



CIHI Annual Report, 2011–2012

At the Heart of Data

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

Table of Contents

Dr. Brian Postl, Board Chair

John Wright, President and CEO

Message From the Board Chair and President

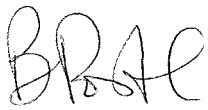
Health care is a field that's always in motion, always operating. As a key partner in decision-making, an entity at the heart of data, we at the Canadian Institute for Health Information (CIHI) must move and keep pace with this field. While this past year has been challenging and rewarding, standing still in the midst of it all was never an option.

To that end, we enhanced the quality, timeliness and expanse of our data while improving the depth and breadth of our analytical reports to meet increasingly complex stakeholder needs. To ensure we continue to do so, we developed a new data plan and a two-year, rolling analytical plan, which were approved by our Board of Directors.

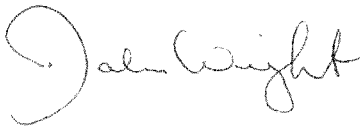
We added Ontario's drug plan data to our holdings, as well as new data on primary health care, continuing care, ambulatory care, home care and medication incidents. We developed new cardiac care and readmission indicators and dug into new areas, including amenable mortality and adverse events. As the use of electronic health records (EHRs) continued to grow, we crafted a vision with jurisdictions and Canada Health Infoway for the use of EHR data to support health system decision-making; the Conference of Deputy Ministers endorsed this vision. We also began work on our new Canadian Multiple Sclerosis Monitoring System to measure and monitor the evolution and treatment of MS and to understand disease patterns, treatment variations and patient outcomes.

We are in a climate where health care dollars are increasingly scarce. With belt-tightening everywhere and some funding sources ending, we made difficult decisions to reduce our expenditures, including a reduction of more than 50 full-time positions. We achieved almost all of this through attrition. Despite the climate and the difficult fiscal circumstances many jurisdictions find themselves in, their support remains strong and is perhaps best illustrated by the fact that they all renewed their bilateral agreements with us, with 2% funding escalators.

In addition to dealing with current challenges, we had to take time to look ahead. The strategic plan that has guided our work in recent years wrapped up at the end of this fiscal year, so we spent considerable time talking with our employees, customers and stakeholders to develop a new plan for the next five years. Given the climate, we have to be increasingly strategic about the work we do, but it's fair to say we're evolving from high growth to be a more stable, priority-established organization. The course we've charted also includes a three-year business plan and a new performance framework. Overall, it's been a year of evolution, and we look forward to what lies ahead.



Dr. Brian Postl
Board Chair



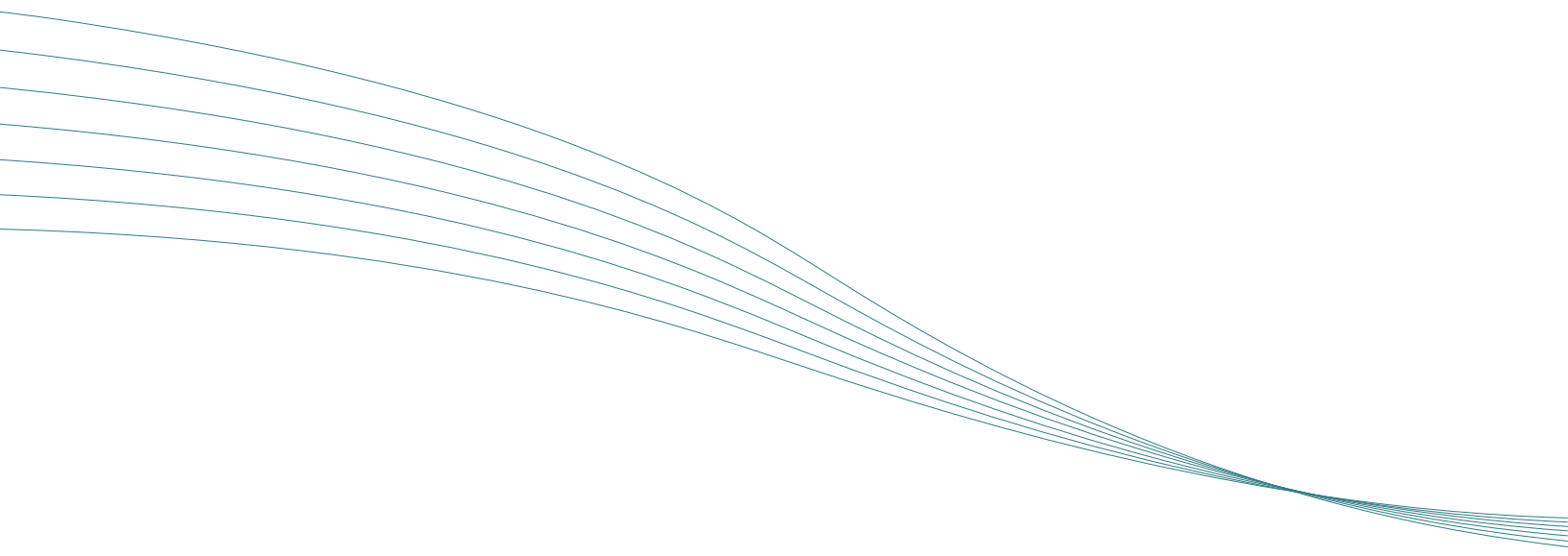
John Wright
President and CEO

Our Accomplishments

Our strategic directions guide our work. Developed with the information needs of our health care partners in mind, they set our path and focus our efforts. We know that our stakeholders rely on our information to measure performance, plan services, build business cases, identify best practices and, ultimately, improve the quality and efficiency of the health system. Since 2008–2009, these have been our strategic directions:

1. **More and better data:** We will enhance the scope, quality and timeliness of our data holdings.
2. **Relevant and actionable analysis:** We will continue to produce quality information and analyses that are relevant and actionable.
3. **Improved understanding and use:** We will work with stakeholders to help them better understand and use our data and analyses; we will do this in a timely and privacy-sensitive manner.

We've worked hard to make strides in each of these areas over the past year. Given that we're a data-focused organization, we think it's important to have performance targets that align with our corporate priorities. That's why, throughout these pages, we've included measurements of how well we've done in meeting our goals.



More and Better Data

Since 1994, we've worked with our partners to build and maintain 27 pan-Canadian databases that allow for comparisons among jurisdictions. The health system, however, is anything but static. The needs of our stakeholders are increasingly diverse and sophisticated, and there are always emerging challenges and information gaps to fill. But whether it's determining what's driving health care costs, allocating resources, redesigning services, dealing with progressively complex care needs or preparing for the impact of an aging population, decisions about the health care system are based on the information we glean from it—and that's a responsibility we take to heart. More and better data is critical to offering holdings that are complete, comparable and continuous.

More Pharmaceutical Data

- The Ontario Ministry of Health and Long-Term Care selected the **National System for Incident Reporting** for mandatory reporting of critical medication and IV fluid incidents. The system was implemented in more than 150 acute care hospitals. In addition, after a successful pilot, the system was launched for use in long-term care facilities across Canada.
- Drug claims data held in the **National Prescription Drug Utilization Information System (NPDUIS) Database** was expanded to include data from Ontario's Ministry of Health and Long-Term Care and Health Canada's First Nations and Inuit Health Branch. As well, a new agreement with British Columbia will see provincial drug claims data submitted to the NPDUIS Database.

More Health Human Resources Data

- We improved the comprehensiveness of our holdings on total physician compensation in Canada with more detailed data on alternative payments.
- We achieved 100% pan-Canadian coverage in our **Occupational Therapist Database** thanks to record-level data that is now being submitted by the Ordre des ergothérapeutes du Québec.

More Joint Replacement Data

- Ontario and British Columbia have now mandated data submission to the **Canadian Joint Replacement Registry (CJRR)**. We expect coverage to increase from about 43% to 83% of all joint replacements performed in Canada.
- We partnered with the orthopedic surgeon community to reduce data elements in the CJRR's minimum data set, which is being aligned with data elements proposed by the International Society of Arthroplasty Registers.

More Home and Continuing Care Data

- We launched the next phase of the **Home Care Reporting System (HCRS)** with the introduction of the interRAI Contact Assessment, which helps screen clients to identify their need for and urgency of home care services.
- Five provinces now participate in HCRS, with 500,000 unique clients and 7.8 million records in the system, including 1.25 million assessments.
- The **Continuing Care Reporting System** has data from more than 1,100 facilities in 7 provinces and territories, with 560,000 unique residents and 3.7 million records in the system (including 2.1 million assessments).

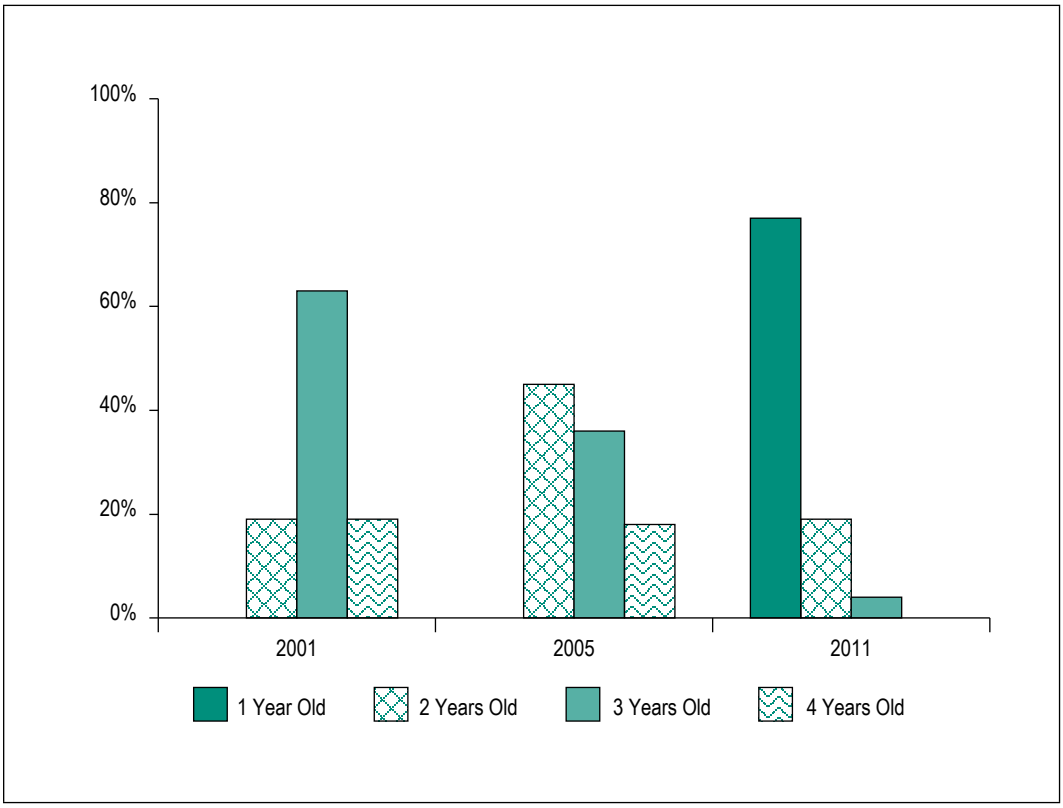
Better Data Quality

- We created custom data quality reports for the 85 hospitals involved in the 2009–2010 **Discharge Abstract Database** data quality study. Reports were also given to all 12 provinces and territories whose hospitals participated.
- We continued to produce data quality reports for deputy ministers; these reports now include the **National Ambulatory Care Reporting System** and the **Canadian Joint Replacement Registry**.

Other Data Developments

- Some regions in British Columbia, Saskatchewan and Nova Scotia are now submitting data to the **National Ambulatory Care Reporting System**.
- We continued to work with the First Nations and Inuit Health Branch at Health Canada on data development initiatives related to First Nations drug and home care data.
- We collaborated with the Mental Health Commission of Canada on plans to develop a broad set of mental health indicators, including indicators on community mental health and addiction.

Currency of Data for Analytical Products



The long-term trend of the currency of our data shows major changes over the last 10 years. In 2011, 77% of our data was a year old or less.

Comprehensiveness of CIHI's Data Holdings, March 31, 2012

Service Type	Data Holdings	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 (DAD/HMDB)						1							
	Day Surgery (DAD/NACRS)						2							
	Emergency Department (NACRS)	✔												
	Ambulatory Clinics (NACRS)													
Continuing and Specialized Care	Inpatient Mental Health (HMHDB)													
	Rehabilitation (NRS)													
	Continuing Care (CCRS)	✔							✔					
	Home Care (HCRS)	✔												
	Organ Registry (CORR)							3		3	3		3	
	Trauma (NTR-MDS)													
	Trauma (NTR-CDS)													
	Joint Replacement (CJRR)	4	4	4	4	4	4	4	4		4	4	4	
Pharma-ceuticals	Pharmaceutical Use (NPDUIS)	5												
	Incident Reporting (NSIR)	✔			✔	✔								
Health Human Resources	Physicians (NPDB)													✔
	Registered Nurses Database (RNDB)*													
	Licensed Practical Nurses Database (LPNDB)*													✔
	Registered Psychiatric Nurses Database (RPNDB)*													
	Nurse Practitioners (NP)*													
	Health Providers (HPDB)													
	Health Providers (HPDB)						✔							
	Pharmacist Database													
	Physiotherapist Database													
	Medical Radiation Technicians (MRTDB)													
	Medical Laboratory Technicians (MLTDB)													
Health Spending	National Expenditures (NHEX)													✔
	CMDB						✔							
	CPCD	✔ 6	✔ 6			✔ 6			✔					

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

* All part of the Nursing Database.

1. Quebec submits data to the Hospital Morbidity Database on an annual basis.
2. Quebec day surgery data is not part of the Discharge Abstract Database (DAD) or Hospital Morbidity Database (HMDB) populations, but it is included in the DAD/HMDB production data sets.
3. Renal dialysis—fully implemented; organ transplant—N/A.
4. Participation is voluntary, so coverage is not complete. Starting in April and July 2012, respectively, Ontario and B.C. will submit data on a mandatory basis.
5. A data-sharing agreement was signed in March 2012; drug claims data will be submitted beginning in 2012–2013.
6. Patient costing is implemented in a subset of health care organizations. Data collection is complete in this subset.

CIHI Data . . .

Helps Change Practice

In a Winnipeg long-term care home, data helped move the use of antipsychotic medications from being a first-line treatment to one of last resort.

The first sign that these drugs were perhaps being overused came from data gathered through indicators developed by interRAI, an international research collaborative, and supported for use in Canada by CIHI. Although regional use of antipsychotic drugs was in line with, or even slightly below, the national average, when staff at the **Winnipeg Regional Health Authority** looked at each of its 38 long-term care homes, the data showed that some homes were well above that average. Among them was **Middlechurch Home of Winnipeg**, where prevalence of use had reached 43%, compared with 30% across the region.

At the region's Personal Home Care Program, Joe Puchniak, Manager of RAI/MDS and Decision Support, and Cynthia Sinclair, Manager of Initiatives, set out to help Middlechurch reduce its rate as part of their project work with the Canadian Health Services Research Foundation's **Executive Training for Research Application (EXTRA)** program. The pair started educating all staff on a dementia care model which emphasized that medications were a last resort for behaviour issues.

Weekly mentoring helped staff develop care plans that looked for alternatives to medication. The following week, everyone would brainstorm about what had worked well and what hadn't. Along the way, RAI data was regularly posted so all staff could see the results of their efforts.

Rates of antipsychotic drug use dropped more than 25% in six months among residents who were on them when the project began. Along the way, staff were empowered by the data and a desire to practise in a different way. Families are also happier their loved ones are on fewer medications, says Laurie Kuivenhoven, Middlechurch's Executive Director. Since the project began, she hasn't had a single complaint of loved ones being doped up.

Because the tools monitor many facets of care, the data also showed that there was no increase in behaviour issues or physical restraint use as medication use dropped. The potential savings are also significant: "If all homes were able to reduce [antipsychotic medication use] to a target range of 5% to 10%, we'd probably be able to save $1 million a year," Sinclair says.

Adds Puchniak, "With this project, we're saving money and providing better care—how great is that? It really is data making a difference. You can't say that enough. If we don't use this data to make a difference, we're missing an incredible opportunity."

Relevant and Actionable Analysis

As the quantity and quality of health information in Canada continue to grow, so do the expectations of our stakeholders. They want to go beyond the numbers and deal with complex issues, such as appropriateness of care and the link between services and health outcomes. We released 33 analytical products this year, but to further increase the depth and breadth of analysis and reporting across our data holdings, we also rolled out a two-year **analytical plan**. This puts more emphasis on meeting the needs of health system policy-makers and system managers, as they have the greatest demand for data and analyses and the strongest influence on the Canadian health system.

Performance Measurement

- We completed the first-ever public pan-Canadian hospital performance report, based on a core set of 30 clinical and financial indicators (in the areas of clinical effectiveness, patient safety and financial performance). After several years of work, the **Canadian Hospital Reporting Project** was released in early April 2012, allowing 600 hospitals in the country to make peer comparisons and learn from each other.

Health Care Costs

- With health expenditures forecast to hit $200.5 billion last year, we released ***Health Care Cost Drivers: The Facts.*** jointly with our annual ***Health Expenditure Trends*** report to shed light on what's behind the increase in health spending.
- Our Activity-Based Funding unit served as a centre of technical expertise in the design, implementation and evaluation of health care funding models, including Ontario's Health Based Allocation Model and Cardiac Services, British Columbia's Cardiovascular Service Funding Model.

Access to Care

- We continued to build wait times indicators for emerging areas of interest, including specialist care and cancer surgery.
- Our new interactive wait times web **tool** displays four years of comparable provincial data and allows for trending over time and access to at-a-glance performance information for all priority-area benchmarks.

High-Impact CIHI Studies Released in 2011–2012

- ***Health Indicators 2011*** focused on new measures of health system performance for mental health services. It included regional-level health indicators for all provinces and territories, including the most recent Quebec data.
- ***Health Care in Canada, 2011: A Focus on Seniors and Aging*** looked at the characteristics of today's seniors, explored an aging population's impact on public health expenditures over the past decade and included a description of seniors' utilization across care settings and strategies for adapting the system to meet their needs in the future.
- In conjunction with the release of *Health at a Glance 2011* from the Organisation for Economic Co-operation and Development (OECD), we released ***Learning From the Best: Benchmarking Canada's Health System***. This examined Canada's place among OECD countries and helped foster an understanding of how we can inform policy decisions through comparisons with other countries.
- To measure the impact advanced maternal age can have on mothers and their babies, ***In Due Time: Why Maternal Age Matters*** examined more than 1 million hospital births over three years. While many older mothers have healthy birth experiences, the associated risks start increasing at age 35 and rise significantly for mothers age 40 and older.
- ***Inpatient Acute Care Use by Patients From Sparsely Populated Health Regions in Western Canada*** profiled acute inpatient care and the patients who receive it in sparsely populated parts of Western Canada.
- As part of our Canadian Population Health Initiative (CPHI) Action Plan, we released ***Disparities in Primary Health Care Experiences Among Canadians With Ambulatory Care Sensitive Conditions***, which looked at access to and appropriateness of primary care. Another report, ***The Role of Social Support in Improving Psychological Distress***, examined structures and functions of social support as drivers in reducing psychological distress.
- We released several reports on health human resources, including those on physicians, nurses, occupational therapists, physiotherapists, pharmacists, medical radiation technologists and medical laboratory technologists, along with a summary report of health care providers in Canada. For the first time, the **Occupational Therapist Database** and **Pharmacist Database** releases included five-year trend data.
- ***Obesity in Canada***, jointly released with the Public Health Agency of Canada, examined how obesity varies across Canada, who's most at risk and possible actions to address it.

Top 10 Products in Media Coverage

1	Data release: More than 5,600 Canadians seriously injured every year from winter activities
2	*Health Care Cost Drivers: The Facts.* and *National Health Expenditure Trends, 1975 to 2011*
3	*Obesity in Canada*
4	*Health Care in Canada, 2011: A Focus on Seniors and Aging*
5	*Wait Times in Canada—A Summary, 2012*
6	*Supply, Distribution and Migration of Canadian Physicians, 2010* and *National Physician Database, 2009–2010 Data Release*
7	Data release: Summer is peak season for wheel- and water-related injuries
8	*Canadian Organ Replacement Register Annual Report: Treatment of End-Stage Organ Failure in Canada, 2001 to 2010*
9	*In Due Time: Why Maternal Age Matters*
10	*Restraint Use and Other Control Interventions for Mental Health Inpatients in Ontario*

CIHI Data . . .

Works to Prevent Medication Incidents

Medication incidents are among the most common adverse events in acute care. They can range from a near miss to those that cause harm: wrong dose, drug, time, route or patient, as well as failure to administer at all. Like many of their peers, nurses at the **Saskatoon Health Region** are determined to minimize the occurrence of medication incidents as much as possible. But pinpointing causes can be a challenge.

That's where the **National System for Incident Reporting (NSIR)** comes in. Developed by CIHI, this voluntary reporting system allows facilities to report medication and IV fluid incidents. Nurses in Saskatoon have used it to track when incidents are occurring on the front lines and the circumstances around them.

Since joining a pilot of the system in 2008, the region has focused on reports generated from NSIR data. The reports present the top medications involved in errors on a unit, as well as the most prevalent contributing factors. Each quarter, they're sent to the same nurses who reported incidents to the system. And because the data is anonymous, no one knows who was involved in the incidents captured in the report.

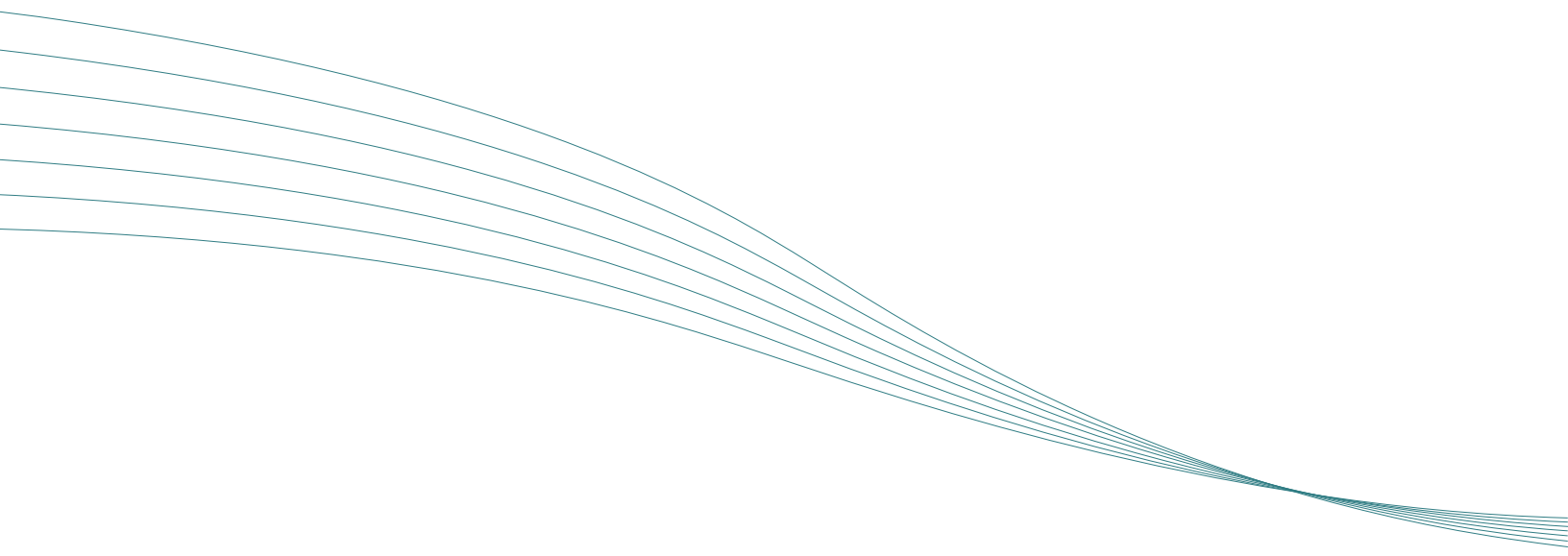
"Closing the loop and bringing the data full circle makes it relevant for staff," says Norma Noesgaard, the region's Facilitator for Releasing Time to Care.

Interruptions are well-documented as a frequent cause of medication incidents. In Saskatoon, the data showed that they were regularly among the top two contributing factors, prompting staff to take action.

In Saskatoon, most interruptions were happening during the 8 a.m. medication round. To help nurses stay focused on that task, one hospital unit directed all phone calls to a ward clerk during rounds. Another unit now uses two-person teams for rounds, with one nurse passing meds while the other serves as a buffer, answering questions or call bells.

Overall, the data shows that the number of interruptions has dropped, and nursing units have been able to sustain this reduction over the last year. Studying the NSIR data each quarter has become regular practice. Every time the region pulls information from the system, it's fed back to the nursing units to allow them to track their improvement efforts. Noesgaard says that with its wealth of information, the system has been an empowering tool.

"People love to see where they're making good things happen. They want to know the good, the bad and the ugly. This gives us a chance to provide data anonymously, but because it's posted, it's really relevant for staff."



Improved Understanding and Use

We collect data. A lot of data. But having all the data in the world matters little if our partners can't put it into action. To ensure health care managers have what they need to support decision-making, access to sound, timely and reliable information is key, as are the tools and resources to understand it. That's why when it comes to our products and services, we place high value on communication, enhancements, education and ease of use.

Timeliness

- Significant enhancements were made to the **Discharge Abstract Database (DAD)**, including new eReports that have improved reporting functionality and better turnaround time. Data for the new reports is now refreshed three weeks after month's end—a great improvement over the previous three-month turnaround.
- eDAD, a bilingual, interactive reporting tool, was released to DAD clients across Canada. It's a significant enhancement to previous reports, offering greater functionality, timelier data that's refreshed monthly (rather than quarterly) and multi-year comparatives.

eReporting, Portal and Website

- We enhanced our e-reporting to help users develop customized solutions to meet their information needs. The **Continuing Care Reporting System**, **National Rehabilitation Reporting System**, **National System for Incident Reporting** and **Portal** all now have advanced reporting capabilities.
- There were nearly 1 million visits to our website last year. To ensure we're meeting our customers' needs, we're using external focus groups and usage statistics to determine where improvements are needed.
- We now have 358 **Portal** users across Canada at 124 sites, in 12 of 13 jurisdictions. Portal users ran more than 100,000 standard and ad hoc reports last year. The most commonly used data was from the **Discharge Abstract Database** (69%).

Customer Focus

- In addition to developing corporate-wide service standards, we continued to implement our customer strategy by clarifying who our priority customers are, focusing on providing meaningful products and services that meet customers' needs and establishing a process to continually improve services based on those needs.
- We've started to centralize our client services with the goal of creating a consistent, streamlined set of processes and a clear gateway to CIHI and everything we provide.

Communication

- We created a new bilingual e-newsletter to profile CIHI's work to an even greater extent. Launched last May, **Land** (English) and **Oasis** (French) have attracted more than 3,000 subscribers combined.
- We also started using quick response codes in our promotional materials to provide a quick and targeted way for people to access our online products and information.

Media Coverage

Fiscal Year	Print Mentions	Broadcast Mentions	Web Mentions	Total Mentions	Total Circulation (Millions)	Total Solicited Mentions Only
2009–2010	941	520	1,493	2,954	502.1	2,052
2010–2011	506	776	1,230	2,512	228.0	2,057
2011–2012	596	1,185	1,328	3,109	341.6	2,457

Collaborative Work

Our regional offices do a great job of identifying opportunities to align our data and products to address regional needs. We continued to work with jurisdictions and other organizations to stimulate performance improvement, enhance data flow and encourage the use of databases, as well reduce the duplication of work. Our efforts this year included the following:

- Signing memoranda of understanding with the Canadian Patient Safety Institute and Accreditation Canada to work on quality and patient safety.
- Co-sponsoring a two-day invitational meeting with the Institute for Health Economics for 20 experts on diagnostic imaging data and analysis. Attendees reviewed our current data and provided advice on how new data sources could be used to support decision-makers.
- Organizing an all-day session in Winnipeg on approaches to health care funding. Approximately 90 senior staff from Manitoba Health and the province's health authorities attended.
- Hosting a webinar series on quality and patient safety indicators in conjunction with the Saskatchewan Ministry of Health and the Health Quality Council.
- Working with Statistics Canada to consult with regional health authorities to evaluate their health system performance information needs.
- Hosting our fourth face-to-face meeting for senior provincial wait time representatives from across Canada. This year's goal was to look at ways to improve consistency and comparability of reporting coronary artery bypass grafts and cancer surgery. The meeting helped us understand provincial wait time questions and emerging priorities.
- Meeting with the Rural Health Exchange and Atlantic Collaborative for the Use of Health Information. The goal was to keep abreast of local issues, highlight any health system changes and share updates.

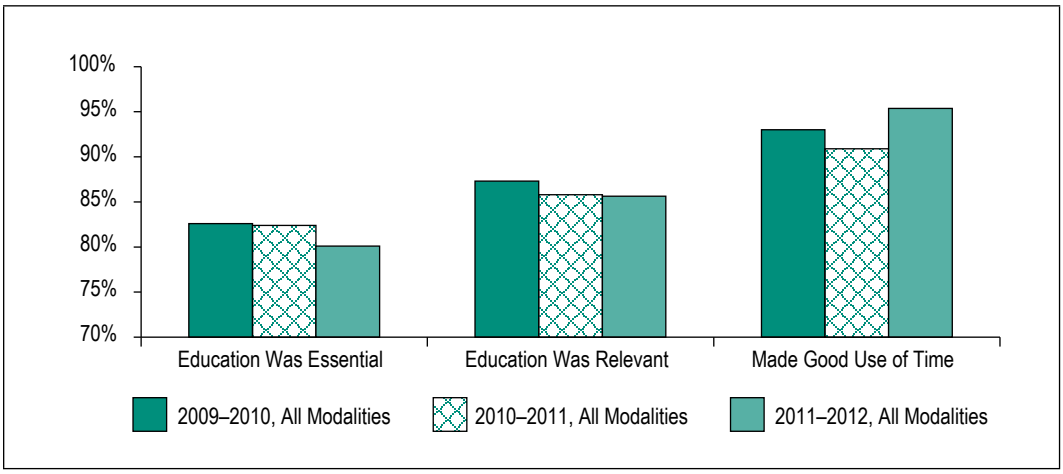
Events Sponsored or Hosted by CIHI and Outreach Activities

Over the course of the last year, we hosted several national and international conferences to increase understanding and use of our data and information. In addition to e-Health (co-hosted with COACH) and the Data Users Conference (co-hosted with Statistics Canada), we hosted an international case mix event. The 27th Patient Classification Systems International (PCSI) Conference in Montréal marked the first time the gathering was held in Canada. With more than 240 attendees from 30 countries, it was the best-attended PCSI Conference ever held outside of Europe.

Always eager to work with national health organizations and stakeholders, we presented at a number of events, including these:

- 2011 Forum of the Canadian Academy of Health Sciences
- Saskatchewan Health Information Management Association Annual Convention
- Quebec Orthopedic Association Annual Conference
- 2011 Statistics Canada Socio-Economic Conference
- Healthcare Interoperability Summit
- Accelerating Primary Care Conference
- Association québécoise des établissements de santé et de services sociaux Conference
- 10th Conference of the Canadian Rural Health Research Society
- Manitoba Provincial Leadership Forum
- Atlantic Deputies' Summit
- Health Insurance Strategic Forum
- Fall 2011 Infoway Partnership Conference
- 27th Patient Classification Systems International Conference
- Meeting on National Health Reporting Framework
- Canadian Association for Health Services and Policy Research Conference

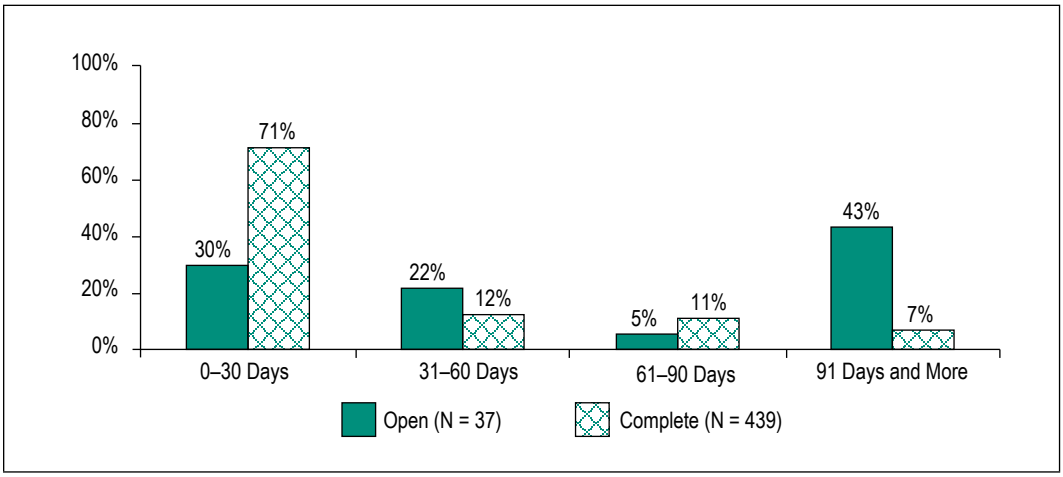
Education Evaluation



Note
Rating of 4 or 5 on a 5-point scale (where 1 is low and 5 is high).

When it comes to turnaround on data requests, the service standard for 2011–2012 was 90 days. Of the 439 requests completed last year, 93% were done within 90 days, while 69% were completed within 30 days.

Data Request Activity by Turnaround/Open Time*



Note

* Data request turnaround time was calculated as the time period from date of request to date of release.

Data Privacy and Security

Stakeholders need to have confidence that the data they provide us is safeguarded. Otherwise, we wouldn't be able to do the work we do. That's why we welcomed news that our status as a prescribed entity was renewed for three years by the Information and Privacy Commissioner of Ontario. This status means that health information custodians in the province, such as the Ministry of Health and Long-Term Care, physicians and hospitals, can provide personal health data to us without the consent of individuals. As a prescribed entity, numerous measures must be in place to protect the health information of Ontarians. The strict responsibilities that come with the designation give our data partners assurance that our privacy and security policies comply with the highest standards to safeguard sensitive information. Other stakeholders across the country can take comfort in the fact that the renewal of our status as a prescribed entity is predicated on the soundness of our privacy and security program. The personal health data provided to us from all stakeholders across the country is safeguarded and protected under the same privacy and security controls.

Our Organization

Our greatest strength is our people, and what's captured in this report is a result of their efforts. We have a highly educated workforce, with a high proportion of staff with advanced degrees. Not only do we need to recruit staff with specialized skills in the competitive field of health information, we need to be able to retain them. A significant portion of our workforce has always fallen into the tenure category of five years of service or less. This past year, we put additional strategies in place to support the recruitment, development and retention of our workforce, and we saw a decrease in the five-years-or-less tenure group, while longer-serving tenure categories grew. We think this shift demonstrates our efforts to create a strong retention program.

Our gender distribution has remained steady over the years, with an overall ratio of 69% female and 31% male. Women also represent 62% of our management ranks.

CIHI Staff by Tenure, Age and Gender

Total Staff	797*
Tenure	
<5 Years	492 (62%)
6–10 Years	208 (26%)
11–15 Years	63 (8%)
16+ Years	34 (4%)
Age	
<29	94 (12%)
30–39	310 (39%)
40–49	233 (29%)
50+	160 (20%)
% Female Staff	**69%**
% Female Mgmt. Staff	**62%**

Note

* This number represents permanent employees and excludes contract staff as of April 1, 2011. It does not reflect the decrease in staffing levels that resulted from a workforce adjustment program implemented in 2011–2012.

CIHI Staff by Education Level

Education Level	Number/Percentage of CIHI Staff
Post-Graduate and Master's	296 (37%)
Undergraduate	291 (37%)
Diploma	192 (24%)
High School	18 (2%)

Sheds Light on the System's Smallest Patients

It started with stories. When the **Provincial Council for Maternal and Child Health** looked at access to care and practice changes to streamline the flow of Ontario's smallest patients, several physicians spoke of the impact babies born to mothers who used narcotics and methadone were having on hospital beds.

These newborns have neonatal abstinence syndrome (NAS)—withdrawal symptoms from their mothers' use of drugs. As Ontario has Canada's highest rate of narcotic use, physicians were seeing more NAS cases and longer lengths of stay among these babies. In neonatal units, it was increasingly difficult to move patients from Level 3 critical care beds (for the sickest and ventilated babies) to Level 2 specialized beds once they'd improved. The suspicion was that the Level 2 beds were being blocked by the growing numbers of NAS babies.

The council turned to CIHI, where data showed that in 2003–2004, 171 infants had been diagnosed with NAS. In 2010–2011, there were 654 cases. That same year, NAS babies across the province used an average of 23.4 hospital beds per day, up from 5.6 a day in 2003–2004. What's more, the average length of stay for a healthy newborn in 2004 was a day and a half, compared with nearly 14 days among NAS babies. By 2010–2011, that had dropped slightly to 13.1 days.

"What people thought was the case turned out to be the case, but the problem turned out to be much bigger than we thought," says Dr. Kimberly Dow, a neonatologist at Kingston General Hospital. "I think everyone was shocked that 23 neonatal beds in the province were occupied by these patients every day."

The council created an NAS working group, co-chaired by Dow, with a goal of encouraging early screening and helping clinicians determine how to best manage pregnant woman and their babies. The expert panel also wanted to see what could be done to prevent the problem. Although there's no easy solution to preventing NAS, screening and treatment guidelines for newborns were in the group's June 2011 report. Those guidelines have been disseminated to all neonatal units that care for Level 3 and Level 2 babies, and all practising pediatricians have been told about them. New clinical guidelines were also posted on the council's website.

"People have been struggling with this population and how to manage it," says Marilyn Booth, the council's Executive Director. "We wanted a consistent approach to prevent every single hospital from having to figure it out for themselves."

Dow says data was instrumental in focusing attention on NAS and improving safety for babies and their moms.

"Without it we wouldn't have known the extent of the problem in the province. And you can't do anything about it unless you know what you're dealing with. It confirmed people's concerns, but more than that, it surprised us. The extent of the problem was shocking."

Looking Ahead

This year, we reached a critical juncture. Not only did the closure of the 2011–2012 fiscal year bring us to the end of the strategic directions we set for ourselves four years earlier, we also saw our five-year funding agreement with Health Canada expire. Needless to say, we spent time looking back over what we've accomplished in recent years and, more importantly, charting our course and setting goals for those that lie ahead.

In developing our new strategic plan, we talked with our customers and stakeholders across the health care system to set priorities. We set specific goals and priorities that we'll pursue through to 2017, while ensuring we remain a forward-thinking organization that can respond to emerging needs and issues. The plan will help us meet the needs of our customers and stakeholders in a timely and privacy-sensitive manner, while enabling the shared objective of improving the health of Canadians.

As we approach our 20th year of operations, we also reflected on what guides our work and interactions. In addition to new values and a new mandate, our plan is founded on a new vision for CIHI's future of linking data to decisions and health outcomes: *Better data. Better decisions. Healthier Canadians.*

To translate this into a concrete action plan, we put together a three-year rolling business plan that sets out how we'll approach our goals and a performance framework to gauge the outcomes that will flow from our work. Both will be updated annually to provide detail on our progress. We see them as critical tools for corporate transparency and accountability.

We'll work with our funders—Health Canada and provincial/territorial ministries of health—to achieve what we set out in our new strategic plan.

Our Strategic Plan

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

Strategic Goals	Priorities
Improve the comprehensiveness, quality and availability of **data**	▸ Provide timely and accessible data connected across health sectors ▸ Support new and emerging sources of data, including electronic records ▸ Provide more complete data in priority areas
Support population health and health system **decision-making**	▸ Produce relevant, appropriate and actionable analysis ▸ Offer leading-edge performance management products, services and tools ▸ Respond to emerging needs while considering local context
Deliver **organizational excellence**	▸ Promote continuous learning and development ▸ Champion a culture of innovation ▸ Strengthen transparency and accountability
Foundation	**Privacy and Security, Data Standards and Quality, Information Technology, Partnerships**

Management Discussion and Analysis

This section provides an overview of our 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 generally accepted accounting principles, 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 is responsible for ensuring that management fulfills its responsibility for financial reporting and internal controls; it oversees this through the Finance and Audit Committee (FAC), which is comprised of directors who are not employees of the organization. Our external auditors, Ernst & Young LLP, conduct an independent audit in accordance with Canadian 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 2011–2012 and previous years, the external auditors have issued unqualified opinions.

In recent years, our organization has evolved from one of high growth to a more stable, priority-established organization. Our annual total budget, consisting of our operating and capital resources requirements, as well as the financing of our pension plans, has reached a financial level slightly over $115 million. We now have 749 employees and we house 27 data holdings.

Total Annual Budget, Employees and Data Holdings

Category	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
Total Annual Budget ($ Millions)	$88.7	$119.0	$115.7	$117.5	$118.6
Total Data Holdings	23	24	24	27	27
Total Employees	608	604	765	797	749

Our ongoing programs and new projects are managed within the terms and conditions of our federal, provincial and territorial agreements, which provide the majority of our annual total source of revenue.

Annual Revenue Profile

Annual Source of Revenue ($ Millions)	2008–2009	2009–2010	2010–2011	2011–2012		2012–2013
	Actual	Actual	Actual	Planned	Actual	Planned
Federal Government	$104.5	$92.3	$98.5	$97.0	$94.7	$89.6
Provincial/Territorial Governments	$16.8	$17.3	$18.4	$18.9	$20.0	$20.9
Other	$2.9	$1.8	$2.1	$2.2	$3.9	$3.1
Total Annual Source of Revenue	$124.2	$111.4	$119.0	$118.1	$118.6	$113.6

The relative revenue contributions of the federal government, the provincial/territorial governments and other sources have been constant over the last few years (in 2011–2012, they were 81%, 17% and 2%, respectively). 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, the building of a comprehensive national health information system. As well, the provincial/territorial ministries of health have funded our core plan through bilateral agreements.

This fiscal year was one of transition as we prepared for an overall reduction in our total annual revenue, effective 2012–2013. This anticipated decrease was related to deferred Roadmap Initiative contributions of $47.9 million from previous funding arrangements with Health Canada, which were depleted over the last few years. Further, as 2011–2012 was the last year of our funding agreements with Health Canada and the provinces/territories, we worked with them to renew these agreements for a three-year term. The bilateral agreements with the provinces and territories will have a 2% annual increase, whereas Health Canada's funding agreement will see a 5% reduction phased in over three years.

Management Explanation of Results

Operating Expenses

Operating Expenses (in Millions)	2008–2009	2009–2010	2010–2011	2011–2012		2012–2013
	Actual	Actual	Actual	Planned	Actual	Planned
Salaries and Benefits	$61.2	$64.4	$71.9	$73.9	$71.3	$72.4
Professional Services, Travel and Advisory Committee Expenses	$30.4	$20.3	$17.4	$15.0	$14.9	$13.7
Occupancy, Information Technology and Other	$17.5	$17.6	$17.8	$18.4	$17.6	$20.8
Total Operating Expenses	$109.1	$102.3	$107.1	$107.3	$103.8	$106.9

Our total operating expenses last year were $103.8 million, a decrease of $3.3 million from 2010–2011. This decrease was largely attributable to cost efficiencies realized in expenses such as professional services, travel and advisory committee expenses. A collective effort to better manage these resources enabled the organization to redirect resources in 2011–2012 and therefore fund our registered pension plan actuarial deficit.

Total remuneration, including any fee allowance or other benefits to our senior management team involved in the accomplishment of our three strategic directions, represented $4.6 million in 2011–2012.

The total expenditure variance of $3.5 million relative to planned 2011–2012 activities related primarily to our workforce adjustment program, which was initiated at the beginning of the year to prepare for the expected overall budget decrease noted above. Management implemented a recruitment freeze in the first six months and achieved the reduction objective of more than 50 positions through attrition earlier than planned. As well, a corporate provision of $1.5 million was included in the 2011–2012 plan to address emerging issues and year-end budget adjustments. The corporate provision is included under Occupancy, Information Technology and Other in the Annual Revenue Profile table. These resources were reallocated, along with savings realized in salaries and benefits, to offset the actuarial deficit of our registered pension plan.

Prior years' results reflected the growth of the organization. Professional services, travel and advisory committee expenses included several one-time activities related to external expertise required during the period of growth, specific contributions toward population health research studies and special projects as well as the Canadian Health Measures Survey conducted by Statistics Canada.

Investments in our three strategic directions remained relatively constant as a proportion of total 2010–2011 and 2009–2010 operating actual and planned expenses.

2011–2012 Actual Operating Expenses by Strategic Direction

Operating Expenses (in Millions)	Dollars	Percentage
More and Better Data	43.9	42%
More Relevant and Actionable Data	27.0	26%
Improved Understanding and Use	32.9	32%
Total	103.8 million	

Capital Investments

Capital Investments (in Millions)	2008–2009	2009–2010	2010–2011	2011–2012		2012–2013
	Actual	Actual	Actual	Planned	Actual	Planned
Furniture and Office Equipment	$2.1	$0.1	$0.2	$0.1	$0.1	$0.1
Computers and Telecommunications Equipment	$6.2	$3.0	$1.5	$2.3	$2.4	$1.7
Leasehold Improvements	$7.3	$0.2	$0.3	—	—	—
Total Capital Investments	$15.6	$3.3	$2.0	$2.4	$2.5	$1.8

Acquisition of capital assets for 2011–2012 amounted to $2.5 million, an increase of $500,000 over 2010–2011. This variance related mainly to increased purchases of computer hardware, software and telecommunications-related equipment. One of our significant investments in 2011–2012 included the replacement of our main database server to better meet utilization and growth requirements, as well as to implement a solution for our disaster recovery plan.

Prior years' results, specifically from 2008–2009 and 2009–2010, included the renewal of our technology infrastructure, telephone system, and financial and web content management software. There were also one-time capital requirements related to the relocation of our Toronto office and some leasehold improvements in our Ottawa and Montréal offices.

Pension Plans

Our contributory defined benefit plan offers our employees annual retirement income based on length of service and final average earnings. Contributions are determined by actuarial calculations and depend on employee demographics, turnover, mortality, investment returns and other actuarial assumptions. CIHI and employee contributions are pooled, invested and professionally managed in accordance with the CIHI Pension Plan—Statement of Investment Policies and Procedures. There are 900 members in the plan, 80% of whom are active participants.

Two valuations are prepared for the plan. The first one is for accounting purposes (see note 8 of the financial statements); the second one is for funding purposes and is also used for regulatory purposes and management of the plan. The valuations for accounting and funding purposes are prepared at different times and use different assumptions. Based on accounting

standards prescribed by the Canadian Institute of Chartered Accountants, on March 31, 2012, the plan reported a surplus of $18.5 million, compared with $9.9 million in 2010–2011. On a funding basis, the plan had a deficit of $5.2 million on January 1, 2011, compared with a deficit of $4.7 million on January 1, 2010.

Management and the FAC continued to monitor the economic environment and took steps to address the unfunded liability. In 2011–2012, we reviewed pension plan design options, prepared and filed a January 1, 2011, funding valuation, increased the employee contribution rate to reach our funding goal ratio of 60% employer/40% employee, made further changes to our investment managers and contributed $4.8 million in excess of the minimum regulatory requirement toward the actuarial deficit. The unfunded liability as reported in the January 1, 2011, funding valuation was fully funded as of March 31, 2012, as a result of our additional contributions. The next funding valuation will be required as of 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, non-biased assurance services designed to add value to and improve our operations. It helps us accomplish our objectives by bringing a systematic, disciplined approach that both evaluates and improves the effectiveness of risk management, control and governance processes. Our internal audit program includes evaluating compliance with administrative policies, procedures and government regulations; assessing the overall effectiveness of controls and processes currently in place; and identifying opportunities for improvement and efficiencies as well as program reviews.

The internal audit activities vary in scope and evolve over time to focus on areas of greatest risk to the organization. In 2011–2012, activities included information technology hardware and systems testing and vulnerability assessment, in addition to an audit of the corporate risk management program. We developed targeted action plans to address the areas for improvement that were recommended by the consultants contracted by us to specifically perform these activities. Upcoming internal audit projects include activities in the areas of corporate governance, project costing and management, information security, and privacy and confidentiality.

Risk Management

At CIHI, we're not averse to taking risks—we just want to make sure they're reasonable, manageable and based on appropriate risk tolerance. We're proactive and mitigate risks where we can. Our risk management program ensures management excellence, strengthened accountability and improved future performance. It also supports planning and priority-setting, resource allocation and decision-making. We focus on risks that cut across the organization, are linked to our strategic directions, are likely to remain for the next three to five years and can be managed by our senior leadership.

Our Risk Management Framework consists of the following four processes, which are geared toward achieving CIHI's strategic directions:

Risk Management Activities for 2011–2012

This past year, our senior management team assessed a number of key risks that, based on their likelihood of occurrence and their potential impact, could prevent us from achieving our strategic directions. Four of these were identified as corporate risks due to their high level of residual risk (risk level after considering existing mitigation strategies).

Risk 1: Sustained Funding Levels

CIHI receives funding from several sources, with the main source being Health Canada. CIHI's current Health Information Initiative agreement came to term March 2012, as did the funding agreements with the provincial/territorial governments. Given the current economic climate and competing fiscal priorities for governments (federal, provincial and territorial), sustained funding is at risk. In the past year, we actively promoted CIHI's role and our value to the health system. This resulted in us successfully securing multi-year funding agreements with provincial/territorial ministries of health. Our ongoing discussions with Health Canada also culminated in successful renewal of the long-term funding agreement effective April 2012. To ensure appropriate use of our funding, we developed a multi-year financial overview and business plan and launched several efficiency initiatives, including automated systems and process improvement.

Risk 2: Electronic Health Records/Electronic Medical Records

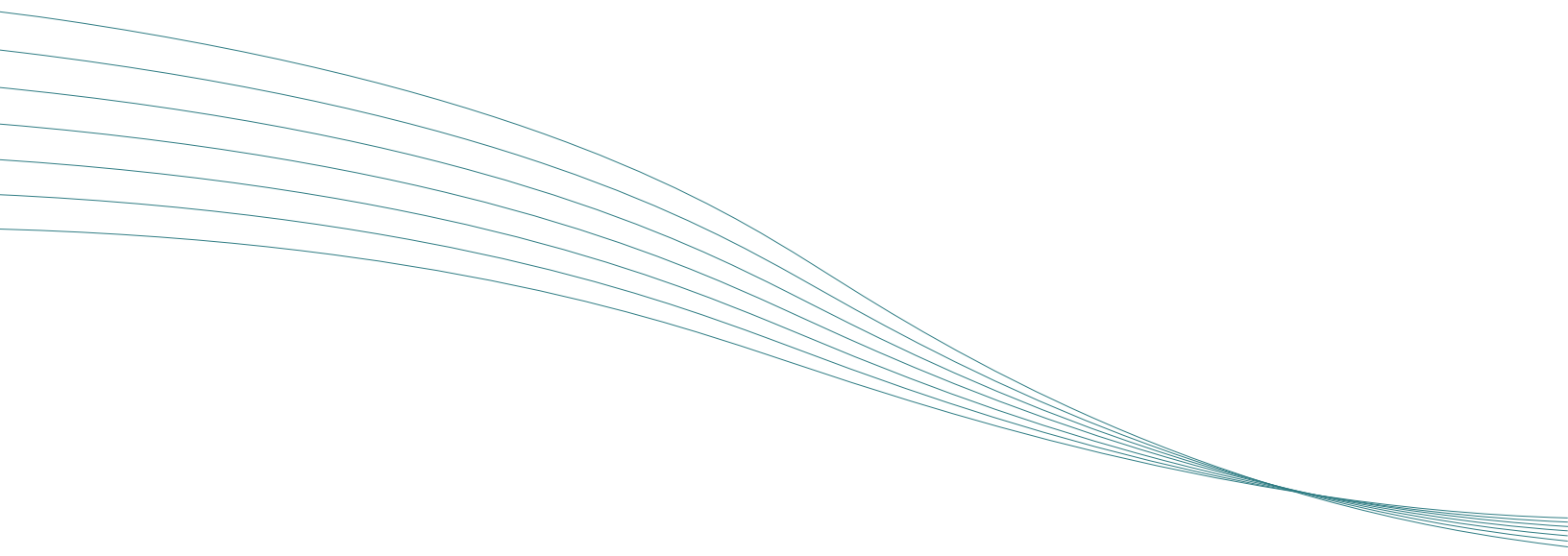
The growing use of electronic health records (EHRs) will change what data is collected and how, as well as how it flows and where it's stored. As a result, some of our existing data sources may be replaced by EHR data. We've continued a leadership role by working with Canada Health Infoway and jurisdictions to engage our stakeholders in the development of a vision for health system use (HSU) of data in Canada. We're also supporting them in their adoption of the Pan-Canadian Primary Health Care EMR Content Standard and HSU data extraction. Our expanding Primary Health Care Voluntary Reporting System certainly enhances our ability to adapt to this new electronic record environment.

Risk 3: Staff Engagement

We've recently evolved from an organization of growth to one of steady state. To prepare for this, we had to operate differently in the last year to transition to a new funding agreement. Management identified a reduction in compensation of $5 million by eliminating 53.5 full-time equivalents by the end of the fiscal year through normal staff turnover. As this had the potential to affect staff morale and engagement, we engaged our people in shaping the future of the organization through the development of our new mission, mandate, values and strategic plan, as well as efficiencies. Open communication and transparency at all levels of the organization was the goal. We kept staff in the loop on our human resources strategy and we continued mitigation strategies, including offering learning and development programs and interesting and challenging work/opportunities. We also continued to measure staff engagement, and the 2011 employee survey held in June had a response rate of 92%. Results were positive, despite a slight decline from the 2009 results. The results continue to present a picture of an engaged workforce, with a few areas—including performance management, recognition and employee satisfaction—being addressed through employee working groups. Their recommendations (60 in total) were given to management, and an implementation plan is in the works.

Risk 4: Stakeholder Support

The need for pan-Canadian data will become less relevant due to decentralization of health care authority and the lack in willingness of provincial/territorial governments to work together. Over the last year, we've promoted information products and services that are most relevant to health care organizations (such as CIHI Portal, dashboards, performance indicators, costing data and the Canadian Hospital Reporting Project). We also increasingly emphasized the value we bring to our partners and demonstrated the value of pan-Canadian comparisons. In response to these changing needs, we pursued more province- and region-specific analyses and projects and sought out local partners where it was appropriate.



Audited Financial Statements

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

We have audited the accompanying financial statements of the Canadian Institute for Health Information (CIHI), which comprise the balance sheets as at March 31, 2012 and 2011, and the statements of revenue and expenses, changes in net assets, and cash flows for the years 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 generally accepted accounting principles, 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, 2012 and 2011, and the results of its operations and its cash flows for the years then ended in accordance with Canadian generally accepted accounting principles.

Ottawa, Canada,
June 21, 2012

Ernst & Young LLP

Chartered Accountants
Licensed Public Accountants

Balance Sheet

As at March 31

	2012 $	2011 $
Assets		
Current:		
Cash and cash equivalents *(note 3)*	**14,664,363**	9,415,915
Accounts receivable *(note 4)*	**3,336,326**	3,273,336
Prepaid expenses	**2,703,515**	2,289,373
	20,704,204	14,978,624
Investments—Roadmap *(note 5)*	**751,664**	9,778,466
Capital assets *(note 6)*	**15,481,218**	17,610,241
Other assets *(note 7)*	**210,283**	478,889
Accrued pension benefit asset *(note 8)*	**18,483,900**	9,863,900
	55,631,269	52,710,120
Liabilities		
Current:		
Accounts payable and accrued liabilities *(note 10)*	**7,675,764**	5,616,554
Unearned revenue	**4,565,077**	5,500,567
	12,240,841	11,117,121
Accrued pension benefit liability *(note 8)*	**597,302**	556,600
Deferred contributions *(note 11)*		
Expenses of future periods	**22,611,894**	18,808,292
Capital assets	**12,640,450**	14,507,704
Lease inducements *(note 12)*	**2,183,612**	2,651,433
	50,274,099	47,641,150
Net Assets		
Invested in capital assets	**2,077,563**	2,115,955
Unrestricted	**3,279,607**	2,953,015
	5,357,170	5,068,970
	55,631,269	52,710,120

Commitments *(note 16)*

See accompanying notes.

On behalf of the Board

Director

Director

Statement of Revenue and Expenses

Year ended March 31

	2012 $	2011 $
Revenue		
Core Plan *(note 13)*	**16,368,700**	16,368,700
Sales	**2,209,405**	1,769,190
Funding—other *(note 14)*	**5,464,478**	2,873,562
Health Information Initiative/Roadmap	**79,681,658**	86,075,097
Other revenue	**391,868**	160,052
	104,116,109	107,246,601
Expenses		
Compensation	**71,304,282**	71,939,221
External and professional services	**11,779,144**	13,229,836
Travel and advisory committee expenses	**3,116,339**	4,194,783
Office supplies and services	**1,027,104**	1,448,429
Computers and telecommunications	**7,018,481**	7,338,178
Occupancy	**9,582,559**	8,972,154
	103,827,909	107,122,601
Excess of revenue over expenses	**288,200**	124,000

See accompanying notes.

Statement of Changes in Net Assets

Year ended March 31

	Invested in Capital Assets	Unrestricted	2012	2011
	$	$	$	$
Balance, beginning of year	**2,115,955**	**2,953,015**	**5,068,970**	4,944,970
Excess (deficiency) of revenue over expenses	**(638,233)**	**926,433**	**288,200**	124,000
Net investment in capital assets	**599,841**	**(599,841)**	**—**	—
Balance, end of year	**2,077,563**	**3,279,607**	**5,357,170**	5,068,970

See accompanying notes.

Statement of Cash Flows

Year ended March 31

	2012 $	2011 $
Operating Activities		
Excess of revenue over expenses	**288,200**	124,000
Items not affecting cash:		
Amortization of capital assets	**4,538,960**	4,660,147
Amortization of lease inducements	**(467,821)**	(468,829)
Pension benefits	**(8,579,298)**	(5,959,500)
Amortization of deferred contributions—capital assets	**(3,736,503)**	(3,927,471)
Loss on disposal of capital assets	**59,153**	185,588
	(7,897,309)	(5,386,065)
Changes in non-cash working capital items *(note 15)*	**646,588**	(7,461,627)
Net change in other assets	**268,606**	(77,702)
Net change in deferred contributions	**5,672,851**	(324,313)
Cash provided by (used in) operating activities	**(1,309,264)**	(13,249,707)
Investing Activities		
Acquisition of capital assets	**(2,474,683)**	(1,960,186)
Proceeds on disposal of capital assets	**5,593**	4,757
Acquisition of investments—Roadmap	**(11,475,922)**	(23,940,090)
Proceeds on disposal of investments—Roadmap	**20,502,724**	29,636,632
Cash provided by investing activities	**6,557,712**	3,741,113
Net change in cash	**5,248,448**	(9,508,594)
Cash and cash equivalents, beginning of year	**9,415,915**	18,924,509
Cash and cash equivalents, end of year	**14,664,363**	9,415,915
Represented by:		
Cash	**864,363**	1,915,915
Short-term investments	**13,800,000**	7,500,000
	14,664,363	9,415,915
Supplementary information		
Interest received	**321,753**	191,120

See accompanying notes.

Notes to Financial Statements

March 31, 2012

1. Organization

The Canadian Institute for Health Information (CIHI) is a national not-for-profit organization incorporated under Part II of the *Canada 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. Accounting Policies

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles.

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.

Investments—Roadmap

Investments—Roadmap are recorded at fair value determined based on quoted market value of the underlying investments.

Capital Assets

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

Computers	5 years
Furniture and equipment	5–10 years
Telecommunication equipment	5 years
Leasehold improvements	Term of lease

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 (2011—13 years). The average remaining service period of the active employees covered by the supplementary retirement plan is 10 years (2011—12 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 designated as held-for-trading and are measured at fair value. Accounts receivable net of allowance for doubtful accounts are designated as loans and receivables and are carried at amortized cost. Accounts payable and accrued liabilities are classified as other financial liabilities and 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 a 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 9, CIHI has an available line of credit that is used when sufficient cash flows are not available from operations to cover operating and capital expenditures.

Future Accounting Changes

The Accounting Standards Board (AcSB) of the Canadian Institute of Chartered Accountants (CICA) has announced that private not-for-profit organizations will be required to adopt Part III of the CICA Handbook or IFRS for years beginning on or after January 1, 2012.

CIHI will adopt Part III of the CICA Handbook for fiscal 2013 and is evaluating the impact of this change 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 (2011—90 days).

4. Accounts Receivable

	2012	2011
	$	$
Operating	**1,626,723**	1,457,319
Funding—other	**1,709,603**	1,816,017
	3,336,326	3,273,336

5. Investments—Roadmap

The investments—Roadmap consist of financial instruments, such as Guaranteed Investment Certificates (GIC) and term deposits.

6. Capital Assets

	2012		2011	
	Cost	Accumulated Amortization	Cost	Accumulated Amortization
	$	$	$	$
Computers	**20,397,033**	**13,818,510**	19,001,611	12,054,825
Furniture and equipment	**6,177,313**	**3,609,044**	6,146,335	3,106,575
Telecommunication equipment	**1,370,066**	**1,002,077**	1,349,627	818,376
Leasehold improvements	**10,717,399**	**4,750,962**	10,694,875	3,602,431
	38,661,811	**23,180,593**	37,192,448	19,582,207
Accumulated amortization	**(23,180,593)**		(19,582,207)	
Net book value	**15,481,218**		17,610,241	

7. Other Assets

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

8. 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:

	2012		2011	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Current service cost, net of employee contributions	**4,577,900**	**41,700**	4,409,800	50,000
Interest cost on accrued benefit obligation	**3,536,700**	**24,600**	2,889,400	26,000
Expected return on plan assets	**(4,079,300)**	**—**	(2,981,300)	—
Amortization of transitional asset	**(57,700)**	**—**	(57,700)	—
Amortization of net actuarial loss (gain)	**27,500**	**(14,000)**	23,500	(6,600)
Pension plan expense	**4,005,100**	**52,300**	4,283,700	69,400

The transitional asset amounted to $923,357 as at April 1, 2000.

Changes in the accrued benefit obligation are as follows:

	2012		2011	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	$	$	$	$
Accrued benefit, obligation beginning of year	**53,034,500**	**460,100**	41,221,300	354,700
Current service cost, net of employee contributions	**4,577,900**	**41,700**	4,409,800	50,000
Interest cost on accrued benefit obligation	**3,536,700**	**24,600**	2,889,400	26,000
Employee contributions	**3,145,700**	**—**	2,745,600	—
Benefits paid	**(987,500)**	**(11,600)**	(1,065,300)	(11,500)
Actuarial gain	**29,958,400**	**41,300**	2,833,700	40,900
Accrued benefit obligation, end of year	**93,265,700**	**556,100**	53,034,500	460,100

Changes in the plan assets are as follows:

	2012		2011	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	$	$	$	$
Fair value of assets, beginning of year	**57,287,400**	**—**	41,153,300	—
Actual return on assets	**2,394,400**	**—**	4,152,700	—
Employer contributions	**12,625,100**	**11,600**	10,301,100	11,500
Employee contributions	**3,145,700**	**—**	2,745,600	—
Benefits paid	**(987,500)**	**(11,600)**	(1,065,300)	(11,500)
Fair value of assets, end of year	**74,465,100**	**—**	57,287,400	—

The plans' assets consist of:

	2012		2011	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	%	%	%	%
Asset category:				
Bonds	**35**	**—**	35	—
Equities	**65**	**—**	65	—
	100	**—**	100	—

CIHI recorded the assets and liabilities as follows:

	2012		2011	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit obligation, end of year	**(93,265,700)**	**(556,100)**	(53,034,500)	(460,100)
Fair value of assets, end of year	**74,465,100**	**—**	57,287,400	—
Funded status—surplus (deficit), end of year	**(18,800,600)**	**(556,100)**	4,252,900	(460,100)
Unamortized transitional asset	**(230,900)**	**—**	(288,600)	—
Unamortized net actuarial loss (gain)	**37,515,400**	**(41,202)**	5,899,600	(96,500)
Accrued pension benefit asset (liability)	**18,483,900**	**(597,302)**	9,863,900	(556,600)

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

	2012		2011	
	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %
Service cost for years ended March 31:				
Discount rate	**6.25**	**6.25**	6.50	6.50
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 of March 31:				
Discount rate	**4.50**	**4.50**	6.25	6.25
Rate of compensation increase	**4.00**	**4.00**	4.00	4.00

9. Bank Indebtedness

CIHI has a line of credit of $500,000 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, 2012, a letter of credit in the amount of $229,600 (March 31, 2011—$230,500) for the purpose of the Supplementary Retirement Plan had been issued against the line of credit. In May 2012, CIHI increased its line of credit to $5,000,000.

10. Accounts Payable And Accrued Liabilities

Accounts payable and accrued liabilities are operational in nature. At the end of the year, an amount of $194,791 (2011—nil) representing the excess contribution received from Health Canada for the Health Information Initiative is payable.

11. Deferred Contributions

Expenses of Future Periods

Since 1999, Health Canada has been significantly funding, through the Roadmap Initiative, 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 contributions were received in the form of global direct payments. The ongoing funding of the Roadmap Initiative along with other funding contributions from Health Canada were consolidated through the Health Information Initiative as of April 1, 2007. 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:

	2012 $	2011 $
Balance, beginning of year	**18,808,292**	20,393,230
Current year contribution received from Health Canada	**81,746,294**	81,746,294
Contribution repayable to Health Canada *(note 10)*	**(194,791)**	—
Restricted investment revenue	**65,268**	77,019
Amount recognized as funding—CIHI operations	**(75,943,920)**	(82,147,626)
Amount transferred to deferred contributions—capital assets	**(1,869,249)**	(1,260,625)
Balance, end of year	**22,611,894**	18,808,292

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:

	2012 $	2011 $
Balance, beginning of year	**14,507,704**	17,174,550
Amount received from Health Information Initiative contribution	**1,869,249**	1,260,625
Amount recognized as funding	**(3,736,503)**	(3,927,471)
Balance, end of year	**12,640,450**	14,507,704

12. Lease Inducements

The lease inducements include the following amounts:

	2012 $	2011 $
Leasehold improvement allowances	**763,205**	986,582
Free rent and other inducements	**1,420,407**	1,664,851
	2,183,612	2,651,433

The amortization of leasehold improvement allowances and free rent and other inducements amount to $223,377 and $244,444, respectively (2011—$224,282 and $244,547, respectively).

13. 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.

14. Funding—Other

	2012 $	2011 $
Provincial/territorial governments	**3,575,625**	2,070,743
Federal government	**560,796**	630,796
Other	**1,328,057**	172,023
	5,464,478	2,873,562

15. Net Change in Non-Cash Working Capital Items

	2012 $	2011 $
Accounts receivable	**(62,990)**	(1,757,796)
Prepaid expenses	**(414,142)**	(91,648)
Accounts payable and accrued liabilities	**2,059,210**	(5,202,209)
Unearned revenue	**(935,490)**	(409,974)
	646,588	(7,461,627)

16. Commitments

The 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:

	$
2013	13,010,823
2014	8,035,528
2015	7,692,654
2016	5,657,949
2017 and thereafter	11,320,747

17. Capital Management

CIHI's objectives when managing capital are to safeguard its ability to continue as an independent not-for-profit organization in an effort to carry out its mandate. Through various contribution agreements, the federal, provincial and territorial ministries of health provide most of CIHI's capital resources. The Investments—Roadmap, restricted by the Health Information Initiative agreement with the federal Ministry of Health, is another source of capital. CIHI manages its related programs and projects within the terms and conditions of these agreements, including the requirement to fund its retirement benefits plans in accordance with related regulations. CIHI's management monitors its capital by reviewing periodically various financial metrics, including cash flow and variances to budget and multi-year forecasts. CIHI has complied with all of its externally imposed restrictions.

Our Leadership and Governance

Senior Management (as of March 31, 2012)

John Wright
President and CEO

Jean-Marie Berthelot
Vice President, Programs

Caroline Heick
Executive Director, Ontario and Quebec

Anne McFarlane
Vice President, Western Canada and Developmental Initiatives

Scott Murray
Vice President and Chief Technology Officer

Louise Ogilvie
Vice President, Corporate Services

Stephen O'Reilly
Executive Director, Atlantic Canada

Jeremy Veillard
Vice President, Research and Analysis

Elizabeth Blunden
Director, Human Resources and Administration

Lorraine Cayer
Director, Finance

David Clements
Director, Corporate Strategy and Education

Anne Cochrane
Director, Corporate Communications and Outreach

Cathy Davis
Director, Acute and Ambulatory Care Information Services

Mark Fuller
Director, Applications and Web Services

Jean Harvey
Director, Canadian Population Health Initiative

Kimberly Harvey
Director, Architecture, Planning and Standards

Michael Hunt
Director, Pharmaceuticals and Health Workforce Information Services

Kira Leeb
Director, Health System Performance

Barbara McLean
Acting Director, Central Client Services

Kathleen Morris
Director, Health System Analysis and Emerging Issues

Anne-Mari Phillips
Chief Privacy Officer and General Counsel

Mea Renahan
Acting Director, Clinical Data Standards and Quality

Francine Anne Roy
Director, Health Spending and Strategic Initiatives

Greg Webster
Director, Primary Health Care Information and Clinical Registries

Douglas Yeo
Director, Methodologies and Specialized Care

Board of Directors (as of March 31, 2012)

Chair of the Board

Dr. Brian Postl
Dean of Medicine, University of Manitoba
Winnipeg, Manitoba

Region 1: British Columbia and Yukon

Mr. Howard Waldner
Chief Executive Officer, Vancouver Island Health Authority
Victoria, British Columbia

Mr. Graham Whitmarsh
Deputy Minister, Ministry of Health Services
Victoria, British Columbia

Region 2: The Prairies, the Northwest Territories and Nunavut

Dr. Chris Eagle
President and Chief Executive Officer, Alberta Health Services
Edmonton, Alberta

Dr. Marlene Smadu
Associate Dean of Nursing, University of Saskatchewan
Regina, Saskatchewan

Region 3: Ontario

Mr. Saäd Rafi
Deputy Minister, Ministry of Health and Long-Term Care
Toronto, Ontario

Ms. Janet Davidson
Canadian Head of the Global Healthcare Center of Excellence, KPMG
Toronto, Ontario

The Board of Directors met in June and November 2011 and March 2012.

Region 4: Quebec

Mr. Denis Lalumière
Assistant Deputy Minister, Strategic Planning, Evaluation and Quality, ministère de la Santé et des Services sociaux
Québec, Quebec

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

Region 5: Atlantic

Mr. Donald Ferguson
Deputy Minister, Department of Health
Fredericton, New Brunswick

Mr. John McGarry
Private Health Administration Consultant
Fredericton, New Brunswick

Canada at Large

Dr. Marshall Dahl
Consultant Endocrinologist, Vancouver Hospital and Health Sciences Centre and Burnaby Hospital
Vancouver, British Columbia

Dr. Vivek Goel
President and CEO, Public Health Ontario
Toronto, Ontario

Chair, CPHI Council

Dr. Cordell Neudorf
Chief Medical Health Officer, Saskatoon Health Region
Saskatoon, Saskatchewan

Health Canada

There is currently no Health Canada representative.

Statistics Canada

Mr. Wayne Smith
Chief Statistician, Statistics Canada
Ottawa, Ontario

Board of Directors Committee Membership

Human Resources Committee

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

The committee met in November 2011 and March 2012.

Members
Brian Postl (Chair)
Marshall Dahl
Vivek Goel
John McGarry
Marlene Smadu

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.

The committee met in November 2011 and March 2012.

Members
Vivek Goel (Chair)
Denis Lalumière
Brian Postl (ex officio)

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 bylaws.

The committee met in May and October 2011.

Members
Chris Eagle (Chair)
Luc Boileau
Cordell Neudorf
Wayne Smith
Brian Postl (ex officio)

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 auditors' report and the appointment of the forthcoming year's auditors, and it provides direction and review of our internal audit program.

The committee met in May and November 2011 and January and March 2012.

Members
John McGarry (Chair)
Janet Davidson
Don Ferguson
Howard Waldner
Graham Whitmarsh
Brian Postl (ex officio)

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Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6

Phone: 613-241-7860
Fax: 613-241-8120
www.cihi.ca
copyright@cihi.ca

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Talk to Us

CIHI Ottawa
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6
Phone: 613-241-7860

CIHI Toronto
4110 Yonge Street, Suite 300
Toronto, Ontario M2P 2B7
Phone: 416-481-2002

CIHI Victoria
880 Douglas Street, Suite 600
Victoria, British Columbia V8W 2B7
Phone: 250-220-4100

CIHI Montréal
1010 Sherbrooke Street West, Suite 300
Montréal, Quebec H3A 2R7
Phone: 514-842-2226

CIHI St. John's
140 Water Street, Suite 701
St. John's, Newfoundland and Labrador A1C 6H6
Phone: 709-576-7006

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At the heart of data

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