CIHI Annual Report, 2012–2013

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

The need for health information has grown significantly over the last 20 years. Today, governments and health professionals are increasingly concerned with the quality and sustainability of the health system. To support improved efficiencies, policy-makers and system managers want comprehensive information on patient safety, health outcomes, system performance and the appropriateness and availability of care. Front-line care workers require better measurement and monitoring systems, and—at the same time—increasing use of health information technology is facilitating access to a richer range of data. In short, the need for—and use of—health information across the system has evolved.

At the **Canadian Institute for Health Information (CIHI)**, we are committed to responding to these evolving needs. We know that good data—good information—is the backbone of good decision-making. This past year has marked the beginning of a transition period at CIHI as we focused, more than ever, on improving the timeliness and accessibility of our data across the continuum of care while continuing to support its use and understanding among our stakeholders.

The year began with the implementation of our new strategic and business plans and the roll-out of a two-year analytical plan. We worked to gather a clearer picture of the health system by providing new analyses on subjects like breast cancer surgery, stroke care and adverse drug reactions that required hospitalization. In collaboration with partners, we continued to develop the Canadian Multiple Sclerosis Monitoring System, creating content standards and readying the system for data submission.

We provided a clear picture of the health system by looking at data across the continuum of care. By creating a new average clinical payment indicator (which combines fee-for-service and alternative-payment data), we enhanced the comprehensiveness of our physician compensation data. We signed data-sharing agreements with Health Canada and the ministries of health in Saskatchewan and Ontario for the National System for Incident Reporting. For the first time, Quebec data was included in the release of the hospital standardized mortality ratio, and we received linkable claims data from British Columbia for the National Prescription Drug Utilization Information System Database.

This year, we also addressed financial challenges for the organization while maintaining the high quality of our data, standards and analyses. Reductions in Health Canada funding resulted in the elimination of full-time positions through attrition. We said goodbye to several members of the Board, as well as to our valued colleagues Jean-Marie Berthelot, Vice President, Programs, and Cathy Davis, Director, Acute and Ambulatory Care Information. We welcomed new Board members and our new Vice President, Programs, Brent Diverty. We were proactive in dealing with an estimated pension funding deficit. To ensure appropriate compensation for our valued staff, we conducted a compensation survey. Using staff input, we revised our policies to provide more flexibility in the workplace and enhanced our approach to recognizing staff accomplishments.

Working within the new fiscal reality, we reviewed our processes and reduced waste, time and spending by undertaking three continuous quality improvement initiatives using the Lean methodology. Based on the positive results of these pilots, we are now rolling out a corporate Lean program.

We also took the time to listen to what our customers had to say about our organization by conducting a survey. Overall results were very positive, with a large majority of stakeholders indicating that CIHI's products and services met their needs and helped them provide efficient and effective health care. However, the results did highlight some specific opportunities for improvement.

In response to customer feedback, we developed a business case to support CIHI's new Integrated eReporting (IeR) initiative. The approved case will help us develop and deploy sustainable solutions to provide clients with timelier access to information and data that is tailored to their specific priorities. IeR will enhance our ability to make meaningful comparisons across the continuum of care and will promote a more seamless customer experience. Continuing this customer focus, we began work on a project to improve our website by making it easier for our stakeholders to search for and find information. We also introduced the Health System Performance Initiative. This new venture aims to position our performance reporting in a way that supports the improvement efforts of Canadian provinces and territories.

Finally, to improve our customers' experience with CIHI, we provided training to all staff that focused on using our values and service standards to create a positive experience across the organization.

Winston Churchill once said, "To improve is to change; to be perfect is to change often." As we approach our 20th anniversary in 2014, these are words to keep in mind. CIHI has long been a trusted provider of comprehensive, comparable and reliable data, but that doesn't mean we can rest on our laurels—we are always improving, evolving and changing. We have taken steps to make our products and services more nimble, integrated and customizable. We will continue on this journey. Working with you, our stakeholders from across the country, we will meet our goals of providing the comparable, actionable and relevant information you need as a foundation for good decision-making.

Dr. Brian Postl
Board Chair

John Wright
President and CEO

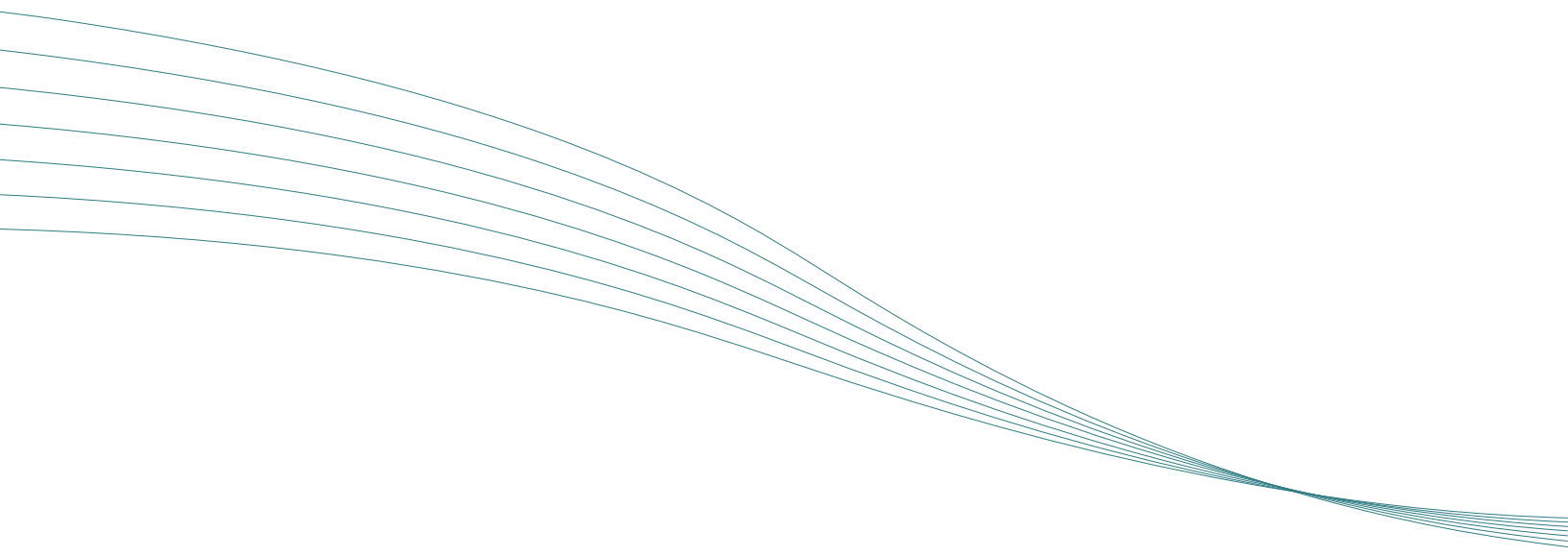
Our Accomplishments

As an independent, non-government organization, CIHI is a respected and unbiased source of data and information; however, our work and our focus have always been shaped by the needs of our stakeholders. Canadian health systems are evolving, and the information needs of our stakeholders are changing—and CIHI must change along with them. We've consulted with our customers to understand their priorities and ensure that the information we provide is not only comprehensive and reliable but also appropriate, timely and easily accessible. Our new strategic directions reflect this and ensure that CIHI continues to be relevant and forward-thinking as we move into the future.

2012 to 2017 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.

Throughout the past year, we've made significant strides toward achieving these goals. The following pages provide examples of our progress: the targets we've met, the targets we've surpassed and the areas that need more work.



Improving the Comprehensiveness, Quality and Availability of Data

Quality, comparable data is the foundation of good decision-making. It provides insight into the health system, and it helps decision-makers understand what is working well and identify areas where improvements may be needed. We've made a commitment to improve the comprehensiveness and availability of the data within and across our 28 data holdings. Here's what we've achieved so far.

Providing Timely and Accessible Data Connected Across Health Sectors

- We launched the enhanced **Continuing Care Reporting System (CCRS)**, which will support future integration across CIHI's electronic reporting systems—preparing the way for increased use of data from electronic health records.
- We began developing the **population risk adjustment grouper (PRAG)** methodology. The PRAG will classify the population based on clinical characteristics and produce estimates of their needs for health care services. It will assist CIHI and clients in monitoring population health, understanding care utilization patterns, explaining variations in resource use and providing a foundation for funding models.

- In recognition of our work with the Canadian Association of Paediatric Health Centres (CAPHC) on the Canadian Paediatric Surgical Wait Time Project, we received CAPHC's 2012 Citizenship Award. The **Discharge Abstract Database (DAD)** and **National Ambulatory Care Reporting System (NACRS)** will begin receiving pediatric wait time data for the first time in 2013–2014. The project will allow CAPHC to access pediatric data through CIHI Portal.
- The **National Prescription Drug Utilization Information System (NPDUIS)** Database is now receiving provincial drug claims data from B.C. Using linked data from the **DAD** and the **NPDUIS Database**, CIHI released ***Adverse Drug Reaction–Related Hospitalizations Among Seniors, 2006 to 2011***.

Integrated eReporting

To support the evolving information needs of our stakeholders, CIHI has begun work on our Integrated eReporting (IeR) initiative. IeR is a structured, planned approach to bringing together health information historically maintained in silos. Benefits of this approach include reduced costs and enhanced standardization. The result? CIHI clients will have

- Enhanced ability to make meaningful comparisons;
- Better understanding of and access to data to support decision-making;
- Access to a single continuum view that spans and integrates multiple databases;
- Timelier access to data; and
- A more seamless and holistic experience when dealing with CIHI's information resources.

Further information about IeR can be found throughout this report.

Data Access Strategy and the Data Liberation Initiative

At CIHI, we pride ourselves on the quality and comparability of our data. However, excellent data means nothing if it is not relevant to, and easily accessed by, our stakeholders. That's why we've launched the **Data Access Strategy** to improve the accessibility and timeliness of CIHI's data.

This year, we began work to facilitate greater access to CIHI's data for researchers using Statistic Canada's Data Liberation Initiative (DLI). For an annual user fee, DLI provides students and faculty at Canadian post-secondary institutions with access to many of Statistics Canada's data and geographic information products.

We began this pilot project by provided registered DLI users with access to two research analytical files containing de-identified samples from the DAD (using fiscal years 2009–2010 and 2010–2011). Each file includes record-level data; one file focuses on clinical data while the other highlights geographic information. The DAD data files include information on key demographic, clinical and case mix variables and are available in both English and French.

The pilot will close in March 2014, and a report will summarize the benefits and challenges of using the DAD research analytical files. The resulting lessons learned will help inform potential roll-outs of research analytical files using other CIHI databases.

Supporting New and Emerging Sources of Data, Including Electronic Health Records

- Working with the Canadian Network of Multiple Sclerosis Clinics, the MS Society of Canada, people living with MS, caregivers, clinicians, researchers, international experts and various governments, we completed the development of the **Canadian Multiple Sclerosis Monitoring System (CMSMS)**. The system is now ready to receive data.
- In collaboration with Canada Health Infoway, we crafted a Canadian vision paper for the **health system use (HSU)** of electronic health information in Canada. The vision, which incorporates stakeholder feedback, was submitted to the Conference of Deputy Ministers of Health in May 2013.
- As part of our HSU work, we assessed the NPDUIS Database, the DAD, NACRS and the **Primary Health Care Information program** to determine their readiness to accept, adapt to and access data from new electronic health record (EHR) and electronic medical record (EMR) systems.
- The Canadian Emergency Department Diagnosis Shortlist received the Canadian Approved Standards designation from Canada Health Infoway's Standards Collaborative Strategic Committee; this is the first of what we expect will be many HSU standards at CIHI to receive this distinction.
- We updated a subset of pan-Canadian primary health care (PHC) indicators to support consistent performance measurement. Two suites of 30 indicators were developed: one focuses on a population-based perspective to support policy and planning needs, and the second is designed to support performance measurement and quality improvement.
- Eight jurisdictions (B.C., Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Newfoundland and Labrador and the Northwest Territories) have either started implementing or confirmed their intention to implement (all or part of) the ***PHC EMR Content Standard***.
- Clinicians from three jurisdictions (B.C., Ontario and Nova Scotia) are currently participating in the **PHC Voluntary Reporting System**, providing de-identified data from 260 family physicians (at 21 sites) and about 500,000 unique patients. This work will deepen our understanding of how to best collect and report on this practice-level primary care data in the future.

Providing More Complete Data in Priority Areas

- Working with our stakeholders, we made significant progress in expanding coverage of our non–acute care reporting systems. Newfoundland and Labrador began employing RAI inpatient and community mental health assessment tools across the province. It also started using a provincial home care reporting system, with province-wide implementation scheduled for later in 2013–2014. Building on work completed with one region, Newfoundland and Labrador will begin implementing CCRS in 2013, as will Alberta.
- We improved the comprehensiveness of our physician compensation data by introducing a new indicator: average gross clinical payment per physician. The indicator combines fee-for-service payments and alternative payments.
- Ministries of health in Ontario and Saskatchewan, along with Health Canada, signed data-sharing agreements for the **National System for Incident Reporting (NSIR)**. We collaborated with Cancer Care Ontario to improve collection of chemotherapy medication incidents. In addition, work is under way to receive data from provincial systems such as the B.C. Patient Safety and Learning System.
- Through expanded collection of emergency department data within **NACRS**, we now have 56% coverage across Canada. Sites submitting to NACRS can take advantage of a clinician-friendly pick-list of terms to improve the efficiency and quality of data collection.
- We streamlined the **Canadian Joint Replacement Registry (CJRR)** data elements and launched a minimum data set in alignment with the International Society of Arthroplasty Registries. CJRR is now accepting Ontario data, and we're working with B.C. to support a province-wide electronic solution for mandatory data collection there.
- In an effort to provide a more pan-Canadian picture of hospital costs, we updated the functionality of the **Canadian Patient Cost Database (CPCD)** and included Quebec financial data in the **Canadian MIS Database (CMDB)**. Quebec information is now available in the cost per weighted case indicator as well as the recently updated **Patient Cost Estimator**.
- Working with the Ontario Ministry of Health and Long-Term Care, we continued to support the deployment and use of the **Health Based Allocation Model (HBAM)** funding methodology. We also continued to meet with jurisdictions and advise them on the design and implementation of activity-based funding as well as other funding models.

Table 1: Comprehensiveness of CIHI's Data Holdings, March 31, 2013

Service Type	Data Holding	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/HMDB)						2							
	Emergency Department	✔												
	Ambulatory Clinics (NACRS)													
Continuing and Specialized Care	HMHDB													
	OMHRS*				✔						✔			
	NRS													
	CCRS													
	HCRS													
	CORR							3		3	3		3	
	NTR-MDS													
	NTR-CDS													
	CJRR	4	4	4	✔		4	4	4		4	4	4	
	CMSMS													
Pharma-ceuticals	NPDUIS	✔									✔			
	NSIR	✔			✔	✔								
Workforce	NPDB													
	RNDB†													
	LPNDB†													
	RPNDB†													
	NP†													
	HPDB													
	OTDB													
	PDB													
	PTDB													
	MRTDB													
	MLTDB													
Health Spending	NHEX													
	CMDB													
	CPCD	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

* OMHRS includes inpatient mental health data for general and psychiatric hospitals.

† All part of the Nursing Database (NDB).

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

CIHI Data . . .

Helps Capture the True Cost of Care

There's nothing simple about organ transplants.

Beyond the procedure itself, pre- and post-operative care can involve long waits and weeks, months or years of tests, assessments, diagnostics and lab work.

At the **Hospital for Sick Children** in Toronto, kids who are in the pre-, peri- and post-transplant phases of care are all active patients in the facility's transplant database. They move from it only if they die or turn 18 (at which point they transfer into the adult system). In recent years, there's been steady growth in the number of children waiting for transplants, but it hasn't always been balanced by an equal movement of people off the list. That's led to a cumulative effect in costs.

"The dilemma is that funding mechanisms typically only fund the episode (the transplant) where the procedure occurs," says Irene Blais, SickKids' former director of decision support. "But it doesn't look at the continuum of care and the impact on the organization through that continuum."

Although some pre- and post-operative costs are funded, what's covered doesn't represent the full cost of the transplant program, and the funding rates haven't been revised in years.

To tell the full story, Blais turned to the hospital's integrated data and costing systems. By illustrating activity beyond the transplant, the decision support team was able to show that the drivers in cost and activity were growing at a faster rate than the ministry was funding them.

So What Did They Do?

The team started with SickKids' registration system, as it included all patients on the transplant waiting list, as well as organ recipients and assessed patients. This allowed them to look across the continuum of care to capture the full range of patient activity. After the data had been sorted into organ groupings, Blais worked with clinical teams who provided clinical protocols outlining how many times patients would be seen and what procedures and tests they'd have done to capture the full scope of activity.

The decision support team validated this work against the hospital's comprehensive case-costing system, which has integrated data from 18 sources, including finance, diagnostics, pharmacy, labs and the operating room. So detailed is this system that Blais could determine, to the minute, how much time nurses spent with every patient every day.

Also among the 18 data sources are CIHI's DAD and NACRS. The DAD captured the reasons why patients were returning to the hospital once they'd left, whether it was rejection-related or something beyond the transplant, given the complex needs of these patients. Among other things, NACRS data told the hospital who was having dialysis or ending up in an emergency room.

"You can't not have DAD or NACRS in there because it's the starting point for understanding patient mix and specific patient populations," Blais says. "Without them, we wouldn't have known why patients were coming back."

A Clearer Picture of the Costs

By using the data, Blais and the team were able to illustrate the true costs of transplants.

“While the bulk of the costs (41%) is still inpatient, 33% of care is delivered on an outpatient basis,” she says. “That’s a whole lot that current funding formulas aren’t taking into consideration.”

Everything outside of that 41% must come out of the hospital’s global budget, which was creating a tighter squeeze given the growing number of patients on the transplant list.

SickKids presented this information to the Ministry of Health and Long-Term Care and secured a base funding adjustment for infrastructure.

“We were able to enhance our ability to impact funding and we’re hoping that at some point they’ll review the methodology and the rates at which they fund transplants,” Blais says.

The hospital is now applying this practice to business cases across the continuum.

“For me, the journey of taking data and turning it into information makes for a more insightful organization,” Blais says. “That can be applied to all streams: operational, process improvement, strategy, research and management. When data is integrated and evidence-based, we can improve our decision-making.”

Supporting Population Health and Health System Decision-Making

Across the country, the quantity and quality of health information available to decision-makers has grown substantially. Over the last year, we've asked ourselves some questions: Where does CIHI fit? How do we remain relevant in a world where health information is increasingly available at the click of a button? Where can we fill an information gap? What are our stakeholders asking for?

We know that our customers respect and value CIHI's products and services. Our challenge lies in translating complex health numbers and data into actionable knowledge that is timely and easily accessed and that can be broken down to show a local context.

Last year, we introduced a two-year rolling analytical plan to ensure that our products and services provide our customers with the data and analyses they need, when they need them, how they need them. This year, we continued this customer focus and released more than 20 analytical products that addressed complex issues, such as appropriateness of care. We worked with our stakeholders to increase the overall depth and breadth of analysis and reporting across all of our data holdings and to provide better reporting for better population health and health system decision-making. And, of course, we introduced our new Health System Performance (HSP) Initiative. Here's a look at how we did.

Producing Relevant, Appropriate and Actionable Analysis

- Working to meet evolving stakeholder needs, we produced the final edition of the ***Health Care in Canada*** report series. The report looked at people's experiences in accessing care across the health system and highlighted successful strategies for decreasing wait times. To supplement the final ***Health Care in Canada*** report, we also released an interactive timeline showing a patient's journey across the continuum of care for knee replacement surgery.
- In an effort to support increased understanding and fill gaps in health information, the **Canadian Population Health Initiative (CPHI)** released two reports focused on Aboriginal peoples: ***Hospital Care for Heart Attacks Among First Nations, Inuit and Métis*** and ***End-Stage Renal Disease Among Aboriginal Peoples in Canada: Treatment and Outcomes***. In addition, CPHI started working on a new analysis that will examine health system planning and decision-making through a population health lens.
- The latest ***Health Indicators*** report focused on the new avoidable mortality indicator. The indicator looks at in-hospital deaths that could have been avoided through timely and effective health care and disease prevention. The report found that while rates of avoidable deaths are decreasing (suggesting that timely health care and disease prevention programs are having a positive impact), significant room remains for improvement. ***Wait Times for Priority Procedures in Canada, 2013*** was a media success, with media circulation numbers surpassing that of every other CIHI product in 2012–2013.
- In July 2012, we released ***Pathways of Care for People With Stroke in Ontario***. The study examined the movements of stroke patients through the health system and shed light on the most common pathways of care for patients, transition points along their journey and areas for improvement.
- In collaboration with the Canadian Partnership Against Cancer, we produced ***Breast Cancer Surgery in Canada, 2007–2008 to 2009–2010***. The report looked at the use of surgery for treating primary, unilateral invasive breast cancer in women. By promoting better understanding of surgical trends and patterns, the report aimed to help improve treatments and strengthen outcomes and quality of life for women with breast cancer.
- Our annual release of the **Hospital Standardized Mortality Ratio (HSMR)** showed that patient care and quality are improving across the country.
- ***Adverse Drug Reaction–Related Hospitalizations Among Seniors, 2006 to 2011*** examined the potential risk factors and drug classes most often associated with adverse reactions. This was the first analysis to use NDPUIS Database data linked with hospital discharge data.

Expanding Our Reach: Media Coverage in 2012–2103

With 20 high-profile reports released this year, CIHI received exceptional media coverage in both quantity and quality.

Table 2: Top Media Products by Number of Media Mentions and Circulation

Focus of Media Product	Total Print and Web Mentions	Circulation in Millions*
April 4, 2012: Canadian Hospital Reporting Project (CHRP)	161	20.6
May 24, 2012: *Health Indicators 2012*	159	68.9
June 21, 2012: Quick Stats indicator updates: childbirth and hospitalization	120	16.7
October 11, 2012: *Breast Cancer Surgery in Canada, 2007–2008 to 2009–2010*	124	19.4
October 30, 2012: *National Health Expenditure Trends, 1975 to 2012*	203	34.9
November 15, 2012: *Supply, Distribution and Migration of Canadian Physicians, 2011*	165	21.3
November 29, 2012: *Health Care in Canada, 2012: A Focus on Wait Times* and *Seniors* and *Alternate Level of Care: Building on Our Knowledge*	151	27.5
December 13, 2012: Hospital standardized mortality ratio, 2011–2012	73	10.3
January 10, 2013: *Regulated Nurses: Canadian Trends, 2007 to 2011*	45	8.9
January 22, 2013: *National Physician Database, 2010–2011 Data Release*	102	33.1
March 19, 2013: *Wait Times for Priority Procedures in Canada, 2013*	54	126.9
March 26, 2013: *Adverse Drug Reaction–Related Hospitalizations Among Seniors, 2006 to 2011*	65	14.9

Note

* Circulation refers to the reach of print and web articles.

Health System Performance

Cross-country consultations conducted by CIHI suggest that there is confusion about HSP measurement, with a large number of organizations reporting at various levels and in an uncoordinated fashion. This leads to what some stakeholders have called a state of indicator chaos in the system.

This past year, CIHI started work on an ambitious three-year plan to strengthen pan-Canadian HSP reporting to provide more transparency for Canadians and greater clarity on performance variations for policy-makers and system managers. Our aim is to deliver more structured and coordinated performance reporting that is tailored to the needs of different audiences, from the general public to health system managers to policy-makers. This initiative builds on more than 10 years of work at CIHI on indicator development and public reporting on performance measurement.

CIHI's HSP Initiative includes five work streams over a three-year period (2012 to 2015).

Table 3: Health System Performance Initiative Work Streams

Work Stream	Objective
Health System Performance Measurement Framework	Build on the CIHI–Statistics Canada Health Indicator Framework to strengthen its evidence base, improve alignment with jurisdictional priorities and make it actionable
Interactive Public Reporting	Deliver cascading sets of performance measurement reports over three years to meet the information needs of the public, health system executives and managers, and policy-makers
Integrated Analytical Environment	Integrate our business intelligence solutions to allow system managers and clinicians to drill down into the data and understand performance drivers
Research and Analysis	Further align CIHI's research and analytical activities with improvement priorities of jurisdictions and continue collaborations with key partners
Capacity-Building	Partner with other health care organizations to deliver practical workshops that promote the use of HSP data and learning of best practices

In 2012–2013, CIHI completed a draft version of the new Health System Performance Framework and shared it widely with our health partners for consultation purposes. We received positive and constructive feedback, and the framework will be finalized in the new fiscal year.

We also began developing a website on HSP designed for the general public and patients. To learn which areas of performance matter most to Canadians, online and in-person public engagement was conducted with more than 3,000 Canadians in February 2013. Results from the consultation will inform the design of a public website, which is expected to launch in the fall of 2013. Future phases will include related websites to meet the information needs of regional health system managers, as well as executives of acute care and long-term care facilities.

We also started work to help build stakeholders' capacity to use HSP data and tools. Customized workshops are being developed for health system managers and analysts in Atlantic Canada; they are planned for the fall of 2013. In addition, we are hosting Health Data Users Day in Vancouver this spring, and we are planning workshops related to HSP measurement at other major conferences, including the National Health Leadership Conference.

Offering Leading-Edge Performance Management Products, Services and Tools

- In March 2013, we released updated hospital performance data for the **Canadian Hospital Reporting Project (CHRP)**. The tool, which includes data from more than 600 acute care facilities, allows hospitals to see how they are performing in 21 clinical and 6 financial areas and to measure their performance against that of their peers—fostering learning and the sharing of best practices.
- Moving forward with the IeR and HSP initiatives, we will examine new, less-traditional ways of providing comprehensive and reliable pan-Canadian information.
- We continued to build on our HSP Initiative, completing public engagement work and starting to develop an HSP website for the general public. We initiated discussions on the feasibility an HSP school to support the understanding and use of HSP data to improve performance across the country.
- We completed an analysis of international comparisons of Canada and its provinces for selected indicators from the Organisation for Economic Co-operation and Development (OECD). The comparison data, which will be released in October 2013, will provide further perspective on our health system—highlighting what is working well and where improvements are needed from an international comparisons standpoint.

Responding to Emerging Needs While Considering Local Context

- To increase our understanding of health human resource issues, we established partnerships with the ministries of education in B.C., Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Newfoundland and Labrador to directly collect their information on health personnel. We also added three new groups of professionals (paramedics, dental assistants and opticians) to the **Health Personnel Database (HPDB)**.
- Quebec data was included in the **HSMR** for the first time this year—painting the most complete picture to date of hospital mortality in Canada.
- In the wake of the 2012 CHRP release, we held consultations across Canada. We spoke to people at various levels of the health system to determine their information needs and assess how well we are meeting these needs. Lessons learned from these consultations and from the evaluation of the CHRP release will feed into our next steps in the HSP agenda.
- We expanded NPDUIS Database data collection by adding six quarters of historical First Nations data, providing more comprehensive information on prescription drugs for First Nations.

Collaborative Work

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

- Undertaking a pan-Canadian study on the rates people should pay to live in a residential care facility for the ministère de la Santé et des Services sociaux du Québec. The study will assess how rates are determined.
- Collaborating with the Institut national d'excellence en santé et en services sociaux to assess the feasibility of using billing data to calculate indicators for percutaneous coronary interventions.
- Working with Health Quality Ontario to develop a Primary Health Care Performance Measurement Summit to coordinate and improve measurement efforts across the province.
- Connecting with the Newfoundland and Labrador Centre for Health Information to discuss the development of three research studies (on diabetes, obesity and psychiatric medications) using existing EHRs. Studies would focus on identifying the issues involved in using EHR data for secondary use.
- Collaborating with the Canadian Patient Safety Institute (Atlantic region) to organize an Atlantic Learning Exchange event to be held in Moncton in 2013. The event is supported by the ministries of health in all four Atlantic provinces.
- Hosting two First Nations and Inuit Health pilot project meetings with Alberta to prepare for data submission and reporting to the **Home Care Reporting System (HCRS)**.
- Consulting with the Assembly of First Nations, the Inuit Tapiriit Kanatami, the Métis National Council, Aboriginal Affairs and Northern Development Canada, Aboriginal health researchers and others regarding two reports on the health of Aboriginal peoples in Canada released in 2012–2013: ***Hospital Care for Heart Attacks Among First Nations, Inuit and Métis*** and ***End-Stage Renal Disease Among Aboriginal Peoples in Canada: Treatment and Outcomes***. The goal of these consultations was to involve all stakeholders in the design, content and dissemination of the reports, to keep them abreast of any issues and to ensure a collaborative approach.
- Supporting the work of health authority CEOs in Western Canada by producing comparable indicators. The CEOs of the large health authorities meet regularly as a group. We provide indicators as part of a scorecard, allowing the CEOs to compare performance and support improvement.
- Working with administrators and service providers in Western Canada to establish the Sparsely Populated Panel. The panel provides a venue for clinicians and administrators who work in rural and remote areas to make their unique data needs and challenges clear to CIHI. Together, we've produced studies on giving birth in rural Canada and service in- and out-flows in rural areas. We've also collaborated on developing a study that looks at hospital services for dental caries (cavities) in young children.
- Building capacity for better use of data across Western Canada by making CIHI's methodologists available to Western clinicians and administrators and by teaching a course on data use at the University of Victoria.

Events Sponsored or Hosted by CIHI and Outreach Activities

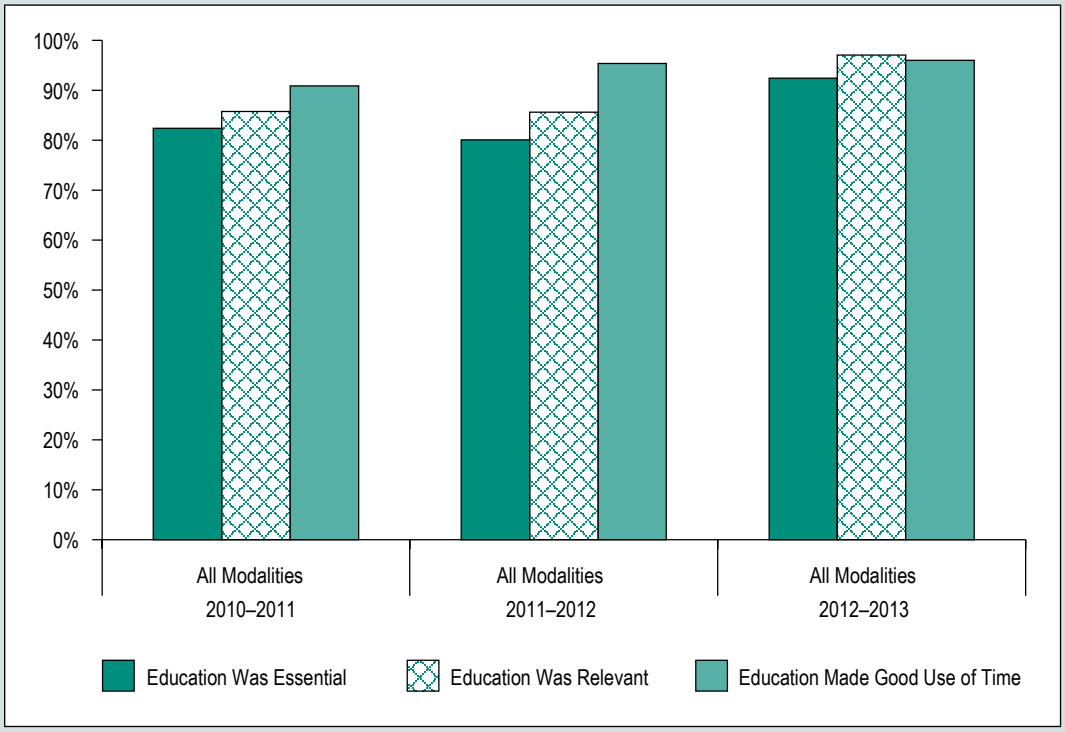
To promote the understanding and use of our products and services, we supported—and also presented and exhibited at—several national and international conferences, including the following:

- 11th International Congress on Nursing Informatics
- 2012 CAPHC Annual Conference
- 2012 Canadian Nurses Association Biennial Convention
- Association des gestionnaires de l'information de la santé du Québec conference
- BC Patient Safety and Quality Council Quality Forum
- Canadian Association for Health Services and Policy Research Conference
- Canadian Association of Medical Radiation Technologists Annual Conference
- Canadian Association of Occupational Therapists Annual Conference
- Canadian Orthopaedic Association Annual Meeting
- Canadian Public Health Association 2012 Conference
- Community Health Nurses of Canada Annual Conference
- e-Health 2012
- Family Medicine Forum 2012
- Health Data Users Conference 2012
- Information Technology and Communications in Health 2013
- interRAI 2012 Conference
- LABCON 2012 (Canadian Society for Medical Laboratory Science's national conference)
- National Health Leadership Conference 2012
- Ontario Hospital Association HealthAchieve 2012
- Saskatchewan Health Care Quality Summit
- Trauma Association of Canada Annual Scientific Meeting

Promoting Understanding and Use Through Education

We are a data organization. We collect data and we provide data. But numbers mean nothing if they are not accessible, comprehensive and actionable. Ensuring our stakeholders understand and use the data we collect is as fundamentally important to us as collecting it in the first place. To this end, we offer a variety of education products to promote the understanding and use of our data, tools and services. Our products also support a culture of data quality in and outside of CIHI.

Figure 1: Education Evaluation



Note

"All modalities" refers to education products delivered as face-to-face workshops, web conferences and self-study products.

Data helps ... Highlight Heart Attack Death Rates

When you're a regional centre for cardiac care, mortality rates are a top concern.

That's why the Rouge Valley Health System in Ontario was surprised to see high rates of 30-day in-hospital mortality following acute myocardial infarction (AMI) in the first **CHRP** release in April 2012.

Although Rouge Valley Health System's heart attack death rates were better than the national and provincial averages in the first two years of data captured, rates had increased to "worse than average" in the last two years.

"That was a big surprise to us," says Rik Ganderton, President and CEO of Rouge Valley. "We thought we were doing pretty well, but in the latest year, we didn't look as good. So it was a bit of 'yikes, what happened?'"

CHRP focuses on performance measurement in acute care. Its foundation is 30 nationally comparable facility-level clinical and financial indicators at every hospital in the country. The indicators are coupled with context, such as hospital profiles, to help users better understand their results. The project's first report was released in April 2012 and included data for the fiscal years 2007–2008 to 2010–2011.

For many other indicators, Rouge Valley had average and better-than-average results. Ganderton says they're examining each of the indicators where they weren't performing adequately to understand what they need to do to improve.

"For some of them, the data quality wasn't good, which is an issue, and with others we've got process problems. We're not handling some patient groups particularly well. Some issues we just can't get to right now—we don't have the time or the resources."

That's not the case with the AMIs. Although there are many performance measures in a hospital, and the higher mortality rates would have shown up eventually, Ganderton says CHRP has given them a different way of looking at the data.

"This hadn't jumped out at us before, so it's certainly one of the areas we're looking into pretty aggressively," he says. "We've been reviewing every single AMI 30-day death case."

Depending on what the review finds, an action plan will be developed to deal with it, Ganderton says.

"It's really trying to peel back the skin of the onion and understand what's happening. We think we've found some coding issues, but we're not sure that's the only thing that's driving it."

After the CHRP release, he took to his blog to talk about Rouge Valley's results. That kind of openness and transparency in health care would have been unheard of not that long ago.

"It was an interesting report that was timely and topical. It was something that struck me," Ganderton says of the blog post. "I think there's a changing culture in my organization. I don't think I'd have the courage to say that it's a culture change in the system yet."

While the proliferation of publicly reported information is generally a good thing, he says the danger from an operator's perspective is that they'll have so many things they're accountable for in the public domain it will be impossible to manage.

"I think people often lose sight of how huge an effort is required and how many people need to be involved to change just one of these indicators. It's astronomical," Ganderton says. "That's why I think we need to be selective—otherwise we're not going to have success."

All that said, he believes CHRP is a useful exercise.

"I think any form of evidence-based decision-making is an improvement."

Delivering Organizational Excellence

Quality is the foundation of our organization: quality data, quality analyses and—most importantly—quality people. The successes captured in this report are the work of the talented, dedicated and creative people who make up our organization. That's why we strive to remain an employer of choice, with hiring, compensation and management practices that encourage staff retention. To this end, our new strategic goals focus on providing CIHI staff with the challenges and opportunities they need to learn and grow. We aim to promote an environment of continuous improvement, and we encourage our staff to develop tools and approaches that increase value and efficiency in an accountable and open manner. Here's a look at what we've done this year to achieve organizational excellence.

Promoting Continuous Learning and Development

- To improve leadership competencies, we implemented the LEADS (Lead Self, Engage Others, Achieve Results, Develop Coalitions, Systems Transformation) framework across the organization. New courses were identified, aligned with the LEADS framework and incorporated into CIHI's Learning and Professional Development curriculum.
- During the survey of our key stakeholders, front-line customer service was identified as an area needing improvement. In response, the Customer Standards Working Group developed a set of service standards to create a positive customer experience across the entire organization. These standards were implemented across CIHI, and all staff have now completed mandatory training on the use of the standards.

- To reinforce our commitment to a work environment free of harassment, bullying and discrimination, we held a series of respectful workplace training workshops. The workshops focused on increasing understanding of the procedures and policies in place to deal with workplace conflict, as well as informal and formal methods of conflict resolution.

Championing a Culture of Innovation

- Providing the provinces with benchmarking data, we updated our interactive wait time web tool with 2012 information. The tool, which received more than 10,000 visits last year, displays five years of comparable provincial data and allows for trending over time and access to at-a-glance performance information.
- Continuing our efforts to foster innovation, we worked with the **Collaboration for Excellence in Healthcare Quality (CEHQ)** to develop a mobile application. The app, which includes indicators from CHRP, will allow CEHQ members to review their hospitals' performance in eight clinical and financial indicators anywhere and at any time. The app was launched in April 2013.
- To address our customers' concerns about finding and searching for information on our website, we launched a project to improve CIHI's web content and search capabilities in September 2012. The project, the first phase of which was completed in April 2013, will make it easier for our customers to find, search for and understand the information they need to make informed decisions.
- To help us maximize value for customers and minimize waste, we piloted Lean processes in a few areas across the organization. The results of these pilots demonstrated that real changes can be made to ingrained processes by empowering staff. Significant improvements in processing time were achieved across all pilot initiatives. We are now moving forward with further Lean initiatives and staff training.

Strengthening Transparency and Accountability

- As a data-driven organization, we know how important it is to be able to measure progress. That's why we developed a new Performance Measurement Framework for the organization, with associated indicators. This framework will measure our success in meeting corporate goals and priorities.
- Building on our collaborative approach to stakeholder engagement, we revised our stakeholder embargo policy to include longer stakeholder embargo access when warranted.
- In the second year of its existence, our bilingual e-newsletter *Land* (English) and *Oasis* (French) reached more than 1,300 subscribers combined. It highlights the way data is being used to improve health care across all aspects of the health system.
- To increase openness and transparency, we voluntarily submitted salary disclosure information to the Government of Ontario. Salaries above $100,000 were published on the government's website as part of Ontario's Public Sector Salary Disclosure 2013.

Results From the Stakeholder Survey

In June 2012, CIHI engaged Harris Decima to conduct the Stakeholder Survey, which evaluated the level of stakeholders' satisfaction with our products, services and performance. We heard back from close to 600 of our stakeholders.

Overall findings were encouraging, with positive and increasingly favourable results shown in a number of areas. Our customers see us as a trusted, neutral and independent source of information. They value the information we provide, and they clearly expressed that our information helps inform health policies and supports the efficient and effective delivery of health services across Canada.

However, there was a slight decline in the ratings surrounding the relevance of our data, analyses and services. Stakeholders expressed their need for products and services that are more timely and actionable and that better integrate data from across different sectors of the health system. They also indicated that our data and analyses are more helpful at a pan-Canadian level than at a local level. Although more people are using our website, they have difficulty navigating and searching it. Furthermore, a slight decline was observed in satisfaction with our customer support services, and stakeholders indicated that they would welcome more direct engagement from CIHI.

As a result of the survey, the following recommendations were approved by the Board of Directors:

- Conduct more/better outreach and engagement with stakeholders, particularly key stakeholders;
- Place more focus on client support services to key stakeholders;
- Place more focus on products/services that target the jurisdictional level;
- Place more focus on delivering data, analyses and services with an emphasis on relevance; and
- Examine and improve CIHI's web presence.

Acting on . . .

Breast Cancer Surgery Data

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.

To do so, it assembled health professionals (and even patients) from across the province to tackle statistics that showed surgery rates vary widely—and to look into *why.* How much was appropriateness a factor? Were there fluctuations in quality of care?

The SSI had its own provincial health statistics to analyze. 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.

Sixty-Five Percent

Dr. Peter Barrett, physician leader at the SSI, said they set up a mastectomy working group soon after the report was released to focus exclusively on CIHI's data. He said that the significant variation shown in the CIHI-CPAC report, when unexplained, implied a quality-of-care issue. "We've been very interested in that in Saskatchewan," said Dr. Barrett, a former CIHI Board member.

This is what the working group was most interested in: 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.

This group assembled breast surgeons from across the province, keen to be involved and find answers. Initial explanations touched on findings from the report, which included the fact that travel distance to a surgical centre could impact a patient's treatment decisions. But there was one problem with that explanation: next-door neighbour Manitoba's crude mastectomy rate was a much-different 36%.

"How do I explain Saskatchewan being the second highest and Manitoba being much lower, provinces that sit adjacent to one another with the same geography?" Dr. Barrett asked. With no clear explanations, they began seeking answers.

Why?

And it's an ongoing pursuit. 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. This summer, patient interviews will begin to help uncover what influences patient choices for mastectomy and breast-conserving surgery.

"It will be fascinating to see why patients choose a certain approach to treating breast cancer," Dr. Barrett said. "There may be a whole pile of reasons we had never considered."

Dr. Barrett said that, in the near future, data is "going to be everything." An accomplished surgeon, he suggested that the system must move away from simply funding more surgical procedures and striving to trim waiting lists.

"We aren't spending enough time looking into patient-reported outcome measures," he said. "That's when you'll really get into shared decision-making. It helps show patients 'Here is what you are likely to get out of this treatment, and here is what you will likely go through to get it.'"

That would certainly be top of mind for breast cancer patients debating life-changing choices about treatment options. As the report shows, there is anything but a uniform approach in Canada in this regard.

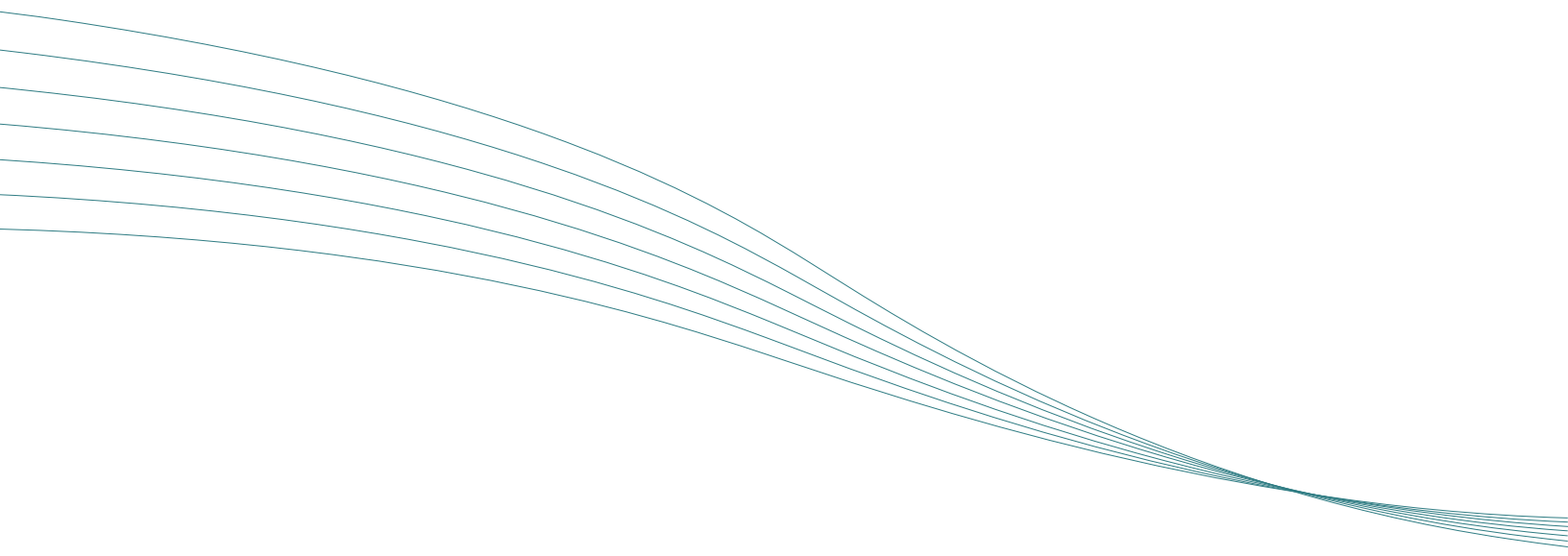
Data Privacy and Security

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 we take seriously.

We have a comprehensive privacy and security program to protect our data holdings, governed by an 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 around both privacy and information security. We are 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 to compile statistical information for the planning and management of the health system. This designation and the strict responsibilities that come with it give our data partners across the country assurance that our privacy and security policies comply with the highest standards in safeguarding important and sensitive information.

Information Security and ISO 27001

Work has begun on the International Organization for Standardization (ISO) 27001 Registration project. ISO 27001 is a standard for the management of information security published by the ISO. This project will design and implement an ISO 27001–compliant information security management system (ISMS) at CIHI and prepare CIHI to apply for ISO certification of the ISMS in 2013–2014.



Looking Ahead

This report has focused on our accomplishments over the past year, and looking back can provide us with valuable lessons. However, if there's one thing we learned this year, it's that we need to be a forward-thinking organization to respond to the changing needs of our customers.

As we approach our 20th anniversary, we will remain focused on our strategic priorities and continue our efforts to maximize the contribution of health information to health care decisions through a range of tools and strategies.

To **improve the comprehensiveness**, **quality and availability of data**, we will

- Continue to enhance the infrastructure and processes to support eReporting across all health sectors;
- Implement initiatives to improve timeliness and accessibility of data and provide patient-focused information, integrated across health sectors;
- Support the CMSMS and increase the information available in our data holdings;
- Lead key elements of the pan-Canadian vision for effective use of EHRs and work to enhance PHC information; and
- Enhance our physician compensation data and expand our health care financing and funding information.

To **support population health and health system decision-making**, we will

- Implement a corporate analytical plan focusing on the priorities of health sector decision-makers;
- Build capacity to use health data and information to support decision-making;
- Deliver an HSP Initiative that meets the needs of the public, health system managers and policy-makers;
- Fill performance measurement gaps in health system efficiency and productivity, and support international comparisons and benchmarking efforts; and
- Enhance partnerships to improve our understanding of stakeholder priorities and to undertake targeted local initiatives.

To **deliver organizational excellence**, we will

- Further develop capabilities to enhance leadership across the organization;
- Share knowledge and promote adoption of best practices while enhancing learning and professional development opportunities;
- Implement an agenda to improve innovation awareness and create the conditions for successful innovation across CIHI;
- Launch a new rolling three-year business plan and enhance our accountability through the new Performance Measurement Framework;
- Enhance CIHI's security standards; and
- Survey employees to determine the level of staff engagement and satisfaction.

Along with the priorities listed above, we will continue to enhance our corporate processes, IT system applications and electronic tools to ensure that our ongoing core 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 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 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 our financial information is reliable and available on a timely basis, that our assets are safeguarded and that our 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 they 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 2012–2013 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, which 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 $110 million between 2009–2010 and 2012–2013.

Table 4: Annual Revenue Profile

Annual Source of Revenue ($ Millions)*	2009–2010	2010–2011	2011–2012	2012–2013	2012–2013	2013–2014
	Actual	Actual	Actual	Planned	Actual	Planned
Federal Government	$88.4	$89.6	$86.6	$81.7	$83.0	$79.3
Provincial/Territorial Governments	$15.9	$16.4	$16.4	$16.7	$16.7	$17.1
Other†	$3.2	$4.8	$8.0	$7.2	$8.5	$4.5
Total Annual Source of Revenue	$107.5	$110.8	$111.0	$105.6	$108.2	$100.9

Notes

* Excludes deferred contributions for the amortization of capital assets and pension plan costs.

† Includes contributions from provincial/territorial governments and agencies 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 and Health Information Initiative, the building and maintenance of a comprehensive and integrated national health information system.

In 2012, we renewed our Health Information Initiative funding with Health Canada for three years, with annual funding of up to $81.7 million in 2012–2013, $79.3 million in the subsequent year and $77.7 million in the final year of the agreement. The Roadmap Initiative funding, provided in the form of global direct payments in previous years, was depleted over the last few years based on the resource requirements of key projects; in 2012–2013, the remaining balance of $1.3 million was accounted for.

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. These agreements, which provided $16.7 million in 2012–2013, were also renewed in 2012 for a three-year term.

Management Explanation of Results

Table 5: Operating Expenses

Operating Expenses ($ Millions)*	2009–2010	2010–2011	2011–2012	2012–2013	2012–2013	2013–2014
	Actual	Actual	Actual	Planned	Actual	Planned
Salaries and Benefits	$64.4	$71.9	$71.3	$72.4	$76.8	$77.5
External Professional Services, Travel and Advisory Committee Expenses	$20.3	$17.4	$14.9	$13.7	$11.2	$9.0
Occupancy, Information Technology and Other	$17.6	$17.8	$17.6	$20.8	$17.3	$16.9
Total Operating Expenses	$102.3	$107.1	$103.8	$106.9	$105.3	$103.4

Note

* Includes amortization of capital assets and pension plan costs.

Our total operating expenses for 2012–2013 were $105.3 million, an increase of $1.5 million over 2011–2012. This increase was largely attributable to an increase in the amortization of the pension plan costs included in the salaries and benefits expense ($9.6 million in 2012–2013; $4.1 million in 2011–2012). 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 Canadian Institute of Chartered Accountants. This overall increase was partially offset by our continued commitment to finding operational efficiencies in external professional services, travel and advisory committee expenses. These resource requirements were reduced by $3.7 million in 2012–2013, and we anticipate reducing them by another $2.2 million in 2013–2014.

Total remuneration, including any fee allowance or other benefits to our senior management team involved in the accomplishment of our three strategic directions, totalled $5.1 million in 2012–2013.

The total expenses variance of $1.6 million relative to planned 2012–2013 activities is due to savings of $1.1 million in salaries and benefits expenses because of a higher actual vacancy rate than planned; operational efficiencies of $2.5 million realized in external professional services, travel and advisory committee expenses; and the corporate provision of $3 million to address emerging issues, which is included in the occupancy, information technology and other expenses. The sum of these key variances is offset by the increase in the amortization of the pension plan cost included in the salaries and benefits expenses, as noted above.

Investments in our three core functions remained relatively constant as a proportion of the total 2011–2012 and 2010–2011 operating actual and planned expenses.

Figure 2: Actual Operating Expenses by Core Function, 2012–2013

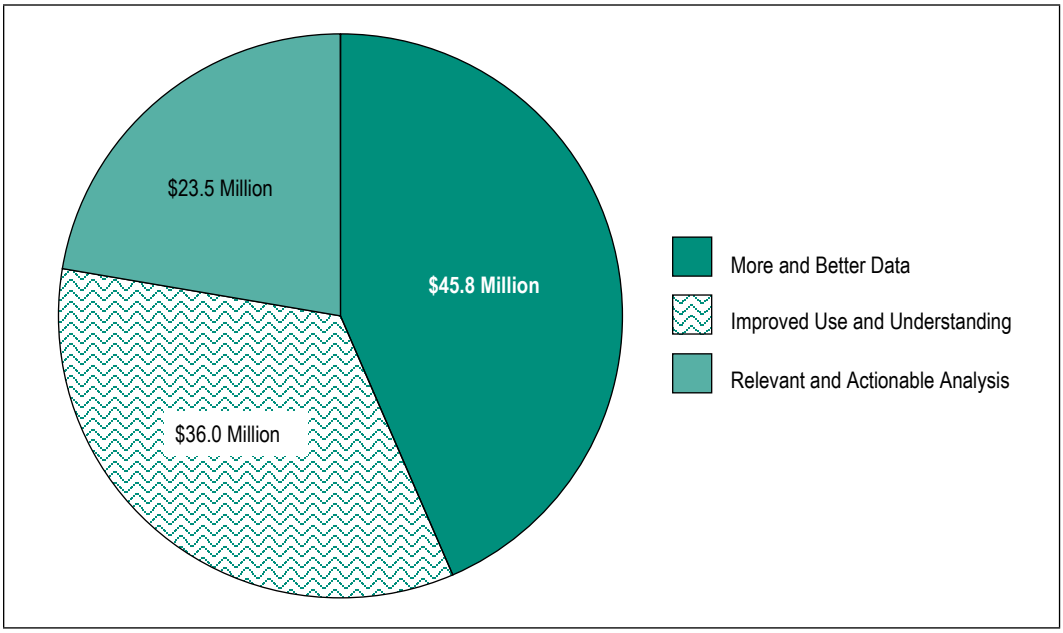


Table 6: Capital Investments

Capital Investments ($ Millions)	2009–2010	2010–2011	2011–2012	2012–2013	2012–2013	2013–2014
	Actual	Actual	Actual	Planned	Actual	Planned
Furniture and Office Equipment	$0.1	$0.2	$0.1	$0.1	$0.1	$0.1
Computers and Telecommunications Equipment	$3.0	$1.5	$2.4	$1.7	$1.8	$1.3
Leasehold Improvements	$0.2	$0.3	—	—	$0.4	—
Total Capital Investments	$3.3	$2.0	$2.5	$1.8	$2.3	$1.4

Acquisition of capital assets for 2012–2013 amounted to $2.3 million, a decrease of $200,000 from 2011–2012. This variance was the result of two factors:

- First, fewer purchases (in the amount of $600,000) of computer hardware, software and telecommunications-related equipment were made in 2012–2013. The related 2011–2012 investment included the replacement of our main database server to better meet utilization and growth requirements, as well as the implementation of a solution for our disaster recovery plan.
- Second, leasehold improvements of $400,000 were performed in 2012–2013 as a result of the consolidation of our Ottawa offices.

Prior years' results, specifically those for 2009–2010, included the renewal of some of our technology infrastructure.

Pension Plans

Our registered defined benefit plan offers our employees an annual retirement income based on length of service and final average earnings; it is funded by both employees and CIHI. The plan's assets as of March 31, 2013, were $98.4 million for a total of 980 members, 73% 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 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 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, 2013, the plan reported a surplus of $23.2 million, compared with $18.7 million in 2011–2012.

On a funding basis, the plan had a deficit of $5.2 million on January 1, 2011, compared with a $4.7 million deficit on January 1, 2010. In early 2012, we funded the deficit in its entirety and continued to monitor the economic environment and the plan's funded status. In October 2012, our external actuaries extrapolated the plan's funded status and identified a significant solvency deficit (assuming a wind-up of the plan) of approximately $29.5 million owing to the exceptional economic/market conditions. As a result, management took steps in 2012–2013 to address the actuarial deficit sooner rather than later. In particular, the employer–employee cost-sharing ratio was increased by five basis points to a ratio of 55 (employer)–45 (employee). A phased-in employee contribution rate increase to help the organization reach this new cost-sharing ratio by January 2015 and align with other defined benefit pension plans took effect on January 1, 2013. We also contributed $8.7 million toward the estimated actuarial deficit.

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 both 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 2012–2013, activities included a corporate governance audit, testing and vulnerability assessments for

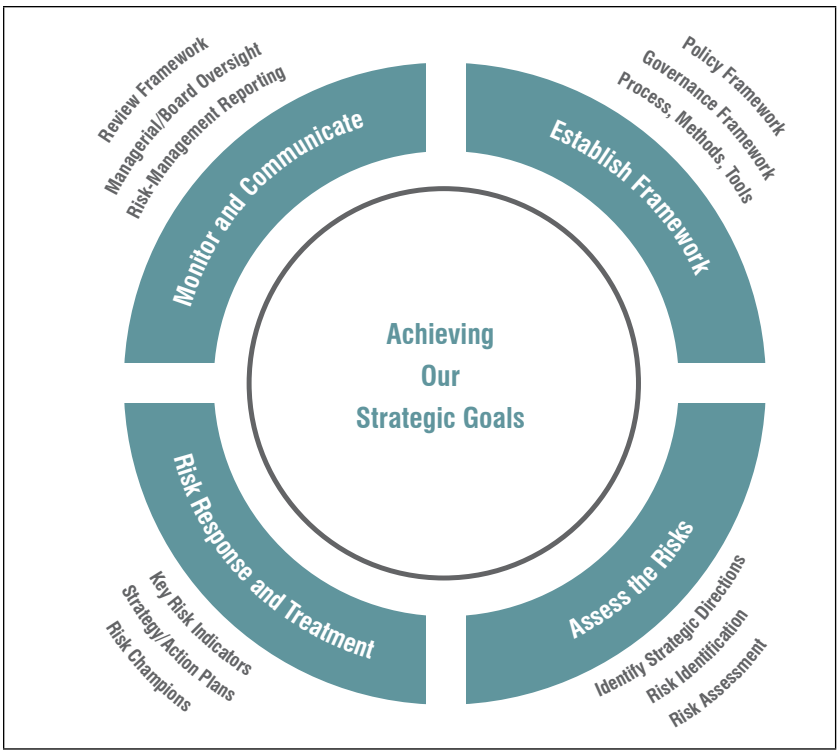
the IT network and selected applications, and a review of access rights for employed and terminated staff and external third-party service providers. It also included privacy audits, such as a compliance audit of an external data recipient regarding CIHI's Data Request Form and Data Protection Agreement. Action plans were developed to address the areas for improvement recommended by the consultants contracted by us to specifically perform these activities. In 2013–2014, the focus of the internal audit program will continue to be on information security and privacy.

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 cut across the organization, have clear links to achieving our strategic goals, are likely to remain evident for the next three to five years and can be managed by the senior leadership of CIHI.

CIHI's Risk-Management Framework consists of the following four cyclical processes targeted at the successful achievement of our strategic goals.

Figure 3: CIHI's Risk-Management Framework



Risk-Management Activities for 2012–2013

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

Renewal of Funding

Last year brought increased financial pressure to CIHI: the Roadmap funding ended in March 2012, and CIHI's Health Information Initiative agreement with Health Canada came to an end. We renewed our funding agreement with Health Canada for a three-year term with a slight reduction in funding over the period. As well, we renewed our funding agreements with all provincial and territorial ministries of health. CIHI's Board approved our realigned multi-year business plan in accordance with our new level of funding.

Electronic Health Records/Electronic Medical Records

The implementation of EHRs across Canada represents an opportunity for CIHI to collect additional data to support health system analyses; it also represents a potential threat to CIHI's existing data supply for those collections that may be affected by EHR adoption. Among our many achievements this year, we developed a report, in collaboration with Canada Health Infoway, outlining the pan-Canadian vision for HSU of data contained in EHRs. This report was presented to the Conference of Deputy Ministers in May 2013. In addition, the Canadian Emergency Department Diagnosis Shortlist received the Canadian Approved Standards designation from Canada Health Infoway's Standards Collaborative Strategic Committee; this is the first of what we expect will be many HSU standards at CIHI to receive this distinction. We also completed EHR readiness assessments for four key CIHI databases and documented examples of HSU of CIHI data in a series of four demonstration projects. This fiscal year also saw two jurisdictions (Ontario and Manitoba) continue their preparation to implement the *PHC EMR Content Standard* in a phased approach.

Corporate Transition/Staff Engagement

For many years, CIHI has lived with sufficient funding; however, new fiscal realities and budget reductions mean that we need to work differently and more efficiently. In an effort to uncover opportunities to improve efficiency and engage staff in devising solutions, CIHI introduced a Lean process improvement initiative following the successful results of three pilot projects. Corporate communication has been a cornerstone to maintaining staff engagement through our CEO's post–Board meeting debriefs and staff town hall meetings. Our senior management team kept staff up to date on corporate initiatives with staff information sessions. Voluntary employee separations remained consistent with the previous year at 8%.

Stakeholder Support

CIHI has found that, due to significant staff turnover in ministries of health across the country, there can be a lack of knowledge and understanding of CIHI's role and mandate. The need for pan-Canadian data can become less relevant due to the decentralization of authority for health care. We continued our collaborative work with the regions through cross-country stakeholder consultations, meetings and presentations. We were able to identify and act upon region-specific needs to develop or enhance our products and services, and we promoted the use of CIHI's analytical reports and tools. We were also able to garner support for the development of new products, analyses and tools such as the HSP reporting system.

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 sheets as at March 31, 2013 and 2012, and April 1, 2011 and the statements of revenue and expenses, changes in net assets, and cash flows for the years ended March 31, 2013 and 2012, 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, 2013 and 2012, and April 1, 2011 and the results of its operations and its cash flows for the years ended March 31, 2013 and 2012 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 21, 2013

Ernst & Young LLP

Chartered Accountants
Licensed Public Accountants

Balance Sheet

As at March 31

	2013 $	2012 $	April 1, 2011 $
Assets			
Current			
Cash and cash equivalents *(note 3)*	**12,288,256**	14,664,363	9,415,915
Accounts receivable *(note 4)*	**2,234,500**	3,336,326	3,273,336
Prepaid expenses	**2,465,859**	2,703,515	2,289,373
	16,988,615	20,704,204	14,978,624
Investments—Roadmap *(note 5)*	**—**	751,664	9,778,466
Capital assets *(note 6)*	**12,896,058**	15,481,218	17,610,241
Other assets *(note 7)*	**402,790**	210,283	478,889
Accrued pension benefit asset *(note 8)*	**23,189,100**	18,714,800	10,152,500
	53,476,563	55,862,169	52,998,720
Liabilities			
Current			
Accounts payable and accrued liabilities *(note 10)*	**4,922,398**	7,675,764	5,616,554
Unearned revenue	**2,764,093**	4,565,077	5,500,567
Deferred contributions *(note 11)*	**2,666,146**	2,591,888	2,256,590
	10,352,637	14,832,729	13,373,711
Accrued pension benefit liability *(note 8)*	**674,003**	597,302	556,600
Deferred contributions *(note 11)*			
Expenses of future periods	**23,347,234**	20,020,006	16,551,702
Capital assets	**9,937,172**	12,640,450	14,507,704
Lease inducements *(note 12)*	**3,344,247**	2,183,612	2,651,433
	47,655,293	50,274,099	47,641,150
Net Assets			
Invested in capital assets	**1,996,046**	2,077,563	2,115,955
Unrestricted	**3,825,224**	3,510,507	3,241,615
	5,821,270	5,588,070	5,357,570
	53,476,563	55,862,169	52,998,720

Commitments and contingent liabilities *(note 16)*

See accompanying notes.

On behalf of the Board

Director

Director

Statement of Revenue and Expenses

Year ended March 31

	2013 $	2012 $
Revenue		
Core Plan *(note 13)*	**16,713,725**	16,368,700
Sales	**2,262,785**	2,209,405
Funding—other *(note 14)*	**5,209,830**	5,464,478
Health Information Initiative/Roadmap *(note 11)*	**81,048,945**	79,681,658
Other revenue	**273,044**	391,868
	105,508,329	104,116,109
Expenses		
Compensation	**76,757,676**	71,361,982
External and professional services	**8,591,476**	11,779,144
Travel and advisory committee expenses	**2,629,463**	3,116,339
Office supplies and services	**1,100,554**	1,027,104
Computers and telecommunications	**7,048,728**	7,018,481
Occupancy	**9,147,232**	9,582,559
	105,275,129	103,885,609
Excess of revenue over expenses	**233,200**	230,500

See accompanying notes.

Statement of Changes in Net Assets

Year ended March 31

	Invested in Capital Assets	Unrestricted	2013	2012
	$	$	$	$
Balance, beginning of year	**2,077,563**	**3,510,507**	**5,588,070**	5,357,570
Excess (deficiency) of revenue over expenses	**(573,606)**	**806,806**	**233,200**	230,500
Net investment in capital assets	**492,089**	**(492,089)**	**—**	—
Balance, end of year	**1,996,046**	**3,825,224**	**5,821,270**	5,588,070

See accompanying notes.

Statement of Cash Flows

Year ended March 31

	2013 $	2012 $
Operating Activities		
Excess of revenue over expenses	**233,200**	230,500
Add (deduct) items not affecting cash:		
Amortization of capital assets	**4,562,238**	4,538,960
Amortization of lease inducements	**(724,959)**	(467,821)
Pension benefits	**(4,397,599)**	(8,521,598)
Amortization of deferred contributions—capital assets	**(3,929,953)**	(3,736,503)
Loss on disposal of capital assets	**327,892**	59,153
	(3,929,181)	(7,897,309)
Changes in non-cash working capital items *(note 15)*	**(3,214,868)**	646,588
Net change in other assets	**(192,507)**	268,606
Net change in deferred contributions	**4,628,161**	5,672,851
Cash used in operating activities	**(2,708,395)**	(1,309,264)
Investing Activities		
Acquisition of capital assets	**(2,309,607)**	(2,474,683)
Proceeds on disposal of capital assets	**4,637**	5,593
Acquisition of investments—Roadmap	**—**	(11,475,922)
Proceeds on disposal of investments—Roadmap	**751,664**	20,502,724
Cash provided by (used in) investing activities	**(1,553,306)**	6,557,712
Financing Activities		
Lease inducements received	**1,885,594**	—
Cash provided by financing activities	**1,885,594**	—
Net change in cash	**(2,376,107)**	5,248,448
Cash and cash equivalents, beginning of year	**14,664,363**	9,415,915
Cash and cash equivalents, end of year	**12,288,256**	14,664,363
Represented by:		
Cash	**(461,744)**	864,363
Short-term investments	**12,750,000**	13,800,000
	12,288,256	14,664,363
Supplementary information		
Interest received	**216,981**	321,753

See accompanying notes.

Notes to Financial Statements

March 31, 2013

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 and First-Time Adoption of Accounting Standards for Not-for-Profit Organizations

a. 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.

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:

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 (2012—13 years). The average remaining service period of the active employees covered by the supplementary retirement plan is 10 years (2012—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 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 flow is not available from operations to cover operating and capital expenditures, including contributions to the CIHI Pension Plan.

b. First Time Adoption of Accounting Standards for Not-for-Profit Organizations

These financial statements are the first financial statements which CIHI has prepared in accordance with Part III of the *CICA Handbook—Accounting*, which constitutes generally accepted accounting principles (GAAP) for not-for-profit organizations in Canada.

In preparing its opening balance sheet as at April 1, 2011 (the Transition Date), CIHI has applied Section 1501, First-time adoption by not-for-profit organizations, retrospectively (other than the permitted exemptions noted hereafter) using the following four principles such that it has

- Recognized all assets and liabilities whose recognition is required by GAAP;
- Not recognized items as assets or liabilities if GAAP does not permit such recognition;
- Reclassified items recognized previously as one type of asset, liability or net assets, but are now recognized as a different type of asset, liability or net assets;
- Applied GAAP in measuring all recognized assets and liabilities.

The accounting policies that CIHI has used in the preparation of its opening balance sheet through the application of these principles has resulted in certain adjustments to balances which were presented in the balance sheet prepared in accordance with Part V of the CICA Handbook, Pre-changeover accounting standards (Previous GAAP). These adjustments were recorded directly to CIHI's net assets at the Transition Date using the transitional provisions set out in Section 1501 and are described below.

Exemptions Elected Upon Transition

Section 1501 provides a number of elective exemption related to standards in Part III of the CICA Handbook. CIHI has elected to use the transition exemptions with respect to the recognition of cumulative actuarial losses at the Transition Date.

Reconciliation

The following table provides a reconciliation of net assets as at April 1, 2011 and the excess of revenue over expenses for the year ended March 31, 2012 as presented under Previous GAAP with those computed under GAAP.

	Excess of Revenue Over Expenses for the Year Ended March 31, 2012 $	Net Assets as at April 1, 2011 $
Excess of revenue over expenses and net assets, Previous GAAP	**288,200**	5,068,970
Recognition of unamortized transitional asset*	**(57,700)**	288,600
Excess of revenue over expenses and net assets, GAAP	**230,500**	5,357,570

*** Recognition of unamortized transitional asset**

Under Previous GAAP, a transitional asset related to pension benefits has not been recognized in the financial statements. Section 1501 requires this amount to be recognized in the opening net assets at the Transition Date.

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 (2012—90 days; April 1, 2011—90 days).

4. Accounts Receivable

	2013	2012	April 1, 2011
	$	$	$
Operating	**1,927,631**	1,626,723	1,457,319
Funding—other	**306,869**	1,709,603	1,816,017
	2,234,500	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

	2013		2012		April 1, 2011	
	Cost	Accumulated Amortization	Cost	Accumulated Amortization	Cost	Accumulated Amortization
	$	$	$	$	$	$
Tangible						
Computers	**8,888,923**	**6,551,231**	9,458,389	6,459,395	9,322,194	5,998,044
Furniture and equipment	**6,215,341**	**4,101,115**	6,177,313	3,609,044	6,146,335	3,106,575
Telecommunication equipment	**1,374,951**	**1,186,679**	1,370,066	1,002,077	1,349,627	818,376
Leasehold improvements	**10,681,880**	**5,608,035**	10,717,399	4,750,962	10,694,875	3,602,431
Intangible						
Computer software	**11,882,906**	**8,700,883**	10,938,644	7,359,115	9,679,417	6,056,781
	39,044,001	**26,147,943**	38,661,811	23,180,593	37,192,448	19,582,207
Accumulated amortization	**(26,147,943)**		(23,180,593)		(19,582,207)	
Net book value	**12,896,058**		15,481,218		17,610,241	

The capital assets include $218,814 (March 31, 2012—$163,053; April 1, 2011—nil) of assets that are not in service at the end of the year. These assets have not been amortized.

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:

	2013		2012	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Current service cost, net of employee contributions	**8,219,000**	**62,200**	4,577,900	41,700
Interest cost on accrued benefit obligation	**4,408,100**	**26,200**	3,536,700	24,600
Expected return on plan assets	**(5,195,500)**	**—**	(4,079,200)	—
Amortization of net actuarial loss (gain)	**2,168,400**	**—**	27,400	(14,000)
Pension plans expenses	**9,600,000**	**88,400**	4,062,800	52,300

Changes in the accrued benefit obligation are as follows:

	2013		2012	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit, obligation beginning of year	**93,265,700**	**556,100**	53,034,500	460,100
Current service cost, net of employee contributions	**8,219,000**	**62,200**	4,577,900	41,700
Interest cost on accrued benefit obligation	**4,408,100**	**26,200**	3,536,700	24,600
Employee contributions	**3,626,900**	**—**	3,145,700	—
Benefits paid	**(2,463,500)**	**(11,700)**	(987,500)	(11,600)
Actuarial gain	**—**	**—**	29,958,400	41,300
Accrued benefit obligation, end of year	**107,056,200**	**632,800**	93,265,700	556,100

Changes in the plan assets are as follows:

	2013		2012	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Fair value of assets, beginning of year	**74,465,100**	**—**	57,287,400	—
Actual return on assets	**8,704,800**	**—**	2,394,400	—
Employer contributions	**14,074,300**	**11,700**	12,625,100	11,600
Employee contributions	**3,626,900**	**—**	3,145,700	—
Benefits paid	**(2,463,500)**	**(11,700)**	(987,500)	(11,600)
Fair value of assets, end of year	**98,407,600**	**—**	74,465,100	—

The plans' assets consist of:

	2013		2012		April 1, 2011	
	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %
Asset category						
Bonds (Canada)	**35**	**—**	35	—	35	—
Equities (Canada)	**25**	**—**	35	—	35	—
Equities (Global)	**40**	**—**	30	—	30	—
	100	**—**	100	—	100	—

CIHI recorded the assets and liabilities as follows:

	2013		2012		April 1, 2011	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit obligation, end of year	**(107,056,200)**	**(632,800)**	(93,265,700)	(556,100)	(53,219,500)	(378,300)
Fair value of assets, end of year	**98,407,600**	**—**	74,465,100	—	57,287,400	—
Funded status—deficit, end of year	**(8,648,600)**	**(632,800)**	(18,800,600)	(556,100)	4,067,900	(378,300)
Unamortized net actuarial loss (gain)	**31,837,700**	**(41,203)**	37,515,400	(41,202)	6,084,600	(178,300)
Accrued pension benefit asset (liability)	**23,189,100**	**(674,003)**	18,714,800	(597,302)	10,152,500	(556,600)

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

	2013		2012	
	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**	6.25	6.25
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	**4.50**	**4.50**	4.50	4.50
Rate of compensation increase	**4.00**	**4.00**	4.00	4.00

	April 1, 2011	
	Registered Retirement Plan %	Supplementary Retirement Plan %
Accrued benefit obligation as at March 31		
Discount rate	6.25	6.25
Rate of compensation increase	4.00	4.00

9. 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, 2013, a letter of credit in the amount of $223,200 (March 31, 2012—$229,600; April 1, 2011—$230,500) for the purpose of the Supplementary Retirement Plan had been issued against the line of credit.

10. Accounts Payable and Accrued Liabilities

Accounts payable and accrued liabilities are operational in nature. At the end of the year, no amount (2012—$194,791; April 1, 2011—nil) representing the excess contribution received from Health Canada for the Health Information Initiative is payable.

The government remittances payable at the end of the year is $486,409 (2012—$80,679; April 1, 2011—$95,296).

11. 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:

	2013 $	2012 $
Balance, beginning of year	**22,611,894**	18,808,292
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	**860**	65,268
Amount recognized as funding	**(77,118,993)**	(75,943,920)
Amount transferred to deferred contributions—capital assets	**(1,226,675)**	(1,869,249)
Balance, end of year	**26,013,380**	22,611,894
Less: Current portion	**2,666,146**	2,591,889
	23,347,234	20,020,005

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:

	2013 $	2012 $
Balance, beginning of year	**12,640,450**	14,507,704
Amount received from Health Information Initiative contribution	**1,226,675**	1,869,249
Amount recognized as funding	**(3,929,953)**	(3,736,503)
Balance, end of year	**9,937,172**	12,640,450

12. Lease Inducements

The lease inducements include the following amounts:

	2013	2012	April 1, 2011
	$	$	$
Leasehold improvement allowances	**962,840**	763,205	986,582
Free rent and other inducements	**2,381,407**	1,420,407	1,664,851
	3,344,247	2,183,612	2,651,433

During the year, free rent and other inducements of $1,885,594 (2012—nil; April 1, 2011—nil) were provided. The amortization of leasehold improvement allowances and free rent and other inducements are $386,571 and $338,388, respectively (2012—$223,377 and $244,444, respectively; April 1, 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

	2013	2012
	$	$
Provincial/territorial governments	**3,723,944**	3,575,625
Federal government	**—**	560,796
Other	**1,485,886**	1,328,057
	5,209,830	5,464,478

15. Net Change in Non-Cash Working Capital Items

	2013	2012
	$	$
Accounts receivable	**1,101,826**	(62,990)
Prepaid expenses	**237,656**	(414,142)
Accounts payable and accrued liabilities	**(2,753,366)**	2,059,210
Unearned revenue	**(1,800,984)**	(935,490)
	(3,214,868)	646,588

16. Commitments and Contingent Liabilities

a. 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:

	$
2014	10,660,241
2015	8,907,300
2016	8,507,883
2017	8,469,030
2018 and thereafter	44,968,947

b. CIHI has received notice of a claim by a former employee. The ultimate result of the pending claim cannot be ascertained at this time. CIHI believes that the resolution of this claim will not have a material adverse effect on liquidity, financial position or result of the operations.

17. Comparative Financial Statements

The comparative financial statements have been reclassified from statements previously presented to conform to the presentation of the 2013 financial statements.

Our Organization

Table 7: CIHI Staff by Tenure, Age and Gender

	2010–2011	2011–2012	2012–2013
Total Staff	**797***	**749***	**730***
Tenure			
<5 Years	492 (62%)	464 (62%)	408 (56%)
6–10 Years	208 (26%)	190 (25%)	213 (29%)
11–15 Years	63 (8%)	64 (9%)	78 (11%)
16+ Years	34 (4%)	31 (4%)	31 (4%)
Age			
<29	94 (12%)	73 (10%)	84 (12%)
30–39	310 (39%)	297 (40%)	280 (38%)
40–49	233 (29%)	220 (29%)	217 (30%)
50+	160 (20%)	159 (21%)	149 (20%)
% Female Staff	**69%**	**70%**	**70%**
% Female Mgmt. Staff	**62%**	**64%**	**61%**

Note

* This number represents permanent employees and excludes short-term contract staff as of April 1 of the fiscal year.

Table 8: CIHI Staff by Education Level

Education Level	2010–2011	2011–2012	2012–2013
Post-Graduate and Master's	296 (37%)	281 (38%)	289 (40%)
Undergraduate	291 (37%)	265 (35%)	242 (33%)
Diploma	192 (24%)	188 (25%)	184 (25%)
High School	18 (2%)	15 (2%)	15 (2%)

Our Leadership and Governance

Senior Management (as of March 31, 2013)

John Wright
President and CEO

Brent Diverty
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 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

We'd like to recognize the valuable contributions of **Jean-Marie Berthelot**, former vice president, Programs, and **Cathy Davis**, former director, Acute and Ambulatory Care Information Services.

Board of Directors (as of March 31, 2013)

Chair of the Board

Dr. Brian Postl
Dean of Medicine
University of Manitoba

Ex Officio

Mr. John Wright
President and Chief Executive Officer
Canadian Institute for Health Information

Region 1: British Columbia and Yukon

Ms. Elaine McKnight
Chief Administrative Officer and Associate Deputy Minister
British Columbia Ministry of Health
(Government)

Dr. David Ostrow
Chief Executive Officer
Vancouver Coastal Health Authority
(Non-Government)

Region 2: Prairies, Northwest Territories and Nunavut

Ms. Marcia Nelson
Deputy Minister
Alberta Health and Wellness
(Government)

Dr. Marlene Smadu
Vice-President of Quality and Transformation
Regina Qu'Appelle Health Region
(Non-Government)

Region 3: Ontario

Ms. Janet Davidson
Canadian Head of the Global Healthcare Center of Excellence
KPMG
(Non-Government)

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

Region 4: Quebec

Dr. Luc Boileau
President and Director General
Institut national de santé publique du Québec
(Non-Government)

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

Region 5: Atlantic

Mr. John McGarry
President and Chief Executive Officer
Horizon Health Network
(Non-Government)

Mr. Kevin McNamara
Deputy Minister of Health and Wellness
Nova Scotia Department of Health and Wellness
(Government)

Canada at Large

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

Dr. Vivek Goel
President and CEO
Public Health Ontario
(Vice Chair)

Health Canada

Mr. Paul Rochon
Associate Deputy Minister of Health
Health Canada

Statistics Canada

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

The Board of Directors met in June and November 2012 and March 2013.

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

- Mr. Howard Waldner, CEO, Vancouver Island Health Authority
- Mr. Graham Whitmarsh, Deputy Minister, Ministry of Health Services, British Columbia
- Dr. Chris Eagle, President and CEO, Alberta Health Services
- Mr. Saäd Rafi, Deputy Minister, Ministry of Health and Long-Term Care, Ontario
- Mr. Denis Lalumière, Assistant Deputy Minister, Strategic Planning, Evaluation and Quality, ministère de la Santé et des Services sociaux du Québec
- Mr. Donald Ferguson, Deputy Minister, Department of Health, New Brunswick
- Dr. Cordell Neudorf, Chief Medical Officer, Saskatoon Health Region

Board of Directors Committee Membership

(as of March 31, 2013)

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.

The committee met in June and November 2012 and January 2013.

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 2012 and March 2013.

Members
Vivek Goel (Chair)
Luc Castonguay
Paul Rochon
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 bylaw.

The committee met in June and October 2012 and February and March 2013.

Members

Janet Davidson (Chair)
David Hallett
Kevin McNamara
Peter Morrison
Luc Boileau
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 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.

The committee met in June and November 2012 and January 2013.

Members

John McGarry (Chair)
Elaine McKnight
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

www.cihi.ca
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