Ministry of Health

Cancer Treatment Services

Follow-Up on VFM Section 3.02, *2017 Annual Report*

RECOMMENDATION STATUS OVERVIEW						
		Status of Actions Recommended				
	# of Actions Recommended	Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	3	3				
Recommendation 2	3	1	1	1		
Recommendation 3	2	2				
Recommendation 4	2	1	1			
Recommendation 5	2			2		
Recommendation 6	1		1			
Recommendation 7	2	1	1			
Recommendation 8	1	1				
Recommendation 9	1	1				
Recommendation 10	2	1	1			
Recommendation 11	2		2			
Recommendation 12	2		1	1		
Recommendation 13	1		1			
Recommendation 14	2		1	1		
Recommendation 15	1		1			
Recommendation 16	1	1				
Recommendation 17	2	1	1			
Recommendation 18	3	3				
Total	**33**	**16**	**12**	**5**	**0**	**0**
%	**100**	**49**	**36**	**15**	**0**	**0**

Overall Conclusion

As of October 31, 2019, the Ministry of Health (Ministry) and Cancer Care Ontario (CCO) had fully implemented 49% of actions we recommended in our *2017 Annual Report*, such as developing a strategy to increase the accessibility of radiation services to patients, implementing a program to increase physician awareness of the availability and benefit of radiation treatment, evaluating the operational efficiency of financial-support programs for cancer drugs, improving the process for sharing information on drug shortages and inventory, assessing the need for additional capital projects to expand capacity for stem cell transplants in Ontario, assessing symptom-management programs in other jurisdictions, establishing provincial standards for the delivery of psychosocial services, and funding hospitals using a consistent methodology that is not historically based.

The Ministry and CCO had made progress implementing an additional 36% of the recommendations, such as analyzing the reasons for delays in scheduling surgical consultations and performing urgent cancer surgeries, establishing education programs for cancer patients on safe usage and handling of take-home cancer drugs, establishing a protocol for communication, drug-sharing and prioritizing patients in the event of a cancer-drug shortage, developing and implementing a long-term strategy to finance and expand psychosocial oncology services, analyzing the reasons for delays in scheduling CT scans and MRIs and taking corrective actions to reduce wait times, as well as evaluating and revising existing funding methods for radiation treatment.

However, the Ministry and CCO had made little progress on 15% of the recommendations, such as assessing the benefits of having a centralized referral and booking process for cancer surgeries, evaluating the need to set standards and oversee delivery of cancer drug therapy at private specialty clinics, implementing centralized referral and booking processes for cancer-related CT scans and MRIs, and developing strategies to reduce the wait times for biopsies performed in hospital operating rooms.

The status of actions taken on each of our recommendations is described in this report.

Background

Cancer, a group of more than 200 different diseases characterized by the uncontrolled spread of abnormal cells in the body, is the leading cause of death in Ontario. In 2018, an estimated 30,600 Ontarians died of cancer (29,000 in 2016).

In 2017/18, Ontario spent about $1.9 billion (approximately $1.6 billion in 2015/16) to treat cancer, most of it for hospital procedures and treatment drugs.

The Ministry of Health (Ministry) has overall responsibility for cancer (or oncological) care in the province. Cancer Care Ontario (CCO) is the provincial agency responsible under the Ministry for funding hospitals, collecting cancer data, developing clinical standards and planning cancer services to meet patient needs.

In 2017, about 100 Ontario hospitals delivered cancer-treatment services across the province's 14 Local Health Integration Networks (LHINs), and 14 of these hospitals were designated as regional cancer centres that deliver the most complex cancer treatments. We found that CCO, in conjunction with the Ministry and hospitals, had effective procedures and systems in place to ensure that most, but not all cancer patients received treatment in a timely, equitable and cost-efficient manner.

We noted that Ontarians' needs were not being met in the areas of stem cell transplants, access to take-home cancer drugs, radiation treatment, PET scans, symptom management and psychosocial oncology services. Wait times for some urgent cancer surgeries and diagnostic services also needed improvement.

Among our findings:

- Urgent surgeries for 15 out of 17 types of cancer did not meet the Ministry's 14-day wait-time target, and we noted significant wait-time variations by region.
- The CCO had determined that 48% of cancer patients province-wide would benefit from radiation treatment, but only 39% actually received it in 2015/16.
- Ontario did not cover the full cost of take-home cancer drugs for all patients. In comparison, British Columbia, Alberta, Saskatchewan and Manitoba covered the costs of all government-approved cancer drugs for all patients.
- In 2015/16, actual wait times for stem cell transplants using the patient's own previously stored cells were about 1.5 times longer than CCO's target wait time. Actual wait times for transplants using stem cells donated by someone else were almost seven times longer than the CCO target.
- Limited capacity for stem cell transplants was first identified as an issue in Ontario in 2009. The Province sometimes sent patients to the United States for the procedure, at an average cost of $660,000 (Cdn), almost five times the $128,000 average cost in Ontario.
- Ontario performed fewer positron emission tomography (PET) scans, which use injected radioactive tracers to create images of cancers, per 1,000 people than elsewhere in Canada and other countries. Ontario had not updated eligibility criteria or OHIP coverage rules for PET scans since 2013, and had been slow to adopt new radioactive tracers.
- Just under half of biopsies performed in hospital operating rooms were done within the Ministry's target wait time of 14 days.
- Review of diagnostic-imaging results by a second radiologist had remained inadequate even though misinterpretation of some results in 2013 led to several incorrect diagnoses in Ontario.
- Psychosocial oncology services, which are provided by such specialists as psychiatrists, social workers and registered dietitians, were insufficient, and varied from hospital to hospital. Support services were also insufficient to help ease patient symptoms and side-effects during treatment. As a result, many patients visited hospital emergency rooms at least once during their treatment.

We made 18 recommendations, consisting of 33 actions, to address our audit findings.

We received commitment from the Ministry and CCO that they would take action to address our recommendations.

On April 18, 2019, Bill 74, *The People's Health Care Act, 2019*, received royal assent. It will come into force on a date to be proclaimed by the Lieutenant General. The legislation is designed to integrate multiple provincial agencies, including the LHINs and CCO, into a single agency called Ontario Health. The Ministry indicated that the new agency would be responsible for overseeing highly specialized care and managing provincial population health programs, including services for cancer patients.

Status of Actions Taken on Recommendations

We conducted assurance work between April 1, 2019 and August 1, 2019. We obtained written representation from the Ministry of Health (Ministry) and Cancer Care Ontario (CCO) that effective October 31, 2019, they had provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

Radiation Treatment

Recommendation 1

To better ensure that cancer patients receive timely and safe radiation treatment, we recommend that

Cancer Care Ontario work with the Ministry of Health and Long-Term Care and hospitals to:

- *develop a strategy to increase the accessibility of radiation services to patients who do not live close to a radiation centre;*
  Status: Fully implemented.

Details

We found in our 2017 audit that radiation treatment was underutilized in all regions of Ontario. CCO indicated that distance from radiation centres and physician referral behaviours were the main reasons for the low utilization rates.

In our follow-up, we found that CCO had updated its 10-year Radiation Treatment Capital Investment Strategy, and released a report to the Ministry and hospitals in November 2018. This strategy will guide and recommend the placement of additional radiation treatment equipment and the development of new or expanded facilities and emerging technologies to keep pace with the growing need for radiation treatment until 2028. CCO engaged various stakeholders in developing key planning principles of this strategy. These principles include extending facilities' operating days for radiation treatment (12 hours per day on all equipment in large facilities, and 11 hours per day in facilities with fewer than six treatment machines), and maximizing the use of treatment capacity in radiation treatment facilities (including cross-LHIN movement of patients to ensure that patients receive high quality care close to home).

CCO will also work with the Ministry's Health Capital Investment Branch and hospitals to secure funding approvals in a timely manner to expand radiation treatment capacity where and when it is needed.

In addition, CCO had analyzed travel times for patients who received radiation treatment in 2016/17. Overall, the median travel time for all patients in Ontario who received radiation treatment was 25 minutes from their residence to the radiation treatment facility.

- *implement a program to increase physician awareness of the availability and benefit of radiation treatment;*
  Status: Fully implemented.

Details

Our 2017 audit found that CCO had set a province-wide target to administer radiation therapy to 48% of cancer patients at some point during their treatment. None of the LHINs met this target in 2015/16. CCO estimated that about 1,500 more patients could have benefitted from radiation therapy had its target been met in 2015/16.

In our follow-up, we found that CCO had worked with the regional cancer centres to increase physician awareness of the availability and benefit of radiation treatment through the following actions:

- CCO created an annual Radiation Utilization report that outlines the use of radiation treatment for patients in Ontario, variations in the use of radiation treatment among LHINs and within each LHIN, and differences between actual rates of patients treated and appropriate rates. CCO completed and shared the latest Radiation Utilization report with all regions in February 2019. This information was expected to help the regions better ensure that radiation treatment could be made available to every cancer patient who could benefit from it. The latest report showed that the provincial utilization rate of 34.1% fell short of CCO's benchmark and target rate of 35.5%, representing approximately 860 patients who could have benefited from radiotherapy but did not receive it. CCO recommended that the root causes of under-utilization and variable utilization should be explored on a hospital and diagnosis-specific basis. To increase physicians' awareness and potential benefits of radiotherapy, CCO suggested increasing outreach activities and locating radiation oncology presence in diagnosing institutions.

- The Regional Radiation Clinical Lead (RRCL) in each LHIN completed a year-end work plan for 2018/19. The RRCLs were responsible for improving radiation treatment through various initiatives. Initiatives to increase radiation utilization included collaborating with regional leads to leverage education sessions and outreach events, and monitoring and evaluating radiation utilization.

- *monitor reviews of radiation treatment plans to determine whether the reviews are done in accordance with clinical guidelines.*
  Status: Fully implemented.

Details

In our 2017 audit, we found that the review of radiation treatment plans by a second radiation oncologist in the early stages of radiation therapy is a quality-assurance process to ensure patient safety and treatment effectiveness, and to detect any errors before administering significant additional doses of radiation. However, hospitals did not consistently perform reviews of radiation treatment plans according to clinical guidelines. For example, 13% of curative treatment plans (intended to cure a cancer) were never reviewed, and another 11% were not reviewed within recommended time frames.

In our follow-up, we found that CCO had monitored reviews of radiation treatment plans, issuing the Peer Review Quality Assurance (PRQA) reports for radical radiation (aiming to cure a cancer) and palliative radiation (seeking to relieve pain and other symptoms) on a monthly basis, regionally and provincially. The February 2019 report showed that the indicators (the percentages of radical and palliative radiation peer reviews) had met the provincial targets. Specifically, the provincial radical peer review rate was 86.9%, above the target of 80%. The provincial palliative peer review rate was 56.9%, above the target of 35% CCO indicated it would continue to monitor these targets to ensure that performance improvements are sustained.

Cancer Surgery

Recommendation 2

To better ensure patients have timely and equitable access to cancer surgery, we recommend that Cancer Care Ontario work with the Ministry of Health and Long-Term Care and hospitals to:

- *analyze the reasons for delays in scheduling surgical consultations and performing urgent cancer surgeries;*
  Status: In the process of being implemented by March 2020.

Details

Our 2017 audit found long wait times for surgical consultations and cancer surgeries. Cancer surgeries with the worst wait-time performance were thyroid, head and neck, and prostate. For example, 10% of urgent thyroid patients waited longer than 31 days—three times longer than the target. CCO informed us that many factors can affect a hospital's ability to meet wait-time targets, including the availability of operating rooms, wait times for surgical preparations, such as MRIs and CT scans, and the complexity of patients' conditions.

In our follow-up, we found that as part of its performance review process for the fourth quarter of 2017/18, CCO requested each region to complete a volume variance analysis indicating the reasons for the increased cancer surgery wait times. The reasons for delay included bed capacity issues related to Alternative Level of Care and incidental cancellation of oncology surgeries; leaves of absence of physicians, nurses and other hospital staff; and lack of dedicated surgical oncology hospital beds. We also noted that in the second quarter of 2018/19, CCO identified hospitals that were the lowest performers and asked each of them to complete an Improvement Action Plan. In the initial phase, CCO required each of these hospitals to perform a root-cause analysis of low performance, and submit action plans with performance improvement strategies by March 2020. CCO indicated that it will continue to monitor performance via the Quarterly Performance Reviews.

- *take corrective action to reduce wait times for surgical consultations and cancer surgeries;*
  Status: Fully implemented.

Details

In our 2017 audit, we found long wait times for surgical consultations and cancer surgeries. For example, for urgent thyroid patients, 10% of patients waited longer than 31 days—three times longer than the target. Cancer surgeries with the worst wait-time performance were thyroid, head and neck, and prostate. These surgeries did not meet the wait-time targets at either the urgent or non-urgent levels.

In our follow-up, we found that CCO managed wait-time performance as part of the Quarterly Performance Review process. The CCO's Surgical Oncology Program had a number of new and/or ongoing initiatives and performance management strategies to monitor and reduce wait times for surgical consultations and cancer surgeries. For example:

- As part of its performance review process for the fourth quarter of 2017/18, CCO requested that each region complete a volume variance analysis indicating the reasons for the increased cancer surgery wait times. The reasons included bed capacity issues related to Alternative Level of Care (ALC) and incidental cancellation of oncology surgeries; leaves of absence of physicians, nurses and other hospital staff; and lack of dedicated surgical oncology hospital beds. In spring 2019, CCO escalated these concerns to the hospitals by issuing performance management letters to the regional vice presidents who manage regional cancer programs.
- CCO specified wait-time indicators for Priority 1 (emergent) and Priority 2 (urgent) cancer surgeries, and regions are required to report their performance on these indicators and develop future action plans. Additionally, quarterly surgical volumes will be shared in this report for monitoring purposes starting in the first quarter of 2019/20.
- CCO created an escalation process that sets internal targets to monitor performance on a quarterly basis. If poor performance is maintained over two quarters, CCO will request the hospital or region to analyze root causes and develop an improvement plan.
- CCO piloted and released the Annual Cancer Surgery Wait Times Trending Report in January 2019 to compare data at the provincial, regional and hospital levels. CCO also updated the Monthly Cancer Surgery Wait Times Trending Report, to monitor and manage regional wait times for cancer surgeries based on internal targets.
- CCO's Disease Pathway Management Program leads have been working together to understand access and volume trends for cancer surgery. The regional surgical oncology leads planned to meet in the fourth quarter of 2019/20 to review reasons for surgery delays to gain further insights.

When specific issues are identified in the Surgical Oncology Program, CCO will address them individually. For example:

- CCO's Surgical Oncology Program began supporting a pilot project in two hospitals in Toronto to transfer intermediate gynecological oncology cases from the hospital with higher surgical demand to the other hospital to improve wait times.
- CCO escalated the reporting of gynecological oncology surgery wait-time reports to every two weeks. This report is sent directly to each of the gynecological surgical leads at every gynecological center in the province. A re-referral/deferral process has been established for gynecological oncology access across the province. This was launched in February 2019. No patients had been re-referred or deferred at the time of our follow-up.

- *assess the benefits of having a centralized referral and booking process for cancer surgeries.*
  Status: Little or no progress.

Details

In our 2017 audit, we found that while some regions implemented a central referral and booking service for some cancer surgeries in an effort to improve wait times and access, this service was not consistently available for all cancer surgeries at all the LHINs.

In our follow-up, we found that the Ministry had not assessed the benefits of having a centralized referral and booking process for cancer surgeries, but it had been monitoring local efforts to test central intake for other areas of high demand services, including diagnostic imaging.

The Ministry was also supporting the expansion of tools and supports, such as eReferral, to improve the appropriateness of diagnostic imaging referrals, and to reduce demand growth for MRI and CT scans. The Ministry planned to continue to work with current local and provincial delivery partners to develop an approach for eReferral, which would include considering MRI and CT for centralized referral and booking. It could also include cancer surgeries in the future. In the Waterloo Wellington region specifically, work was under way to implement eReferral in the cancer services referral pathway for the 2019/20 fiscal year.

Cancer Drug Therapy

Recommendation 3

To better ensure patients have equitable and timely access to the cancer drugs they need, we recommend that the Ministry of Health and Long-Term Care work with Cancer Care Ontario to:

- *evaluate the operational efficiency of financial support programs for cancer drugs;*
  Status: Fully implemented.

Details

Our 2017 audit found that cancer patients who did not qualify for the Ontario Drug Benefit Program and needed financial support could apply for the Trillium Drug Program (Trillium). This program requires proof of annual household income to determine the coverage and deductible. In addition, Ontarians requiring many take-home cancer drugs, or other drugs not available on the Ontario Drug Benefit formulary, must have their physicians or nurse practitioners apply for authorization through the Exceptional Access Program (EAP). The application processes for these programs were manual and lengthy.

In our follow-up, we found that the Ministry had evaluated the operational efficiency of financial support programs for cancer drugs, and had implemented a number of changes to modernize, optimize and streamline the application processes for both Trillium and the EAP.

We also noted that the Ministry has taken the following actions to address these recommendations:

- The Ministry implemented a web-based IT solution called SADIE that will make drug request reviews through the EAP (including all cancer drugs) more efficient for prescribers and the Ministry. As of June 26, 2019, the SADIE is in full production and available to all prescribers to support patients' needs for appropriate and timely access to drugs covered through the EAP. Drug criteria are also accessible in SADIE to prescribers.
- The Ministry streamlined and expedited reviews of requests made through the EAP's Telephone Request Service that provides responses, typically the next business day, to requests for selected drugs, including some cancer drugs. The EAP made Rydapt (a type of cancer drug) available through the Telephone Request Service in October 2018. The Ministry indicated that most cancer drugs would be available through this service by October 2019, following staff training and stakeholder communication.
- The Ministry streamlined EAP approval by collaborating with manufacturers and other stakeholders to develop drug-specific request forms for new products. These new forms

enhance efficiency by collecting all of the information needed to assess a request, avoiding missing information.

- The Ministry enhanced transparency for drugs that could be considered by the EAP. To support prescribers making decisions about patient eligibility, the Ministry posts the provincial funding criteria for frequently requested EAP drugs publicly on its website, as well as updates when new drugs are added to the EAP or criteria are changed. In addition, the Ministry created an online search tool that allows the public to look up drugs to determine their availability through the EAP.

- *simplify and streamline the request and application process for financial support for cancer drugs.*
  Status: Fully implemented.

Details

Further to the Ministry's response to the previous action under **Recommendation 3**, we found that the Ministry had made applying for Trillium more efficient and flexible for patients, and used technology to optimize EAP applications, streamlining and enhancing criteria transparency. For example:

- As of May 1, 2018, the application for the Trillium Drug Program has included mandatory consent to verify income information with the Canada Revenue Agency (CRA) for the 2018/19 benefit year. Benefits for patients include:
  - faster application processing by reducing back-and-forth letters due to incomplete income information;
  - no requirement for annual paper proof of income and automatic renewal; and
  - no disruption to drug coverage due to delays in providing paper proof of income.
- The Ministry worked with the CanCertainty Coalition (representing more than 30 Canadian patient groups, cancer health charities, and caregiver organizations, joining together with oncologists and cancer care professionals to improve the affordability and accessibility of cancer treatment) and Canadian Cancer Society to develop and post information (including answers to frequently asked questions) on the Canadian Cancer Society's website to assist patients with understanding the Trillium Drug Program.

Recommendation 4

To better ensure cancer drugs are used by patients safely at home, we recommend that Cancer Care Ontario work with the Ontario College of Pharmacists, the Ministry of Health and Long-Term Care, and hospitals to:

- *establish education programs for cancer patients on safe usage and handling of take-home cancer drugs and monitoring programs to assist cancer patients on adhering to proper use of oral cancer drug therapy at home;*
  Status: In the process of being implemented by May 2020.

Details

We found in our 2017 audit that while patients using take-home cancer drugs should follow special instructions for administration and safe handling of oral cancer drugs, some patients were not adequately educated and monitored in the use of these drugs.

In our follow-up, we found that CCO had established a Pharmacy Oncology Task Force to examine Ontario's pharmacy service model for take-home cancer drugs. The mandate of this Task Force was to deliver recommendations and advice to CCO on potential provincial pharmacy service models for take-home cancer drugs that optimize safe, high-quality, patient-centred care. This included recommendations on patient and provider education on safe medication use, toxicity monitoring and adherence to proper use. To ensure comprehensive input, the Task Force included representation from various stakeholder

groups, including clinicians, patients, pharmacists and the Ontario College of Pharmacists.

In December 2018, CCO met with the Ontario College of Pharmacists to provide an update on the work of the Oncology Pharmacy Task Force. The draft report of the Task Force was completed and provided to the Ministry on March 25, 2019. The Ministry provided comments on the report for consideration by CCO to determine next steps, including patient education and timelines for delivery. The final report was posted on the CCO's website on April 25, 2019.

We also noted that CCO had taken the following actions to address this recommendation:

- CCO, in partnership with the de Souza Institute, developed education modules for oral chemotherapy. CCO has been working with an external partner hospital to determine if it can develop an online version of the education modules, to be available on the CCO website. It was expected to be launched by the first quarter of 2020/21. If the modules are not ready for the website by the anticipated date, CCO will implement a mitigation strategy and ensure that electronic versions of the education modules are available for download to patients and families.
- As part of CCO's 2018/19 Systemic Treatment Program's quality initiative work, the Regional Cancer Programs (RCPs) were asked to improve monitoring and adherence for oral chemotherapy. RCPs would develop local initiatives to enable or enhance regular toxicity monitoring, as well as assessment of patient adherence to treatment. RCPs that identify patient education as a gap could develop specific education programs on take-home cancer drugs. This is a multi-year project; in 2018/19, funding was allotted for a current-state survey, as well as gathering baseline data and developing a project charter. All RCPs submitted their project charters by May 1, 2019, and they were approved. RCPs have started the implementation phase of the projects planned for the 2019/20 fiscal year. Final evaluation of the projects is due by May 1, 2020.

- *evaluate whether to require that pharmacists who dispense cancer drugs receive specialized cancer-drug-therapy training and are familiar with cancer therapy regimens, including oral cancer drug regimens.*

  Status: Fully implemented.

Details

Our 2017 audit found that take-home cancer drugs could be dispensed by any pharmacy in Ontario. In comparison, Alberta required that take-home cancer drugs be dispensed only at designated pharmacies by pharmacists who are specially trained in cancer drug therapies and dosages.

As mentioned above, CCO had established a Pharmacy Oncology Task Force to examine Ontario's pharmacy service model for take-home cancer drugs. The Task Force made recommendations on provider (including pharmacist) training and competencies. The draft report by the Task Force was completed and provided to the Ministry on March 25, 2019. The Ministry provided comments on the report for consideration by CCO to determine next steps, including patient education and timelines for delivery. The final report was posted on the CCO's website on April 25, 2019. CCO has initiated discussion with the Ontario College of Pharmacists about any training and education programs required for pharmacists.

CCO was also developing the Regional Systemic Therapy Program Standards for Training and Education for Providers. These evidence-informed standards have been finalized and published, and can be accessed through the CCO's website.

Recommendation 5

To help ensure cancer patients receive safe cancer drug therapy, we recommend that the Ministry of Health and Long-Term Care:

- *work with Cancer Care Ontario to evaluate the need to set standards and oversee delivery of cancer drug therapy at private specialty clinics;*
  Status: Little or no progress.

Details

We found in our 2017 audit that many private clinics were not regulated or licensed by the Ministry or CCO, and not subject to the same level of oversight and standards as hospitals for cancer drug therapy. They were not required, for example, to have an on-site emergency department, nor did they have to employ oncologists or nurses specialized in oncology to provide cancer services.

In our follow-up, we found that the Ministry had not worked with CCO to evaluate the need to set standards and oversee delivery of cancer drug therapy at private specialty clinics. The Ministry indicated that it would meet with CCO to discuss this recommendation, as standards would presumably be required in order to inspect private specialty clinics that perform cancer drug therapy.

- *work with the College of Physicians and Surgeons of Ontario to evaluate the feasibility to include cancer drug therapy treatments in its inspections on private specialty clinics.*
  Status: Little or no progress.

Details

Our 2017 audit found that Ontario's College of Physicians and Surgeons (College) did not have the authority to inspect or assess the delivery of cancer drug therapy at private specialty clinics.

In our follow-up, we found that the Ministry had not worked with the College to evaluate the feasibility of including cancer drug therapy treatments in its inspections of private specialty clinics. The Ministry indicated that the *Oversight of Health Facilities and Devices Act, 2017*, legislation regarding oversight of community health facilities, has not moved forward. The proposed Act was designed to consolidate oversight of independent health facilities and out-of-hospital premises. It is also expected to enable the expansion of oversight to non-regulated facilities and services, including private specialty clinics. The Ministry planned to continue working with the College to explore the feasibility of including cancer drug therapy treatments in the College's inspections on private specialty clinics.

Recommendation 6

To better ensure cancer patients receive safe and accurate doses of cancer drugs, we recommend that the Ministry of Health and Long-Term Care (Ministry) work with the Ontario College of Pharmacists and hospitals to implement the remaining recommendations from the Ministry's review of the provincial cancer-drug-supply system, especially to address inadequacies in communication and implementation of drug specifications and preparations.

Status: In the process of being implemented by December 2019.

Details

We found in our 2017 audit that, after 1,000 patients at four hospitals received lower-than-intended doses of two cancer drugs in March 2013, the Ministry conducted a review of the province's cancer-drug supply system. The Ministry made 12 recommendations to address the root cause of the incident. While most of the recommendations had been addressed, we noted that one, to ensure traceability of computer-based clinic and hospital records for patients and their treatments, remained a concern.

In our follow-up, the Ministry informed us that all recommendations that could be implemented directly by the Ministry had been completed or were near completion. Regarding traceability of computer-based clinic and hospital records, the Ministry indicated it would liaise with partners (including Health Canada, College of Pharmacists of Ontario, Ontario Hospital Association, and CCO) to help determine whether this recommendation could be considered complete by December 2019.

Recommendation 7

To help ensure a stable and effective supply of cancer drugs, we recommend that Cancer Care Ontario work with the Ministry of Health and Long-Term Care and hospitals to:

- *improve the process for sharing information on drug shortages and inventory;*
  Status: Fully implemented.

Details

We found in our 2017 audit that while the LHINs were supporting local communication among hospitals and hospital pharmacies, there was no provincial communication network connecting all hospital pharmacies in Ontario. Neither the Ministry nor CCO had policies on appropriate levels of cancer drugs that hospitals should keep in their inventories.

In our follow-up, we found that the Ministry and CCO improved the process for sharing information about drug inventory and potential shortages, including information about cancer drugs. For example:

- They gathered information through participation on national and provincial stakeholder committees such as the Provincial/Territorial Drug Shortages Task Team and Canadian Association of Provincial Cancer Agencies' Drug Supply Disruption Team.
- They provided regular updates to stakeholders via drug shortage memos with information about supply status, duration of shortage and patient prioritization.
- They posted Ontario Drug Stock Monitoring materials on the Ministry's online tool to share information with stakeholders. This website includes update memos issued by the Ministry and CCO on drug shortages and manufacturer information, as well as other resources.

CCO also supported the Ministry managing inventory at LHINs. The Ministry developed and launched an inventory-tracking tool called DSTrack to collect real-time inventory information about cancer and non-cancer drug shortages. The LHIN Drug Leads are responsible for populating this tool, which can also be used to share drugs between the LHINs.

- *establish a protocol for communication, drug-sharing and prioritizing patients in the event of a cancer-drug shortage.*
  Status: In the process of being implemented by March 2020.

Details

Our 2017 audit found that Ontario established no clear provincial protocol or guideline that hospitals, CCO or the Ministry could use to manage drug shortages. Specifically, nearly 78% of hospitals that responded to our survey indicated that the Ministry, LHINs and CCO should more actively provide help and guidance to hospitals during cancer-drug shortages.

As mentioned above, the Ministry and CCO implemented routine practices for stakeholder communication and drug-sharing at the provincial level. A protocol to prioritize patients, which relies on information including the specific cancer drug shortage, and an impact assessment with advice from provincial cancer leads/clinical experts have been implemented.

CCO also developed an action plan for drug shortages that includes consultation with stakeholders to refine and formalize the current process. In addition, CCO drafted a protocol to manage responses during drug shortages. CCO planned to review the protocol and its communications approach with the Ministry. The protocol is expected to be finalized with regional and provincial cancer leads by March 2020.

Specialized Cancer Treatment and Supportive Services

Recommendation 8

To better ensure the needs of cancer patients requiring stem cell transplants are met in a timely and equitable

manner, we recommend that the Ministry of Health and Long-Term Care work with Cancer Care Ontario and hospitals to assess the need for additional capital projects, and streamline and expedite the review and approval processes for capital funding to expand capacity for stem cell transplants in Ontario.

Status: Fully implemented.

Details

We found in our 2017 audit that while inadequate capacity for stem cell transplants has been raised as an issue since 2009, the Ministry, CCO and hospitals did not develop a capital-investment plan until 2016 to address the issue. The four capital expansion projects approved in 2016 require further approvals for each phase. These subsequent approvals were delayed, even though the Ministry indicated that stem cell projects were its top priority.

In our follow-up, we found that the Ministry had expedited planning and construction for investment projects in the following six facilities after assessing the need for increased access to stem cell transplants:

1. University Health Network/Princess Margaret Hospital
2. The Ottawa Hospital
3. Hamilton Health Sciences
4. Sunnybrook Health Sciences Centre
5. London Health Sciences Centre
6. Hospital for Sick Children

To expedite the review and approval for projects that addressed stem cell transplant capacity, the Ministry's Health Capital Investment Branch streamlined the capital planning process by combining planning, where feasible. This included combining Stage 1: Proposal and Stage 2: Functional Program and/or combining design and drawing Stages 3.1 and 3.2, where feasible. In one project, Stages 1 through 3 were combined to expedite the planning process.

Recommendation 9

To better ensure cancer patients' symptoms are monitored, managed and treated properly and in a timely manner, we recommend that Cancer Care Ontario work with hospitals to assess symptom-management programs in other jurisdictions and determine whether similar programs can be implemented in Ontario to divert cancer patients from emergency rooms.

Status: Fully implemented.

Details

We found in our 2017 audit that support services in Ontario were inadequate to help ease patient symptoms and side-effects during cancer treatment, and lagged behind those of other jurisdictions, such as Manitoba and the U.S. As a result, many cancer patients visited hospital emergency rooms at least once during their treatment.

In our follow-up, we found that CCO had assessed symptom-management programs in other jurisdictions and started the following initiatives to divert cancer patients from emergency rooms:

- CCO developed a framework for Patient Reported Outcomes through consultation with clinical experts, regional cancer centre staff, and patient and family advisors. The framework allows patients to focus on what is most relevant to their experience, help identify issues early, track symptoms over time and improve outcomes. The framework also facilitates conversations with care providers and increases patient involvement in care. The pilot of this framework was implemented for head and neck cancer patients in two cancer centres in March 2019.
- CCO developed a toxicity management model of care and released related recommendations in the fourth quarter of 2017/18. A Steering Committee was formed to oversee the implementation of the model. Examples of actions to implement the recommendations include: improving symptom monitoring by developing an electronic tool (eTool) for patients to alert their healthcare team when symptoms need attention; improving service by triaging patients based on their symptoms to decrease emergency department visits;

and improving self-management by helping patients to understand and manage their symptoms and side-effects at home, when appropriate. The eTool project was expected to be launched by April 2020. With changes in the provincial health-care system and the transition of CCO into Ontario Health, the eTool project will go to Ontario Health for approval. As such, the timeline may change depending on the direction given.

- CCO, through a competitive process, entered into a contract with a vendor to provide 24/7 oncology nursing support to cancer patients to address patients' toxicity issues and reduce the use of emergency rooms. All cancer patients being treated or monitored by a medical or radiation oncologist in Ontario would have access to this service when it is fully implemented. At the time of our follow-up, this service had been implemented in 23 hospitals. CCO planned to continue working with the vendor to implement 24/7 oncology nursing support for the remaining 51 hospitals by December 2019.

Recommendation 10

To help ensure cancer patients receive sufficient and consistent psychosocial services across the province, we recommend that Cancer Care Ontario work with hospitals to:

- *develop and implement a long-term strategy to finance and expand psychosocial oncology services available to cancer patients;*
  Status: In the process of being implemented by April 2020.

Details

We found in our 2017 audit that according to the Canadian Association of Psychosocial Oncology, as many as 40% of cancer patients required help from specialized professionals in addition to their medical treatment. However, we noted that in 2016/17, only 5.8% of patients received consultations with dietitians, and only 6.6% received consultations with social workers.

In our follow-up, we found that CCO's Psychosocial Oncology Program had collaborated with its Capacity Planning team to develop a long-term strategy, as well as capacity and human resource recommendations for each of the specialized disciplines related to psychosocial services. Initial analysis was completed for social work and dietetics. Capacity planning for the remaining disciplines (speech language pathology, occupational therapy, physical therapy, psychology) was expected to be complete by April 2020.

In addition, to further understand and manage resources, CCO incorporated psychosocial services into its new Quality-Based Procedure funding model for radiation patients. This requires expert panels to quantify radiation patient needs for psychosocial services for each specialized discipline.

- *establish provincial standards for the delivery of psychosocial services in Ontario.*
  Status: Fully implemented.

Details

Our 2017 audit found that psychosocial oncology services were not consistently available to patients across the province. More than half of the 14 regional cancer centres did not have a dedicated psychiatrist, occupational therapist, psychologist, or physiotherapist on site.

In our follow-up, we found that CCO had released a report called Recommendations for the Delivery of Psychosocial Oncology Services in Ontario to specify the standard of psychosocial care expected for cancer patients, and their family members. This report aimed to ensure the range of necessary psychosocial services were provided consistently and in a timely way to all cancer patients and their families in Ontario. Recommendations in this report were built on a foundation of person-centred care principles and core values, as well as existing models of care across Canada. The service delivery framework was released in the first quarter of 2018/19 and was available on CCO's website.

Cancer Diagnostic Procedures

Recommendation 11

To better ensure that cancer patients benefit from PET scans for diagnosis and treatment, we recommend that the Ministry of Health and Long-Term Care work with Cancer Care Ontario to:

- *streamline and expedite the processes for adopting and funding new radioactive tracers in PET scanning, including updating the eligibility criteria for OHIP-insured PET scan services;*
  Status: In the process of being implemented by December 2019.

Details

We found in our 2017 audit that, since 2013, Ontario had not updated the eligibility criteria for OHIP coverage of PET scans, which covered only patients with very specific medical conditions and diagnostic needs. We also noted that Ontario had been slow to adopt new radioactive tracers, even though a number of them had been used in PET scans in other jurisdictions.

In our follow-up, we found that the Ministry and CCO had streamlined and expedited processes for adopting and funding new radioactive tracers in PET scanning. For example:

- A new PET scan radioactive tracer for neuroendocrine cancer patients obtained Health Canada and Ontario Cancer Research Ethics Board approvals in the fourth quarter of 2018/19, and has been available for use since mid-March 2019.
- A new radioactive tracer for PET scans for recurrent prostate cancer had been available at two of six hospital sites across the province. The remaining four sites were in the final stages of approval to provide PET scans. Full implementation was expected by December 2019.

- *increase awareness of the availability of PET scanning and its usage in some clinical scenarios.*
  Status: In the process of being implemented by December 2019.

Details

Our 2017 audit found that 41% of the province's PET scan capacity was unused in 2016/17, suggesting that more patients could have received and potentially benefited from PET scans without adding more PET scanners. The Cancer Quality Council of Ontario reported that PET utilization was likely affected by physician awareness and referral patterns.

In our follow-up, we found that the CCO had developed and distributed referral forms with all eligibility criteria for PET scans. By having all eligibility criteria on one form, referring physician specialists have all the information they need in one location and are able to refer their patients for scans more easily.

In addition, CCO had been re-developing the website (**www.petscansontario.ca**) to better guide physicians and patients to information relevant to patient care and referrals. CCO planned to publicly post all referral forms. In May 2019, CCO started testing the website and launched it in June 2019.

To support targeted outreach to referring physicians where PET scans were underused (for lymphoma, for example), CCO planned to update previous analyses to understand where there are higher rates of patients who are not having a PET scan. This information would inform discussions with relevant specialists to make them aware of recommended practice, provide them with the tools to support referrals, highlight the clinical benefits to their patients of PET scans to inform care, and understand potential barriers to referrals. A comprehensive communication plan was expected to be finalized by the end of December 2019.

Recommendation 12

To better ensure cancer patients receive timely and equitable access to CT scans and MRIs, we recommend that the Ministry of Health and Long-Term Care work with Cancer Care Ontario and hospitals to:

- *analyze the reasons for delays in scheduling CT scans and MRIs and take corrective actions to reduce wait times for cancer patients;*
  Status: In the process of being implemented by March 2020.

Details

We found in our 2017 audit that only 59% of CT scans and 51% of MRIs for cancer patients were performed within the Ministry's wait-time targets. We also noted significant wait-time variations among hospitals. For example, cancer patients had to wait up to 49 days for CT scans at one hospital, compared to up to 11 days at another hospital just five kilometres away.

In our follow-up, we found that the Ministry worked with CCO to reduce unnecessary demand for MRI and CT by developing indicators to measure referral practices. CCO carried out a preliminary analysis of referral appropriateness for MRI and CT, and made recommendations on what indicators would be needed to accurately quantify appropriateness of referrals. Once the Ministry had the necessary data, it planned to compare referrals across Ontario, quantify the impact of inappropriate referrals on wait times, and identify key drivers of inappropriate demand. The Ministry would then use this information to develop a plan to reduce inappropriate referrals.

Indicators to measure referral appropriateness were expected to be finalized by December 31, 2019. A plan to improve referral appropriateness was targeted for completion by March 2020.

- *implement centralized referral and booking processes for cancer-related CT scans and MRIs.*
  Status: Little or no progress.

Details

Our 2017 audit found that cancer patients experienced significant variations in wait times for CT scans and MRIs, depending on the hospital. In addition, many waited longer than the Ministry's target of 10 days. The significant wait-time variations were due mainly to the lack of a centralized referral and booking system to help smooth volumes among hospitals.

In our follow-up, we found that the Ministry had not implemented centralized referral and booking processes for cancer-related CT scans and MRIs. However, the Ministry had started taking other actions such as monitoring local efforts to test central intake for high-demand services (including diagnostic imaging). The Ministry was also supporting the expansion of tools, such as eReferral, which uses electronic communication among providers to improve appropriateness of diagnostic imaging referrals. The Ministry will continue to work with current local and provincial delivery partners to develop an approach for eReferral, including consideration for centralized referral and booking processes for MRIs and CT scans.

Recommendation 13

To better ensure cancer patients receive quality diagnostic-imaging services, we recommend that the Ministry work with Cancer Care Ontario and the hospitals to implement a province-wide mandatory peer-review program based on the recommendations of Health Quality Ontario.

Status: In the process of being implemented by March 2020.

Details

We found in our 2017 audit that the number of reviews of diagnostic-imaging results by a second radiologist was inadequate, even though misinterpretation of results in 2013 led to several incorrect diagnoses in Ontario. We noted that 48% of hospitals we surveyed did not perform regularly scheduled reviews of diagnostic images. The Ministry had not taken steps to implement the province-wide peer-review program recommended by Health Quality Ontario (HQO).

In our follow-up, we found that the Ministry had been working with HQO to implement the peer-review program. In March 2019, HQO engaged the Joint Department of Medical Imaging (formed by the University of Toronto, Sinai Health System, the University Health Network and Women's College Hospital) to develop a provincial Radiology Peer Learning Program. The program would foster continuous quality improvement in diagnostic imaging, improved care, and enhanced patient outcomes and experiences. The Ministry indicated that ongoing engagement of clinicians and expansion of the Learning Program is expected to be completed by March 2020.

Recommendation 14

To better ensure cancer patients receive timely diagnostic services, we recommend that the Ministry of Health and Long-Term Care work with Cancer Care Ontario and the hospitals to:

- *regularly track and monitor wait times of biopsies performed in clinics and hospital procedure rooms, as well as those done in hospital operating rooms;*
  Status: In the process of being implemented by March 2020.

Details

We found in our 2017 audit that limited biopsy wait-time data was available in Ontario, because CCO only tracked wait times for biopsies performed in hospital operating rooms, and not those done in clinics or hospital procedure rooms.

In our follow-up, we found that CCO had been working to identify barriers to diagnostic services and improve data collection of biopsy surgery procedures. CCO planned to provide recommendations and digital options or solutions by March 2020. Recommendations and options would be aimed at improving wait-time information on biopsy procedures for performance management purposes.

- *develop strategies to reduce the wait times for biopsies performed in hospital operating rooms.*
  Status: Little or no progress.

Details

Our 2017 audit found that fewer than half (46%) of biopsies performed in hospital operating rooms were done within the Ministry's target wait time of 14 days. Ten percent of patients waited 78 days, or almost six times longer than the target.

As mentioned above, the Ministry indicated that strategies to improve wait times would be developed once more complete and actionable biopsy data was available. In the interim, CCO had begun engaging with clinical leadership to understand areas of focus and data requirements.

Funding Cancer Treatment Services

Recommendation 15

To better ensure radiation funding is equitable and reflects the actual services delivered by hospitals, we recommend that the Ministry of Health and Long-Term Care work with Cancer Care Ontario to evaluate and revise existing funding methods for radiation treatment so as to fund hospitals based on a consistent rate and actual services delivered.

Status: In the process of being implemented by April 2021.

Details

We found in our 2017 audit that both the Ministry and CCO funded hospitals for radiation services, but they did not use a consistent method or rate to determine amounts, which resulted in inequitable funding among hospitals. CCO acknowledged that the funding approach for radiation treatment required revisions to ensure consistent and equitable funding for hospitals.

In our follow-up, we found that CCO had evaluated funding methods for radiation treatment, and submitted a Radiation Quality-Based Procedures (QBP) Business Case to the Ministry in January 2018. QBPs are health-care services for which

evidence-based best practices have been defined; providers are compensated for those services based on an established price. The Ministry indicated that it would work with system partners to explore introducing radiation treatment as a QBP in future years. The QBP for radiation treatment is expected to be implemented on April 1, 2021, pending the Minister's approval.

Recommendation 16

To better ensure that funding for cancer drug therapy is appropriate and reflects the actual services delivered by hospitals, we recommend that Cancer Care Ontario fund hospitals using a consistent methodology that is not historically based.

Status: Fully implemented.

Details

We found in our 2017 audit that from 2014/15 to 2016/17, CCO provided hospitals a total of $107 million for cancer drug therapy based on historical funding rather than service volumes.

In our follow-up, we found that CCO had provided detailed analyses to hospital CEOs, informing them that historical-based funding for cancer drug treatment would be eliminated. The CCO also worked with the Ministry to recalculate the historical-based funding and articulated this in the Ministry's 2018/19 funding letters to hospitals. Therefore, all hospitals are now receiving funding based on services delivered and the complexity of those services, eliminating any funding variation, inconsistency and unfairness.

Recommendation 17

To better ensure that cancer treatment services are delivered effectively and efficiently to meet patient needs, we recommend that the Ministry of Health and Long-Term Care:

- *incorporate a component of performance-based funding in the current funding model to provide incentives for improving the performance of the cancer system in Ontario;*

  Status: In the process of being implemented by December 2019.

Details

We found in our 2017 audit that cancer funding from CCO to hospitals, and from the Ministry to CCO, was volume-based or fixed. None of the CCO funding to hospitals was tied to how well they perform against measures, such as wait times and quality of services. Similarly, none of the Ministry funding to CCO was linked to CCO's performance compared to provincial cancer-program targets.

In our follow-up, we found that the Ministry had been exploring opportunities to incorporate performance-based funding in its current hospital funding model, based on lessons learned internationally and from Ontario's Emergency Department Pay-for-Results program. This initiative was piloted in acute care hospitals across the province from April 2018 to April 2019. The pilot program used a shadow-billing approach to demonstrate how performance on a small set of quality indicators would theoretically impact hospital funding. The Ministry planned to review the pilot indicators as part of the evaluation, and the inclusion of cancer-specific indicators would be explored at that time. An evaluation of the pilot was expected to be finalized in December 2019. The Ministry also indicated that it was in the process of exploring applying the performance assessment approach to Ontario Health Teams.

- *provide Cancer Care Ontario with timely funding decisions for proper planning and budgeting of cancer services.*

  Status: Fully implemented.

Details

Our 2017 audit found that the Ministry did not provide cancer funding to CCO on a timely basis. Our review of the Ministry's funding letters to CCO between 2012/13 and 2016/17 showed that CCO

only received formal financial commitments either in the middle or toward the end of the fiscal year.

In our follow-up, we found that the Ministry began the 2018/19 CCO Master Accountability Agreement approvals process in December 2017 and received Minister's approval confirming funding in the first quarter of 2018/19. This was an improvement from our 2017 audit which indicated that CCO had only received funding commitments later in the fiscal year.

Accountability and Oversight of Ontario's Cancer Programs

Recommendation 18

To better ensure regional cancer programs are managed and operated by regional vice presidents (RVPs) effectively and efficiently to meet patient needs, we recommend Cancer Care Ontario:

- *work with hospitals to assess and improve the current reporting and accountability structure for RVPs;*
  Status: Fully implemented.

Details

We found in our 2017 audit that while CCO relies on the 14 RVPs to drive performance improvements and integrate cancer care across Ontario, 12 of the 14 RVPs had other full-time responsibilities, in addition to managing their regional cancer centres and cancer programs. With these additional responsibilities, it was difficult for RVPs to devote sufficient time to collaborate with system partners in their regions to improve cancer performance.

In our follow-up, we found that CCO had assessed and improved the reporting accountability structure for RVPs. In April 2018, CCO revised the role description for RVPs, and received endorsement from hospital CEOs for the revision. This revised role description articulates the reporting structure and accountabilities of the RVP role. The RVP plays an integral role in the co-ordination of cancer care across Ontario by being jointly accountable to the President and CEO of CCO, and the President and CEO of the hospital. The role supports provincial, regional and organizational planning. Collectively, RVPs and CCO's Executive Team form the Provincial Leadership Council (PLC) for cancer care, which guides the development and implementation of provincial and regional cancer strategies. The PLC works in tandem with CCO's Clinical Council, which represents CCO's clinical leadership, to identify clinical best practices and quality initiatives necessary for safe, high-quality cancer care.

Overall, the RVP is responsible for executing, at the provincial and regional levels, the vision, mission, and goals of CCO, as well as championing and influencing system transformation of the cancer system in the region.

- *work with hospitals to assess the performance of RVPs on an annual basis against program objectives and targets;*
  Status: Fully implemented.

Details

Our 2017 audit found that CCO policy required the hospitals and CCO to jointly assess and document the performance of each RVP annually. However, we noted that CCO did not always conduct the required annual performance evaluations of the RVPs. CCO only assessed half of the 14 RVPs in 2016, three of whom had not been assessed for three years.

In our follow-up, we found that CCO had completed all RVP performance evaluations for 2018/19. CCO had also updated the performance review process, including the reporting template and a 360-degree feedback questionnaire (which gathers feedback from an employee's subordinates, colleagues and supervisors) to align with the role description of the RVPs.

- *collaborate with the Ministry of Health and Long-Term Care and Local Health Integration Networks when establishing priority indicators*

and targets to minimize competing demands between cancer and other programs.

Status: Fully implemented.

Details

Our 2017 audit found that CCO established performance indicators and annual improvement targets in collaboration with its RVPs, but neither the Ministry nor the LHINs participated in this process. In addition, CCO only met with the executive management of hospitals once a year, and no Ministry or LHIN staff attended these meetings. As a result, cancer programs often competed with other hospital programs and priorities for shared services.

In our follow-up, we found that CCO had collaborated with the Ministry and LHINs when establishing priority indicators and targets. In developing the 2019/20 priority indicators, CCO asked RVPs to share the indicators with stakeholders (including CEOs and LHINs) for feedback. Additionally, CCO met with the Ministry to discuss the 2019/20 targets in June 2019. CCO planned to continue working with the Ministry to assess any further opportunities to build on this process.