Saskatchewan Cancer Agency Review

Phase One Report

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Executive Summary

Saskatchewan Health intends to commission reviews of a number of health organizations each year as part of its accountability role.

A small team of experienced consultants was appointed by Saskatchewan Health: Acute and Emergency Services to undertake this review.

This Report summarizes the exploratory phase of the review of the Agency. In this Phase, recommendations are made in governance and mandate areas and a high level assessment of the operations of the Agency was completed to identify specific areas for a more detailed and focused review in a further phase.

This exploratory phase involved Board members and staff of the Agency, and management staff of the Saskatchewan Health and the two larger health regions. It was completed using a combination of documentation review and key informant interviews.

Findings and opinions are noted, and specific recommendations for action are provided for discussion between the Department, the Agency and other key partners. The recommendations are grouped into seven strategic focus areas:

- Mandate
- Governance
- Clinical Governance / Leadership
- Research
- Partnerships / Relationships with RHAs
- Financial Management
- Pharmaceutical Policy

The recommendations are summarized in Section 3.0 and include changes in the legislation and mandate of the Agency within a provincial cancer control strategy, adjustments to the Board composition to reflect similar changes in regional board composition, the need for a significant focus on clinical governance within the management system and, the development of a clinical directional plan.

Further recommendations address the need for more formal agreements about roles and protocols to support the shared nature of the prevention, diagnosis, treatment and care of cancers, changes to the funding mechanisms to reflect key cost-escalators and the need for longer term capital investment strategies, and support for processes to improve the management of cancer drugs that are subject to rapid change and generate significant cost pressures. Finally there is a recommendation that the practice of Regions charging the Agency for clinical services be discontinued.

1.0 Introduction

1.1 Background

This review has been requested by the Department of Health. It is the first of a number of reviews intended to be conducted in the province as part of an ongoing process.

Saskatchewan's health system has undergone substantial change since the passing of *The Cancer Foundation Act* in 1979, including a renewed focus on governance and accountability and the establishment of larger regional health boards. Several aspects of the 1979 legislation require the Agency to have a different relationship with the government than the regional health authorities (RHAs).

In addition, technological advancements in cancer drugs and equipment, along with highly specialized human resource requirements, make cancer treatment highly inflationary. Despite increases in funding, the rising costs of cancer treatment continue to challenge the Agency in managing the growth and costs of its cancer programs and services for the province.

This situation signals the need to revisit the mandate and priorities of the Saskatchewan Cancer Agency (SCA) and to establish an enduring mandate that will position Saskatchewan to deliver high quality, sustainable cancer prevention and treatment services into the future.

1.2 Project Scope and Deliverables

This project is being conducted in two phases**. In Phase One** we address governance and mandate questions and conduct a high level assessment of the operations of the Agency to identify areas for more detailed and focused review in phase two.

Areas reviewed:

- Legal and practiced interpretation of mandate and powers,
- Exercise of governance accountability,
- Relationships and relative roles with key partners,
- Clinical governance issues,
- Optimal delivery structures and processes,
- Optimal governance and management structures,
- Contemporary management practices,
- Desirable range of programs and services,
- Related human resource requirements and allocation,
- Appropriate pharmaceutical coverage policies.

Specifically, this brief report outlines the results of Phase One. It includes:

- a brief overview of the process used to conduct the review;
- findings and recommendations ,
- suggestions for more detailed review in Phase Two.

1.3 Overview of Process

This phase of the review was conducted using a combination of review of documentation and key informant interviews. The overall approach and timelines included:

- Initial meetings with Department and Agency leaders to clarify objectives and scope.
- Site visits and meetings with key informants (Appendix A)
- Collection and review of backgroundand comparative information (Appendix B)
- Working group sessions with the consultants, agency and department representatives.
- Draft report preparation
- Review of recommendations and finalized summary report

2.0 Findings and Recommendations

The Saskatchewan Cancer Agency has a proud history, one that began even before its inception in 1979. It was an early leader in Canada in the use of cobalt therapy and in the use of many other modalities for cancer treatment. The CEO is an active participant in CAPCA and in recent years the Agency has moved to develop a total cancer strategy in line with the Canadian Strategy for Cancer Control.

Today, Cancer treatment in Saskatchewan is provided through a combination of services from the Regional Health Authorities and the Cancer Agency. Broadly stated:

- Treatment planning, chemotherapy and radiation therapy are provided by the SCA,
- The Regions, primary care physicians and others provide a broad range of prevention, diagnostic, treatment, supportive and end of life care

Depending on the type and stage of cancer, a patient may have a combination of services and treatments from a number of providers.

The SCA also partners with the regions to deliver the Community Oncology Program of Saskatchewan (COPS) , which allows patients to receive chemotherapy in COPS centres close to their home communities.

The SCA operates two cancer clinics: the Saskatoon Cancer Centre (SCC) and the Allan Blair Cancer Centre (ABCC) in Regina. These clinics are co-located with hospitals governed and administered by their respective health authorities. They operate on an outpatient basis, Monday to Friday, 8:30 am to 4:30 pm. Each clinic has a New Patient Office (NP) to accept referrals, book appointments, and ensure timely and appropriate follow up of cancer patients.

Other services provided through the Cancer Centres include:

- Public education related to prevention, early detection and treatment of cancer;
- Early cancer detection through the Screening Program for Breast Cancer (SPBC) and the Prevention Program for Cervical Cancer (PPCC);
- Support services to assist in the social, emotional and economic needs of patients;
- Delivery of a provincial Malignant Hematology / Stem Cell Transplant Program, which provides assessment and treatment of aggressive or advanced blood cancers;
- Management of cancer patient lodges, which provide room and board for out-of-town patients undergoing treatment at the cancer centres in Regina and Saskatoon;
- Participation in clinical trials research sponsored by the National Cancer Institute of Canada, North Central Cancer Treatment Group, Radiation Therapy Oncology Group and the Children's Cancer Group, among others; and
- Laboratory research carried out in the Saskatoon Cancer Centre Research Unit.
- Cancer Registry and surveillance.

Saskatchewan Health vision and the SCA vision

The Saskatchewan Health Performance Plan is built on *The Action Plan for Saskatchewan Health Care*. The plan identifies a vision statement, *Building a province of healthy people and healthy communities,* and four goals:

- Improved access to quality health services;
- Effective health promotion and disease prevention;
- Retain, recruit and train health providers; and

- A sustainable, efficient, accountable, quality health system.

The SCA vision is: “Excellence in patient care and cancer control”. The SCA mission is: “To deliver effective and sustainable research, education, prevention, early detection, treatment and supportive care programs for the control of cancer in Saskatchewan”.

The SCA Strategic Plan “*A Proud History * A Planned Future*” reflect the Department’s vision and goals and specifies through its strategic directions and action plan the strategy proposed to move the organization forward.

Our findings and recommendations are summarized into a number of interrelated sections:

- Mandate
- Governance
- Clinical Governance / Leadership
- Research
- Partnerships / Relationships with RHAs
- Financial Management
- Pharmaceutical Policy

2.1 Mandate

The SCA mandate has evolved through a combination of the Act that formed it, subsequent legislation, and direction from Saskatchewan Health through the Accountability Frameworks and Operational Plan Reviews. Its mandate has also been impacted by changes in the political and social environment including the development of Regional Health Authorities (RHA’s) which have a different legislative and regulatory framework.

The Agency is also facing a number of other pressures, including; increased demand due to the aging of the population and the increase in survival rates, increased focus on quality of care / medico-legal issues, accountability and privacy issues; pressure to balance increasing urbanization with demands for local access in a large province with a small population.

The Agency has also responded to a national and international movement towards a comprehensive cancer control approach. Within Canada this has been led by CSCC (the Canadian Strategy for Cancer Control) which is a partnership of CAPCA, the Canadian Cancer Society, Health Canada and the National Cancer Institute of Canada. This calls for a comprehensive, coordinated approach to the full spectrum of cancer control.

To ensure consistency of direction, the SCA’s long-term goals need to be fully aligned with those of the province and province-wide concerns have to be addressed collaboratively. This requires updating legislation, clarifying and aligning expectations and understandings, and clearly communicating the results.

2.1.1 Findings

Comparison of Cancer Foundation Act with the Regional Health Services Act

The Cancer Foundation Act 1979 (last amendment 1997) makes the Agency ultimately responsible for the care provided to all Saskatchewan residents diagnosed with cancer. Section 4 of the Act states that all eligible patients are "entitled to care and treatment at the expense of the foundation" [agency], except for those services for which payment is made pursuant to The Saskatchewan Medical Care Insurance Act.

The Act does not reflect changes in government philosophy and practice over the last 25 years, such as those reflected for RHA's in the Regional Health Services Act 2002 (consolidated 2004). Examples would include:

- Responsibilities re the employment and termination of the CEO not included
- Part VII on Governance (no reference to public access to by-laws, minutes and meetings; liability etc)
- Part VIII on Planning, Financial and Reporting Matters and Part IX on Accountability not included
- The number of members on the Board (not more than 12 for RHA's – 7-11 for SCA)
- No section on disqualification of members ("3 strikes rule" etc)

Inter-provincial comparisons

A review of cancer organizations across Canada (see table 1 below) indicates that eight out of ten of Canada's provinces have formally structured cancer control agencies/programs (although two of these are now led by the Provincial Ministry of Health), Of the latter two provinces, New Brunswick has just accepted a report recommending a Provincial network with most of the responsibilities of an agency under the auspices of the Department of Health and Wellness, while PEI sends its patients out of province and therefore has not set up a provincial structure.

While there is some variation in approach, agency activities are directed towards similar missions that include: reducing the incidence of cancer; reducing mortality from cancer; improving the quality of life of those living with cancer.

Generally, the agencies' cancer control activities are extensively linked and integrated through community cancer clinics, and provincial networks. The Cancer Care Ontario's (CCO) Memorandum of Understanding with the Government describes this well:

"CCO is the province-wide cancer agency mandated by the Government of Ontario to provide strategic direction and leadership for all components of Ontario's Cancer Control System and to provide certain Cancer Control Services through the operation of Regional Cancer Centres and other provincial cancer programs, as appropriate. CCO provides overall strategic direction and leadership and develops and promotes adherence to standards and guidelines both provincially and on a regional basis. It works in partnership with non CCO funded stakeholders in leading, developing and implementing regional and provincial cancer programs."

Cancer control systems are usually underpinned by a number of enabling services (web-site, provincial practice standards and management guidelines, a cancer registry and surveillance and outcomes information).

Table 1 Comparison of Cancer Organizations across Canada

	Organization	Legal Mandate	Agreements with other organizations	Treatment programs	Community Programs	
Sask	Province-wide Agency with 2 major centres	(Cancer Foundation Act 1979)	Agreement and Leases with RHA's	Radiation & chemo: Beds in adjacent hospitals	COPS (16 centres)	Operates Lodge
BC	Province-wide Agency (part of Provincial Health Services Authority) with 3 major centres	(Public Hospital under Hospitals Act, a separate legal entity (Societies Act)	(Draft partnership Framework with RHA's)	Radiation and chemo: 34 beds plus beds in hospitals	Regional cancer centres & community networks	Hostels operated by CCS
Alberta	Province-wide Agency with 2 major centres	(Cancer Programs Act)	(Multi-Year Performance agreement with Ministry)	Radiation and chemo; Beds in adjacent hospitals	17 treatment facilities, 4 associate centres and 12 community cancer centres	Hostels operated by hospitals
Man	Province-wide Agency with 2 major centres	(Act of Legislature)	("working in partnership" with RHA's)	Radiation and chemo: Beds in adjacent hospitals	14 community cancer programs	Externally operated lodge
Ontario	Province-wide Agency with regional centres	(Cancer Act)	MOU with Ministry –sets out roles, accountability etc.; affiliation agreements	Treatment through partner hospitals or Princess Margaret Hospital	CCOR's (Regional Committees to coordinate and promote standards and guidelines)	PMH has a lodge , otherwise run by hospitals
N.S.	Province-wide Agency reporting to government	"inception" in 1998	n/a	Treatment through hospitals	"works with "community based organizations	Lodges run by CCS and hospitals
Nfld	Province-wide Agency, now reporting to government	"Established" in 1971". Recently incorporated into the Ministry of Health	n/a	treatment through their outpatient facility and hospitals	4 regional cancer sites	CCS assistance re boarding homes
Que, NB and PEI	Quebec has just established a "Centre" reporting to government; NB has just accepted a review recommending a "network" reporting to government; PEI has no organization					

International comparisons

Canada is regarded as a leader in the development of a comprehensive cancer control strategy but many other countries are now developing their own cancer control plans. European countries such as Italy, Germany, France and Denmark have nationally developed plans while the UK, New Zealand and Australia have also been developing national strategies. While the organization of the services varies, there is agreement on the principles of coordination of prevention, screening, promotion, access to the best treatment through to palliative care.

2.1.2 Reviewer's interpretation/opinion

The review team does not believe the current act reflects contemporary practice in Cancer Control, nor the strategic directions outlined in the SCA Strategic Plan; including:

- population based approach to cancer control,
- full spectrum of care – through supportive, rehabilitation, palliative
- health service delivery research – knowledge development and translation to practice,
- provincial practice standards and management guidelines, or
- how it works, e.g. – through partnerships / networks.

The Canadian Strategy for Cancer Control lists the following priorities and the Agency reports on progress on each of these in its annual report:

- Development of Standards and guidelines;
- Primary prevention;
- Rebalancing focus;
- Human Resource Planning;
- Research Priorities.

While the Agency leads some of these initiatives and is a partner in others, it is our view that the Act should reflect these priorities.

Questions were raised in our interviews as to how the SCA mandate should be achieved in terms of role and responsibility. There are different views between the RHA and the SCA about who is responsible for "delivering" patient care – who "owns" the patient. This lack of clarity has the potential to damage relationships between the SCA and the Regions and negatively impact standards and continuity of care. Some key informants expressed views that the time has come to stop isolating one disease category and that the SCA role could be reduced to research, standards & protocols, prevention, promotion, and education. There was also a suggestion made that the breast and cervical screening programs could be run by the RHAs. A number of regional representatives we interviewed told us that their role includes the full range of health services with no exclusion for cancer.

The rationale for the Agency keeping treatment services like radiation and outpatient chemotherapy is that a broader role for the Agency, one which includes treatment services, helps to achieve the goal of having consistent standards and of quickly being able to translate new evidence to practice. While these benefits could be accomplished with the RHA's providing treatment services consistent with guidelines produced by the Agency, it would be more difficult.

Our interviews suggest that the SCA mandate and how it is operationalized is not as well understood as it could be. Also, despite having a Strategic Plan, the vision, mission and clinical direction of the Agency is not well understood by SCA partners.

In terms of organization, the national standard is a provincial agency/program with broad responsibility for stewardship of a provincial cancer control strategy. Two Provinces (BC and, shortly, Ontario) have a Provincial Region or provincial network within which their Cancer Agency fits and others are a direct program of the provincial Ministry of Health. However, in all models, it is clear that a close working relationship between the program and the government is necessary for the success of a cancer control strategy.

Finally, in 2003 SCA commissioned a report on Planning Communications (the Linnen Report -May 2003). It noted potential mandate conflicts with the Canadian Cancer Society, especially in the areas of fundraising and public education. This has led to some confusion about the Agency's role and vision in education and prevention. The SCA's public education role was also recently reduced and funds redirected to other priority areas. It was mentioned that SCA has not been involved in much public education planning by the Cancer Society and the advocacy groups, or the Provincial Chronic Disease Coalition and we also received comments that SCA is not as active as it could or should be in prevention and promotion beyond breast and cervical cancer screening. This aspect is addressed below in section 2.4.

2.1.3 Recommendations - Mandate

There is a range of potential roles for the SCA in directly providing cancer control services for the province. All would see the Cancer Agency providing provincial stewardship for cancer control and leading the development of standards, protocols, monitoring, surveillance & reporting, research, education and training, screening programs and partnering in the area of primary prevention. The question lies primarily in who should be responsible for delivering the cancer treatment.

- The **narrowest role** would see the Regions deliver all inpatient and outpatient cancer care including radiation oncology, leaving the Agency the role of broad stewardship of the provincial cancer control strategy.
- **A broader role** for the Agency, one similar to the current model – would have health service delivery provided by both the Agency and the Health Authorities based on a formal comprehensive partnership agreements between SCA, the RHA's and the Canadian Cancer Society.
- The third would see **increased "ownership" of the full spectrum** of cancer control by the SCA including more direct accountability by the SCA for treatment, including staffing and managing the COPS programs and their expansion, payment of physicians for surgical oncology, and direct management and budget control over inpatient oncology units.

While there may be some advantages to the first option - limiting the SCA's role to non treatment services – in that roles and accountability would be clearer and the potential for conflict over service arrangements less - the evidence from British Columbia and elsewhere is that provincial stewardship and significant control of treatment improves population outcomes for cancer. As table 1 shows, most provinces in Canada have agencies/programs that provide both stewardship and some direct patient care. A brief survey of the international approaches in the UK and elsewhere show a similar approach.

The third option has some advantages in terms of the ability to roll out a provincial strategy more easily – particularly in the expansion of the COPS program, and the implementation of standards in surgical procedures – but would be more complicated to operationalize.

We recommend option two - the continuation of an Agency with a broad provincial, population health mandate for cancer control strategies and a mixed delivery model, but with stronger framework agreements between the Agency and the RHAs[1]. This option has the advantages of facilitating the adherence to standards, ease of implementation, flexibility in service planning and operations, reduction in potential duplication of service, strengthening of the continuum of care, and staffing efficiencies. It will require government to responding to policy issues and to support standards set by the Agency through mechanisms such as the accountability guidelines to the Regional Health Authorities. The third option could be explored in two to three years after an evaluation of the impact of implementation of the recommendations in this Phase One and Phase Two report.

Accordingly we make the following recommendations:

M.1	Retain the concept of an Agency with a broad provincial, population health mandate for cancer control strategies and a mixed delivery model, but with stronger framework agreements between the Agency and the RHAs and supportive government accountability guidelines and action.
M.2	Update the Legislation as proposed in Appendix C to reflect a more contemporary cancer control strategy the concept of the Agency as described in M 1 and changes in government philosophy and practice over the last 25 years, such as those reflected for RHA's in the Regional Health Services Act 2002 (consolidated 2004) .
M.3	Develop framework agreements with the RHA's and the Canadian Cancer Society that clearly delineate the role and responsibility for different elements of the cancer control strategy (see Recommendations R.2 & RP.5)

2.2 Governance

As expressed in the Department's Accountability document, the nature of governance includes relationships with other organizations. These include Saskatchewan Health, the Regional Health Authorities and the Canadian Cancer Society.

The Agency is accountable to the Minister of Health. However, the SCA Board will have reporting expectations of its senior management team that may expand upon the reporting expectations identified in the Accountability Document.

[1] Further discussed on page 20

It is generally accepted that Boards have a policy role and should not unreasonably interfere with operations. However, this does not exempt Boards from their legal responsibilities to monitor and evaluate the services provided by the organization and be accountable for the overall operation of the organization. Reports prepared by the management team regarding compliance with the Accountability Document and/or Board requirements serve to measure performance against expectations of both the Minister and the Board.

2.2.1 Findings

The Cancer Foundation Act provides for the membership to be “at least seven and not more than eleven members”. It also specifies that these shall include a physician agreedupon with the College of Physicians and Surgeons, a full -time member of the College of Medicine of the University of Saskatchewan and a person agreed upon with the Canadian Cancer Society. The Regional Health Services Act does not provide any such specification.

In terms of the responsibility to relate to other organizations, SCA representatives take part in joint planning forums involving the Minister, Saskatchewan Health officials, RHAs and the SCA that are in place to build relationships within the accountability framework. These include:

- Minister’s Forum
- Leadership Council
- Joint Committees (Financial Management, Health Human Resources, Information Management, Community Based Services, Institutional Supportive Care, Acute and Emergency Services) as applicable.
- Senior Medical Officers Committee

The following table outlines our findings from a review of Board meetings minutes for 2004. The Board held 8 meetings from January 2004 to December 2004. They are summarized as follows

Attendance	There are intended to be 11 members but the Government did not appoint one member during the year. The attendance varied from 6 to 8 members so a quorum was achieved at every meeting though narrowly twice (and not achieved at the January 2005 meeting). Four Board members missed at least five of the eight meetings, including the representatives from the College of Medicine and the College of Physicians and Surgeons.
Content:	• Every meeting included the normal review of agenda and minutes and appeared to be conducted appropriately. Every meeting included a report from the Chair (except one) and from the Management, that included a report of the financial statements. There was also a section on community/ownership linkage that reported on the relationships with partners and on

	three occasions there were meetings with reps from Saskatchewan Health, SAHO and the Saskatoon RHA as part of the Board meeting. The Minister and Deputy were also invited at another time but were not able to attend. Finally the Board dealt with normal Board issues such as Medical staff Reviews and the planning calendar • At five meetings there were education/orientation sessions for the Board on subjects such as Physics and Radiation Therapy, Malignant Haematology/Stem cell transplants, COPS and Prevention • Over the year the Board dealt with important issues, including the Operational Plan, Accreditation Survey, Patient Satisfaction Survey, Board and CEO evaluation, Medical staff appointments, Approval of a new Clinical Management System, Quality Improvement Report
Governance:	The Board is a Policy Governance Board following a modified Carver model and reviews portions of its policies at each meeting.

2.2.2 Reviewer's interpretation/opinion

- This review of Board minutes for 2004 indicates that the Board is operating as a Policy governance body using a "Modified Carver Model". This is common elsewhere for health care organizations but discussions with Dept representatives indicate that there has been a shift in expectation to a Board governance model more akin to a "corporate" style of governance that provides a stronger oversight mandate without being a management board. It is not clear that this change has been clearly defined and communicated to the SCA Board.

- There have been issues related to attendance of some Board members and questions of whether it is it necessary to have legislation define that the Dean or other medical representation be on the Board. There is no requirement for medical representation on the RHA Boards and this would not be necessary if there were a functioning Medical Advisory Committee at the Agency (see Clinical Governance Section). There are representatives from RHA boards on the Board but their role is not formally defined as representative. The Canadian Cancer Society representative role is operational but it needs to be clear that the reason for this representation is the important role the Society plays in health promotion, public education, primary prevention and other aspects of the overall cancer control strategy.

- There has been one vacancy for more than a year (recently delayed pending the outcome of this review) and also a number of Board members are up for reappointment shortly.

- The Board has completed its self-evaluation, but this was just before the time the new RHA self-evaluation format was being introduced. The Board has also completed an evaluation of the CEO by the Board but again there has been no external review of how effective this was.

- RHA's have a "three misses" rule – with reasonable exceptions. SCA also use this criterion but while there has only rarely been a case of not having a quorum it has not been effective in increasing Board attendance.

- While the Chair and CEO are invited and do participate actively in the Minister's Forum and Leadership Council respectively, there has been less attention paid to governance education at SCA than in the RHAs.

- We received several suggestions about the idea of formal cross membership of the RHA and SCA Boards (bi-directional)

A recent article in the McKinsey Quarterly presenting information from a survey of corporate directors (April 1, 2005 Robert Felton and Pamela Keenan Fritz) had interesting perspective on Directors role. The following statements/quotes highlight their findings.

"Board oversight will improve only if directors can develop a more comprehensive picture of the performance of their companies and learn to participate more deeply in discussions about strategy and leadership.

Having focused for a time on accounting-compliance issues, they are now determined to play an active role in setting the strategy, assessing the risks, developing the leaders, and monitoring the long-term health of their companies."

The report states that Directors want to be more actively involved in three areas:

1. "Organizational health" (the organization's ability to survive and develop over the longer term) and its short-term financial performance,
2. Strategy and assessment of risk, and
3. Leadership.

The re-emphasis of focus suggested by the McKinsey article suggests Boards move into some of the areas that may have been previously regarded as high-level management strategy rather than governance.

2.2.3 Recommendations - Governance

G.1	Modify the Cancer Foundation Act to remove the requirement for medical or professional Board appointments, include ex-officio cross appointment of Regina and Saskatoon RHA board members supplemented by a formally appointed, cross-representative member from a rural Health Authority who would have some responsibility to communicate with governors of other rural health authorities. The Regional Health Services

	Act should also be modified to reflect the cross-appointments. Retain the membership from the Canadian Cancer Society on a cross appointment basis.
G.2	Modify governance processes to reflect Saskatchewan Health's current corporate governance model. Include clearly defined statements and board education reflecting the philosophy of the Department and the important role governors play in ensuring organizational effectiveness.
G.3	Complete a skills inventory of the current Board. Government should develop regulations around the skill requirements for Board members.. Identification of potential candidates should be recognized as a shared responsibility of the SCA and Saskatchewan Health and appointments made to balance the Board in line with government criteria for Board members skills and experience.
G.4	Ensure the Department's philosophy on Board governance model is clearly articulated and communicated.

2.3 Clinical Governance / Leadership

Strong clinical leadership is required for the SCA to fulfill its mandate as the provincial steward for cancer control. As a small province Saskatchewan faces particular challenges related to recruitment and retention of clinicians. The fact that many of the oncologists are recently recruited and foreign trained adds to the complexity and heightens the importance of having appropriate structures and processes in place to ensure consistent practice based on agreed upon standards.

2.3.1 Findings

A description of the clinical management of the organization is laid out in the Accreditation Survey Report of late 2002. The Accreditation report also noted a number of achievements:

"The organization has maintained and enhanced patient care services in all areas despite staff shortages and turnover. This was accomplished in large part due to the competent professional contributions of front-line staff. The environment is caring and responsive and reflects dedication of staff. Considerable progress has been made in the development of clinical practice guidelines, improved access to diagnostic services and provision of supportive psychosocial care to patients and families.

Important human resource issues in recruitment, retention and worklife have been addressed. Occupational health and safety services have been refreshed and are well communicated amongst staff. Specific compensation incentives have improved staffing levels in the critical area of radiation therapy.

Quality improvement has become a high priority for the organization with new investment focused on education and indicator development. Many teams have initiated projects to assess service quality and utilization. Practice guideline development has progressed in spite of shortages of oncologists and clinical leaders. Some guidelines are posted on the agency's web site while others are in circulation for provisional approval."

The Accreditation report also made a number of the recommendations that have been or are being addressed, such as the development of the Clinical Management system, work on Clinical Practice Guidelines and Quality Improvement plans.

Through the interview process a number of concerns or opportunities for improvement were noted. These have been grouped by theme below.

Clinical Practice

- There is variation in clinical practice between the two sites and rather limited communication between the clinical teams. While this has improved since the Executive Director of the Saskatoon Clinic began operating as Acting Executive

Director of the Regina Clinic, it is still a problem. There is a need to complete the development of clinical practice guidelines and publish them on the external website. While a number of guidelines have been developed through a consensus model approach with representatives from radiation and medical oncology from both sites, more monitoring needs to be done to ensure compliance. The Regions are supportive of standard protocols, however, they are concerned that current protocols change frequently or are introduced without consultation, prior information or appropriate staff education.

- Concerns were expressed about the practice of providing 4th, 5th and 6th lines of treatments and heroic end of life care to patients to the detriment of ability to see new patients.

- A number of people noted the need to improve the coordination of patient care and communication between the Agency and the hospitals.

- There have been difficulties in getting out-of-hours support with the result that patients go to Emergency Departments that are already overcrowded.

Cancer Service Model

- There is a need to review the way high risk/low volume/high cost programs are delivered in the province. A high priority is the need to look at the paediatric oncology program given the low volume of service and the fact that there is only one paediatric oncologist in Regina. Integrated clinical leadership would provide an opportunity to develop a strong provincial paediatric oncology program. This would complement a broader provincial strategy related to paediatrics. The province is currently consulting with the regions and providers on the organization of pediatric services given the small pediatric population and shortage of pediatric specialists. Saskatoon Health Region is also examining ways to further consolidate / strengthen pediatric programming.

- The stem cell program which was set up as a provincial program is having difficulties in managing demand and should be addressed as a priority in phase 2 as part of the clinical directional plan.

- The COPS program is seen to be very successful, but its very success is leading to challenges in managing the workload. One would expect that over time there would be a significant expansion of the services that could be provided at the local community level if proper resources, training, and support were available.

Scope of Services

- We were told that the SCA is doing more follow ups than other centres– (approx.36000 follow-ups a year with 2500 new patients). Shifting a greater proportion of the work to family physicians / mail follow up would reduce wait times. This may require strengthening their support to the family practice community, including potentially the development of a primary care oncology network similar to that operated in B.C.

General

- We learned that waiting time for treatment is a growing problem. The current process is that there is a triaging of new patient referrals with urgent cases seen first. 50 days was identified as a benchmark for average wait. – although there is recognition that this is not necessarily the best indicator. There is some work underway by the Program Evaluation group to look at definitions of wait times (through a CIHR grant with the other western provinces) which will help in the Agency develop a better standard and measure of wait times in order to effectively address them.

- In addition, there are differences in culture between the Agency with its salaried physician group and the Regions with its fee for service consultants that at times appear to cause friction. While we understand that there is an impact assessment completed when a new oncologist position is approved there have been problems in terms of unexpected workload for the Regions.

2.3.2 Reviewer's interpretation/opinion

While this brief phase one review did not provide an opportunity to meet with many front line staff, nor patients and family, our impression was that of an organization and staff committed to providing high quality care.

It is however, our opinion is that the current organizational structure with the two clinics operating very independently does not provide the strong clinical governance required to achieve the vision and goals of the organization. We believe this has contributed to variation in practice between the two sites and difficulty in addressing a number of clinical issues, including those related to the stem cell program. Opportunities for streamlining services and reducing duplication are also missed with this "two clinic" model approach.

Given the history of recruitment difficulties it was suggested that the University could be involved more in recruitment as they are with the RHAs.

To summarize, it is our opinion that the current structure will not support the evolution of the Agency to provide provincial leadership for a strong provincial cancer control strategy. Moving from a "two clinic" to a "provincial program" model would also provide opportunities to reduce duplication, reallocate resources to areas which are seen to be under resourced.

2.3.3 Recommendations – Clinical Governance

CG.1	Review the stem cell program as an early element of Phase Two of this Operational Review.
CG.2	Implement an organizational structure that would support the evolution of a

	strong cancer control strategy in the province. ▪ Move to a provincial program model with clear provincial leadership and stronger clinical governance. ▪ Restructure the Management Committee (MCC) to include medical leaders, pharmacy and nursing to strengthen clinical leadership. ▪ Reactivate the Medical Advisory Committee to ensure the Board receives appropriate clinical advice
CG.3	Develop a Clinical Directional Plan (PHASE 2) This Plan, which would be complementary to the Strategic Plan, would outline key clinical directions and strategies for implementing the clinical components of a provincial cancer control strategy. It would identify: ▪ the opportunities presented by the new Clinical Management System, ▪ the direction related to expansion of community based services and support of family practitioners, ▪ the plan for service rationalization for high cost/risk and low volume services such as pediatrics and Stem Cell programs.
CG.4	As a highest priority in the service rationalization area begin the process of developing an integrated paediatric oncology program. This would need to involve considerable community and stakeholder consultation.
CG.5	Develop a process to jointly appoint SCA physicians with the RQ and Saskatoon Health Regions to reflect the nature of their shared roles. Tie specialized physician recruitment with other Western Canada labour market strategies.

2.4 Research

A comprehensive research program is an integral part of any successful cancer control program and is one of the five priorities of the Canadian Strategy for Cancer Control. It also can serve as a catalyst for hiring of physicians. It is therefore important that research is well organized and suitably funded.

2.4.1 Findings

Research Organization

The Research Group is a part of the Saskatchewan Cancer Research Network in order to foster a collaborative approach to cancer research in the province. This Network is comprised of the University of Saskatchewan, the University of Regina, Canadian Cancer Society, Saskatchewan Health and the Saskatchewan Health Quality Council. Within the SCA, research is currently split into three reporting lines (Basic, Clinical and Epidemiological) though we understand that Dr. Carlsen has eventual oversight over all of the research undertaken with the SCA.

In spite of the networking activity, the research department is independent of the University and it was suggested that this causes it to miss out on opportunities for accessing university funding – for example the university is currently expanding the area of social/ population/ outcomes research but there is no connection to the University School of Public Health (it was commented that the relationship needs "hardwiring").

Research Funding

In 2003/04 the SCA provided $413,149 in grant money to a number of research projects *(compared to Manitoba's $4.7 million, BC's $3.0 million and Alberta's $17.9 million)*. In addition, over $1 million in external grants was received by researchers working for the Agency in 2003/04. NCIC grants only account for $100,000 of this. The government provides $560,000 through the Health Research Fund and this, together with funding from the budget of the Agency, pays for clinical research and also the salaries of the research staff.

2.4.2 Reviewer's interpretation/opinion

There appear to be gaps in undertaking the full spectrum of research especially in the epidemiological area. Bringing all the research more formally together would assist in filling these gaps, given a commitment to undertaking the full spectrum of research.

It is certainly advantageous to do research in a clinical setting but care must be taken not to miss out on opportunities that would be available to research that are more closely related to the University.

Funding is needed for general or targeted research – the current passive fundraising method sometimes results in donations for inappropriate research that is not suited to the interests and abilities of the researchers. While logistics would need to be worked out with the Canadian Cancer Society, the research department could be self sustaining and the money used to cover the 7 employees currently being funded out of the operating grant as well as providing assistance with grant-writing etc. It is suggested that setting up an Institute within the SCA, but with an Advisory Board similar to other jurisdictions, would encourage innovative ideas and an Agency-wide focus on research that would assist with this problem.

2.4.3 Recommendations

R.1	Revise the organization of research to encourage a closer coordination of activity across the spectrum and make arrangements for a closer tie-in to the University.
R.2	Consider the creation of a Research Institute with an Advisory Board. The role of this Institute would be to set future directions, provide a focus and impetus for all research performed in the Agency and to encourage local fund-raising for cancer research (see section 2.6 on funding and financial management)

2.5 Partnerships and Relationships

As noted above the Cancer Agency cannot achieve its goals for effective cancer control without working closely with other organizations. This requires both goodwill and a system of formal agreements that ensures that all parties understand their role and part in this objective.

2.5.1 Findings

Agreements with the Saskatoon and Regina Regional Health Authorities are out of date, inconsistent, signed by earlier organizations, and relate solely to operating concerns. A number of comments were made that successes and mutual problem-solving were mainly attributable to personal relationships at various levels.

A Memorandum of Understanding was developed in September 2001 relating to the Community Oncology Program of Saskatchewan (COPS). These state the goals of COPS, and delineate joint responsibilities and those of SCA and the COPS Centre respectively. This is still in draft at this point.

In British Columbia, the BC Cancer Agency has developed a draft Partnership Framework with the RHA's "for the implementation of cancer control in the communities". While Saskatchewan would want to develop a framework relating to its own situation the major processes and contents of this might be a useful start. The organizations formed a Regional Advisory Council to develop and implement the framework as follows:

- Develop and agree on Operating Principles
- Review, clarify and agree to Roles and Assigned Responsibilities/Accountabilities
- Develop and implement a reporting and evaluation process that monitors Performance Measures/Quality indicators
- Develop an Operating Plan (1-5 years)
- Complete a Resources Framework and establish a baseline

This is all performed in the context of the implementation of the Canadian Strategy for Cancer Control

BC Cancer Agency has also recently developed a partnership with the Vancouver Island Health Authority whereby all outpatient cancer care (including community cancer clinics) will be managed by the Agency. This is a shared management model that bears a closer look by Saskatchewan as it expands its COPS program.

2.5.2 Reviewer's interpretation/opinion

Relationships with the RHAs

We believe there is a need to clarify relationships with the RHAs related to COPS and service arrangements. New purchased service agreements now in development need

to be finalized and consistent between the two participating regions; Saskatoon and Regina Q'Appelle RHA's are frustrated at the inability to conclude the purchased service arrangements – as is SCA. Based on input we had received, it might be appropriate for the Ministry to take a more active role in resolving the Purchased Services Agreement. Examples raised during the interviews included:

- The need to work more closely together on joint major capital decisions with the Regions (e.g. a new CT scanner was purchased at the same time as the hospital purchased one with the result that there are now two under-utilized facilities. Also UPS systems were upgraded at the same time.
- SCA clinical decision-making affects regional costs, but they have no input into the appointment process and we understand the Regions are expected to grant privileges?
- Operating agreement charges are tied to FTE's not standards or service provision.
- Nurses on inpatient oncology units and pharmacists report to a hospital manager. This at times leads to challenges related to direction and priority setting. The Oncology unit also a CTU so there is competition for beds and subsequent turnover of nurses who want to work in just oncology
- RHA's and the SCA have a responsibility for health promotion, but there is no evidence that there has been much collaboration in this area.

One of the issues we were concerned about was the tension between the Agency and the Regions over the costs of purchased services for clinical care. Agreements were different between Regions, out of date, and raised questions about "double billing" government. It also led to an unhealthy "your patient/my patient" dynamic. We believe that the "purchasing" of clinical services on a contractual basis between the Agency and the regions is inappropriate, causes increased bureaucracy, and may create an artificial barrier in the responsibility for the continuum of care. Accordingly we are suggesting that the Department recognizes these pressures and adopts a different approach – i.e. that the Department fund the regions directly for the clinical services it delivers, including that to the Agency patients. Service arrangements, response times, and volumes will need to be negotiated and planned for jointly.

Relationship with the Department

The Accountability Agreement has clarified roles and accountability and is seen as a positive opportunity for regular discussion about relationships, intentions and goals. The Leadership Council provides a forum for the CEO of the SCA and regional CEOs to meet with the Department to share information and address issues of common concern. The meetings of the Chairs with the Minister also provide an important vehicle for consideration of high-level governance and public policy issues.

A concern was expressed that contact between the Agency and the Ministry should be at the Deputy Minister and Assistant Deputy Minister level and currently involves too much detail, which is attributed to the level of detail required by Treasury Board in its relationship with the Department.

Relationship with the **Quality Council,** which is doing process improvement work with the SCA on patient/information flow for breast cancer. They will subsequently look at

process improvement for prostate care. They will be an important partner in ongoing quality management.

Relationship with the Canadian Cancer Society.

The Canadian Cancer Society and the SCA have been working together for many years., and there are good relationships at the Board and CEO level. Nevertheless, there has been some confusion about roles in certain areas such as education and fund-raising, and there are opportunities for more partnership initiatives on a number of fronts. While the Agency has the overall mandate for Cancer Control over the whole spectrum, the Cancer Society is a very important partner in areas of health promotion, primary prevention, public education etc. and this needs to be recognized at all levels.

There are opportunities to re-think the management responsibilities for the lodges and to clarify the going-forward approach to funding the structural deficit.

In a tour of the province last year by the Society it was clear that people want the two organizations to work together. There is an opportunity for SCA and CCS to reach an agreement on a new approach to funding research without inappropriately duplicating effort.

2.5.3 Recommendations – Relationships / Partnerships

RP.1	In order to assist in understanding roles and relationships – redraft the accountability matrix to more clearly indicate roles L (lead) P (partner), (See attached draft framework in Appendix F)
RP.2	Do not pursue the development of an inter-agency agreement for clinical services. Incorporate expectation, volumes, access times, quality metrics, and funding into the Accountability Agreement between the Department and the Health Authorities.
RP.3	Develop a framework agreement and a decision-making protocol that recognizes the inter-dependencies of the agencies (eg in imaging and inpatient care). Include a purchased services agreement within this overall agreement. This could also include shared responsibility for health promotion (see Linnen Report recommendation 3 re maximising joint messaging). Also consider the opportunity for interaction between management teams including perhaps the possibility of having one cross-membership on each team? Joint review process PHASE 2
RP.4	Review the possibility of standardizing the contact levels with Saskatchewan Health at the same levels as the RHA's
RP.5	Develop a formal agreement with the Canadian Cancer Society on a shared approach to health promotion and education as well as to fundraising

2.6 Funding and Financial Management

This section did not form a major focus of the Phase I Review but a high level assessment gave rise to a number of comments and observations that lead us to make recommendations in this area.

2.6.1 Findings

A review of the Operating Plans and budget documentation appears to demonstrate completeness and inclusiveness of priority setting exercises. However, while a review of the actual application of these processes was not undertaken, we received many comments from staff about the rigour of the budget process and the emphasis on priority setting, indicating that these processes are operational.

There are significant opportunities to use the introduction of the CMS as a way to look at streamlining work processes and addressing issues such as variation in practice. There may be a potential ability to reallocate staff based on efficiency gains.

There has also been much discussion about separating out the drug budget from the operating budget and reviewing the drug increases separately. The organization has been driven primarily by fiscal imperatives and the inflationary cost of pharmaceuticals has led to erosion of other important services and infrastructure support.

2.6.2 Reviewer's interpretation/opinion

While comprehensive Operating Plans have been presented, the ongoing requests for large increases cause concern within Saskatchewan Health as to these processes. The Agency stated that they would welcome a review of best practices for financial planning activities, using other jurisdictions as a model. Our review of the documentation indicates a strong budgeting process with clear guidelines on priority setting and emphasizing the requirement for a status quo budget. What would improve the process is more clinical input at the Management and Board levels where the final decisions are being made (see recommendations in sections 2.2 and 2.3) and the development of a Clinical Directional Plan.

There has been positive recent capital provision for Linear Accelerators but there is concern within the Agency about the model for long term capital investment. There is also a concern about the lack of medical input into overall capital purchasing decisions.

The Lodges have a structural deficit. There should be clearer direction about whether they should be self-supporting or what other resource should be available for making up the deficit. In the absence of this, there is reticence to increase costs. Saskatchewan is the only Agency in Canada (apart from Princess Margaret Hospital) that operates lodges. Generally they are operated by the Canadian Cancer Society or an adjacent hospital or other organization.

Although there are well-prepared and presented planning documents there are feelings that the planning processes have not been inclusive and consequently there is not understanding and buy-in by all managers and partner agencies. We could not determine whether this is due to external deadlines or internal processes. There were also comments that there is not a strong in-house planning capacity and that the major "planned" area is Information Management where there was appropriate internal (but not necessarily external) process, high level adoption and alignment with operational planning.

As discussed in Section 2.4 there is a need to raise more funds for research. Additionally, though funds have been provided in recent years for major capital investment there is a need to review the whole long-term capital investment process and to consider providing an opportunity for some targeted fundraising for specific capital requirements. Because of the experience in other provinces of unhealthy competition between the Agency and the Society it would be important to develop an agreed-upon approach to the benefit of both organizations.

2.6.3 Recommendations – funding and financial management

F.1	Begin funding the Agency through three budget lines (operating grant, physician salaries, and cancer drug program) with separate funding parameters, rather than through an operating grant alone.
F.2	Consider devolving the responsibility for the operation of the lodges to either the Regional Health Authority or the Canadian Cancer Society. The question of the structural deficit will need to be resolved.
F.3	Reevaluate the process for long-term capital investment.
F.4	Consider beginning targeted fundraising in cooperation with the Canadian Cancer Society. Either activate the Foundation formally or hire a fundraiser within the Agency.

2.7 Pharmaceutical / Drug Policy

We did not focus in depth on this area since a detailed Pharmacy Task Force Report was completed recently and the recommendations are being implemented. However, because of the importance of this area to clinical care and to the budget, we are including some comments and recommendations based on our high level review

2.7.1 Findings

In order to strengthen its management of cancer drugs, the SCA established a Pharmacy Task Force comprised of oncologists, pharmacists, SCA senior managers, and Saskatchewan Health officials. The Agency submitted its final report to the department on January 10, 2005 along with its plans and priorities for implementation. In October 2004, the Agency established an Implementation Committee to oversee and direct the process for implementing the recommendations of the Task Force.

In its communication, the Agency advised the Department that it is currently working to address the recommendations related to staffing of the pharmacy program, which includes recruitment of two vacant pharmacy positions created in 2004/05. The Agency will examine the implications of creating an Agency-wide pharmacy department that would provide administrative, distributive and clinical pharmacy services that better meet the current and future needs of the SCA.

The document includes a review of the structures and processes used to manage: drug approvals, drug coverage, drug utilization, and drug purchasing/inventory management. Although the Task Force recommendations may not substantially reduce the inflation of high-cost cancer drugs, they will better position the Agency to address this ongoing challenge.

Some of the major issues that the Task Force felt needed to be addressed are as follows:

- The lack of transparency and/or confidence in the SCA's drug approval process
- The need to implement a strong drug utilization management in order to ensure that available resources are utilized to their maximum effectiveness.
- The ability of the SCA to be responsible operationally for the growing spectrum of cancer chemotherapies and supportive cancer therapies.

The recommendations of the Task Force are included as Appendix E

2.7.2 Reviewer's interpretation/understandings

In discussion with the Pharmacist and others the following appeared to be major challenges:

- Variation in practice between the Regina and Saskatchewan Clinics
- No pharmacy and therapeutics committee (although there is PODAP - Provincial Oncology Drug Approval Process - that meets weekly)

- There is no formal formulary – just e-mails from pharmacist to physicians regarding new drugs and drug information
- There is a problem with the lack of in-house staff. When the Health Authorities are short-staffed the Agency staff levels are sometimes reduced.
- There is general agreement there should be a separate budget for drugs and an oversight committee to look at what is coming a year ahead, be more proactive, and be ready when other provinces start approving new drugs.
- There is a need to share palliative care management with other organizations such as hospice societies

2.7.3 Recommendations

P.1	Adopt Task Force recommendations and move forward with implementation
P.2	Explore the impact of implementing drug coverage policies similar to other provinces where some supportive drugs such as antiemetics are moved to the provincial formulary and subject to co-pay arrangements.
P.3	Set up a separate body with representatives of Sask Health and SCA to approve new drugs to be added to the formulary and develop a funding strategy for their implementation. Develop a Cancer Drug Stabilization Funded as suggested in SCA's Operational Plan .
P.4	Make an agreement with the Health Authorities regarding permanent and consistent levels of staffing or move to bring the staff into the Agency

3.0 Summary of Recommendations

Mandate

M.1	Retain the concept of an Agency with a broad provincial, population health mandate for cancer control strategies and a mixed delivery model, but with stronger framework agreements between the Agency and the RHAs and supportive government accountability guidelines and action.
M.2	Update the Legislation as proposed in Appendix C to reflect a more contemporary cancer control strategy and the concept of the Agency as described in M 1.
M.3	Develop framework agreements with the RHA's and the Canadian Cancer Society that clearly delineate the role and responsibility for different elements of the cancer control strategy (see Recommendations R.2 & RP.5)

Governance

G.1	Modify the Cancer Foundation Act to remove the requirement for medical or professional Board appointments, include ex-officio cross appointment of Regina and Saskatoon RHA board members supplemented by a formally appointed, cross-representative member from a rural Health Authority who would have some responsibility to communicate with governors of other rural health authorities. The Regional Health Services Act should also be modified to reflect the cross-appointments. Retain the membership from the Canadian Cancer Society on a cross appointment basis.
G.2	Modify governance processes to reflect Saskatchewan Health's current corporate governance model. Include clearly defined statements and board education reflecting the philosophy of the Department and the important role governors play in ensuring organizational effectiveness.
G.3	Complete a skills inventory of the current Board and make appointments to balance the Board in line with government criteria for Board members skills and experience. Identification of potential candidates should be recognized as a shared responsibility of the SCA and Saskatchewan Health.
G.4	Ensure the Department's philosophy on Board governance model is clearly articulated and communicated.

Clinical Governance

CG.1	Review the stem cell program as an early element of Phase Two of this Operational Review.
CG.2	Implement an organizational structure that would support the evolution of a strong cancer control strategy in the province. ▪ Move to a provincial program model with clear provincial leadership and stronger clinical governance. ▪ Restructure the Management Committee (MCC) to include medical leaders and pharmacy to strengthen clinical leadership.
CG.3	Develop a Clinical Directional Plan (PHASE 2) This Plan, which would be complementary to the Strategic Plan, would outline key clinical directions and strategies for implementing the clinical components of a provincial cancer control strategy. It would identify: ▪ the opportunities presented by the new Clinical Management System, ▪ the direction related to expansion of community based services and support of family practitioneres, ▪ the plan for service rationalization for high cost/risk and low volume services such as pediatrics and Stem Cell programs.
CG.4	As a highest priority in the service rationalization area begin the process of developing an integrated paediatric oncology program. This would need to involve considerable community and stakeholder consultation.
CG.5	Develop a process to jointly appoint SCA physicians with the RQ and Saskatoon Health Regions to reflect the nature of their shared roles. Tie specialized physician recruitment with other Western Canada labour market strategies.

Research

R.1	Revise the organization of research to encourage a closer coordination of activity across the spectrum and make arrangements for a closer tie-in to the University.
R.2	Consider the creation of a Research Institute or Foundation in partnership with the work of the Canadian Cancer Society with an Advisory Board. The role of this Institute would be to set future directions and to encourage local fund-raising for cancer research

Relationships with Partners

RP.1	In order to assist in understanding roles and relationships – redraft the accountability matrix to more clearly indicate roles L (lead) P (partner), (See attached draft framework in Appendix F)
RP.2	Do not pursue the development of an inter-agency agreement for clinical services. Incorporate expectation, volumes, quality metrics, and funding into the Accountability Agreement between the Department and the Health Authorities.
RP.3	Develop a framework agreement and a decision-making protocol that recognizes the inter-dependencies of the agencies (eg in imaging and inpatient care). Include a purchased services agreement within this overall agreement. This could also include shared responsibility for health promotion (see Linnen Report recommendation 3 re maximising joint messaging). Also consider the opportunity for interaction between management teams including perhaps the possibility of having one cross-membership on each team? Joint review process PHASE 2
RP.4	Review the possibility of standardizing the contact levels with Saskatchewan Health at the same levels as the RHA's
RP.5	Develop a formal agreement with the Canadian Cancer Society on a shared approach to health promotion and education as well as to fundraising

Funding and Financial Management

F.1	Begin funding the Agency through three budget lines (operating grant, physician salaries, and cancer drug program) with separate funding parameters, rather than through an operating grant alone.
F.2	Consider devolving the responsibility for the operation of the lodges to either the Regional Health Authority or the Canadian Cancer Society. The question of the structural deficit will need to be resolved.
F.3	Reevaluate the process for long-term capital investment.

F.4	Consider beginning targeted fundraising in cooperation with the Canadian Cancer Society. Either activate the Foundation formally or hire a fundraiser within the Agency.

Pharmaceutical

P.1	Adopt Task Force recommendations and move forward with implementation
P.2	Explore the impact of implementing drug coverage policies similar to other provinces where some supportive drugs such as antiemetics are moved to the provincial formulary and subject to co-pay arrangements.
P.3	Set up a separate body with representatives of Sask Health and SCA to approve new drugs to be added to the formulary and develop a funding strategy for their implementation. Develop a Cancer Drug Stabilization Funded as suggested in SCA's Operational Plan .
P.4	Make an agreement with the Health Authorities regarding permanent and consistent levels of staffing or move to bring the staff into the Agency

4.0 Next Steps

This high level review of the Saskatchewan Cancer Agency and the environment within which it operates illustrates the significant opportunities and challenges the Agency faces and confirms the importance of clarifying its role and defining its relationships with other organizations more clearly.

The recommendations from this phase of the work include two areas that we feel deserve a more detailed review as Phase II of this project. These are:

CG.3 The Development of a Clinical Directional Plan.

This Plan, which would be complementary to the Strategic Plan, would outline key clinical directions and strategies for implementing the clinical components of a provincial cancer control strategy. It would identify:

- the opportunities presented by the new Clinical Management System,
- the direction related to expansion of community based services and support of family practitioners,
- the plan for service rationalization for high cost/risk and low volume services such as pediatrics and Stem Cell programs.

For this planning process to be successful, we believe an appropriate clinical governance and management infrastructure to support the province's cancer control strategy needs to be put in place.

R.3 Finalization of the framework agreement and a decision-making protocol.

These agreements will recognizes the inter-dependencies of the agencies, the SCA, and the government in designing and implementing a full cancer control strategy for residents of Saskatchewan.

RockBank Consulting Ltd would be pleased to work with the Agency, the Department and others to assist in the implementation of the Phase 1 recommendations if requested.

We hope that this review has been a useful exercise and will assist the Department and the Agency in meeting their respective goals.

Appendix A: Interview List

Saskatchewan Health:

- John Wright, Deputy Minister
- Duncan Fisher, ADM
- Lauren Donnelly, Executive Director , Acute and Emergency Services
- Rod Wiley, Executive Director, Regional Policy,
- Valerie Phillips, Director, Central Support and Policy, Acute and Emergency Services
- Kathleen Handford, Project Manager, Acute and Emergency Services

Saskatchewan Cancer Agency:

- Board members: Gary Semenchuck (Chair), Don Leitch ,Carol Beck, Diana Ermel. Plus meeting with full Board
- Bob Allen, Chief Executive Officer
- Dr. David Popkin, Executive Director, Saskatoon Cancer Centre, A/ED Allan Blair Centre
- Kevin Lacey, Executive Director, Finance
- Dr. Svein Carlsen, Executive Director, Health Research
- Huguette Gauthier, Associate Executive Director, Allan Blair Cancer Centre
- Ivan Olfert, Associate Executive Director, Saskatoon Cancer Centre
- Dennis Karakochuk, Executive Director, Human Resources
- Bill Morton, Executive Director, Information Management
- Judy Nurse, Executive Director, Education & Corporate Affairs
- Kathy Gesy, Manager, Pharmacy Services
- Denise Budz, Director of Nursing, Saskatoon Cancer Centre
- Dr. Mohamed Mohamed, Director of Radiation Oncology
- Dr. Chris Mpofu, Pediatric Oncologist
- Craig Beckett, Director of Medical Physics, Allan Blair Centre
- Jon Tonita, Director of Program Evaluation and surveillance Inf. Management
- Dr M Jancewicz, A/Director of Medical Oncology, Alln Blair Centre
- Lois Harrison, Executive Director, Prevention and Early Detection Division
- Heather Stuart, Director of Cancer Registry, Privacy Officer
- Cheryl Whiting, Coordinator, COPS – ABCC
- Dr. Patricia Tai, Director of Radiation Oncology, ABCC

Other Organizations:

- Dr. Ben Chan, Chief Executive Officer, Health Quality Council
- Dr. William Albritton, Dean, College of Medicine
- Dolores Herring, Board Chair Canadian Cancer Society
- Keith Karasin, Executive Director

Regina Qu'Appelle Regional Health Authority

- Brian Rorbek, Executive Director of Facilities Management,
- Val Lusk, Executive Director of Finance,
- Jim Slater, Head of Diagnostics,
- Diane Larrivee, VP Specialty Care

Saskatoon Regional Health Authority:

- Susan Bazylewski, VP Hospital Services,
- Barry Maber. Physician Vice President,
- Marg Brannen. Manager of Nursing – Medical & Oncology,
- Corey Miller. General Manager – Medical Imaging,
- Lorna Clarke. Senior General Manager – Hospital Services

Other provinces

- Tony Fields, VP Medical Affairs and Community Oncology, Alberta Cancer Board
- Roy West, Professor of Epidemiology, Health Sciences Centre, St John's Newfoundland
- Eshwar Kumar, Dept of Radiation Oncology, Saint John Regional Hospital, NB

Appendix B: Partial listing of Background information reviewed

Saskatchewan Cancer Agency Strategic Plan 2003-2008
Saskatchewan Cancer Agency Operation Plan Submissions 2005/6 and 2004/5
Saskatchewan Cancer Agency Master Operational Plan
Saskatchewan Cancer Agency 2005/6 Annual Budget Guidelines
Saskatchewan Cancer Agency Annual Reports 2002/3 and 2003/4
Saskatchewan Cancer Agency Cancer Control Reports 1979-2001 and 2004
Saskatchewan Cancer Agency Board minutes for the year 2004
Saskatchewan Cancer Agency Accreditation Survey Report 2002 and follow up reports
Regional Health Services Act 2002 (amemded to 2004)
Cancer Foundation Act 1979 (amended to 1997)
Pharmacy Task Force Report – May 2004 and Drug Approval Flowchart
Planning Communications for the Saskatchewan Cancer Agency: 2003 and beyond (HJ Linnen and Associates)
Accountability Document 2004/5
Report on Quality Improvement April-June 2004 and Concerns handled by Quality of Care Coordinator April 1 to December 31, 2004
Draft COPS Memorandum of Understanding
Lease agreements Regina Health Board and University Hospital Board
Affiliation Agreement – University of Saskatchewan
BC Cancer Agency Partnership Framework for the implementation of Cancer Control in the communities July 2003
Website of the Canadian Association of Provincial Cancer Agencies
Website of each of the provincial cancer agencies or hospitals

Appendix C: Proposals for Revision of the Cancer Foundation Act, 1979

Existing provision	Proposed Provision	Explanation/comments
5(2) The members appointed pursuant to subsection (1) shall, subject to subsection (3), include: (a) one physician agreed upon between the minister and the council of The College of Physicians and Surgeons of the Province of Saskatchewan; (b) one full-time member of the faculty of the College of Medicine of The University of Saskatchewan agreed upon between the minister and the dean of that college; and (c) one person agreed upon between the minister and the board of directors of the Saskatchewan Division of the Canadian Cancer Society. (3) Where no agreement is reached under clause (2)(a), (b) or (c) within three months from the date of the commencement of negotiations, the Lieutenant Governor in Council may appoint a person who has the qualifications specified in clause (2)(a), (b) or (c), as the case may be, to be a member. 1979, c.C-2.1, s.5; 1979-80, c.14, s.2.	**5**(2) The members appointed pursuant to subsection (1) shall, subject to subsection (3), include (a.) one person agreed upon by the Minister from each of the boards of Regina Q'Appelle, Saskatoon and one other health authorities to provide formal cross-communication at the governance level and (b.) one person agreed upon between the minister and the board of directors of the Saskatchewan Division of the Canadian Cancer Society. (3) Where no agreement is reached under clause (2) within three months from the date of the commencement of negotiations, the Lieutenant Governor in Council may appoint a person who has the qualifications specified in clause (2), as the case may be, to be a member.	History of poor attendance. Brings Cancer Foundation legislation into line with Regional Health Board provisions. Provides for improved communication between agencies at the governance level.
Duties of foundation **11** The foundation shall conduct a program for the diagnosis, prevention and treatment of cancer which shall include:	The Foundation shall provide a cancer control program for the people of Saskatchewan, planned according to provincial needs within a centralized planning, policy and budget structure, with implementation of provincial standards and guidelines through a coordinated community network system.	Needs new wording to reflect Canada-wide Cancer Control strategy consistent with current strategic models underlying National and International initiatives in cancer control at a population level. (e.g The BC Cancer Agency mandate: "a publicly governed and funded organization with a mandate to provide a cancer control program for the public of British Columbia" <u>Advantages:</u> defines cancer control rather

		than cancer treatment/care as the operating paradigm; defines the population of the province – the healthy, high risk well, acutely ill with cancer, chronically ill, cured and dying – as the population of interest for cancer control;
(a) the laboratory and clinical investigation of cancer problems;	Combine with (b)	
(b) the co-ordination of facilities for treatment of cancer;	the provision of clinical (interventional) services across the spectrum of prevention, early detection, treatment and supportive, rehabilitative and palliative/end-of-life care	
(c) the continued operation of clinics operated under *The Cancer Control Act* and the establishment and operation of any other clinics that the foundation may consider advisable for the examination and diagnosis or treatment of patients in the province or persons suspected of being afflicted with cancer or with any other disease or condition which any clinic may become equipped to examine, diagnose or treat;	e.g. It works in partnership with non-SCA funded stakeholders in leading, developing and implementing regional and provincial cancer programs…..(not necessary to include other diseases?)	Need to recognize the COPS program in partnership with Health Authorities and also relationship with Regina and Saskatoon Regions for other services (inpatient beds etc) .
(d) the establishment, maintenance and operation of hostels in connection with clinics or participation with any other person in the establishment, maintenance and operation of those hostels;	Also some comment needed about support services to assist in the social, emotional and economic needs of patients staying in the hostels.	(currently provided in partnership with the Canadian Cancer Society and others)
(e) the adequate reporting of cases of cancer and the recording and compilation of data relating to cancer;		
(f) the education of the public in the importance of early diagnosis, prevention and treatment of cancer;		
(g) the provision of facilities for undergraduate and post-graduate study relating to cancer;		

(h) the training of technical personnel to assist in the examination, diagnosis, treatment or study of cancer;		
(i) the provision of funds to physicians and other qualified persons for postgraduate training concerned with cancer;		
(j) the adoption of any measures that may be considered necessary for preventing or minimizing the development or spread of cancer;	Specify screening and prevention programs, particularly Breast (SPBC) and Cervical (PPCC)	Current practice
(k) the correlation and co-ordination, by voluntary means, of the work and studies of all agencies, clinics or persons in the province that may have similar objects or purposes or that may be carrying on similar or related work or studies;	Provincial practice standards and management guidelines through networks and tumour groups	The system is underpinned by a number of enabling services (web-site, provincial practice standards and management guidelines, the cancer registry and surveillance and outcomes information).
(l) the study of radiation hazards arising from the use of x-ray generators and radioactive materials and substances and recommendations for the establishment of protective devices and facilities in respect of those hazards;		
(m) the conduct of, the participation in or the provision of assistance for research projects in connection with the diagnosis, prevention or treatment of cancer.	Broaden the wording of the types of projects to incorporate cancer research across the four pillars of biomedical, clinical, socio-behavioural and health systems as well as health services delivery research (knowledge translation)	
12 For the purposes of carrying out the provisions of this Act, the foundation may:		
(c) conduct or participate in the conduct of seminars, lectures and short-term courses to assist physicians and other professional persons in becoming more knowledgeable about the diagnosis and treatment of cancer.		

Appendix D: Report on Mandate – Summary of National and Provincial Activity

Canada-wide summary[2]

Seven out of ten of Canada's provinces have formally structured cancer control agencies most of which have a responsibility for a system of cancer control. Those provinces who do not have such agencies are moving towards such structures or comparable coordinating mechanisms. In general, agency activities are directed towards similar missions that include:

- Reducing the incidence of cancer
- Reducing mortality from cancer
- Improving the quality of life of those living with cancer

A few decades ago most provincial cancer agencies were devoted to clinic based modality oriented treatment such as radiation and systemic therapy. There has been gradual progression towards developing population based systems of cancer control along with geographically distributed services including networks and linking systems to achieve consistent patient centred evidence based care. Many of the provinces have Cancer Acts, which clearly define these responsibilities. Those without Cancer Acts have government-approved mandates established under provincial society's acts or other enabling legislation.

Each of the provincial cancer agencies share a vision for the future that would be characterized by further development in the comprehensiveness and integration of well defined systems of cancer control, not only at the national level but within the various provincial jurisdictions.

As an interprovincial organization involving all provinces CAPCA has established the vehicle through which the provincial cancer agencies can not only coordinate their activities but can contribute as a partner to the Canadian Strategy for Cancer Control.

CAPCA has established six priorities in order to move forward with its mission. These priorities are:

- Development of a nation wide cancer related human resources plan.
- Development and promotion of standards and guidelines for all aspects of cancer control.
- Development of a comprehensive and integrated cancer information management and surveillance system to inform policy decisions.
- The assessment of new and evolving technology.
- Communication and education.
- In order to assist in achieving the mission and the priorities of CAPCA a number of policy advisory committees have been established.

[2] Source: CAPCA website

A more detailed review of the mandates of the Provincial Cancer Organizations follows:

Saskatchewan

The Saskatchewan Cancer Agency's mandate comes from the Cancer Foundation Act, 1979. Within the Act it stipulates that the agency is responsible for:

a. Laboratory and clinical investigation
b. Coordination and operation of cancer treatment facilities
c. Operation of cancer hostels
d. Collection, recording and reporting of cancer data
e. Public education on prevention, early diagnosis, and treatment of cancer
f. Providing undergraduate, postgraduate and technical training of cancer professionals
g. Adopting measures for cancer prevention
h. Coordination of all works and studies of all agencies, clinics and persons in the province related to cancer
i. Study of radiation hazards arising from the use of x-ray generators and radioactive material and recommendations for protective devices and facilities in respect of those hazards
j. Conduct research related to the prevention, diagnosis and treatment of cancer.

British Columbia

The BC Cancer Agency is a publicly governed and funded organization with a mandate to provide a cancer control program for the public of British Columbia.

The cancer control program comprises the provision of clinical (interventional) services across the spectrum of prevention, early detection, treatment and supportive, rehabilitative and palliative/end-of-life care; cancer research across the four pillars of biomedical, clinical, socio-behavioural and health systems; and education directed towards the public, persons with cancer, and health professionals, (continuing professional education), including training programs for several health professional disciplines. The Agency's cancer control activities are extensively linked and integrated through regional cancer centres, community cancer centres and clinics, and provincial networks. The system is underpinned by a number of enabling services (web-site, Cancer Agency Information System, provincial practice standards and management guidelines, the cancer registry and surveillance and outcomes information).

The Agency serves the population of British Columbia and provides health promotion and maintenance programs to the "well" and "at risk" public, as well as direct and indirect treatment and care services to persons with cancer through it's cancer centres and community networks.

Alberta

The Alberta Cancer Board is mandated by the government of Alberta under the *Cancer Programs Act* to coordinate all cancer research, prevention and treatment programs in the province of Alberta. Its services include cancer prevention and screening, patient and professional education, diagnosis and treatment, and basic and applied research.

It is able to integrate research efforts with clinical practice, ensuring that Albertans benefit from the latest scientific advances in cancer treatment.

Manitoba

CancerCare Manitoba is charged by an Act of the legislature of Manitoba with responsibility for cancer prevention, detection, care, research and education for the people of Manitoba. As a Centre of choice, CCMB is dedicated to enhancing the quality of life for those living with cancer and blood disorders, and to improving control of cancer for all Manitobans.

Ontario

Cancer Care Ontario (CCO) is the province-wide cancer agency mandated by the Government of Ontario through the Cancer Act to provide strategic direction and leadership for all components of Ontario's Cancer Control System and to provide certain Cancer Control Services through the operation of Regional Cancer Centres and other provincial cancer programs, as appropriate. CCO provides overall strategic direction and leadership and develops and promotes adherence to standards and guidelines both provincially and on a regional basis. It works in partnership with non CCO funded stakeholders in leading, developing and implementing regional and provincial cancer programs.

CCO has the following mandate and objectives: to reduce the burden of cancer on the people of Ontario; to be the principal advisor to the Minister on all matters relating to the Cancer Control System and Cancer Control Services; to be accountable for assessing, monitoring and reporting to the Minister on the organization and status of the Cancer Control System and Cancer Control Services, including all matters relating to access, effectiveness and quality; in co-operation with publicly funded providers and agencies and other key stakeholders to lead in the development of an overall strategic plan for the Cancer Control System and the delivery of Cancer Control Services in Ontario; in co-operation with publicly funded providers and agencies and other key stakeholders to develop plans for presentation to the Ministry on resource distribution and coordination of all Cancer Control Services in the province as a whole and in each region of the province; to develop through the CCORs, in consultation with the DHCs, regional plans for the delivery of Cancer Control Services in each region of the province and to recommend the plans to the Minister; to plan, fund, provide and manage services in the Regional Cancer Centres, in partnership with hospitals and in other facilities as necessary; to develop, disseminate, monitor, report on and encourage adherence to standards and guidelines for all Cancer Control Services; to promote and contribute to the development and funding of cancer research, alone and in combination with other research funders; in partnership with the Ministry, institutions of learning and other relevant parties, to plan, promote and contribute to the education and training of health professionals providing Cancer Control Services; to promote and support programs designed to prevent cancer and programs in cancer related patient and public education; to gather and disseminate information about cancer; as necessary to further its objects and mandate, and in accordance with the provisions of this MOU and other agreements, the Freedom of Information and Protection of Privacy Act (FIPPA), the Act and other legislation, to directly or indirectly collect personal health information; and to do any other things that it or the Minister considers necessary or advisable to attain its objects or fulfill its mandate.

We understand that a new provincial network is being established and that CCO will be part of this network.

Cancer Care Nova Scotia

Cancer Care Nova Scotia will help achieve excellence in cancer prevention, treatment, care and research for all Nova Scotians. Since its inception in 1998 *Cancer Care Nova Scotia* coordinates, evaluates, and strengthens cancer services. Working with others in the field of cancer and health, our programs cover prevention, screening, education, treatment, follow-up care and palliation. Our work is community-focused, patient-centred, cost-effective and based on sound evidence.

Newfoundland Cancer Treatment & Research Foundation

The Newfoundland Cancer Treatment and Research Foundation (NCTRF) was established in 1971 as a provincial health care organization. Our mission is to serve the people of Newfoundland and Laborador by providing excellent and comprehensive cancer treatment, prevention, screening and supportive programs; actively participating in the education of health care professionals and providers; continuing and fostering research of high quality; and operating effective cancer registries.

We understand that as the Newfoundland Government has announced in March 2005 that the Foundation is to be subsumed under the provincial Ministry of Health

Quebec

A Centre for Cancer Control has recently been formed and is to take on the Cancer Control responsibility for the Province reporting to the Health Ministry.

New Brunswick

A report of December 2003 has been accepted in March 2005 and a Network is to be established that takes on most of the functions of an Agency. It will have a provincial cancer control leader reporting directly to the Minister of Health and a leadership team comprised of each of the elements of cancer control, together with advisory committees and an advisory council reporting to the Department of Health and Wellness.

PEI

No formalized Cancer agency. Most patients go to Nova Scotia or New Brunswick for treatment.

Appendix E: Recommendations from Pharmacy Task Force

The following is a summary of the major recommendations of the Task Team:

Major Recommendations:

Recommendations 1 to 8 are directed at improving the drug approval process and drug utilization management within the Agency.

Target time frames for implementation are broken down into Short-term (0 to 3 months), Medium-term (3 to 6 months), and Long-term (6 to 12 months).

1. The Saskatchewan Cancer Agency implement a new formalized structure to their drug approval process that includes two major committees – the Pharmacy and Therapeutics Committee and the Drug Assessment Committee. (Short)

2. The Saskatchewan Cancer Agency needs to incorporate the reviews of anti-cancer agents performed by the Common Drug Review (CDR) program in the same way the provincial drug plan's Formulary Committee will streamline their approval process through consideration of CDR recommendations. This needs to be clearly communicated in Agency drug approval policies. (Medium)

3. The Saskatchewan Cancer Agency needs to maintain a "quick response" approval process for "undesignated indications" of cancer therapies. This Exceptional Drug Coverage (EDC) process should also be used as an appeal process for drug approval decisions if new medical evidence becomes available to support a particular drug application. (Medium)

4. The Saskatchewan Cancer Agency develop a formal policy governing the administration and payment terms for cancer drugs that are not formally approved for coverage under the Agency's drug benefit list. (Medium)

5. The Saskatchewan Cancer Agency needs to ensure the transparency of their drug approvals processes and policies through broad communication with all staff, health stakeholders and cancer patients including the use of an appeal process for drug approval for cancer agents not covered through the Agency's approved drug benefit list. (Medium)

6. The Saskatchewan Cancer Agency continue to support their clinicians towards the development of provincial treatment guidelines for the treatment of cancer. These treatment guidelines need to be incorporated into Agency policies governing drug coverage and utilization. (Long)

7. The Saskatchewan Cancer Agency needs to establish a more timely and formal process for evaluating, predicting and budgeting future drug expenditures for cancer treatments. (Medium)

8. The Saskatchewan Cancer Agency formalize its Drug Utilization Management process for all approved therapies through the newly formed Drug Assessment Committee (DAC) to ensure the most appropriate use of SCA resources. (Short)

Recommendation 9 provides direction to the SCA with respect to future changes the SCA needs to consider with respect to the scope of coverage for cancer drugs and the reimbursement model for cancer drugs.

9. The Saskatchewan Cancer Agency should continue to provide coverage for approved cancer chemotherapies and supportive drug therapies used directly in the management of cancer until such a time that the Agency and Government agree to operational changes required with respect to maintaining the provision of an agreed to provincial standard of care and long-term financial stability of the systemic drug therapy program. (Short) This assessment needs to include a detailed analysis of such issues as:
    i. Funding for cancer drug therapy
    ii. The scope and responsibility for supportive drug coverage
    iii. The reimbursement model for cancer drugs

Recommendations 10 to 14 provide direction to the SCA with respect to the current contract service agreement, inventory management, and pharmacy resourcing.

10. The SCA renegotiate its service agreements with the Saskatoon and Regina regional health authorities as they pertain to the provision of pharmacy services. (Medium).

11. The SCA examine the implications of recruiting and hiring their own pharmacists, pharmacy technicians and support personnel with the intent of creating an Agency-wide pharmacy department that can provide administrative, distributive and clinical pharmacy services that better meet the current and future needs of the SCA. (Medium)

12. The SCA consider expanding their pharmacy services in both cancer centre pharmacies to provide inpatient distributive and clinical consultation services for cancer patients on oncology wards and seen in ambulatory care within the RHA's. (Long)

13. The SCA structure the new Pharmacy Department in order to ensure that the suggested administrative, clinical and distributive roles of the department can be implemented. (Medium)

14. The Saskatchewan Cancer Agency should maintain complete stewardship over the purchase, contract negotiation, and inventory management for all cancer drug therapies currently being provided to Saskatchewan cancer patients and covered by the Agency. (Medium).

Appendix F: Draft Role and Accountability Framework

L – Leadership . P – Partner.

	Dept of Health	SCA	Regions	CCS	Other Advocacy & Support Groups
System					
▪ Provincial Cancer Control Strategy	P	L	P	P	P
▪ Drug Approval, Impact Assessment and Funding Strategy	P	P			
▪ Population Health Monitoring, Surveillance and Reporting		L			
▪ Development and Dissemination of Clinical Practice Guidelines		L	P		
The Continuum of Care					
▪ Primary Prevention / Reduction in Population's Risk Factors	P	P	P	P	P
▪ Screening / Early Detection		P	P	?	?
▪ Diagnosis and Treatment Planning		L			
▪ Radiation Therapy Treatment		L			
▪ Systemic Therapy Treatment		L	P		
▪ Surgical Treatment		P	L		
▪ Rehabilitation and Support		P	P	?	P
▪ Palliative Care / End of Life		P	P		P
Research					
▪ Basic Research		L			
▪ Health Service Delivery Research		P	P		
▪ Clinical Trials		L			
Education					
▪ Cont. Health Professional / CME for Oncology		L	P	?	
▪ Oncology. academic training		L	P		