CIHI Annual Report, 2013–2014

Better data. Better decisions. Healthier Canadians.

Canadian Institute for Health Information

Institut canadien d'information sur la santé

Our Vision

Better data. Better decisions.
Healthier Canadians.

Our Mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values

Respect, Integrity, Collaboration, Excellence, Innovation

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Dr. Brian Postl, Board Chair


John Wright, President and CEO

Message From the Board Chair and President

As the **Canadian Institute for Health Information** (CIHI) wraps up our first two decades of work, we're taking time to reflect on what we've learned.

We recognize that as Canadian health systems evolve, so do the information needs of our customers and stakeholders. Last year alone, CIHI had 300 data requests and released more than 25 reports and analyses. We are actively collecting data and providing timely information to an ever-growing list of clients. We are continually being asked for data to support decision-making on complex issues like the quality and affordability of health care, the needs of an aging population and the challenges of delivering care more efficiently while achieving better outcomes.

In short, the demand for health information has never been greater. And CIHI is keeping pace.

How? To align with our strategic priorities, we've focused our efforts on effective data access and integration strategies, like implementing new timeliness standards for processing third-party data requests. Our website has been enhanced to make it easier for users to access our data and find out what is available. As well, we're contributing data to the Data Liberation Initiative, a partnership between post-secondary institutions and Statistics Canada that aims to improve access to Canadian data resources.

Earlier in the year, we launched **OurHealthSystem.ca**, an innovative, user-friendly, interactive website that allows Canadians to compare indicators of health and health services from province to province—and even hospital to hospital. The website has received positive feedback and is just one in a series of creative initiatives under the health system performance umbrella. CIHI is also poised to lead the development of new performance indicators at the multi-stakeholder Consensus Conference scheduled for fall 2014.

And there's more. For the first time, we have comprehensive drug claims data from British Columbia and, based on a successful pilot project, CIHI is now working with B.C. to support data submission to our ambulatory care reporting system. We are also working with our jurisdictional partners to expand the collection of patient-level physician billing data.

All in all, it's been a productive year.

In spite of these successes, it likely comes as no surprise that we continue to face the complex challenges of working in a climate that demands continual belt-tightening while increasing efficiencies. Health care dollars are increasingly scarce and, like many other health-centred organizations, CIHI has adjusted to these fiscal realities of an uncertain financial future while still delivering on our mandate. This means, among other things, we that are focusing on our priorities and looking at how we can do things more efficiently.

We are midway through our 2012 to 2017 strategic plan—drawing on our strengths and the solid foundation that has been two decades in the making to focus on the corporate priorities of improving the quality of data, supporting health system decision-making and delivering organizational excellence.

This year, we are taking the time to look back and celebrate 20 years of growth and accomplishments. However, it's equally important that we take the time to look at what's down the road. There is no doubt that CIHI's horizon is bright. Led by a knowledgeable management team and guided by an exceptional Board of Directors, CIHI's dedicated employees continue to collaborate with partners to disseminate timely and relevant health system data and to provide more comprehensive analyses that touch on all parts of the system.

Note From the Board Chair

It is my distinct pleasure, on behalf of CIHI's Board of Directors and staff, to acknowledge the immense contribution of outgoing president and CEO John Wright.

To say that John has been a capable leader for CIHI would be an understatement. Our most significant achievements over the four years of John's tenure stemmed from his vision, insightfulness and passion for CIHI's mandate. His understanding of our organization and its important role in the Canadian health environment has served us well and garnered much respect from our partners and stakeholders. On a personal level, John's engaging communication style and unending good humour have endeared him to Board members and staff alike.

It is also my pleasure to formally welcome our new CEO to the fold. David O'Toole comes to CIHI with a long and distinguished career in the Ontario public sector. The depth of his experience and leadership will be a valuable asset to our organization, and we are eager to continue to move forward under his guidance.

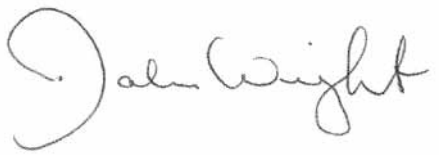
Thank you, John, for being such an integral part of CIHI's history: we wish you well in your future endeavours. And welcome, David, to your new role at CIHI: we look forward to working with you.

Brian Postl

We're proud of the innovative thinking behind all of our initiatives. Perhaps most importantly, we are proud that they are a clear and tangible response to the changing information needs of our clients and stakeholders.

Our vision statement says it all: Better data. Better decisions. Healthier Canadians. The efforts we make and the work we do, in these and all areas, will serve to reinforce CIHI's position on the health care landscape: that of a stable, focused and highly relevant organization that is recognized internationally as a leader in providing the health information that drives decision-making and policy development.

Dr. Brian Postl
Board Chair



John Wright
President and CEO

Our Accomplishments

Our 20th year of operations is a significant milestone—serving to remind us of the importance of our mandate and presenting an opportunity to look forward with fresh eyes.

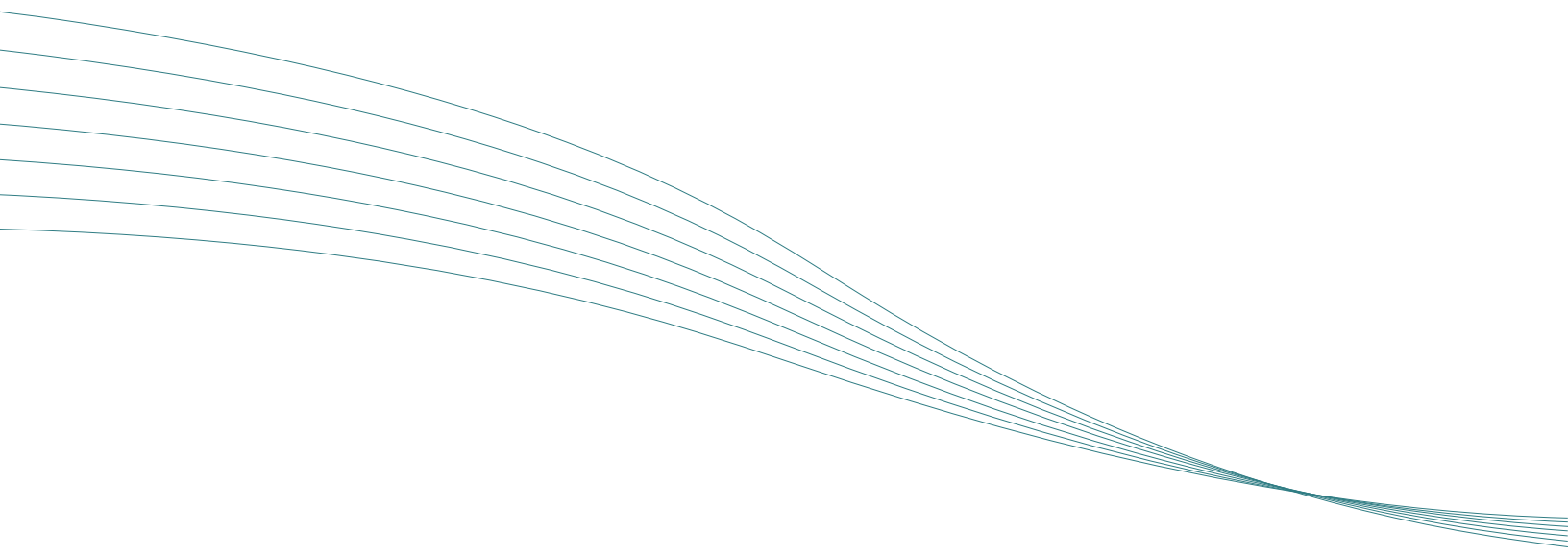
In this second year of CIHI's 2012 to 2017 strategic plan, we continued to build on our vision for CIHI's future of linking data to decisions and health outcomes. We've augmented that vision with conscious efforts to engage and listen: consulting with our customers and stakeholders to assess our effectiveness and to set priorities for health information in the coming years. This collaborative planning helps us ensure that CIHI remains a relevant and forward-thinking organization that is responsive to emerging needs.

Our approach is embodied in our strategic goals:

1. **Improve the comprehensiveness, quality and availability of data**
   - We will provide timely and accessible data connected across health sectors.
   - We will support new and emerging data sources, including electronic health records.
   - We will provide more complete data in priority areas.
2. **Support population health and health system decision-making**
   - We will produce relevant, appropriate and actionable analyses.
   - We will offer leading-edge performance management products, services and tools.
   - We will respond to emerging needs while considering local context.
3. **Deliver organizational excellence**
   - We will promote continuous learning and development.
   - We will champion a culture of innovation.
   - We will strengthen transparency and accountability.

We've worked hard to make strides in each of these areas. This annual report is full of examples of our progress over the past fiscal year: the targets we've met, the goals we've surpassed and the areas that we're still developing.

As we celebrate 20 years of CIHI, we remain confident in the strength of our strategic plan and in our renewed mandate, vision and values. These provide a solid foundation that supports our ongoing efforts to respond to stakeholder needs, help health systems make evidence-based decisions and, ultimately, improve the health of Canadians.



Improving the Comprehensiveness, Quality and Availability of Data

Today, data is being generated, collected and distributed with ever-increasing speed. However, we know that there are always more efficient and effective ways to improve how that data is managed and maintained.

Data is at the heart of who we are and what we do. This year, in alignment with our strategic priorities, CIHI directed its efforts toward providing more complete data while integrating data across health sectors. Our goal is to add value and provide results with a patient-centred focus.

Providing Timely and Accessible Data Connected Across Health Sectors

CIHI continues to improve the accessibility and timeliness of its data in many ways.

- A revamped **Access Data** page on CIHI's website provides a convenient and easy way to learn about how CIHI's data can be made available. A second, new web page, called **Data Holdings**, provides an overview of all the data held at CIHI and its availability.
- We implemented new processing timelines for third-party data requests, resulting in quicker turnaround.
- Hospital inpatient data from the Discharge Abstract Database (DAD) has been made available to researchers and students at post-secondary institutions through the Data Liberation Initiative in partnership with Statistics Canada. More data will be made available this coming year.

- CIHI Portal is a popular means to access CIHI data—the number of users doubled this year. New features make it easier to create dashboards and dynamic graphs to increase the understanding and use of the data. Access is now enhanced with the availability of bilingual hospital inpatient and emergency department (ED) data and reports.
- CIHI's new, interactive **OurHealthSystem.ca** website was designed to help Canadians access data about their health system easily and to learn about how the system is performing.
- **Quick Stats** on CIHI's website offers another source of free, publicly available aggregate data.
- Two key releases related to physician data were made available earlier than last year: *National Physician Database, 2011–2012 Data Release* came out four months earlier and *Supply, Distribution and Migration of Canadian Physicians, 2012* was released two months earlier.
- In an effort to connect data across health sectors to provide a system view of issues and to follow patients across the continuum of care, CIHI released the following reports using linked data:
  - *Hospital Admission Risk Prediction*
  - *The Effect of Bearing Surface on Early Revisions Following Total Hip Arthroplasty*
  - *Leaving Against Medical Advice: Characteristics Associated With Self-Discharge*
  - *End-of-Life Hospital Care for Cancer Patients*

Supporting New and Emerging Data Sources, Including Electronic Records

The vision paper *Better Information for Improved Health: A Vision for Health System Use of Data in Canada* was endorsed by the deputy ministers of health in May 2013. This document presents a unique opportunity created by the transition to electronic health records to raise awareness of the importance of collecting standardized data for health system uses.

Stemming from this, new work has begun on preparing and positioning the DAD for the future electronic health record environment. Options for this multi-year transition are being developed. Other programs, such as home care, continuing care, rehabilitation and ED/ambulatory care, are already collecting data at the point of care and are therefore well positioned to take advantage of advances in digital health.

Work is continuing in the area of primary health care. Content standards for electronic medical records and clinician-friendly pick-lists have been developed and validated by clinicians, nurse practitioners and decision-support specialists, with the intent of accelerating jurisdictional adoption and supporting structured data capture at the point of care.

To support a more balanced view of health system performance, CIHI has been working with jurisdictions to collect standardized measures of the quality of acute care services from the patient perspective and will be developing a data repository and reporting capability for patient experience data in the coming year.

Providing More Complete Data in Priority Areas

With the support of data providers and our jurisdictional partners, 2013–2014 was a very good year for data expansion.

- Following a successful implementation in B.C. EDs, the National Ambulatory Care Reporting System (NACRS) now contains data on more than 10 million ED visits annually, representing approximately 60% of ED visits across the country.
- The Canadian Joint Replacement Registry (CJRR) saw tremendous growth this year with mandatory electronic reporting in Ontario and British Columbia, along with submissions from Manitoba. This is the first year of implementation for CJRR's minimum data set and electronic submission by all data providers.
- Patient-level costing data, critical to CIHI's Case Mix products, received an important expansion with the participation of the IWK Health Centre in Nova Scotia.
- Consultations related to national health expenditure reporting took place. Based on our clients' feedback, we developed new, contemporary information products to engage users. We improved our website, created an executive toolkit, introduced infographics to CIHI's releases, created plain-language summaries of reports and enhanced our social media strategy.
- Pharmaceutical data at CIHI has been enhanced with the addition of historical claims data from B.C. Regular data submissions have been initiated, bringing the total number of jurisdictions participating to nine.
- This year, CIHI continued to work with Saskatchewan and Alberta to receive and analyze detailed physician billing data in support of key projects, including work to develop a population grouping methodology.
- The Alberta First Nations Home Care pilot project (led by the Alberta regional office of Health Canada) added 5 new communities in August 2013, increasing the number of sites to 11. Plans call for an additional five to seven new sites each year over the next three to five years, at which time all First Nations communities in Alberta will participate in CIHI's Home Care Reporting System (HCRS).
- After its first year of implementation, the Canadian Multiple Sclerosis Monitoring System (CMSMS) now holds more than 14,000 records on 2,800 persons living with MS. A pilot program is under way to expand data collection.

Table 1: Comprehensiveness of CIHI's Data Holdings, March 31, 2014

Health Care Category	Data on . . .	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	N.L.	Y.T.	N.W.T.	Nun.
Acute and Ambulatory Care	Inpatient hospitalizations	●	●	●	●	●	●[1]	●	●	●	●	●	●	●
	Day surgeries	●	●	●	●	●	●[2]	●	●	●	●	●	●	●
	Emergency departments	◐	●	◐	◐	●	●	⋯	◐	◐	○	●	○	○
	Ambulatory clinics	○	●	○	○	◐	○	○	◐	○	○	○	○	○
Continuing and Specialized Care	Hospital mental health	●	●	●	●	●	●	●	●	●	●	●	●	●
	Ontario mental health	○	○	○	◐	●	○	○	○	○	◐	○	⋯	○
	Rehabilitation	◐	◐	◐	◐	●	○	◐	◐	●	◐	—	—	—
	Continuing care	●	●	●	◐	●	○	◐	●	○	◐	●	⋯	○
	Home care	◐	●	●	◐	●	○	○	●	●	●	●	⋯	○
	Organ replacement	●	●	●	●	●	●	◐[3]	●	◐[3]	◐[3]	—	◐[3]	—
	Trauma (minimum data set)*	●	●	●	●	●	●	●	●	●	●	●	●	●
	Trauma (comprehensive data set)*	●	●	◐	●	●	●	●	●	—	●	—	—	—
	Joint replacements	●	◐[4]	◐	●	●	◐[4]	◐[4]	◐[4]	○	◐[4]	◐[4]	◐[4]	—
	Multiple sclerosis	○	◐	◐	●	⋯	○	○	○	○	○	○	○	○
Pharmaceuticals	Prescription drugs	●	●	●	●	●	—	●	●	●	◐	⋯	—	—
	Incidents	●	●	◐	◐	◐	○	●	◐	⋯	●	●	●	◐
Workforce	Physicians	●	●	●	●	●	●	●	●	●	●	◐	⋯	⋯
	Registered nurses	●	●	●	●	●	●	●	●	●	●	●	●	●
	Practical nurses	●	●	●	●	●	●	●	●	●	●	●	●	◐
	Psychiatric nurses	●	●	●	●	—	—	—	—	—	—	◐	—	—
	Nurse practitioners	●	●	●	●	●	●	●	●	●	●	—	●	●
	Occupational therapists	●	●	●	●	●	●	●	●	●	●	●	●	●
	Pharmacists	●	●	●	●	●	○	●	●	●	●	●	●	○
	Physiotherapists	●	●	●	●	●	●	●	●	●	●	●	—	—
	Radiation technologists	◐	●	●	●	●	●	●	●	●	◐	◐	◐	◐
	Laboratory technologists	◐	●	●	●	●	●	●	●	◐	◐	●	◐	◐
Health Spending	Health expenditures	●	●	●	●	●	●	●	●	●	●	●	●	●
	MIS	●	●	●	●	●	●	●	●	●	●	●	●	○
	Patient costs	●[5]	●[5]	○	○	●[5]	○	○	⋯	○	○	○	○	○

Legend

▲ Denotes progress in data collection efforts as compared with previous fiscal year.

● Complete Data Collection ◐ Partial Data Collection ● Data Submission Plans Being Developed

⋯ In Discussion ○ Not Implemented — Not Applicable

Notes

* 2013–2014 was the last year of data collection for the National Trauma Registry; historical data will be maintained.

1. Quebec submits MED-ÉCHO data on an annual basis. This data is processed and appended to the Discharge Abstract Database (DAD) to create the Hospital Morbidity Database (HMDB).
2. Quebec day surgery data is included in merged DAD/HMDB production data sets; the appropriate reference for this data is the HMDB.
3. Renal dialysis—fully implemented; organ transplant—not applicable.
4. Participation is voluntary and thus not complete.
5. Patient costing is implemented in a subset of health care organizations. Data collection is complete in this subset.

Data Privacy and Security

No matter what we're working on, we remain committed to protecting the privacy of our data and ensuring the security of the personal health information within our organization. Being entrusted with data that deals with sensitive information is a responsibility CIHI takes seriously.

We have a comprehensive privacy and security program to protect our data holdings, governed by the overarching Privacy and Security Framework. The framework is based on best practices for privacy and information management from across the public, private and health sectors. It includes a robust set of policies, procedures and protocols related to both privacy and information security.

CIHI is a prescribed entity under Ontario's *Personal Health Information Protection Act, 2004*. This allows health information custodians in Ontario—such as the Ministry of Health and Long-Term Care, hospitals and physicians—to disclose personal health information to us without patient consent for analysis or compilation of statistical information for the planning and management of the health system. The strict responsibilities that come with this designation assure our data partners across the country that our privacy and security policies comply with the highest standards in safeguarding important and sensitive information. Over the past year, we have been working with the Office of the Information and Privacy Commissioner of Ontario to renew our prescribed entity status.

To further strengthen our security program, CIHI implemented its 27001:2005 Information Security Management System (ISMS), which provides a structured methodology for the management and continual improvement of CIHI's information security posture. It provides for a formalized approach to decision-making based on risk; business objectives; and legislative, regulatory and contractual requirements. It also allows management to systematically examine the organization's information security risks and to design and implement a cohesive suite of information security controls and other forms of risk treatment. Further, it provides a mechanism for ongoing review to ensure that the information security controls continue to meet the organization's information security requirements over time.

CIHI is working toward certification of ISMS by ISO—the International Organization for Standardization. Achieving this certification will demonstrate CIHI's commitment to information security and the principles set out in its Privacy and Security Framework.

Data Quality

Data quality is fundamental to CIHI's mandate and a key corporate priority. Our data quality program is recognized nationally and internationally for its comprehensiveness and high standards. Improving quality is a collaborative and continuous effort. We work with all our data suppliers and users to improve the accuracy, comparability, timeliness, usability and relevance of our data and information products, and we work to promote a culture of data quality in and outside of CIHI.

Here are some of CIHI's recent data quality achievements.

- Released the 10th annual report on data quality to provincial and territorial deputy ministers of health.
- Examined quality issues related to the integration of CIHI data and conducted in-depth investigations into such areas as quality indicators and case mix.
- Collaborated with the Nova Scotia, Quebec and Saskatchewan ministries of health to refine the classification of their health expenditure data to improve comparability across jurisdictions.
- Launched the redeveloped Continuing Care Reporting System (CCRS), which includes timelier and more comprehensive data quality monitoring and reporting.
- Improved the information captured on stroke patients within the DAD through education and more comprehensive monitoring.
- Collaborated with the Ordre des infirmières et infirmiers du Québec, enhancing the education information captured in the Nursing Database (NDB).
- Produced quarterly data quality reports to monitor key data used in Ontario's funding model.
- Presented information on CIHI's data quality program at two international data quality conferences.

Improving Access to CIHI's Data

This year, the **Access Data** page on our website was enhanced to make it easier for stakeholders and the general public to gain access to free, publicly available data through

- Interactive tools on areas such as wait times and other hospital indicators, patient cost estimates and health system performance;
- **Quick Stats**, which provides aggregate-level health system data from a variety of data sources; and
- Analytical publications with figures, graphs and tables.

As well, graduate students can access CIHI's data at no cost through the Graduate Student Data Access Program. Researchers can also access a sample data set from the DAD through Statistics Canada's Data Liberation Initiative at no cost.

Clients submitting data to CIHI have access to additional interactive, secure and web-based reports.

And, for users who are unable to obtain the required data from any of the above sources, CIHI accepts requests for specific data at an aggregate or record level, where appropriate.

CIHI Data . . . Sheds Light on New Brunswick Health System Report Card

For three years, the New Brunswick Health Council (NBHC) has produced a **Health System Report Card** that shows where improvements are needed, where things are getting better and where they may be slipping.

Michelina Mancuso, the NBHC's executive director of Performance Measurement, says the report cards aims to help understand how to help deliver the best outcomes—the best quality care—at a reasonable cost. "We want to get a clearer picture of the citizens' care experience in New Brunswick," she says.

The **2012 report card** grades a balanced list of health care indicators to arrive at overall marks for accessibility, appropriateness, effectiveness, efficiency, safety and equity. It is changing perspectives in the areas of primary, acute and specialty care. While citizens know that their care experience is being assessed, health care decision-makers and physicians can see the forest for the trees—how various pieces of the system fit together. And health officials can better understand how to allocate resources to lead the province toward a sustainable health system.

CIHI's Influence

Three years back, the NBHC used a swath of CIHI's indicators (enabling provincial comparisons) as a base. From there, it added more indicators—many from CIHI—such as readmission rates and cost per weighted case. As Mancuso puts it, "With 50% of our indicators, CIHI is the foundation of the report card."

She says that CIHI's involvement, which includes support and guidance, gives legitimacy to the NBHC's approach. This has sparked a trusting relationship with the province's medical professionals. It has also meant that the NBHC has access to the best data available.

The NBHC's list of indicators has now evolved from 48 to 137. The organization is converting data into knowledge, particularly among the major indicators vital to the system such as access to care. The report card revealed that access to family doctors is rising but wait times for appointments remain a burden. This, in turn, affects inefficiencies elsewhere in the health care system.

The NBHC is most proud of its safety dimension, on which it scored an A grade. Of its 20 safety indicators, many are from CIHI; others are based on data from patient responses to care experience surveys. The NBHC also added more indicators from CIHI's **Canadian Hospital Reporting Project**, which yielded further insight into gaps in the system.

There was a key new finding this year: the province succeeds more at avoiding mortality through treatment rather than through prevention. The indicators show a need to focus on primary health care to reduce demand for hospital services. This allows NBHC to tell a story that will resonate in the community, namely: "Once a person is sick, we do well in treating him or her, but what are we doing to prevent him or her from getting sick in the first place?"

Supporting Population Health and Health System Decision-Making

CIHI collects a great deal of complex data. Our ongoing challenge is to use that data to generate actionable knowledge—knowledge that is delivered in a timely fashion, meaningful to jurisdictions, directly actionable and responsive to the needs of our clients and stakeholders.

This year, in accordance with our strategic priorities, we have worked to match our products and services with the needs of our clients. Our focus is on supporting population health and health system decision-making.

Producing Relevant, Appropriate and Actionable Analysis

CIHI's two-year Analytical Plan helps ensure our products provide our customers with the right information, when they need it and how they need it. This year, we provided data workbooks, infographics, PowerPoint slides, fact sheets and plain-language public summaries for many of our releases.

Key Releases in 2013–2014

In keeping with our mandate to increase the reporting of cancer data, we released *End-of-Life Hospital Care for Cancer Patients* in April 2013.

Health Indicators 2013, released in May, featured an In Focus section that highlights the expanded reporting of health indicators by socio-economic status.

Leaving Against Medical Advice: Characteristics Associated With Self-Discharge (October 2013) and *Chronic Disease Management in Primary Health Care* (February 2014) focused on quality and patient safety.

International Comparisons: A Focus on Quality of Care was released in January 2014, along with a companion web tool that allows users to compare provincial results with those of countries in the Organisation for Economic Co-operation and Development (OECD).

This year was the ninth in which we released wait time data. *Wait Times for Priority Procedures in Canada, 2014* includes wait time data for knee and hip replacement, hip repair, cataract surgery and radiation therapy. This year's report also included new data on wait times for five different types of cancer surgery.

Population Health and Health Care: Exploring a Population Health Approach in Health System Planning and Decision-Making (February 2014) provides insight into population health approaches used by organizations across Canada.

Top 10 CIHI Media Products

Table 2: Top 10 Media Products by Total Mentions

Focus of Media Product	Total Mentions
Physician migration and remuneration reports (September 26)	350
ED visits (February 13)	289
Annual report: *National Health Expenditure Trends, 1975 to 2013* (October 29)	211
***Benchmarking Canada's Health System: International Comparisons* (November 21)**	154
***End-of-Life Hospital Care for Cancer Patients* (April 30)**	112
***Treatment of Preventable Dental Cavities in Preschoolers* (October 17)**	102
Prescription drug spending (March 6)	88
OurHealthSystem.ca (November 7)	83
***Hospital Births in Canada: A Focus on Women Living in Rural and Remote Areas* and childbirth Quick Stats (July 4)**	66
***Health Indicators 2013*/self-injury data (May 23)**	53

Table 3: Top 10 Media Products by Circulation

Focus of Media Product	Circulation in Millions
ED visits (February 13)	47.0
Physician migration and remuneration reports (September 26)	45.2
Prescription drug spending (March 6)	37.8
***Canadian Organ Replacement Register Annual Report* (February 25)**	30.2
***Benchmarking Canada's Health System: International Comparisons* (November 21)**	26.2
Annual report: *National Health Expenditure Trends, 1975 to 2013* (October 29)	21.1
***International Comparisons: A Focus on Quality of Care* (January 23)**	21.0
Surgical wait times (March 27)	18.8
***Treatment of Preventable Dental Cavities in Preschoolers* (October 17)**	17.7
OurHealthSystem.ca (November 7)	16.9

Offering Leading-Edge Performance Management Products, Services and Tools

CIHI's Health System Performance Project: A Bigger-Picture Perspective

We completed the second year of our three-year initiative to enhance pan-Canadian health system performance reporting in 2013–2014. The objective of this initiative is to help jurisdictions in their efforts to improve the health of Canadians by

- Providing structured and coordinated pan-Canadian reporting on health system performance, tailored to the needs of our audiences;
- Producing analytical tools and products that support jurisdictional improvement priorities;
- Working with our partners to build capacity for using and understanding performance measurement and tools; and
- Reducing "indicator chaos" by working with our partners to identify which indicators are most important, how they relate to each other and how they can best support improvements.

One of the key products delivered this year was **OurHealthSystem.ca**, an interactive website specifically designed to provide performance indicators and information to a general public audience. This website, launched in November 2013, was designed using input from a series of public consultations. The result is an informative, user-friendly website that uses clear language and engaging infographics to report results at the national, provincial/territorial, health region and hospital levels for 15 indicators, grouped into five themes: access, quality of care, spending, health promotion and disease prevention, and health outcomes.

CIHI's **Indicator Library**, also released in November, provides a one-stop shop for standard information about 60 important performance indicators. The library makes it easy for stakeholders to get information about methodology, rationale, interpretation and data quality in a consistent format.

We also redeveloped the Health System Performance Measurement Framework to support the understanding and context of health system performance. Building on the CIHI/Statistics Canada Health Indicators Framework developed in 1999, the redesigned framework incorporates new dimensions of increasing interest to policy-makers, such as patient experience and value for money, and shows how performance dimensions interconnect with one another.

This year CIHI delivered a three-day pilot school on health system performance to a wide range of participants from the four Atlantic provinces, including ministry representatives, health region senior managers and decision-support analysts. The school focused on health system performance diagnosis and evaluation and actions for improvement.

During the past year, CIHI worked with an interjurisdictional group to develop a questionnaire to survey patient experiences in acute care hospitals. This survey tool can be used to support the reporting of patient experience indicators.

Health System Performance: What's on the Horizon

Key products and activities for the health system performance initiative planned over the next year include

- A publicly available performance reporting website to meet the information needs of executives and decision-makers in regional health authorities and hospitals;
- A second publicly available website that will report results of performance indicators for long-term care facilities;
- The initial phase of a private web-based analytical tool that will help users in health regions and hospitals explore and better understand their performance results;
- Development of indicators of hospital-acquired infections and other measures of in-hospital harmful incidents;
- A Consensus Conference of key stakeholders to guide us in determining short- and long-term indicator development priorities and in considering indicators that might be retired;
- Additional health system performance schools in Ontario and Manitoba;
- The start of work to develop a database for storing and reporting on patient experience survey results; and
- Ongoing updates of indicator results on **OurHealthSystem.ca**, as well as expansion of the **Indicator Library** to include more indicators, to ensure that these tools remain current.

CIHI held consultations across Canada with 100 people from various levels of the health system to determine what kind of information they use to measure and manage their health systems and the extent to which CIHI and Statistics Canada's Health Profiles were supporting this work. Lessons learned from the consultation and from the evaluation of the Canadian Hospital Reporting Project (CHRP) release will feed into CIHI's continuing work in health system performance.

Integrated eReporting

CIHI's Integrated eReporting program, launched in May 2013, is a structured, planned approach to bringing information together from several different sources into a single reporting environment.

Building upon the richness of CIHI's eReports and Portal tool, this integrated approach makes it easier for our clients to access the data they need. For example, an integrated, interactive reporting environment will support improved interactive, online analysis for health system managers and offer (to authorized users) a drill-down of results, including access to chart-level details.

- This product provides users with access to results for open-year data, allowing earlier previewing of public reports as well as timely access to data to support quality monitoring and improvement.
- This product lays the foundation for an analytical source of truth (ASOT) for hospital care, a central data repository containing enriched data. An ASOT supports data integration and the creation of analytical products from a single common source, helping to make the data more useful to our clients.

CIHI Data . . . Informs Patients' Choices for Breast Cancer Surgery

The four-year **Saskatchewan Surgical Initiative** (SSI) aims to cut surgery wait times by three months by 2014. Its goal is to improve your experience if you are a surgical patient.

One of the key activities for the initiative was for SSI to analyze its own provincial health statistics. And last fall, CIHI's breast cancer surgery report added some additional **revealing statistics** to the mix. Produced in collaboration with the Canadian Partnership Against Cancer (CPAC), this report examined the rates of mastectomy versus breast-conserving surgery (aka lumpectomy), of re-excisions and of other surgical procedures and complications. It uncovered wide variations in breast cancer surgery across the nation.

The data showed a crude mastectomy rate in Saskatchewan of 65%, second only to Newfoundland and Labrador's 69% as the highest in Canada. (The mastectomy rate varied greatly across Canada, dropping to 26% in Quebec.) Also on the agenda: variations across regions and facilities. But there was one problem with that explanation: next-door neighbour Manitoba's crude mastectomy rate was a much-different 36%.

To find out why cancer patients choose certain approaches—driven in part by the CIHI-CPAC report—a University of Saskatchewan study is under way. Patient interviews held in summer 2013 are helping to uncover what factors influence patient choices for mastectomy and breast-conserving surgery.

CIHI's Outreach Activities

Over the last year, we hosted several events designed to increase the understanding and use of our data and information:

- Health Data Users Day in Vancouver, hosted in collaboration with Statistics Canada
- CIHI's Health System Performance School, held in Halifax
- Health System Funding: The Canadian Picture, held in Toronto
- National Forum on High Users of Health Care, also held in Toronto
- Eyes Open to Patient Costing and Funding Approaches, co-hosted with Capital District Health Authority in Halifax

Always eager to work with and learn from health organizations, partners and stakeholders, CIHI participated in a number of events across Canada, such as the following:

- Saskatchewan Health Care Quality Summit 2013
- International Federation of Health Information Management Associations Congress
- Atlantic Health Quality and Patient Safety Learning Exchange 2013
- e-Health 2013
- Canadian Association for Health Services and Policy Research Annual Conference
- Canadian Public Health Association 2013 Annual Conference
- National Healthcare Leadership Conference
- Canadian Neurological Sciences Federation Annual Convention
- Canadian Society of Hospital Pharmacists Summer Education Sessions
- College of Medical Lab Technologists Association Annual Meeting
- interRAI Conference 2013
- Canadian Association of Paediatric Health Centres Annual Conference
- Manitoba Rural and Northern Health Healthcare Workshop
- Canadian Home Care Association Summit 2013
- Health Council of Canada—National Symposium on Quality Improvement
- Ontario Hospital Association—HealthAchieve 2013
- Family Medicine Forum 2013
- Health Quality Ontario—Health Quality Transformation 2013
- Canadian Society of Hospital Pharmacists Professional Practice Conference
- University of British Columbia Centre for Health Services and Policy Research 26th Annual Health Policy Conference
- British Columbia Patient Safety and Quality Council Quality Forum 2014
- Ontario Long Term Care Association: Together We Care

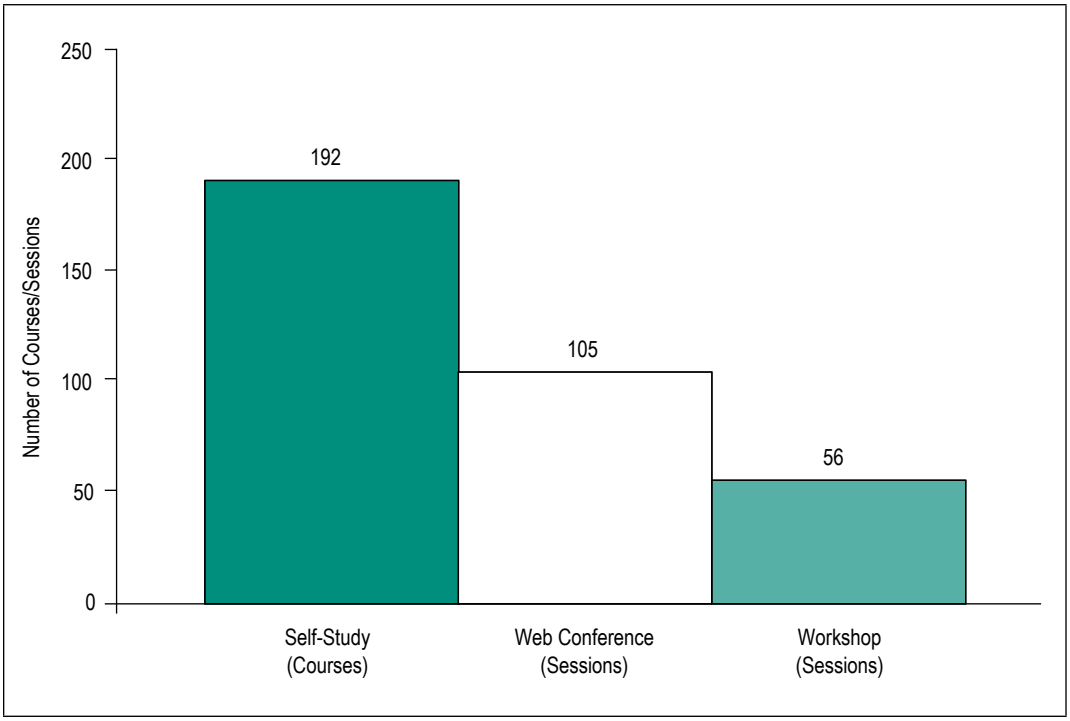
Customized Education

CIHI offers leading-edge courses, workshops, online learning and customized education to help our clients access the latest information and stay on top of evolving standards. They also help clients understand data collection and interpret CIHI's information to help make informed decisions.

- Self-study courses are available in both English and French and can be accessed online 24/7.
- Web conferences are live sessions delivered over the internet, in both English and French, by one or more instructors to a group of learners.
- Workshops are face-to-face sessions delivered by an instructor, in both English and French, that can be half-day, one-day or two-day sessions.

CIHI offered more than 350 courses in 2013–2014.

Figure 1: Self-Study, Web Conference and Workshop Education Offerings, 2013–2014



Source
CIHI Learning Centre

CIHI's Collaborations, at Home . . .

This year we continued to build on the strength of our partnerships with organizations that are working to improve health care in Canada.

- Meetings were held with the Canadian Blood Services Steering Committee to secure support for the organ donor efficiency project.
- An agreement was signed with Statistics Canada for the collection of residential long-term care facilities data for 2012–2013.

- Discussions were initiated to create a joint report on falls with Accreditation Canada and the Canadian Patient Safety Institute.
- A draft agreement was submitted to the Selkirk Mental Health Centre and Manitoba Health for the implementation of the RAI–Mental Health (RAI-MH) to support facility and provincial information needs related to inpatient mental health and addiction services.
- The First Nations, Inuit and Métis Health–Alberta Home and Continuing Care pilot project was expanded to include seven new communities from across Alberta.
- A patient costing and funding conference was held in Halifax in February 2014, in response to a request from Nova Scotia's Capital District Health Authority to build capacity in its use of costing data to support its strategic planning and budgeting efforts.

. . . and Abroad

CIHI understands that value can be gained from understanding how Canadian results compare internationally, as they help to enhance accountability, promote benchmarking and increase mutual learning. With this in mind, CIHI undertook several initiatives this year in collaboration with the OECD.

- We collected and provided Canadian data to the OECD and participated in expert advisory meetings with the OECD on selected topics of interest to Canada.
- CIHI hosted a meeting of the OECD Health Care Quality Indicators (HCQI) Expert Committee Bureau in fall 2013 to refocus and reduce the indicators of quality of care reported in the OECD's *Health at a Glance* biennial report. Canada will chair the HCQI Expert Committee in 2014.
- The Canadian submission for phase 1 of the OECD cardiovascular and diabetes project was launched.
- We contributed to several high-profile analytical and policy reports, including benchmarking health information infrastructures across countries and launching work on cardiovascular diseases and diabetes.
- *Benchmarking Canada's Health System: International Comparisons* was released in November 2013. This report looks at how Canada performs compared with the other OECD member countries on a variety of indicators of health system performance.

This year CIHI received several international delegations. In July 2013, visitors from the Ministry of Health in Tunisia and from the Nederlands Instituut voor Accreditatie in de Zorg (NIAZ) visited CIHI's offices and met with staff. The focus was on quality and standards in health care.

In November 2013, CIHI received a delegation from Japan's Tokyo-based Nomura Research Institute. Their visit focused on learning about CIHI and what we do, and more specifically on how data can be used to help keep health care costs down.

CIHI Data . . . Helps Manage Medication for Patients

There is a specific purpose behind every prescribed drug. Still, each drug requires context: a decision on medication needs to be based on the overall picture of the patient. This story is about the pharmaceutical picture.

Medication reconciliation (med rec) is the formal process of identifying all medications a patient is taking and using that list to provide him or her with correct medications at each transition of care. At its heart, med rec keeps patients safe, reducing complications and side effects. Staying organized in this way can take a bite out of the $2.6 billion annual price tag for drug-related hospitalizations.

Last November, **a unique report** on med rec emerged that painted a broad-stroke picture. **Accreditation Canada** led the project—with partners CIHI, the **Canadian Patient Safety Institute** and the **Institute for Safe Medication Practices Canada**—to illustrate how proper communication around medications fosters safer care.

Managing Multiple Medications

CIHI data helped show that med rec is key to preventing patient safety incidents. Specifically, med rec can reduce ED visits as well as the number of Canadians readmitted to hospitals—more than 180,000 patients returned to hospital within a month in 2010. By preventing drug interactions and side effects, med rec helps keep patients out of the hospital.

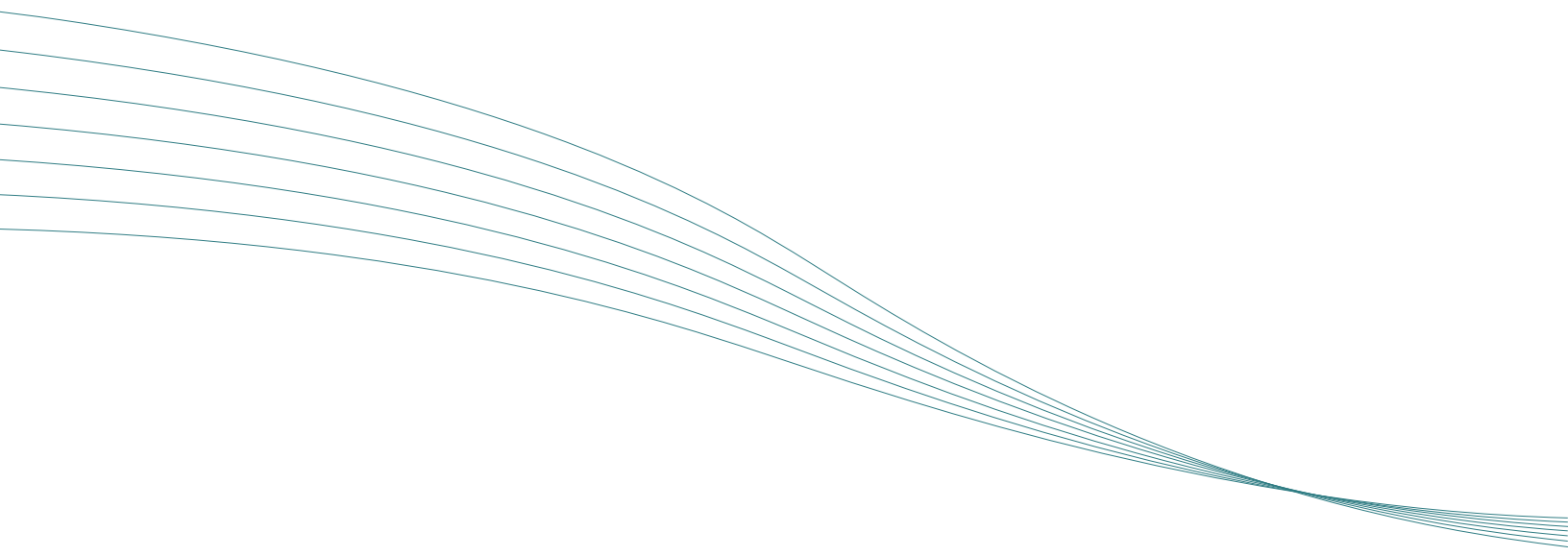
That is especially prudent for the 6.8 million Canadians with such ambulatory care sensitive conditions as asthma, chronic obstructive pulmonary disease, diabetes, hypertension and heart diseases. CIHI data shows that 58% of patients with at least one such condition reviewed their drugs with their family physician, while 40% said their medications were not well managed.

Then there are the aging baby boomers. Already, seniors take more drugs—including four times as many over-the-counter products—than anyone else. The value of proper medication management is clear when you consider that 63% of seniors take at least 5 drugs and 23% take at least 10. One-quarter of Canadian seniors use medications to treat three or more conditions.

So where do we go from here? Resources are in place to help push med rec further and make it a priority from coast to coast. As part of a **National Medication Reconciliation Strategy**, a curriculum for health care practitioners is being developed, along with tools, resources and technology supports.

Check out, for example, **this interactive map** of innovative med rec resources across Canada. And since med rec is everyone's responsibility, patients included, there is a new app for iPhones and iPads: **MyMedRec**, launched in 2012, permits Canadians to manage medications safely and appropriately.

Wherever patients transition in the health care spectrum, their current list of drugs should transition right along with them.



Delivering Organizational Excellence

Our people are the foundation of our success. That's why CIHI strives to remain an employer of choice with hiring, compensation and management practices that encourage staff retention.

The priorities outlined in our strategic plan reflect this commitment. We are investing in learning and development programs for staff, fostering a culture of innovation across the organization and focusing on outcomes through ongoing performance evaluation.

Here's how we did this year.

Promoting Continuous Learning and Development

We launched a management support program that helps newly appointed managers and directors get up to speed with the policies, procedures, culture, expectations and day-to-day responsibilities for their department or branch.

To continue developing our staff's technical skills, we produced three elearning analytical courses on how to apply statistical/epidemiological techniques to CIHI's data to better support our delivery of high-quality health information products.

On the leadership development front, training for the LEADS capability framework—Lead self, Engage others, Achieve results, Develop coalitions, System transformation—was successfully delivered in the Ottawa and Toronto offices. As well, we started to expand the LEADS program beyond formal leaders.

Work on our new career planning program is well under way. The program will include tools that help employees understand what their options are for managing their career at CIHI, including a job profile bank, self-assessment tools, a career path, learning and professional development options and support in identifying career progression options. The formal launch of this new program is slated for September 2014.

Championing a Culture of Innovation

Several improvements to CIHI's external website were undertaken this year: enhancements were made to the home page and redundant, outdated and trivial webpages were removed.

Lean management techniques are a key tool for fostering innovation while improving internal processes and are becoming an integral component of our day-to-day work at CIHI. We developed our own internal capacity by providing Lean training both in-house and externally. As well, 16 staff have achieved Greenbelt certification or are in the process of doing so.

Several Lean projects were launched in 2013–2014:

- Increasing timeliness and availability of Canadian MIS Database (CMDB) data
  - The CMDB is a key data source for CIHI's financial indicators. With the inclusion of these indicators in CIHI's integrated products (e.g., health system performance products), the timeliness and availability of CMDB data becomes more critical. The goal is to understand current processes and challenging areas where internal efficiencies can be found to create a streamlined and efficient data intake and quality assurance process.
- An improved process for developing media releases
  - We implemented efficiencies in the production process for media releases by applying Lean to address the number of reviews/approvals and reduce the number of handoffs.
- A process to improve the effectiveness and service level of recruitment
  - The recruitment process is a collaborative effort between the Human Resources department and hiring managers. The process, which involves many steps, is sometimes hindered by an excessive number of guidelines and checklists that may cause it to be ineffective and restrictive. The goal is to ensure that the process is focused on attracting the right talent.

CIHI increased its social media presence by introducing its **Pinterest** page with the release of the *National Health Expenditure Trends* annual report.

We also found innovative ways to save money through procurement. A new mobile device plan was implemented, with planned savings of $150,000 over three years. Enhancements were made to the contracting process, which netted more than $300,000 of savings in the year. As well, we identified savings on our travel expenses.

Strengthening Transparency and Accountability

This year CIHI began reporting on a new performance measurement framework and corporate indicators.

The 2013 employee survey was completed in June by 94% of eligible staff, with very positive results.

2013 CIHI Employee Survey

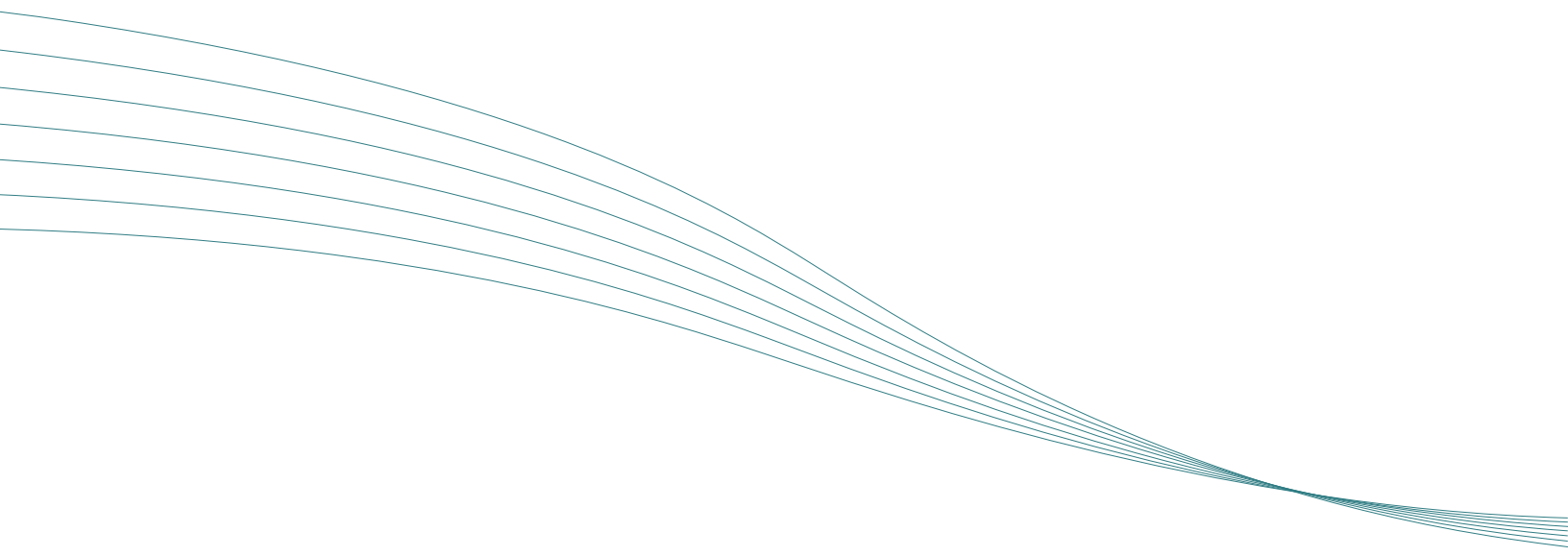
Every two years, CIHI's employees are invited to participate in an internal staff engagement and satisfaction survey. Areas surveyed include communication, training and development, compensation and benefits, risk/innovation, job stress and operating efficiency.

In 2013, CIHI's employee survey garnered an impressive 94% response rate and showed a 2% increase in overall satisfaction compared with 2011. Since CIHI introduced the employee survey in 2001, results have been above average compared with other organizations that participate in this type of survey.

Employee surveys provide a valuable opportunity to celebrate successes and identify opportunities for improvement. Management uses the results to foster pride and provide clear direction. Here are some highlights of the 2013 survey:

- Employees have very favourable perceptions of the clarity of direction at CIHI.
- Feelings related to teamwork/cooperation continue to be well above the norm, and most employees believe they work in a cooperative atmosphere.
- Most employees rate the quality of the products and services CIHI provides to clients favourably.
- All aspects of leadership exceed the overall norm and have improved.
- Recognition of efforts has improved and continues to be well above the norm.
- Overall morale within branches is rated highly compared with the norm.

In identifying opportunities for improvement, employees cited the need for CIHI to be more receptive to changing market needs for health information by maintaining a client focus and improving risk/innovation initiatives.



Our Organization

Employee Demographics

The number of full-time employees has decreased over the past three fiscal years to 718 in 2013–2014. This is a result of the staff reduction measures put in place in response to CIHI's reduced funding.

Employees with five years or less of service represented 48% of the workforce, down from 56% in the previous fiscal year. The number of employees with 6 to 10 years and 11 to 15 years of service increased by 6% and 1%, respectively, from the previous year. These changes in years of service are in line with the growth surge CIHI experienced from 2007 to 2009.

The average age of employees has slowly and steadily increased over time. In terms of education, the numbers have remained fairly consistent year over year.

Table 4: CIHI Employee Demographics

	2013–2014	2012–2013	2011–2012
Total Staff	**718**	**730**	**750**
Years of Service			
5 or Less	346 (48%)	408 (56%)	464 (62%)
6–10	249 (35%)	213 (29%)	190 (25%)
11–15	87 (12%)	78 (11%)	64 (9%)
16+	36 (5%)	31 (4%)	31 (4%)
Age			
Younger Than 30	66 (9%)	84 (12%)	73 (10%)
30–39	241 (34%)	280 (38%)	297 (40%)
40–49	236 (33%)	217 (30%)	220 (29%)
Older Than 50	175 (24%)	149 (20%)	159 (21%)
Female	69%	70%	69%
Education			
Post-Graduate and Master's	284 (40%)	289 (40%)	281 (38%)
Undergraduate	241 (34%)	242 (33%)	265 (35%)
Diploma	180 (25%)	184 (25%)	188 (25%)
High School	13 (2%)	15 (2%)	15 (2%)

Senior Management (as of March 31, 2014)

John Wright
President and CEO

Brent Diverty
Vice President, Programs

Caroline Heick
Executive Director, Ontario, Quebec and Primary Health Care Information

Anne McFarlane
Vice President, Western Canada and Developmental Initiatives

Scott Murray
Vice President and Chief Technology Officer

Stephen O'Reilly
Executive Director, Atlantic Canada and Integrated eReporting

Louise Ogilvie
Vice President, Corporate Services

Jeremy Veillard
Vice President, Research and Analysis

Elizabeth Blunden
Director, Human Resources and Administration

Lorraine Cayer
Director, Finance

David Clements
Director, Corporate Communications and Outreach

Mark Fuller
Director, Health Information Applications

Michael Gaucher
Director, Pharmaceuticals and Health Workforce Information Services

Jean Harvey
Director, Canadian Population Health Initiative

Kimberly Harvey
Director, Integration Services

Michael Hunt
Director, Health Spending and Strategic Initiatives

Kira Leeb
Director, Health System Performance

Cal Marcoux
Chief Information Security Officer

Barbara McLean
Director, Central Operations and Services

Kathleen Morris
Director, Health System Analysis and Emerging Issues

Anne-Mari Philips
Chief Privacy Officer and General Counsel

Mea Renahan
Director, Clinical Data Standards and Quality

Francine Anne Roy
Director, Strategy and Operations

Gregory Webster
Director, Acute and Ambulatory Care Information Services

Douglas Yeo
Director, Methodologies and Specialized Care

Board of Directors (as of March 31, 2014)

Chair

Dr. Brian Postl
Dean of Medicine
University of Manitoba

Canada at Large

Dr. Verna Yiu
Vice President, Quality, and Chief Medical Officer
Alberta Health Services

Dr. Marshall Dahl
Consultant Endocrinologist
Vancouver Hospital and Health Sciences Centre

Region 1 (British Columbia and Yukon)

Dr. David Ostrow
Chief Executive Officer
Vancouver Coastal Health Authority

Dr. Heather Davidson
Assistant Deputy Minister, Planning and Innovation
British Columbia Ministry of Health Services

Region 2 (Prairies, Northwest Territories and Nunavut)

Dr. Marlene Smadu
Vice-President, Quality and Transformation
Regina Qu'Appelle Health Region

Ms. Janet Davidson
Deputy Minister
Alberta Health and Wellness

Region 3 (Ontario)

There is currently no non-government member.

Mr. David Hallett
Associate Deputy Minister
Ministry of Health and Long-Term Care

Region 4 (Quebec)

Dr. Luc Boileau
President and Director General
Institut national de santé publique du Québec

Mr. Luc Castonguay
Assistant Deputy Minister, Planning, Performance and Quality Assurance
Ministère de la Santé et des Services sociaux

Region 5 (Atlantic)

Mr. John McGarry
President and Chief Executive Officer
Horizon Health Network

Mr. Bruce Cooper
Deputy Minister, Department of Health and Community Services
Government of Newfoundland and Labrador

Statistics Canada

Mr. Peter Morrison
Assistant Chief Statistician, Social, Health and Labour Statistics
Statistics Canada

Health Canada

Mr. George Da Pont
Deputy Minister of Health
Health Canada

The Board met in June 2013, November 2013 and March 2014.

We would like to recognize the contributions of several departing Board members:

- Dr. Vivek Goel, President and CEO, Public Health Ontario
- Mr. Paul Rochon, Associate Deputy Minister, Health Canada
- Ms. Elaine McKnight, Chief Administrative Officer and Associate Deputy Minister, British Columbia Ministry of Health
- Mr. Kevin McNamara, Deputy Minister, Nova Scotia Department of Health and Wellness
- Ms. Marcia Nelson, Deputy Minister of Health, Alberta Health

Board Committees

Human Resources Committee

The Human Resources Committee assists the Board in discharging its oversight responsibilities relating to compensation policies, executive compensation, senior management succession and other key human resources activities.

Privacy and Data Protection Committee

The Privacy and Data Protection Committee reviews and makes recommendations on the direction of the privacy program, reviews the findings of the privacy audit program, formulates recommendations for our privacy and data protection practices based on audit reports and advises the Board on implications of significant developments in privacy legislation. This committee also receives reports of major incidents within CIHI that could be seen as constituting a breach of confidentiality and submits an annual report to the Board.

Governance Committee

The Governance Committee assists the Board in improving its functioning, structure, composition and infrastructure. This committee also exercises the powers and duties of the nominating committee, in accordance with our bylaw.

Finance and Audit Committee

The Finance and Audit Committee reviews and recommends approval of the broad financial policies, including the yearly operational plans and budget, and reviews the financial position of the organization and our pension plan. This committee also formulates recommendations on the financial statements, the public accountant’s report and the appointment of the forthcoming year’s public accountants, and it provides direction and review of our internal audit program.

Table 5: Board Committee Membership, March 31, 2014

Committee	Members	Met
Human Resources	Brian Postl (Chair) Marshall Dahl John McGarry Marlene Smadu	June 2013 November 2013 March 2014
Privacy and Data Protection	Brian Postl (Chair) Luc Castonguay Heather Davidson	November 2013 March 2014
Governance	Janet Davidson (Chair) Luc Boileau George Da Pont David Hallett Peter Morrison Brian Postl	May 2013 September 2013 October 2013 January 2014
Finance and Audit	John McGarry (Chair) Bruce Cooper David Ostrow Brian Postl Verna Yiu	June 2013 November 2013 January 2014

CIHI celebrates

20 YEARS • ANS 1994 • 2014

Pre-CIHI

1988: National Health Information Council (NHIC) formed by Conference of Deputy Ministers to improve health information in Canada. ● **1989:** NHIC recommends that a task force assess the state of health information; it is led by the late Dr. Martin Wilk, former chief statistician of Canada. ● **1991:** *Health Information for Canada, 1991: A Report by the National Task Force on Health Information* (a.k.a. the Wilk Report) recommends creating a national health information coordinating council and an independent institute for health information.

1994

CIHI opens doors on **February 1, 1994**, through merger of Hospital Medical Records Institute (HMRI) and The Management Information Systems (MIS) Group. ● **CIHI's Board** becomes national health information coordinating council. ● **Rhéal Leblanc** named first CEO. ● CIHI's **focus** is to expand health information standards across health services, implement the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), examine Canadian Resource Intensity Weights (RIWs) and Case Mix Group (CMG) overlay and start redeveloping Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP) to become Canadian Classification of Health Interventions (CCI). ● CIHI starts with **3 databases**: Discharge Abstract Database (DAD), Ontario Trauma Registry (OTR) and Canadian Organ Replacement Register (CORR). ● Along with Toronto and Ottawa **offices**, CIHI has small offices in Edmonton, Vancouver and Halifax (former HMRI offices); the small ones close in a couple of years. ● CIHI begins with **112** employees.

1995

Privacy, confidentiality and security policy adopted. ● ***CIHI Directions ICIS*** quarterly newsletter launched. ● CIHIers have their work cut out for them: **projects multiply** and databases jump from 3 to 9 (with transition of employees and databases from Health Canada and Statistics Canada). ● Number of employees expands to **132**.

Statistics Canada, Health Canada and CIHI initiate **national consultation process** to develop roadmap for health information in Canada. ● National **health expenditure report** now published by CIHI instead of Health Canada. ● Work starts on developing **ICD-10-CA** (the Canadian enhancement to ICD-10) and CCI. ● Inaugural set of **strategic directions** released. ● First ***Products and Services Catalogue*** published.

1997

CIHI goes online with its first **website**. ● First **bilateral agreements** signed with 9 provinces and territories, providing them with access to CIHI's products and services. ● **Partnership for Health Informatics/Telematics** launched. ● CIHI launches precursor to the Continuing Care Reporting System (**CCRS**), the Ontario Chronic Care Patient System (**OCCPS**), our first venture into the electronic health record.

1996

1998

Richard Alvarez named CEO in January. ● CIHI, Health Canada and Statistics Canada hold **national consultation** on health information needs in Canada. ● **Health Information Needs Assessment** completed. ● First ***Maclean's Health Report*** published in collaboration with CIHI and Statistics Canada, which increases public visibility for CIHI. ● First employee **Rewards and Recognition** (R&R) event held.

1999

CPHI SPC
Canadian Population Health Initiative | Initiative sur la santé de la population canadienne

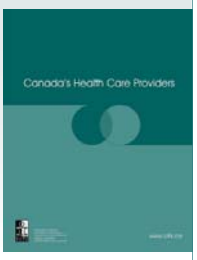
Canadian Population Health Initiative (**CPHI**) established. ● National e-Claims Standard Initiative (**NeCST**) established to standardize electronic health claims information—very influential and still used today. ● CIHI starts presenting **public health information** as well as traditional acute care information; data collection and reporting systems need to reflect the change. ● **Health Information Roadmap Initiative** begins, to take place over 4 years: $95 million federal grant for CIHI and Statistics Canada, start of 38 new projects. ● **Intranet** site for employees created.

2000

CIHI's first ***Health Care in Canada*** report launched at national press conference. ● CIHI reaches **193** full-time employees. ● **New for staff:** orientation package, buddy system and bi-weekly employee newsletter begin.

2001

Staggered implementation of **ICD-10-CA** and CCI begins across provinces and territories. Canada is the first country with an electronic format. ● CIHI introduces its first eReport: **eCHAP** (electronic Comparison of Hospital Activity Program). ● First ***Canada's Health Care Providers*** report published. ● Clients gain access to some CIHI educational material 24/7 with first **eLearning** course. ● CIHI focuses on **collaboration** and **data quality**. ● First **employee survey** shows high staff satisfaction.



2002

Roadmap II: In federal budget, CIHI and Statistics Canada get $95 million (over 4 years) to sustain original Roadmap objectives and federal, provincial and territorial reporting of comparable performance indicators. ● CIHI has **269** full-time employees.

2003

CIHI Board receives 2003 national **Conference Board of Canada/Spencer Stuart award** for innovation and excellence in governance. ● **Roadmap II+:** In federal budget, CIHI and Statistics Canada get $70 million more (over 3 years) for needs identified in 2003 Health Accord (primary care, home care, access to care, wait times, health human resources, pharmaceuticals). ● Development of Canadian Medication Incident Reporting and Prevention System (**CMIRPS**) begins. ● **Surveys** on physicians and nurses done. ● New **health indicators** identified, based on newly developed Health Indicator Framework. ● **Data Quality** Strategy and Data Quality Framework (DQF) Assessment launched. ● **Victoria** office opens.

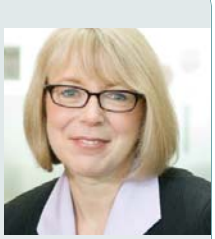
National Capital Region's Top 15 Employers
As featured in the Ottawa Citizen

CPHI outlines 4 strategic themes in action plan: place and health; healthy weights; determinants of mental health and resilience; and reducing gaps in health. ● CIHI produces more than **50 analytical products**. ● CIHI featured as one of Ottawa's **top 15 employers**.

2006

Roadmap III: Federal budget includes $110 million (over 5 years) to address needs identified in first ministers' 10-Year Plan to Strengthen Health Care (a.k.a. 2004 Health Accord). ● **Education registrations** for health professionals (face-to-face, eLearning, web conferences and video/teleconferences) increase by 2,000 from previous year to 8,300 across Canada. ● CIHI again named one of **Canada's top 100** employers and now one of **Ottawa's top 10**. ● **Montréal** office opens. ● CIHI has **20 databases** and **454** full-time employees.

2005



Bilateral agreement with Quebec signed: CIHI now has one with every province and territory. ● **Edmonton** office opens (later closes in 2010). ● *Maclean's* names CIHI one of Canada's **top 100 employers**. ● With Canadian Institutes of Health Research (CIHR), CIHI releases first national **information on adverse events** in Canadian hospitals. ● First **CPHI report** published: *Improving the Health of Canadians*. ● **Confidentiality** agreements now signed annually by CIHIers. ● CIHI first receives **prescribed entity status** under the *Personal Health Information Protection Act, 2004*. ● Many CIHI **products** made available **free of charge** on website. ● **Glenda Yeates** starts as CEO in August. ● Full-time employees number **402**.

Canadian Institute for Health Information
Institut canadien d'information sur la santé

2004

ten years dix ans
taking health information further
à l'avant-garde de l'information sur la santé

Canada's Top 100 Employers 2005
as featured in MACLEAN'S

2007

Federal budget provides up to $22 million per year to enhance coverage of data holdings and continue developing comparable health indicators. ● **CIHI Portal** goes online. ● First report on hospital standardized mortality ratio (**HSMR**) produced; eHSMR helps keep track of mortality rates. ● **CMG+** grouping methodology implemented (except in Quebec), developed with ICD-10-CA/CCI data; Canada only country with methodology that addresses both higher-cost patients and data quality. ● CIHI featured as one of Ottawa's **top 20 employers**.

2008

Atlantic office opens in **St. John's**. ● After more than a decade of sounding out "C–I–H–I," pronunciation officially changes to **"KAI-HI"** as part of rebranding efforts. ● CIHI runs **23 databases** and has **718** full-time employees.

2009

Patient Cost Estimator released; innovative online tool provides data on costs of many inpatient health services. ● **NACRS submission levels** introduced, permitting facilities to send emergency department wait time information quickly and efficiently to National Ambulatory Care Reporting System. ● **Privacy Awareness Month** (January) and **Security Awareness Month** (September) launched. ● New and improved intranet site developed: **CIHighway**. ● New branding gives all products consistent **look and feel**. ● CIHI uses **Twitter**: first tweet is about drug spending.

2010

John Wright starts as CEO in January. ● CIHI launches brand-new **website**. ● More reports **published online**, fewer are printed. ● CIHI now has **27 databases** and peaks at **797** full-time employees.

A vision for **health system use** of electronic data in Canada, developed in collaboration with Canada Health Infoway, receives endorsement by the Conference of Deputy Ministers of Health. ● CIHI pilots first **mobile app**, developed with Collaborative for Excellence in Healthcare Quality (CEHQ). ● Interactive website created for general public: **OurHealthSystem.ca**. ● Online **Indicator Library** brings together data, definitions and more in one place. ● Refreshed national **health expenditure report** with infographics released. ● CIHI's **Customer Experience** program launched. ● CIHI runs **28 databases**. ● Revamped **employee recognition program** launched. ● Full-time employees total **711**.

2013

New **vision and mission** approved, along with corporate values: respect, innovation, collaboration, excellence, integrity. ● CIHI starts 3-year plan to strengthen **health system performance** reporting. ● Online tool Canadian Hospital Reporting Project (**CHRP**) gives access to data for 600+ facilities. ● **Lean** process improvements begin.

2012

First pan-Canadian **hospital performance** report launched. ● **Major study** released: *Health Care Cost Drivers: The Facts*. ● **Wait times web tool** displays 4 years of comparable provincial data and allows for trending over time. ● 50-year-old **DAD mainframe retired**; data processing migrates to new system, resulting in greater efficiency and capacity for growth. ● CIHI develops and releases a pan-Canadian Primary Health Care **Electronic Medical Record** Content Standard.

2011

Looking Ahead

This report has focused on our accomplishments over the past year, and there is no doubt that looking back can provide us with valuable lessons. However, if there's one thing we have learned over 20 years, it's that we have to be flexible as we move forward in order to meet the ever-changing needs of our clients.

The foundation of our approach is the comprehensiveness and strength of our strategic priorities. A program of work based on these priorities is designed to maximize CIHI's contribution and influence through a range of innovative tools and strategies.

As CIHI looks ahead to 2014–2015, management has identified a set of activities to deliver on the strategic goals and priorities outlined in the *Business Plan, 2014 to 2017*.

Strategic Goal 1: Improve the Comprehensiveness, Quality and Availability of Data

To **provide timely and accessible data connected across health sectors**, CIHI will

- *Continue to enhance the infrastructure and processes to support improved health system performance eReporting across health sectors*. We will continue to produce innovative reporting initiatives to support health system performance management.
- *Continue to implement initiatives to improve the timeliness, quality and accessibility of data*. We will conduct a data surveillance pilot for the DAD; improve access to data for decision-makers, researchers and post-secondary students; and continue to implement data access strategy initiatives, including providing access to preliminary data and participating in Statistics Canada's Data Liberation Initiative.

- *Provide patient-focused health information by integrating data from across sectors*. We will develop a population risk adjusted grouping methodology, enhance the internal linkage methodology and infrastructure, and work with jurisdictions to increase receipt of linkable patient-level data.

To **support new and emerging data sources, including electronic records,** CIHI will

- *Explore and acquire data in emerging priority areas*. We will seek partners to develop a patient experience survey data holding, explore development of a patient-reported outcome measures data holding, continue work to acquire Vital Statistics death data and explore opportunities to expand mental health information.
- *Lead key elements of the pan-Canadian vision for the effective use of electronic records by health systems*. We will promote the health system use of data collected in e-health solutions and seek opportunities to acquire new data while preserving the existing data supply.
- *Enhance primary health care (PHC) information by developing standards and access to new data and information sources*. We will develop clinician pick-lists to support data elements in the PHC priority subset, continue to support adoption and implementation of electronic medical record standards, and produce analytical reports using available PHC-related data.

To **provide more complete data in priority areas,** CIHI will

- *Provide more comprehensive information on Canada's physicians*. We will continue to expand the collection of physician billing and alternate payment plan data.
- *Expand health care financing and funding information*. We will support jurisdictions in funding initiatives and continue to expand and enhance organization- and patient-level cost data and information about health expenditures in the non-acute sector.
- *Expand information in key data holdings to support health care quality, patient safety and outcomes*. We will expand collection of population-level pharmaceutical data and reporting of medication incident data. We will also continue to support uptake of existing data holdings such as CJRR, CCRS, HCRS and NACRS.

Strategic Goal 2: Support Population Health and Health System Decision-Making

To **produce relevant, appropriate and actionable analysis,** CIHI will

- *Implement a corporate analytical plan that is focused on the most relevant themes for decision-makers and system managers*. We will deliver a corporate analytical agenda aligned with priorities of jurisdictions, including quality and safety, health system efficiency and equity.

- *Build the capacity of health system stakeholders to use health data and information to support decision-making through education and engagement*. We will evaluate new capacity-building initiatives and implement initiatives such as health system performance, case mix and activity-based funding schools, a data users' day and student-related initiatives.

To **offer leading-edge performance management products, services and tools,** CIHI will

- *Deliver a health system performance agenda focused on meeting the needs of the public and health system managers and policy-makers*. We will release new quality and safety indicators and new region- and facility-level performance reports, and we will support the emergence of performance benchmarking initiatives.
- *Fill performance measurement gaps in health system efficiency and productivity*. We will develop analytical reports on health system efficiency and hospital productivity.
- *Use international comparisons, when possible, and initiate international benchmarking efforts*. We will release a joint report with the Canadian Institutes of Health Research (CIHR) on Canadian results for The Commonwealth Fund's annual health policy survey, and we will continue our involvement in OECD activities.

To **respond to emerging needs while considering local context,** CIHI will

- *Enhance our partnerships and relationships to assist in improved priority-setting to meet the needs of health system stakeholders*. We will renew a joint analytical plan with Statistics Canada. We will also continue to identify and build value-added partnerships at provincial, territorial and regional levels and leverage these partnerships to identify and respond to emerging health information needs.
- *Undertake targeted local initiatives that provide a solid basis for potential scaling up across Canada*. We will explore the expansion of diagnostic imaging analysis activities, continue work on case mix and activity-based funding initiatives under way in various jurisdictions, produce tailored analyses to support stakeholders in low-population areas and work with priority stakeholder groups to support their local analytical needs with a view to scale up across Canada.

Strategic Goal 3: Deliver Organizational Excellence

To **promote continuous learning and development,** CIHI will

- *Develop leadership capabilities to enhance leadership at all levels of the organization*. We will assess the new leadership support program and continue to implement leadership development programs and tools.
- *Share knowledge and promote adoption of leading practices*. We will implement a new coaching and mentoring program for CIHI staff.
- *Enhance learning and professional development offerings*. We will implement enhanced technical skills training for data analysts, assess technical skills training for information technology staff and identify enhancements, continue with current professional development offerings and provide support for emerging organizational needs.

To **champion a culture of innovation,** CIHI will

- *Implement an agenda to improve innovation awareness and create the conditions for successful innovation within CIHI*. We will continue to implement Lean initiatives, evaluate and enhance the corporate Lean program and implement task group recommendations on risk and innovation.

To **strengthen transparency and accountability,** CIHI will

- *Implement a rolling three-year business plan and associated processes*. We will revise and update the organization's multi-year business plan and review funding agreements with federal/provincial/territorial governments.
- *Enhance accountability through the performance measurement framework*. We will complete a stakeholder survey and a performance audit, assist Health Canada with its evaluation of CIHI and continue to monitor and report on organizational performance against established targets and with a focus on outcome measures.
- *Enhance the privacy and security program*. We will conduct an ISO certificate audit, consider options for expanding the scope of ISO security standards and participate in the review of CIHI's prescribed entity status.

In addition to, and in support of, the priority initiatives outlined above, CIHI will continue to focus on enhancing its corporate processes, IT system applications and electronic tools. We will also ensure that our ongoing core program of work and key functions are carried out in the most efficient and effective manner possible.

Management Discussion and Analysis

This section provides an overview of CIHI's operations and an explanation of our financial results. It should be read in conjunction with the financial statements contained in this annual report.

In accordance with Canadian accounting standards for not-for-profit organizations, the preparation of the financial statements as well as the integrity and objectivity of the data in them are management's responsibility. We design and maintain systems of internal controls to provide reasonable assurance that the financial information is reliable and available on a timely basis, that the assets are safeguarded and that the operations are carried out effectively.

The Board of Directors carries out its financial oversight responsibilities through the Finance and Audit Committee (FAC), which is made up of directors who are not employees of the organization. Our external auditors, Ernst & Young LLP, conduct an independent audit in accordance with Canadian generally accepted auditing standards and express an opinion on the financial statements. The auditors meet on a regular basis with management and the FAC and have full and open access to the FAC, with or without the presence of management. The FAC reviews the financial statements and recommends their approval by the Board of Directors. For 2013–2014 and previous years, the external auditors have issued unqualified opinions.

This section includes some forward-looking statements that are based on current assumptions and subject to known and unknown risks and uncertainties that may cause the organization's actual results to differ materially from those disclosed.

CIHI receives the majority of its funding, based on a proportional model, from the provincial/territorial ministries of health and the federal government. While the proportion coming from these two levels of government has evolved, it has been relatively constant over the last few years. Our ongoing program of work related to our core functions and key priority initiatives is managed within the total annual source of revenue, which averaged approximately $108 million between 2010–2011 and 2013–2014.

Table 6: Annual Revenue Profile

Annual Source of Revenue ($ Millions)*	2010–2011	2011–2012	2012–2013	2013–2014	2013–2014	2014–2015
	Actual	Actual	Actual	Planned	Actual	Planned
Federal Government	$89.6	$86.6	$83.0	$79.3	$77.7	$77.7
Provincial/Territorial Governments	$16.4	$16.4	$16.7	$17.1	$17.1	$17.4
Other†	$4.8	$8.0	$8.5	$4.5	$4.9	$5.2
Total Annual Source of Revenue	$110.8	$111.0	$108.2	$100.9	$99.7	$100.3

Notes

* Reflects annual revenue on a cash basis; therefore, excludes depreciation and pension plan accounting expenses–related revenue.

† Includes contributions from provincial/territorial governments for one-time special-purpose programs/projects as well as lease inducements received specifically in 2012–2013.

Since 1999, Health Canada has significantly funded, through a series of grants and contribution agreements referred to as the Roadmap Initiative or Health Information Initiative (HII), the building and maintenance of a comprehensive and integrated national health information system.

The HII funding agreement with Health Canada that was renewed in 2012 included a phased-in 5% reduction over three years. As a result, annual funding went from $81.7 million in 2012–2013 to $77.7 million in 2014–2015.

In 2013–2014, some delays were encountered with a few key projects, which gave rise to an underspending of $1.6 million of the HII funding. Per our agreement with Health Canada and subject to annual approval, this amount will be carried forward to 2014–2015.

Through bilateral agreements, the provincial/territorial ministries of health continued to fund our Core Plan, a set of products and services provided to the ministries and identified health regions and facilities. Effective 2012–2013, these agreements provide for an annual 2% increase and accounted for $17.1 million in 2013–2014.

Management Explanation of Results

Table 7: Operating Expenses

Operating Expenses ($ Millions)*	2010–2011	2011–2012	2012–2013	2013–2014	2013–2014	2014–2015
	Actual	Actual	Actual	Planned	Actual	Planned
Salaries and Benefits	$71.9	$71.3	$76.8	$77.5	$75.6	$79.8
External Professional Services, Travel and Advisory Committee Expenses	$17.4	$14.9	$11.2	$9.0	$8.8	$10.8
Occupancy, Information Technology and Other	$17.8	$17.6	$17.3	$16.9	$16.3	$16.1
Total Operating Expenses	$107.1	$103.8	$105.3	$103.4	$100.7	$106.7

Note

* Includes amortization of capital assets and pension plan costs.

Our total operating expenses for 2013–2014 were $100.7 million, a decrease of $4.6 million over 2012–2013. This decrease is mainly attributable to a reduced need for contract staff and external consultants to assist with our program of work and key initiatives. As well, our occupancy costs are lower as a result of the consolidation of the Ottawa offices.

Total remuneration, including any fee allowance or other benefits to our senior management team involved in the accomplishment of our three strategic directions, totalled $5 million in 2013–2014.

The total expenses variance relative to planned 2013–2014 activities amounts to $2.7 million and relates primarily to the underspending noted above and a lower amortization amount of the pension plan costs included in the salaries and benefits expenses. For accounting purposes, the annual pension plan expense is based on an accounting standard that has an underlying methodology and interest rates prescribed by the Chartered Professional Accountants of Canada.

As a proportion of the total operating expenses, our actual investments in our three core functions remained relatively in line with the planned expenses.

Figure 2: Actual Operating Expenses by Core Function, 2013–2014

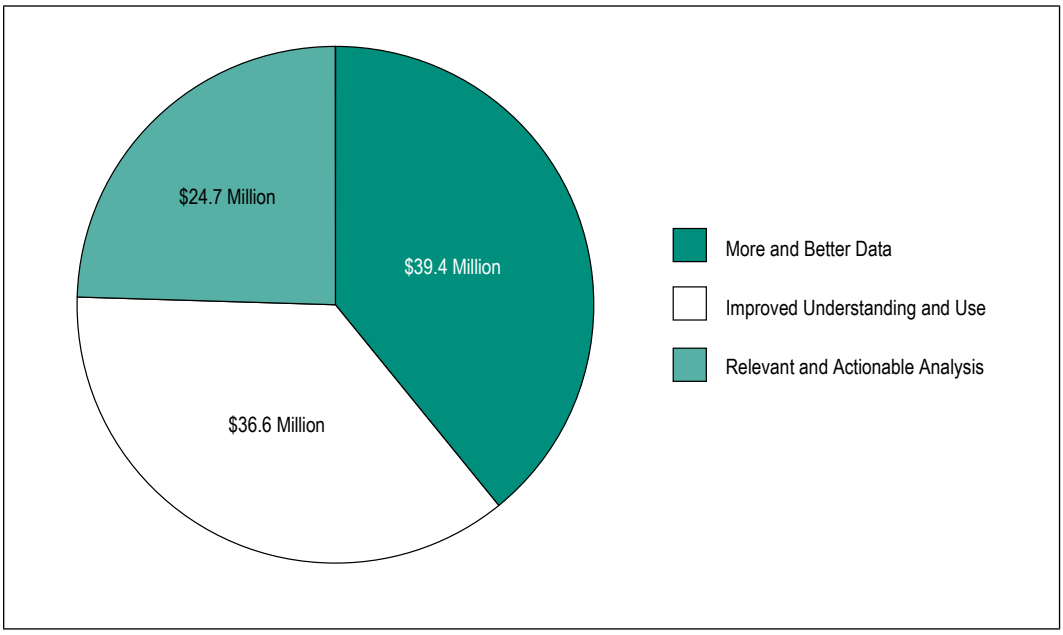


Table 8: Capital Investments

Capital Investments ($ Millions)	2010–2011	2011–2012	2012–2013	2013–2014	2013–2014	2014–2015
	Actual	Actual	Actual	Planned	Actual	Planned
Furniture and Office Equipment	$0.2	$0.1	$0.1	$0.1	—	—
Computers and Telecommunications Equipment	$1.5	$2.4	$1.8	$1.3	$2.3	$0.7
Leasehold Improvements	$0.3	—	$0.4	—	$0.1	—
Total Capital Investments	$2.0	$2.5	$2.3	$1.4	$2.4	$0.7

Acquisition of capital assets for 2013–2014 amounted to $2.4 million, a slight net increase of $100,000 from 2012–2013. One-time leasehold improvements of $400,000 were completed in 2012–2013 as a result of the consolidation of our Ottawa offices, whereas additional investments in computer hardware, software and telecommunications-related equipment were made in 2013–2014, primarily related to the ongoing upgrade of the network infrastructure for our offices.

The capital assets variance of $1 million relative to planned 2013–2014 activities relates to information technology and telecommunications. Due to resource availability in the current year, a number of initiatives planned for 2014–2015 were accelerated to 2013–2014. These included a network switch and other related equipment replacement, as well as the renewal of computers and laptops.

Pension Plans

Our registered defined benefit pension plan offers our employees an annual retirement income based on length of service and final average earnings; it is funded jointly by employees and CIHI. The plan assets as of March 31, 2014, were $122 million for a total of 948 members, 74% of whom are active participants.

Contributions are determined by actuarial calculations and depend on employee demographics, turnover, mortality, investment returns and other actuarial assumptions. CIHI's and employees' contributions are pooled, invested and professionally managed by five investment managers to ensure diversification. To exercise effective management and stewardship of the investment funds, the investment managers' performance and the investment policy are reviewed annually.

Two actuarial valuations are prepared for the plan. The first one is for accounting purposes (see note 7 of the financial statements); the second one is for funding purposes and also for regulatory purposes and management of the plan. The actuarial valuations for accounting and funding purposes are prepared at different times and use different methodologies and assumptions. Based on the accounting actuarial valuation, on March 31, 2014, the plan reported a surplus of $23 million, compared with $23.2 million on March 31, 2013.

On the funding basis, the plan deficit of $5.2 million reported to the regulatory authorities as at January 1, 2011, was funded in its entirety by the end of 2011–2012. In fall 2012, as a result of exceptionally poor economic/market conditions, our external actuaries extrapolated a significant solvency deficit of approximately $29.5 million. Based on these results, and with no indication of significant market recovery in the foreseeable future, CIHI's management proactively made voluntary special payments to the plan of $8.7 million in 2012–2013 and $2.4 million in 2013–2014 to address the deterioration of the plan's funded status. In addition to these payments and the positive and impressive returns on investments, we anticipate that the plan is fully funded as at January 1, 2014. An actuarial valuation for funding purposes as at that date is currently under way.

Also, we continued our efforts to reach the employer–employee cost sharing ratio of 55–45, respectively. Employees' contribution rates were increased by 0.3% on January 1, 2013, and January 1, 2014.

In addition to the contributory defined benefit plan, we supplement the benefits of employees participating in the plan who are affected by the application of the *Income Tax Act*'s maximum pension limit. The supplementary plan is not pre-funded and we make benefit payments as they become due. These benefits are accrued and recognized in our financial statements in accordance with applicable accounting rules.

Internal Audit Program

Our internal audit program provides independent and objective assurance to add value to and improve our operations. It helps us accomplish our objectives by bringing a systematic, disciplined approach that evaluates and improves our control and governance processes.

Our annual audit plan is prepared using a risk-based methodology that targets our audit resources at areas of highest risk, significance and value for the organization. In 2013–2014, activities included vulnerability assessments for the IT network and selected applications, as well as audits of access rights for terminated staff and consultants, including access to unencrypted health card numbers. The contracting processes, adherence to CIHI's privacy and security policies, and CIHI's pension plan governance and prudent investment practices were also reviewed. Action plans were developed to address the areas for improvements recommended by the consultants contracted by us to specifically perform these activities.

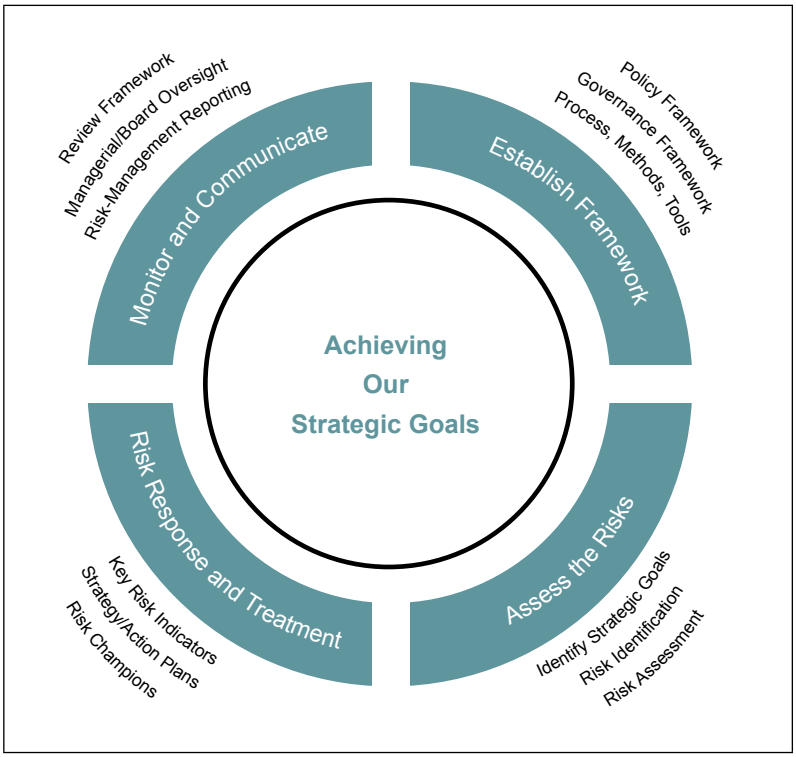
In 2014–2015, the focus of the internal audit program will continue to be on information security and privacy, as well as contracting and procurement.

Risk Management

The goal of CIHI's risk management program is to foster reasonable risk-taking based on risk tolerance. CIHI's approach to risk management is to proactively deal with future potential events through risk mitigation strategies. This risk management program serves to ensure management excellence, strengthen accountability and improve future performance. It supports planning and priority-setting, resource allocation and decision-making. CIHI is committed to focusing on corporate risks that can be applied across the organization, have clear links to achieving our strategic directions, are likely to remain evident for the next three to five years and can be managed by CIHI's senior leadership.

CIHI's *Risk-Management Framework* consists of the following four cyclical processes targeted toward the successful achievement of our strategic directions:

Figure 3: CIHI's Risk-Management Framework



Risk Management Activities for 2013–2014

The executive management team assessed a number of key risks that could prevent CIHI from achieving its strategic directions based on their likelihood of occurrence and their potential impacts. Four of these were identified as corporate risks due to their high level of residual risk (risk level after considering existing mitigation strategies).

Remaining Relevant

The increased availability of data from internal jurisdictional systems, including clinical registries, could make the need for national/pan-Canadian data seem less relevant. CIHI addressed this concern by recommitting to its emerging issues and rapid response programs. In addition, we completed the initial phase of the Integrated eReporting initiative and launched **OurHealthSystem.ca**. Through successful discussions with federal/provincial/territorial ministries of health, CIHI received targeted funding to develop products and services that are useful to multiple jurisdictions, including the patient experience survey database and the Canadian component of The Commonwealth Fund's survey.

Electronic Health Record/Electronic Medical Record

The opportunities to be realized from implementing electronic health records (EHRs) and electronic medical records (EMRs) across Canada could be offset by the lack of standardized data, which prevents us from generating usable information from these data sources. CIHI is continuing to hold discussions with Health Canada and Canada Health Infoway on the impact of the evolving EHR/EMR environment on CIHI, and we continue to demonstrate CIHI's role in the use of data to improve the health system with the Conference of Deputy Ministers.

In the last year, CIHI developed a multi-year plan to ready and align DAD data collection with the external EHR environment. We successfully secured a collaborative demonstration project to test, validate and refine assumptions for the DAD's future data supply with an Ontario facility, and discussions are in progress with regions in Alberta and B.C. to do the same.

We also increased awareness of the lessons learned from using PHC data for health system use via numerous presentations across the country.

Funding

CIHI experienced a progressive decline in funding over its three-year Health Canada funding agreement, which comes to term in March 2015. To meet financial pressures, CIHI maximized its use of available funding toward new priority investments and successfully managed the employee pension plan. We developed business cases to support our pending funding request to Health Canada and developed opportunities to cost-share new initiatives with provincial ministries.

Building Relationships

New provincial bodies in Canada's health care system have emerged, such as provincial quality/health councils that have similar mandates as CIHI's: to report on health system performance. To address these potential overlapping roles, CIHI continued to support regional/provincial initiatives, such as a forum on the use of continuing care data at the delivery level. Our exploration of additional opportunities to engage federal/provincial/territorial sectors and key stakeholder groups enabled CIHI to identify and act upon region-specific needs to develop or enhance our products and services (e.g., undertaking further work on indicator development for the Regina Qu'Appelle Health Region).

Audited Financial Statements

To the Board of Directors of the Canadian Institute for Health Information

Report on the Financial Statements

We have audited the accompanying financial statements of the Canadian Institute for Health Information (CIHI), which comprise the balance sheet as at March 31, 2014, and the statements of revenue and expenses, changes in net assets, and cash flow for the year then ended and a summary of significant accounting policies and other explanatory information.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' responsibility

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

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

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of CIHI as at March 31, 2014, and the results of its operations and its cash flows for the years then ended, and in accordance with Canadian accounting standards for not-for-profit organizations.

Report on Other Legal and Regulatory Requirements

As required by the *Corporations Act* (Ontario), we report that, in our opinion, Canadian accounting standards for not-for-profit organizations have been applied on a basis consistent with that of the preceding year.

Ottawa, Canada,
June 19, 2014

Ernst & Young LLP

Chartered Accountants
Licensed Public Accountants

Balance Sheet

As at March 31

	2014 $	2013 $
Assets		
Current		
Cash and cash equivalents *(note 3)*	**14,985,889**	12,288,256
Accounts receivable *(note 4)*	**1,601,019**	1,933,367
Prepaid expenses	**3,034,327**	2,465,859
	19,621,235	16,687,482
Capital assets *(note 5)*	**11,265,372**	12,896,058
Other assets *(note 6)*	**166,969**	402,790
Accrued pension benefit asset *(note 7)*	**22,985,852**	23,189,100
	54,039,428	53,175,430
Liabilities		
Current		
Accounts payable and accrued liabilities *(note 9)*	**5,985,004**	4,621,265
Unearned revenue	**2,433,219**	2,764,093
Deferred contributions *(note 10)*	**4,663,218**	2,666,146
	13,081,441	10,051,504
Accrued pension benefit liability *(note 7)*	**739,865**	674,003
Deferred contributions *(note 10)*		
Expenses of future periods	**22,908,296**	23,347,234
Capital assets	**8,595,366**	9,937,172
Lease inducements *(note 11)*	**2,755,870**	3,344,247
	48,080,838	47,354,160
Net Assets		
Invested in capital assets	**1,964,611**	1,996,046
Unrestricted	**3,993,979**	3,825,224
	5,958,590	5,821,270
	54,039,428	53,175,430

Commitments *(note 15)*

See accompanying notes.

On behalf of the Board

Director

Director

Statement of Revenue and Expenses

Year ended March 31

	2014 $	2013 $
Revenue		
Core Plan *(note 12)*	**17,050,273**	16,713,725
Sales	**2,370,426**	2,262,785
Funding—other *(note 13)*	**2,218,267**	5,209,830
Health Information Initiative *(note 10)*	**78,938,509**	81,048,945
Other revenue	**264,245**	273,044
	100,841,720	105,508,329
Expenses		
Compensation	**75,585,111**	76,757,676
External and professional services	**6,196,672**	8,591,476
Travel and advisory committee expenses	**2,643,654**	2,629,463
Office supplies and services	**854,977**	1,100,554
Computers and telecommunications	**6,621,034**	7,048,728
Occupancy	**8,802,952**	9,147,232
	100,704,400	105,275,129
Excess of revenue over expenses	**137,320**	233,200

See accompanying notes.

Statement of Changes in Net Assets

Year ended March 31

	Invested in Capital Assets	Unrestricted	2014	2013
	$	$	$	$
Balance, beginning of year	**1,996,046**	**3,825,224**	**5,821,270**	5,588,070
Excess (deficiency) of revenue over expenses	**(643,351)**	**780,671**	**137,320**	233,200
Net investment in capital assets	**611,916**	**(611,916)**	**—**	**—**
Balance, end of year	**1,964,611**	**3,993,979**	**5,958,590**	5,821,270

See accompanying notes.

Statement of Cash Flows

Year ended March 31

	2014 $	2013 $
Operating Activities		
Excess of revenue over expenses	**137,320**	233,200
Add (deduct) items not affecting cash		
Amortization of capital assets	**3,926,421**	4,562,238
Amortization of lease inducements	**(588,377)**	(724,959)
Pension benefits	**269,110**	(4,397,599)
Amortization of deferred contributions—capital assets	**(3,076,605)**	(3,929,953)
Loss on disposal of capital assets	**50,980**	327,892
	718,849	(3,929,181)
Changes in non-cash working capital items *(note 14)*	**796,745**	(3,214,868)
Net change in other assets	**235,821**	(192,507)
Net change in deferred contributions	**3,292,933**	4,628,161
Cash provided by (used in) operating activities	**5,044,348**	(2,708,395)
Investing Activities		
Acquisition of capital assets	**(2,356,941)**	(2,309,607)
Proceeds on disposal of capital assets	**10,226**	4,637
Proceeds on disposal of investments—Roadmap	**—**	751,664
Cash used in investing activities	**(2,346,715)**	(1,553,306)
Financing Activities		
Lease inducements received	**—**	1,885,594
Cash provided by financing activities	**—**	1,885,594
Net increase (decrease) in cash	**2,697,633**	(2,376,107)
Cash and cash equivalents, beginning of year	**12,288,256**	14,664,363
Cash and cash equivalents, end of year	**14,985,889**	12,288,256
Represented by:		
Cash (bank indebtedness)	**1,285,889**	(461,744)
Short-term investments	**13,700,000**	12,750,000
	14,985,889	12,288,256
Supplementary information		
Interest received	**197,539**	216,981
Interest paid	**62**	—

See accompanying notes.

Notes to Financial Statements

March 31, 2014

1. Organization

The Canadian Institute for Health Information (CIHI) is a national not-for-profit organization continued under Section 211 of the *Canada Not-for-Profit Corporations Act*.

CIHI's mandate is to lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

CIHI is not subject to income taxes.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations.

The following are the significant accounting policies:

Revenue Recognition

CIHI follows the deferral method of accounting.

Funding contributions are recognized as revenue in the same period as the related expenses are incurred. Amounts approved but not received at the end of the period are recorded as accounts receivable. Excess contributions which require repayment in accordance with the agreement are recorded as accrued liabilities.

Contributions provided for a specific purpose and those restricted by a contractual arrangement are recorded as deferred contributions, and subsequently recognized as revenue in the same period as the related expenses are incurred. Contributions provided for the purchase of capital assets are recorded as deferred contributions—capital assets, and subsequently recognized as revenue over the same terms and on the same basis as the amortization of the related capital assets.

Interest revenue is recorded as period income on the basis of the accrual method.

Restricted investment revenue and investment losses on restricted contributions are debited or credited to the related deferred contributions account and recognized as revenue in the same period as eligible expenses are incurred.

Capital Assets

Capital assets are recorded at cost and are amortized on a straight-line basis over their estimated useful lives, as follows:

Tangible	
Computers	5 years
Furniture and equipment	5–10 years
Telecommunication equipment	5 years
Leasehold improvements	Term of lease
Intangible	
Computer software	5 years

Lease Inducements

Lease inducements, consisting of leasehold improvement allowances, free rent and other inducements, are amortized on a straight-line basis over the term of the lease.

Pension Benefits

The actuarial determination of the accrued benefit obligations for pensions uses the projected benefit method prorated on service which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors.

For the purpose of calculating the expected return on plan assets, those assets are valued at fair value.

Actuarial gains or losses arise from the difference between actual long-term rate of return on plan assets for a period and the expected long-term rate of return on plan assets for that period or from changes in actuarial assumptions used to determine the accrued benefit obligation. The excess of the net accumulated actuarial gain or loss over 10% of the greater of the benefit obligation and the fair value of plan assets is amortized over the average remaining service period of active employees. The average remaining service period of the active employees covered by the registered pension plan is 13 years (2013—13 years). The average remaining service period of the active employees covered by the supplementary retirement plan is 10 years (2013—10 years).

Foreign Currency Translation

Revenue and expenses are translated at the exchange rates prevailing on the transaction date. Any resulting foreign exchange gains or losses are charged to miscellaneous income or expenses. Foreign currency monetary assets and liabilities are translated at the prevailing rates of exchange at the balance sheet date.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from management's estimates as additional information becomes available in the future.

The estimated useful lives of capital assets and the amount of accrued liabilities, including the accrued pension benefits, are the most significant items for which estimates are used.

Financial Instruments

Financial instruments are measured at fair value on initial recognition. Subsequent to initial recognition, they are accounted for based on their classification. Cash and cash equivalents as well as investments are measured at fair value. Accounts receivable net of allowance for doubtful accounts and accounts payable and accrued liabilities are carried at amortized cost. Because of the short-term nature of the accounts receivable as well as the accounts payable and accrued liabilities, amortized cost approximates fair value.

It is management's opinion that CIHI is not exposed to significant interest rate or credit risks arising from the financial instruments.

a. Interest Rate Risk

Interest rate risk refers to the adverse consequences of interest rate changes on CIHI's cash flows, financial position and investment income.

b. Credit Risk

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur financial loss.

Credit risk concentration exists where a significant portion of the portfolio is invested in securities which have similar characteristics or similar variations relating to economic, political or other conditions. CIHI monitors the financial health of its investments on an ongoing basis.

In addition, as disclosed in note 8, CIHI has an available line of credit that is used when sufficient cash flow is not available from operations to cover operating and capital expenditures, including contributions to the CIHI Pension Plan.

Future Accounting Change

In December 2013, the Accounting Standards Board (AcSB) of the Chartered Professional Accountants of Canada (CPA Canada) released Reporting Employee Future Benefits by Not-For-Profit Organizations, Section 3463 in Part III of the CPA Canada Handbook, which will replace the existing Section 3461. Of note, Section 3463 requires that remeasurements pertaining to actuarial gains/losses, past service cost/credit, curtailments and settlements, are to be recognized directly in the balance sheet, rather than in the statement of revenue and expenses; and presented as a separately identified line item in the statement of changes in net assets.

Not-For-Profit Organizations will be required to adopt Section 3463 for annual financial statements relating to fiscal years beginning on or after January 1, 2014. Accordingly, CIHI will transition to this new standard, effective April 1, 2014. Management is currently evaluating the impact of Section 3463 on its financial statements.

3. Cash and Cash Equivalents

Cash and cash equivalents are comprised of cash and short-term investments with a variety of interest rates and having original maturity dates of less than 90 days (2013—90 days).

4. Accounts Receivable

	2014 $	2013 $
Operating	**1,544,224**	1,626,498
Funding—other	**56,795**	306,869
	1,601,019	1,933,367

Government refunds receivable at the end of the year are $387,313 (2013—$5,857).

5. Capital Assets

	2014		2013	
	Cost $	Accumulated Amortization $	Cost $	Accumulated Amortization $
Tangible				
Computers	**9,913,346**	**6,566,892**	8,998,314	6,573,109
Furniture and equipment	**6,200,124**	**4,565,626**	6,215,341	4,101,115
Telecommunication equipment	**1,269,348**	**1,187,150**	1,374,951	1,186,679
Leasehold improvements	**10,781,810**	**6,700,356**	10,681,880	5,608,035
Intangible				
Computer software	**11,943,303**	**9,822,535**	11,773,515	8,679,005
	40,107,931	**28,842,559**	39,044,001	26,147,943
Accumulated amortization	**(28,842,559)**		(26,147,943)	
Net book value	**11,265,372**		12,896,058	

The capital assets include $819,172 (2013—$218,814) of assets that are not in service at the end of the year. These assets have not been amortized.

6. Other Assets

Other assets consist of rent deposits to landlords for office space as well as prepaid software, equipment support and maintenance expenses.

7. Accrued Pension Benefits

CIHI has a contributory defined benefit plan (Registered Retirement Plan) which offers its employees annual retirement income based on length of service and highest consecutive five-year average earnings. In addition, CIHI supplements this benefit to plan members who are affected by the application of the *Income Tax Act's* maximum pension limit (Supplementary Retirement Plan).

The most recent actuarial valuation for funding purposes of the Registered Retirement Plan was prepared by Mercer, a firm of consulting actuaries, as of January 1, 2011. The next valuation will be as of January 1, 2014.

The fair value of the plans' assets and accrued benefit obligations for accounting purposes are determined by Mercer as at March 31 of each year.

The following tables present the plans' funded status and amounts recognized in CIHI's balance sheet.

The pension plans' expenses include the following components:

	2014		2013	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Current service cost, net of employee contributions	**8,176,400**	**64,600**	8,219,000	62,200
Interest cost on accrued benefit obligation	**4,991,900**	**29,700**	4,408,100	26,200
Expected return on plan assets	**(6,694,500)**	**—**	(5,195,500)	—
Amortization of net actuarial loss	**1,625,500**	**—**	2,168,400	—
Pension plans expenses	**8,099,300**	**94,300**	9,600,000	88,400

Changes in the accrued benefit obligation are as follows:

	2014		2013	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	$	$	$	$
Accrued benefit, obligation beginning of year	**107,056,200**	**632,800**	93,265,700	556,100
Current service cost, net of employee contributions	**8,176,400**	**64,600**	8,219,000	62,200
Interest cost on accrued benefit obligation	**4,991,900**	**29,700**	4,408,100	26,200
Employee contributions	**3,847,000**	**—**	3,626,900	—
Benefits paid	**(4,275,400)**	**(11,600)**	(2,463,500)	(11,700)
Actuarial loss (gain)	**(7,102,800)**	**25,700**	—	—
Accrued benefit obligation, end of year	**112,693,300**	**741,200**	107,056,200	632,800

Changes in the plan assets are as follows:

	2014		2013	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	$	$	$	$
Fair value of assets, beginning of year	**98,407,600**	**—**	74,465,100	—
Actual return on assets	**16,099,500**	**—**	8,704,800	—
Employer contributions	**7,896,100**	**11,600**	14,074,300	11,700
Employee contributions	**3,847,000**	**—**	3,626,900	—
Benefits paid	**(4,275,400)**	**(11,600)**	(2,463,500)	(11,700)
Fair value of assets, end of year	**121,974,800**	**—**	98,407,600	—

The plans' assets consist of:

	2014		2013	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	%	%	%	%
Asset category				
Bonds (Canada)	**34**	**—**	35	—
Equities (Canada)	**25**	**—**	25	—
Equities (Global)	**41**	**—**	40	—
	100	**—**	100	—

CIHI recorded the assets and liabilities as follows:

	2014		2013	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit obligation, end of year	**(112,693,300)**	**(741,200)**	(107,056,200)	(632,800)
Fair value of assets, end of year	**121,974,800**	**—**	98,407,600	—
Funded status—surplus (deficit), end of year	**9,281,500**	**(741,200)**	(8,648,600)	(632,800)
Unamortized net actuarial loss (gain)	**13,704,352**	**1,335**	31,837,700	(41,203)
Accrued pension benefit asset (liability)	**22,985,852**	**(739,865)**	23,189,100	(674,003)

The actuarial assumptions, which represent management's best estimate assumptions used to determine costs and benefit obligations, were as follows:

	2014		2013	
	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %
Service cost for years ended March 31				
Discount rate	**4.50**	**4.50**	4.50	4.50
Expected long-term rate of return on assets	**6.75**	**—**	6.75	—
Rate of compensation increase	**4.00**	**4.00**	4.00	4.00
Accrued benefit obligation as at March 31				
Discount rate	**4.70**	**4.70**	4.50	4.50
Rate of compensation increase	**4.00**	**4.00**	4.00	4.00

8. Bank Indebtedness

CIHI has a line of credit of $5,000,000 with a financial institution bearing interest at prime rate. This credit facility is secured by a general security agreement on all assets with the exception of information systems. As at March 31, 2014, a letter of credit in the amount of $204,200 (2013—$223,200) for the purpose of the Supplementary Retirement Plan had been issued against the line of credit.

9. Accounts Payable and Accrued Liabilities

Accounts payable and accrued liabilities are operational in nature and include, in particular, an amount of $139,066 (2013—nil) representing the annual excess contribution received from Health Canada for the Health Information Initiative.

The government remittances payable at the end of the year is $85 (2013—$185,227).

10. Deferred Contributions

Expenses of Future Periods

Since 1999, Health Canada has been significantly funding the building of a comprehensive national health information system and infrastructure to provide Canadians with the information they need to maintain and improve Canada's health system and the population's health. Health Canada's funding contribution is received annually based on CIHI's capital resources requirements.

Deferred contributions related to expenses of future years represent unspent restricted contributions. The changes for the year in the deferred contributions—expenses of future years are as follows:

	2014 $	2013 $
Balance, beginning of year	**26,013,383**	22,611,893
Current-year contribution received from Health Canada	**79,293,900**	81,746,294
Contribution repayable to Health Canada *(note 9)*	**(139,066)**	—
Restricted investment revenue	**—**	860
Amount recognized as funding	**(75,861,904)**	(77,118,992)
Amount transferred to deferred contributions—capital assets	**(1,734,799)**	(1,226,675)
Balance, end of year	**27,571,514**	26,013,380
Less: Current portion	**4,663,218**	2,666,146
	22,908,296	23,347,234

Capital Assets

Deferred contributions related to capital assets include the unamortized portions of restricted contributions with which capital assets were purchased.

The changes for the year in the deferred contributions—capital assets balance are as follows:

	2014 $	2013 $
Balance, beginning of year	**9,937,172**	12,640,450
Amount received from Health Information Initiative contribution	**1,734,799**	1,226,675
Amount recognized as funding	**(3,076,605)**	(3,929,953)
Balance, end of year	**8,595,366**	9,937,172

11. Lease Inducements

The lease inducements include the following amounts:

	2014	2013
	$	$
Leasehold improvement allowances	**705,395**	962,840
Free rent and other inducements	**2,050,475**	2,381,407
	2,755,870	3,344,247

During the year, free rent and other inducements of nil (2013—$1,885,594) were provided. The amortization of leasehold improvement allowances and free rent and other inducements are $257,445 and $330,932, respectively (2013—$386,571 and $338,388, respectively).

12. Core Plan

The Core Plan revenue relates to a set of health information products and services offered to Canadian healthcare facilities, regional health authorities and provincial/territorial ministries of health. Provincial/territorial governments have secured CIHI Core Plan on behalf of all facilities in their jurisdiction.

13. Funding—Other

	2014	2013
	$	$
Provincial/territorial governments	**2,148,700**	3,723,944
Other	**69,567**	1,485,886
	2,218,267	5,209,830

14. Change in Non-Cash Working Capital Items

	2014	2013
	$	$
Accounts receivable	**332,348**	1,402,959
Prepaid expenses	**(568,468)**	237,656
Accounts payable and accrued liabilities	**1,363,739**	(3,054,499)
Unearned revenue	**(330,874)**	(1,800,984)
	796,745	(3,214,868)

15. Commitments

CIHI leases office space under different operating leases, which expire on various dates. In addition, CIHI is committed under various agreements with respect to professional contracts and software and equipment maintenance and support. The minimum amounts payable over the next five years and thereafter are as follows:

	$
2015	11,321,932
2016	9,273,120
2017	8,999,583
2018	8,702,968
2019 and thereafter	37,145,382

16. Comparative Financial Statements

The comparative financial statements have been reclassified from statements previously presented to conform to the presentation of the 2014 financial statements.

Production of this report is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

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