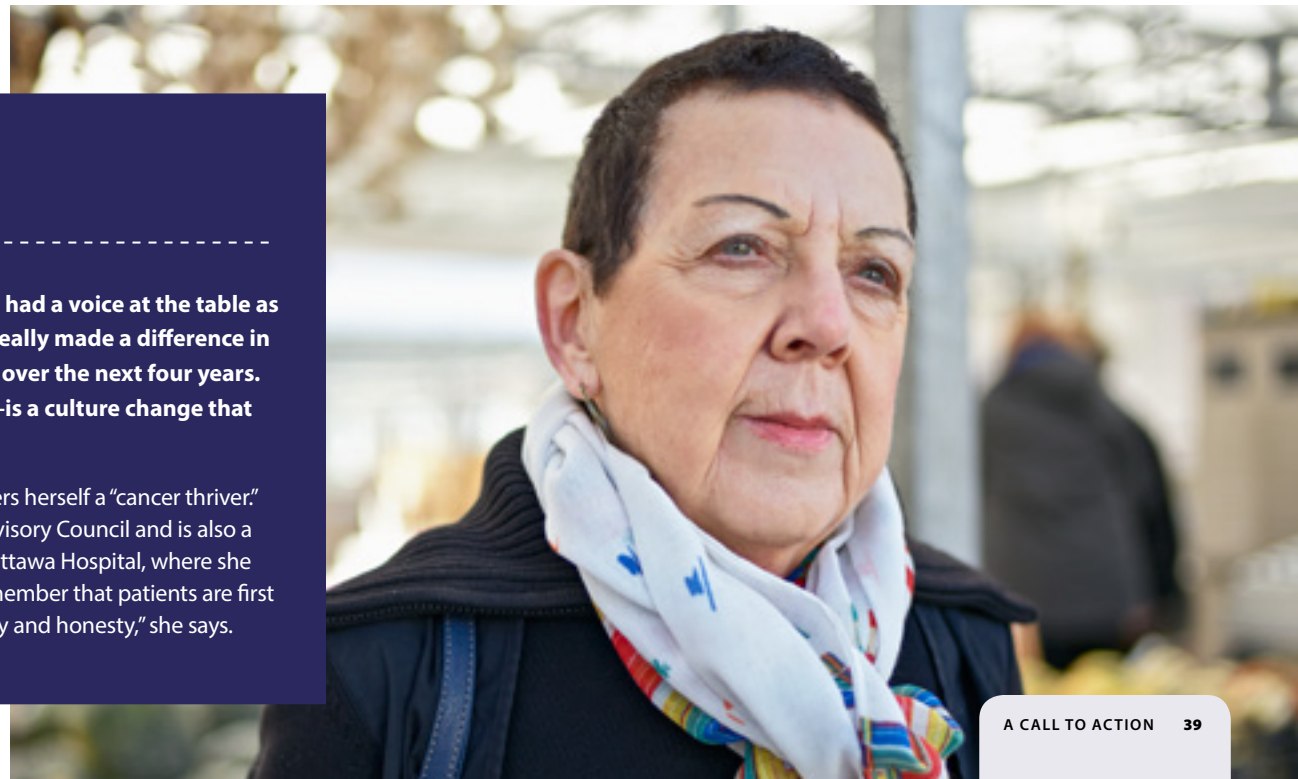
OCP IV clearly outlines the strategic direction and what we need to accomplish over the next four years as we continue to work to reduce the risk of individuals developing cancer while ensuring the delivery of high-quality services for current and future patients. Everyone involved in the planning and delivery of cancer services in Ontario should reference this document routinely and repeatedly as we bring this plan to life in communities across the province.

Successfully fulfilling OCP IV's goals will require the ongoing active involvement and collaborative efforts of all our partners, from bedside to boardroom, from patients and families and frontline care providers to regional cancer planners and staff at Cancer Care Ontario and the Ministry of Health and Long-Term Care. Working together, we will improve patient care at every stage of the cancer care continuum.

Patricia P.

"I want cancer patients and their families to know that they had a voice at the table as CCO developed this plan. The patient and family advisors really made a difference in determining how cancer services are going to be provided over the next four years. Listening to patients—putting them at the centre of care—is a culture change that needs to spread across the healthcare system."

Patricia P. was treated for breast cancer in 2004 and now considers herself a "cancer thriver." She is a member of Cancer Care Ontario's Patient and Family Advisory Council and is also a patient advisor with both the Regional Cancer Centre and The Ottawa Hospital, where she received her treatment. She asks healthcare professionals to remember that patients are first and foremost people. "Treat me as a person, with respect, dignity and honesty," she says.





Cancer Care Ontario

Working together to
create the best health
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