Canadian Institute for Health Information (CIHI)

President’s Quarterly Report and Review of Financial Statements as at June 30, 2011

Board Report

August 2011
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Introduction
This document provides an overview of some of the significant accomplishments achieved during the first quarter of fiscal 2011/2012 (i.e. April 1 to June 30, 2011), as well as a review of CIHI’s financial statements as at June 30, 2011. This document includes the following sections:

- **President's report** – highlights some of the recent developments and updates affecting CIHI-identified priority initiatives and select major programs for the first quarter of fiscal 2011-2012, as well as other items of interest.

- **Financial highlights and statements** – presents CIHI’s financial situation as at June 30, 2011.

- Appendix A – a high-level progress update on fiscal 2011-2012 priority initiatives.


- Appendix C – our regular external environmental scan.

- Appendix D – a list of recent and upcoming reports and conferences of interest.
President’s Report

<table>
<thead>
<tr>
<th>Corporate Highlights</th>
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</thead>
<tbody>
<tr>
<td><strong>Renewal of Prescribed Entity Status</strong></td>
</tr>
<tr>
<td>• A revised report describing CIHI’s privacy and security program for the renewal of CIHI’s prescribed entity status under Ontario’s Personal Health Information Protection Act, 2004 (PHIPA) was submitted to the Ontario Information and Privacy Commissioner’s office. Feedback received indicates that they are satisfied with the submission. CIHI expects that its prescribed entity status will be renewed in November.</td>
</tr>
<tr>
<td><strong>Human Resources</strong></td>
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<tr>
<td>• The biennial employee survey was conducted during the last two weeks of June. An excellent response rate of 92% of eligible employees was achieved. The results of the survey will be presented at the November 2011 Board meeting.</td>
</tr>
<tr>
<td>• CIHI’s annual Rewards and Recognition (R&amp;R) event was held June 9th. The one day event in both Ottawa and Toronto, linked via videconference, brought together almost 700 employees. The event kicked off with opening remarks by John Wright, and keynote speaker – Dr. Brian Goldman, and ended with an awards ceremony.</td>
</tr>
<tr>
<td>• Anne-Mari Phillips joined CIHI on August 2 as the Chief Privacy Officer and Legal Counsel. She is replacing Mimi Lepage, who left in May to take on the position of Executive Director of the Information and Privacy Policy Secretariat at the Treasury Board Secretariat. Prior to joining CIHI, Anne-Mari worked as Legal Counsel with Health Canada and PHAC, with the Government of Yukon as Managing Counsel of the Solicitors Group, and the Executive Director of the YK Human Rights Commission. Anne-Mari brings with her a broad range of experience and expertise in various areas of the law, including privacy, as well as management experience.</td>
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<tr>
<td>• Caroline Heick will be the Executive Director, Ontario and Quebec beginning October 1, 2011. Caroline is completing a secondment with the Canadian Partnership Against Cancer where she is currently the Executive Lead, Office of Strategy and Performance. Prior to the secondment, Caroline worked at CIHI for eight years. Her most recent position was Director, Acute and Ambulatory Care Information Services and previously she was the Director of Data Quality and Classifications and Director, Standards. She also played a role in establishing the implementation of ICD-10-CA and CCI in Quebec.</td>
</tr>
<tr>
<td><strong>Annual Report</strong></td>
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<tr>
<td>• CIHI’s Annual Report was released on June 30th, a full month ahead of schedule. The Report includes enhanced financial and accountability content.</td>
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### More and Better Data

| National Ambulatory Care Reporting System (NACRS) | The NACRS implementation project in British Columbia, funded in part by the Ministry of Health, is proceeding. The first Emergency Department data has now been received from Vancouver Coastal Health Authority. Physician leads from across the BC Health Authorities attended a meeting to discuss the impact of this implementation on clinicians and to identify strategies for using these data. |
| Electronic Health Record Data | The vision for using electronic health record data to support health system decision-making within Canada was endorsed by the Conference of Deputy Ministers (CDM) of Health in June 2011; next steps include further refinement and communication of the vision, as well as demonstration projects to showcase the benefits of having and using health record data to support improvements within the health system. This topic will be coming forward to the Board at the November 2011 Board meeting. |
| Canadian MS Monitoring System (CMSMS) | At the CDM meeting in June, CIHI also presented on the CMSMS and was successful in obtaining support to proceed with the project. At the meeting, it was recommended that the project accept additional oversight from a working group that will include representatives from the provinces, territories, Health Canada, the Public Health Agency of Canada and CIHI. The working group is to provide project guidance and inform the DMs regarding CMSMS project status. 

- Following the meeting, CIHI re-engaged with the 27 MS clinics in scope for the CMSMS project. Thus far, support has been received from BC, SK, MB, ON, NS and NL, and negotiations are continuing with QC and AB. 

- Preliminary work is progressing, including the development of environment and technical scans to summarize key initiatives and data collection activities within the MS environment – both within Canada and internationally. In addition, several meetings will be held in August and September, one of which is to bring together 40-60 clinicians, researcher, individuals living with MS and other experts in MS, to participate in a facilitated Information Needs Workshop. Findings of the workshop will guide the identification of a national minimum data set and information system for the CMSMS. |
| Canadian Organ Replacement Registry (CORR) | Canadian Blood Services (CBS) presented their proposal for a Canadian Organ and Tissue Donation and Transplantation system to the Conference of Deputy Ministers (CDM) in June. The CDM is considering the proposal and implementation costs over the next few months and plans to make a decision later in 2011. CIHI is collaborating with CBS to ensure current and future roles for CIHI and CORR are clear and that duplication is minimized. |
## More and Better Data

### Health Spending
- A Q3 update to the Patient Cost Estimator will provide users with estimates for Quebec patient costs. Quebec patients had previously been excluded from the tool.
- The synthesis report on Health Care Cost Drivers has been drafted and is scheduled for public release in early November 2011.

### National System for Incident Reporting (NSIR)
- NSIR completed a very successful pilot test of its system in the long-term care sector, with 23 sites across 3 provinces participating. NSIR will officially launch for the long-term care sector in autumn 2011.
- Staff have begun a project with Cancer Care Ontario to enhance NSIR’s collection of systemic treatment incident data.

### Rehabilitation Data
- In early August, CIHI presented at a key American conference for inpatient rehabilitation services information. Hosted by UDSmr, which licenses CIHI’s use of a clinical instrument in the National Rehabilitation Reporting System (NRS), the conference focuses on the use of standardized data and information for funding and outcome measurement in this sector. The presentation highlighted CIHI’s innovations and success with NRS data and reporting over ten years, and included comparative American and Canadian indicators.

### Mental Health Data and Information
- Meetings were held between CIHI and Correctional Services Canada (CSC) to further explore their interest in the RAI-MH instrument, which is a core component of CIHI’s Ontario Mental Health Reporting System (OMHRS). If implemented in CSC’s five Regional Treatment Centres, OMHRS would represent one of the first instances in the world where the same detailed clinical and outcomes information is collected in the correctional system and in the inpatient mental health system for people living with mental illness.
- Following up on a February 2011 meeting, CIHI continues to collaborate with representatives from the Mental Health Commission of Canada (MHCC) on a range of data and information activities. This includes CIHI participation on a new MHCC expert working group to further define indicators that would be used to monitor and evaluate the new Mental Health Strategy for Canada.
- CIHI has agreed to host the next meeting of the interRAI Network of Excellence in Mental Health (iNEMH) meeting in St. John’s, NL in May 2012. This international network involves researchers and clinicians from approximately 15 countries, and meets regularly to advance applications of the interRAI instruments for mental health. To support knowledge exchange, a one-day conference for local clinicians, system managers, and policy-makers is also being proposed to coincide with the international meeting.
### More and Better Data

| Home and Continuing Care | • One new community joined the Alberta First Nations, Inuit Health RAI-Home Care pilot project.  
• The transition to fully support the Ontario Long-term Care implementation is complete. CIHI has provided education and client support to just under 700 long-term care homes in Ontario. With this transition, CIHI handled 1475 queries in Q1 alone from Ontario long-term care stakeholders. |
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<td>Primary Health Care (PHC) Data &amp; Information</td>
<td>• CIHI recently launched a project to update the pan-Canadian PHC indicators. Input will be obtained from a broad range of stakeholders, including policy makers, clinicians, the Canadian Patient Safety Institute, the Canadian Health Services Research Foundation, Accreditation Canada and the Canadian Institutes of Health Research to name just a few. Our goal is to develop a widely used set of indicators organized into two suites of approximately 30 indicators each. One suite will be designed to support population-based PHC monitoring and the other suite will support practice-based quality improvement and performance measurement.</td>
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### More Relevant and Actionable Analysis

| Health Indicators | • On June 8th, 2011, the Health Indicators report was released which included a focused look at mental health. It elicited a very strong media response, particularly at the community level. On the day of the release, the federal government announced funding to support positive mental health in communities across Canada, a direct response to the finding of high hospitalization rates for self-injury among youths. The e-Publication was live at the same time as the release of the report. It has much more data than the report, including the ability to run reports at regional, provincial & territorial and national levels by gender, SES etc.  
• For the 2012 Report, work is underway to develop a set of avoidable mortality indicators and a narrative section focusing on avoidable mortality. The primary objective is to assess the extent of avoidable mortality in Canada and to assess the effect of health policies and therapeutic interventions on population health.  
• For 2013, Regional Performance Profiles, a Business Intelligence (BI) tool is being investigated. It will provide Regional Executive Management and/or Boards of Directors with relevant information/indicators to manage the performance of health systems at the regional level. |
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<tr>
<td>Obesity in Canada</td>
<td>• The joint report with the Public Health Agency of Canada, Obesity in Canada was released on June 20, 2011. The report release elicited an exceptionally strong media and public response, with 224 mentions in the six days following the release (print, radio, television across Canada).</td>
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</table>
## More Relevant and Actionable Analysis

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</table>
| **Canadian Hospital Reporting Project (CHRP)** | • CHRP’s Year 2 Release - a new release for the CHRP tool was released to clients on June 8th, including 3 years of comparative data and two new reports.  
• Work is underway for the preparation of the CHRP public release. Meetings, related to the design and development of a CHRP public website tool, are ongoing and a draft outline for the associated analytic report has been developed. |
| **Cardiac Care Indicators** | • Following successful stakeholder engagement across jurisdictions on the Cardiac Care Quality project, the cardiac care quality indicators have been calculated for all cardiac centres (n=33) in all provinces (except Quebec). Final comparative results are planned for dissemination (private release) to cardiac centres in late August.  
• These indicators are expected to be incorporated into CHRP (for private release only) in 2012/13. |
| **Collaborating for Excellence in Healthcare Quality (CEHQ)** | • Meetings are ongoing with two Working Groups (Technical and E-Reporting) to define requirements for the reporting of a dashboard of performance measures for CEHQ Hospitals. |
| **Wait Times Web Tool** | • A prototype for an interactive wait-times web tool was completed in May. To start, the tool will display three years of comparable pan-Canadian wait time data for priority area procedures. With this tool CIHI will continue to grow as the key source of credible pan-Canadian wait time and access data for planning, management and evaluation. Work is underway to build the tool for a targeted ‘soft’ launch in November 2011. |
| **International Comparisons** | • CIHI calculated a set of Health Care Quality Indicators for the OECD bi-annual publication “Health at a Glance”. The report provides international comparisons on different aspects of the performance of health systems in OECD countries. The report is scheduled for release in November 2011. An analytical report on international comparisons (“How Canada Compares”) is under development for release on November 17, 2011 when the OECD report is released.  
• In conjunction with the OECD’s release of *Health at a Glance 2011*, CIHI will be releasing an analytical product with a working title of *Learning from the Best: Benchmarking Canada’s Health System to the Best in the OECD*. The objective of this product will be to focus in on Canadian results, examining Canada’s place among the OECD countries with the best results. It will guide policy-makers and the public in understanding |
### More Relevant and Actionable Analysis

| how we could learn from and inform policy decisions through comparisons to other countries. |

### Improved Understanding and Use

#### Outreach
- CIHI Executives presented or will be presenting at the following events August to November 2011:
  - Meeting with the Canadian Network of MS Clinics (Montreal, QC)
  - 2011 Forum of the Canadian Academy of Health Sciences (Ottawa, ON)
  - Saskatchewan Health Information Management Association (SHIMA) Annual Convention (Moose Jaw, AB)
  - 2011 Statistics Canada Socio-Economic Conference (Gatineau, QC)
  - Accelerating Primary Care Conference (Edmonton, AB)
  - 27th PCSI Conference (Montreal, QC)
  - Meeting on National Health Reporting Framework (Ottawa, ON)
  - Manitoba Provincial Leadership Forum (Winnipeg, MB)
  - Health Insurance Strategic Forum (Cambridge, ON)

#### Communications
- CIHI released a new video success story in the first edition of our new customer e-publication, Land (launched May 2011). The video, which looks at how data helped combat depression in a Nova Scotia nursing home, is receiving very positive feedback.
- Quick Read (QR) codes have been implemented into our promotional materials, providing an additional targeted point of access to CIHI’s online products and information.

#### Education
- In conjunction with the Saskatchewan Ministry of Health and the Health Quality Council, CIHI hosted a Webinar Series on Quality and Patient Safety Indicators. Webinars are becoming a popular vehicle to provide detailed information to specific audiences in a cost-efficient way.

### Regional Updates

#### Western Office
- CIHI organized an all-day session on approaches to funding in Winnipeg on May 18. Approximately 90 senior staff from the Ministry and all health authorities attended this event which evaluations show to have been very successful.
- Indicator Chaos Summit – this event, hosted by the Canadian Patient
## Regional Updates

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<tr>
<th>Ontario Office</th>
<th>Quebec Office</th>
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<tr>
<td>Safety Institute and the Health Quality Councils from BC, Alberta and Saskatchewan, was designed to discuss the proliferation of indicators and the duplication in reporting as experienced by providers and administrators. CIHI staff used the opportunity to inform participating organizations about CIHI’s indicator products and the processes used to develop them.</td>
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<td>• The National System for Incident Reporting (NSIR) long term care pilot project is successfully completed; 10/23 facilities were in Ontario.</td>
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<td>• Ontario has included over 60 of the 106 Primary Health Care EMR Content Standard data elements in version 4 of their vendor requirements. CIHI is supporting aspects of vendor testing. Version 5 of the vendor specification, scheduled for release in 2012, will likely include the remaining data elements.</td>
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<td>• Excellent progress is being made toward all deliverables associated with the CIHI and Ontario MOHLTC service agreement to support the implementation of Ontario’s Health Based Allocation Model (HBAM).</td>
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<tr>
<td>• First set of reports were released to Ontario stakeholders on July 21, 2011</td>
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<td>• Education sessions are being delivered</td>
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<td>• A comprehensive data quality work plan has been developed.</td>
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<td>• Private reports were sent to the 18 RHA CEO’s with their results for the indicator “Wait times for hip fracture repair”.</td>
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<td>• A kick-off meeting was held at the Ministry to discuss inclusion of Québec into CHRP private and public reports. CIHI is currently reviewing/developing alternative methodologies to allow inclusion of Québec data while ensuring an adequate level of comparability.</td>
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<td>• A first draft of the 2012-2015 bilateral agreement was sent to the Ministry in June.</td>
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<td>• A go-live date for the inclusion of Québec ER data in NACRS was deferred from January 2012 to later in 2012/13 due to delays in receiving Québec test data required for system building.</td>
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</table>
### Regional Updates

**Atlantic Office**

- The report *Health Care Use at the End of Life in Atlantic Canada* was released during Q1. The report’s findings were also disseminated through presentations and poster displays at several regional conferences.

- The Rural Health Exchange held its inaugural meeting. The purpose of this group is to provide a forum for sharing information relevant to rural health decision makers. CIHI will assist the group in utilizing products and tools to aid in the increased uptake and use of CIHI data with a rural perspective.

- Discussions between the NL Centre for Health Information and CIHI regarding submission of EMR data to the Primary Health Care Voluntary Reporting System have been positive. CIHI’s EMR Content Standards were included in a recently released provincial EMR Request for Proposal.
Financial Highlights and Statements

The following section provides an overview of key financial considerations and results with regards to recent developments and accomplishments achieved during the first quarter of FY 2011/2012.

Last year, the Board approved for FY 2011/2012 an Operational Plan and Budget (Plan) of up to $118.7 million consisting of an annual operating budget of $107.3 million, $2.4 million in capital expenditures and $9 million in contribution to the CIHI Pension Plan. Health Canada is the primary source of funding through the Health Information Initiative ($81.8 million). Funding sources also include the Roadmap carry-forward ($6.4 million) and $16.4 million of provincial/territorial funding contributions relating to the Core Plan bilateral agreements.

Management continues to effectively deliver on its core programs and functions and is making solid progress on the new strategic initiatives that are designed to further CIHI’s strategic directions and address priority health information needs (refer to the President’s Report). The year-to-date operating under-spending in the order of $4 million is primarily explained by some timing differences in activities for programs/projects. This under-spending at the first quarter is consistent with previous years. As per the allocation of program/project resources by strategic direction on page 17, activities in the areas of Primary Health Care, Standards, Health Reports/Special Studies/Analysis, Delivery of National Conferences/Education and Outreach and Other Activities account for most of the year-to-date under-spending. Notwithstanding, the overall year-to-date results are as expected when compared with actual trends from previous fiscal years taking into account the progress achieved to date and the new projects/activities.

The following represents the significant known financial variances to the approved budget based on the recent review and first quarterly results:

- new revenue of approximately $2 million relating to the Canadian MS Monitoring System project. The expenses from this project will be recovered from the Public Health Agency of Canada.
- additional revenue of $1.2 million to offset expenses incurred for the implementation of NACRS in British Columbia. The funding contribution from the respective ministry for this initiative was received in prior years.

The financial statements included on pages 12, 14 and 16 present CIHI’s financial position as at June 30, 2011, and the detailed results of its operations for the first three months of the fiscal year. The notes to the financial statements, presented on pages 13 and 15, provide details related to specific lines of the Balance Sheet and the Statement of Revenue and Expenses.

Of note, the working capital ratio, which measures CIHI’s ability to discharge its current liabilities in a timely manner, remains positive and satisfactory at 1.4:1 (1.4:1 as at March 31, 2011). The closing balances of the Balance Sheet accounts on page 12 are reasonably in line with the Institute’s operating cycle.

Capital expenditures are proceeding well. The year-to-date under-spending relates to timing differences in activities. For more details, refer to the capital expenditures table on page 16.

The most recent analysis indicates that the Roadmap investments income for the current year will be close to the original estimate of $65,000.
Management will monitor the budgets and ensure resources are best re-allocated from the operating and capital budgets to meet this fiscal year’s deliverables and commitments and will draw as required on the corporate provision of $1.5 million that was set aside to respond to emerging issues and offset year-end budget adjustments.
### Balance Sheet ($, 000)
as at June 30, 2011

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2011</th>
<th>March 31, 2011</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Short - Term Investments $</td>
<td>17,624</td>
<td>9,416</td>
<td>1</td>
</tr>
<tr>
<td>Receivables $</td>
<td>4,296</td>
<td>3,273</td>
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<tr>
<td>Prepaid Expenses $</td>
<td>1,046</td>
<td>2,768</td>
<td>3</td>
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<tr>
<td></td>
<td><strong>22,966</strong></td>
<td><strong>15,457</strong></td>
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<tr>
<td><strong>LONG TERM ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments-Roadmap $</td>
<td>6,704</td>
<td>9,778</td>
<td>4</td>
</tr>
<tr>
<td>Capital Assets $</td>
<td>16,317</td>
<td>17,610</td>
<td>5</td>
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<tr>
<td>Accrued Pension Benefits $</td>
<td>9,783</td>
<td>9,307</td>
<td>6</td>
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<td></td>
<td><strong>32,804</strong></td>
<td><strong>36,695</strong></td>
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<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$55,770</strong></td>
<td><strong>$52,152</strong></td>
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<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
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</tr>
<tr>
<td>Accounts Payable and Accrued Liabilities $</td>
<td>6,516</td>
<td>5,616</td>
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<tr>
<td>Deferred Contributions - Health Information Initiative $</td>
<td>4,371</td>
<td>-</td>
<td>8</td>
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<tr>
<td>Unearned Revenue $</td>
<td>5,644</td>
<td>5,500</td>
<td>9</td>
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<tr>
<td></td>
<td><strong>16,531</strong></td>
<td><strong>11,116</strong></td>
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<tr>
<td><strong>LONG TERM LIABILITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred Contributions - Expenses of Future Periods $</td>
<td>18,166</td>
<td>18,809</td>
<td>10</td>
</tr>
<tr>
<td>Deferred Contributions - Capital Assets $</td>
<td>13,469</td>
<td>14,507</td>
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<tr>
<td>Lease Inducements $</td>
<td>2,535</td>
<td>2,651</td>
<td>12</td>
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<tr>
<td></td>
<td><strong>34,170</strong></td>
<td><strong>35,967</strong></td>
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<tr>
<td><strong>NET ASSETS</strong></td>
<td><strong>5,069</strong></td>
<td><strong>5,069</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
<td><strong>$55,770</strong></td>
<td><strong>$52,152</strong></td>
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</table>
Notes to Balance Sheet as at June 30, 2011

1. Cash and Short-term Investments are presented net of outstanding cheques as at June 30, 2011, and include $7.1 million in term deposits. The term deposits yield 1.30% and all mature by mid August.

2. Receivables are accounts related to the sale of products and services including the provision of the Core Plan through provincial/territorial bilateral agreements. The Receivables also include special purpose funding contributions such as $447,000 from the Ontario Ministry of Health and Long-Term Care for the Ontario Trauma Registry, Ontario Mental Health Reporting System and Health Based Allocation Model project; and $140,000 from Statistics Canada for various transferred programs. Subsequent to quarter end, approximately $1.4 million of Receivables have been received.

3. Prepaid Expenses are payments that have yet to be recognized as expenses and consist of: $484,000 for rent deposits to landlords for office space, and $562,000 for prepaid software, equipment support/maintenance and other expenses.

4. Investments-Roadmap consists of $6.7 million in GIC’s with a yield of 1.2% maturing at the end of July.

5. Capital Assets net of accumulated amortization include $6.6 million of computers and telecommunications equipment, $2.9 million of furniture and $6.8 million of leasehold improvements. The capital assets are amortized over their estimated useful lives using the straight-line method: 5 years for computer hardware/software and office/telecommunications equipment; 10 years for furniture; and lease term for leasehold improvements. All assets acquired during the year are amortized based on the month of acquisition.

6. Accrued Pension Benefits represent the sum of the current and prior year’s accounting pension expense for both the registered and supplementary retirement plans less the accumulated cash contributions made by CIHI. Employer contributions including special payments towards actuarial deficits to the CIHI Pension Plan are made in accordance with the January 1, 2010 actuarial valuation. The January 1, 2011 actuarial valuation is currently being finalized and will be filed with the regulatory authorities in September. The employer contributions and special payments will be adjusted at that time to reflect the revised rate and amounts.

7. Accounts Payable and Accrued Liabilities are operational in nature. The accounts payable of $3.1 million are mostly current (less than 30 days). The accrued liabilities represent an estimate of $3.4 million for goods received and services rendered up to the end of the quarter (e.g. external professional services, advisory groups, printing, travel, etc.) as well as payroll and benefits accruals.

8. The Health Information Initiative related funding is recognized as revenue in the same period as the related expenses are incurred. Funding recognized but not received at the end of the period is recorded as Receivable – Health Information Initiative. Contributions received from Health Canada but not yet recognized as revenue are recorded as Deferred Contributions – Health Information Initiative.

9. Unearned Revenue relates mainly to $5.6 million of funding contributions from British Columbia Ministry of Health for NACRS three-year implementation project and other special projects such as pharmaceuticals, health indicators and patient safety. The contributions are recognized as revenue in the same period as the related expenses are incurred.

10. Deferred Contributions – Expenses of Future Periods represent unspent restricted contributions. The funding is recognized as income to match the occurrence of specific expenditures for projects and activities, including the pension accounting expenses.

11. Deferred Contributions – Capital Assets represent contributions provided for the purpose of capital assets acquisitions. The deferred contributions are recognized as revenue on the same basis as the amortization of the related capital assets.

12. Lease Inducements represent the leasehold improvement allowances, other inducements and free rent received/provided over the years for Toronto, Ottawa and Montreal offices. The allowances and free rent are amortized over the period of their respective leases.
# Operating Budget ($,000)
for the Three-Month Period Ending June 30, 2011

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<tr>
<th></th>
<th>Actual (YTD)</th>
<th>Budget (YTD)</th>
<th>Variance</th>
<th>Notes</th>
<th>Approved Budget (12 months)</th>
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<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales</td>
<td>549</td>
<td>535</td>
<td>14</td>
<td>1</td>
<td>1,949</td>
</tr>
<tr>
<td>Core Plan</td>
<td>4,092</td>
<td>4,092</td>
<td>-</td>
<td>2</td>
<td>16,368</td>
</tr>
<tr>
<td>Funding - Health Information/Roadmap</td>
<td>20,800</td>
<td>24,655</td>
<td>(4,056)</td>
<td>3</td>
<td>86,647</td>
</tr>
<tr>
<td>Funding - Other</td>
<td>888</td>
<td>812</td>
<td>74</td>
<td>4</td>
<td>3,169</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>75</td>
<td>39</td>
<td>39</td>
<td>5</td>
<td>155</td>
</tr>
<tr>
<td><strong>TOTAL REVENUES</strong></td>
<td>26,202</td>
<td>30,130</td>
<td>(3,928)</td>
<td></td>
<td>107,288</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation</td>
<td>18,302</td>
<td>19,130</td>
<td>828</td>
<td>6</td>
<td>73,357</td>
</tr>
<tr>
<td>External and Professional Services</td>
<td>1,455</td>
<td>2,859</td>
<td>1,403</td>
<td>7</td>
<td>9,194</td>
</tr>
<tr>
<td>Travel and Advisory Committee Expenses</td>
<td>749</td>
<td>1,375</td>
<td>627</td>
<td>8</td>
<td>4,281</td>
</tr>
<tr>
<td>Office Supplies and Services</td>
<td>357</td>
<td>480</td>
<td>123</td>
<td>9</td>
<td>1,175</td>
</tr>
<tr>
<td>Computer and Telecommunications</td>
<td>3,058</td>
<td>3,578</td>
<td>518</td>
<td>10</td>
<td>7,848</td>
</tr>
<tr>
<td>Occupancy</td>
<td>2,270</td>
<td>2,324</td>
<td>54</td>
<td>11</td>
<td>9,333</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>-</td>
<td>375</td>
<td>375</td>
<td>12</td>
<td>1,500</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td>26,202</td>
<td>30,130</td>
<td>3,928</td>
<td></td>
<td>107,288</td>
</tr>
<tr>
<td><strong>SURPLUS (DEFICIT)</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>
Notes to the Operating Budget for the Three-Month Period Ending June 30, 2011

1. Sales include products and services of CIHI over and above those sold as part of the Core Plan (i.e. fee-for-service basis).
2. Core Plan subscriptions represent revenue from the bilateral agreements with provincial/territorial governments.
3. Funding – Health Information/Roadmap was less than anticipated in the first quarter because of some under-spending in programs/projects. A review of planned expenditures indicates that most of the year-to-date under-spending will correct itself over the subsequent quarters; a more thorough assessment will be undertaken as part of the regular mid-year budget review.
4. Funding - Other represents contributions from the federal government for programs transferred from Statistics Canada as well as special contributions from provincial/territorial governments and other agencies (i.e., British Columbia special studies/projects, Ontario Mental Health Reporting System, Ontario Trauma Registry and Ontario Health Based Allocation Model, Canadian MS Monitoring System). These funding contributions are recognized as revenue in the same period as the related expenses are incurred.
5. Other Revenue includes interest income generated from the bank accounts and ad hoc short-term investments as well as miscellaneous income.
6. Compensation includes both full time employees and agency/contract staff. The year-to-date positive variance is a timing difference and relates primarily to changes made to the merit-based system included in the new compensation strategy effective April 1, 2011. The recent review indicates that the attrition factor on approved staff complement is relatively in line with the budgeted rate of 6%. A more definite projection of both contract staff and staff compensation and benefits will be performed as part of the mid-year budget review.
7. The External Professional Services include accruals for services rendered to date. The year-to-date favourable variance is primarily explained by a timing difference in activities. At the end of Q1, the unrecorded contractual commitments pertaining to this fiscal year are in the order of $2.3 million.
8. The year-to-date favourable variance in Travel and Advisory Committee Expenses is primarily explained by a timing difference in activities; however, the recent review indicates minor over estimation of resources in some areas.
9. Office Supply and Services include printing, postage/courier/distribution, office equipment and supplies and insurance.
10. Computers and Telecommunications include supplies, software/hardware support and maintenance, minor software costs and upgrades, telecommunications line charges and long distance charges as well as depreciation of computers and telecommunications assets. The year-to-date favourable variance relates to a timing difference in hardware maintenance costs.
11. Occupancy Costs includes rent, facilities maintenance, furniture and leasehold improvement.
12. The Corporate Provision set aside by Management, is essentially a contingency for emerging issues and year-end adjustments (e.g. benefits/pension costs, revenue shortfall, etc).
Capital Budget ($,000)
for the Three-Month Period Ending June 30, 2011

<table>
<thead>
<tr>
<th></th>
<th>Actual YTD</th>
<th>Budget YTD</th>
<th>Variance</th>
<th>Approved Budget (12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniture and Office Equipment</td>
<td>$ 1</td>
<td>$ 10</td>
<td>$ 9</td>
<td>$ 40</td>
</tr>
<tr>
<td>Leasehold Improvements</td>
<td>-</td>
<td>15</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>Information Technology and Telecommunication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>616</td>
<td>600</td>
<td>2,300</td>
</tr>
<tr>
<td></td>
<td>$ 17</td>
<td>$ 641</td>
<td>$ 624</td>
<td>$ 2,400</td>
</tr>
</tbody>
</table>

Note: The above excludes $51K of commitments up to July 7, 2011.
## Program/Project Resources by Strategic Directions ($,000)
for the Three-Month Period Ending June 30, 2011

<table>
<thead>
<tr>
<th></th>
<th>Approved</th>
<th>Actual YTD</th>
<th>Budget YTD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MORE AND BETTER DATA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Services</td>
<td></td>
<td>$4,784.6</td>
<td>$4,996.0</td>
<td>$211.4</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td></td>
<td>943.6</td>
<td>1,291.6</td>
<td>348.0</td>
</tr>
<tr>
<td>Health Human Resources</td>
<td></td>
<td>1,241.4</td>
<td>1,370.2</td>
<td>128.8</td>
</tr>
<tr>
<td>Clinical Registries</td>
<td></td>
<td>954.4</td>
<td>624.1</td>
<td>(330.3)</td>
</tr>
<tr>
<td>Health Expenditures</td>
<td></td>
<td>1,018.3</td>
<td>1,118.1</td>
<td>99.8</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td></td>
<td>818.8</td>
<td>913.6</td>
<td>94.8</td>
</tr>
<tr>
<td>Standards</td>
<td></td>
<td>1,278.7</td>
<td>1,620.5</td>
<td>341.8</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td>11,039.8</td>
<td>11,934.1</td>
<td>894.3</td>
</tr>
<tr>
<td><strong>MORE RELEVANT AND ACTIONABLE ANALYSIS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Indicators</td>
<td></td>
<td>1,020.3</td>
<td>1,001.0</td>
<td>(19.3)</td>
</tr>
<tr>
<td>Hospital Performance Indicators</td>
<td></td>
<td>511.6</td>
<td>778.6</td>
<td>267.0</td>
</tr>
<tr>
<td>Canadian Population Health Initiatives (CPHI)</td>
<td></td>
<td>836.3</td>
<td>1,134.2</td>
<td>297.9</td>
</tr>
<tr>
<td>Health Reports, Special Studies and Analysis</td>
<td></td>
<td>4,476.8</td>
<td>5,276.3</td>
<td>799.5</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td>6,845.0</td>
<td>8,190.1</td>
<td>1,345.1</td>
</tr>
<tr>
<td><strong>IMPROVED USE AND UNDERSTANDING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Support Services</td>
<td></td>
<td>1,986.4</td>
<td>2,116.1</td>
<td>129.7</td>
</tr>
<tr>
<td>Delivery of National Conferences/Education (1)</td>
<td></td>
<td>3,826.2</td>
<td>4,452.2</td>
<td>626.0</td>
</tr>
<tr>
<td>Outreach and Other Activities</td>
<td></td>
<td>2,504.9</td>
<td>3,062.8</td>
<td>557.9</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td>8,317.5</td>
<td>9,631.1</td>
<td>1,313.6</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td></td>
<td></td>
<td>375.0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Operating Expenses / Resources</strong></td>
<td></td>
<td>$26,202.3</td>
<td>$30,130.3</td>
<td>$3,928.0</td>
</tr>
</tbody>
</table>

Note: Indirect Costs/FTEs included in this analysis are allocated to programs/projects on the basis of direct costs. These costs include corporate functions such as human resources, finance, administration, facility management, libraries, distribution services, information technology support, telecommunications, planning and project management, publication/translations services, privacy and legal services, Executive and Board secretariat. This allocation method is in accordance with the accounting/financial reporting guidelines.

(1) CIHI's education programs help facilities and their staff use the various CIHI products for effective management. Various methods of delivery are used (e.g. distance-learning tools, workshops, self-learning products, blended delivery modes)
Appendix A
Summary Progress Report of FY2011/12 Priority Initiatives
First Quarter Highlights – 2011/12 Priority Initiatives

The following accomplishments, based on the FY2011-12 Operational Plan and listed by Strategic Direction, highlight the progress of key priorities for the first quarter of FY2011-12.

More and Better Data

- Increase jurisdictional uptake of select reporting systems, with a continued focus on Home and Continuing Care, pharmaceuticals, medication incidents, and emergency visits
  - Delivered customized coding workshops to support the First Nations HCRS Alberta Pilot Implementation project. Collaborated with Ontario MoHLTC and interRAI in the development of education blitz, producing two job aids to address data quality concerns with RAI-MDS 2.0, sections on Visiting Nurses (P1b) and Management of Equipment (P3).
  - Completed NSIR Long-Term Care pilot. Assessment is currently underway, with the formal launch expected in FY2011-12 Q3. Prepared for Ontario-wide roll-out of NSIR to acute care hospitals.
  - Released new Management Reports for NACRS FY2011-12. These reports, which are updated on a daily basis, help facilities track the timeliness, quality and completeness of their submissions and also identify opportunities to improve the overall quality of data submissions.
- Continue to develop and implement CIHI’s primary health care information program
  - Drafted and signed 4 new Data Sharing Agreements for the Primary Health Care Voluntary Reporting System (PHC VRS) Program. Currently over 250 clinicians are participating in the PHC VRS. Developed and pilot tested “Outcomes” Methodology for reports. Released Quality Management Information Compass (QMIC) and paper-based provider feedback EMR PHC reports.
- Expand our program of work to address data gaps in the areas of aboriginal health and community Mental Health
  - Partnered with CPHI to establish the Cardiovascular Disease Analysis Advisory Group and established communication with First Nations, Inuit and Métis to identify contacts as analytic advisors.
  - Reviewed next steps to develop an ethnicity database, identifying data elements and approaches to third party access to aboriginal data with the First Nations, Inuit and Métis Health internal Working Group.
  - Received support in principle from Newfoundland and Labrador Regional Mental Health Directors and Department of Health and Community Services representatives regarding further implementation of the RAI-MH (OMHRS and CMH) instruments in FY2011-12.
  - Participated in discussions with the Mental Health Commission of Canada on the formation of a cross-organizational initiative for the development of a broad set of Mental Health indicators, including Community Mental Health and Addiction indicators.
- Collaborate with jurisdictions and Canada Health Infoway to advance health system use of data and the pan-Canadian agenda related to EHRs/EMRs
  - Drafted Project Charter for Phase 2 (Adoption, Implementation, and Maintenance) of the Electronic Medical Records (EMR) Content Standards project. Released draft PHC EMR Content Standards v2 Business View to the CIHI internet site and to the Canada Health Infoway Wiki-site. Signed up Saskatchewan, Manitoba, Ontario and Newfoundland and Labrador to implement all (or part) of the PHC EMR Content Standards.
More Relevant and Actionable Analysis

- Publicly release the Canadian Hospital Reporting Project (CHRP) results and pursue enhancements to CHRP
  - Updated the CHRP eTool with a number of new features and enhancements, including release of data for FY2007-08, FY2008-09 and FY2009-10, new indicators and two new sets of clinical and financial reports.
- Implement a rolling multi-year analytical plan and release reports and special studies on priority themes such as access to care/wait times, patient outcomes, continuity of care, cancer, cost/productivity, seniors/aging
  - Presented an overview and introduction to the Corporate Analytical Plan to the Board of Directors on June 3rd. Several of the 25 analytic products for FY2011-12 are pending first review of data/preliminary analysis.
  - Released 6 new indicators for Wait Times and Mental Health: Wait Time for Hip Fracture Surgery (within 48 hours), 30-Day Readmission for Mental Illness, Patients with Repeat Hospitalizations for Mental Illness, Self-injury Hospitalization, Mental Illness Hospitalization Rate, Mental Illness Patient Days.
- Complete the implementation of the CPHI Action Plan 2007-2012
  - Released Obesity in Canada, jointly with the Public Health Agency of Canada. Delivered education and presentations on Population Health and on Positive Mental Health. Participated on the Steering Committee and Scientific Committee for the Chronic Disease Prevention Alliance of Canada conference, which is scheduled for February 2012.

Improved Understanding and Use

- Continue to support the adoption and uptake of the CIHI Portal and enhance/expand client access to eReports
  - Completed Service Agreements for 10 new community hospitals within the Canadian Association of Paediatric Health Centres. Continued Portal deployment with the Canadian Stroke Network and the Provincial Council for Maternal and Child Health.
  - Deployed several upgrades to the Portal, including updates to DAD Neonatal Intensive Care Unit metrics and to NRS Body Mass Index (BMI), weight metrics and all of the ICD-10-CA attributes; annual changes to the NACRS Data Mart; and a special release of new threshold functionality for all MicroStrategy projects in Portal for all levels of users.
- Continue to enhance CIHI’s newly launched website
  - Drafted online strategy to increase CIHI’s online presence through the use of the internet web site and social media. Released Case Mix Client tables and completed significant updates to CIHI’s internet to better showcase Case Mix products.
- Implement the newly developed customer strategy
  - Formed the new Central Client Services team and initiated the Customer Relationship Management Upgrade, Identity Management and Organization Index Redevelopment projects.
- Seek renewal of CIHI’s status as a prescribed entity under the Ontario Personal Health Information Protection Act and implement follow-up recommendations from the Office of Information and Privacy Commissioner of Ontario
  - Completed response to comments received from the Office of the Information and Privacy Commissioner of Ontario (IPC/ON) on CIHI’s January 10, 2011 submission. Submitted an interim report to the IPC/ON on May 31, 2011 and approval is pending and due by October 31, 2011, the end of 3-year review period.
Appendix B
Quarterly Performance Indicators
Introduction
After the 2007/08 multi-stakeholder consultation and strategic planning exercise, CIHI identified three new strategic directions and priorities for the years 2008/09 to 2011/12. These are:

- **More and Better Data** – CIHI will enhance the scope, quality and timeliness of our data holdings
- **Relevant and Actionable Analysis** – CIHI will continue to produce quality information and analyses that are relevant and actionable
- **Improved Understanding and Use** – CIHI will work with stakeholders to help them better understand and use our data and analyses in their day-to-day decision-making, and will do so in a timely and privacy-sensitive manner.

In support of these strategic directions are the core elements that underpin the work that CIHI undertakes. All corporate performance indicators have been aligned with CIHI’s strategic directions through their respective strategic actions and priorities. A framework outlining corporate performance indicators that measure progress in achieving CIHI’s strategic directions has been developed and is in use.

Note: CIHI is in the process of finalizing new strategic directions for the fiscal years starting 2012/2013 to 2016/2017. Revised corporate performance indicators are also being developed to align with the new strategic directions and will be in use for that same time period.

For the year 2011-2012, a temporary and smaller set of performance measures has been developed and are reflected in this document. These are listed in the table below.

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Desired Outcome</th>
<th>Measures (reflects progress in achieving outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>More and Better DATA</strong></td>
<td>Increased comprehensiveness of pan-Canadian data along the continuum of care</td>
<td># of jurisdiction participating in reporting systems</td>
</tr>
<tr>
<td><strong>Relevant and actionable ANALYSIS</strong></td>
<td>Quality indicators and analysis that result in health and health system improvement (relevant and actionable)</td>
<td>Success stories – using CIHI data and information</td>
</tr>
<tr>
<td><strong>Improved UNDERSTANDING &amp; USE</strong></td>
<td>Increased use of data for health system management and policy development</td>
<td># of data requests by type of organization</td>
</tr>
<tr>
<td></td>
<td>Stakeholders who value CIHI education sessions</td>
<td>Stakeholder satisfaction with education workshops offered</td>
</tr>
<tr>
<td><strong>Supportive INFRASTRUCTURE</strong></td>
<td>Increased responsiveness to stakeholders</td>
<td>ITS service desk response rates for external users</td>
</tr>
</tbody>
</table>
More and Better Data

**Enhanced/Expanded Data Holdings**

**Canadian Joint Replacement Registry (CJRR)**
- The Ontario Ministry of Health and Long Term Care (MOHLTC) has now mandated CJRR submission across all hospitals in Ontario effective April 1, 2012. Electronic only, monthly reporting to CJRR has been tied to conditions associated with Wait Time Funding for 2011/12. This will increase CJRR coverage from 43% to 75% of all procedures.

**Relevant and Actionable Analysis**

**Physician Retirement**
- The Physician Retirement release sparked an in-depth conversation across the social media sphere. CBC.ca generated reader input with its online survey which asked, "Would you see a senior physician?" Over 600 readers took part. Twitter and comment sections of news websites were also busy with people commenting on the story.

**Drug Expenditures**
- The Drug Spending report caused the government of Nova Scotia to issue a press release on its new generic drug Fair Pricing Policy that cited CIHI’s report as “evidence” that the province needed to act to reduce costs for its people.
- The government of BC cited CIHI’s report as evidence that the province was doing an exemplary job of controlling costs, in light of criticism that the province’s generic drug prices were more expensive.
- Canada's Research-Based Pharmaceutical Companies (Rx&D) also issued a press release, titled *New CIHI Report Shows That New Medicines Are Not the Cost Driver in Canadian Health Care* to point out the leveling in drug spending and to call on governments to invest in “new scientific discoveries so that Canadians have access to the right medication at the right time.”
- The report also spurred calls for re-examinations of the provincial drug program in Quebec. A La Presse editorial by Ariane Kroll used the finding of Quebec’s high per capita spending as proof of the need to re-evaluate Quebec policies that protect the pharmaceutical industry.

**Health Indicators, 2011**
- On the day of the Health Indicators 2011 report release the federal government announced funding to support positive mental health in communities across Canada, a direct response to the finding of high hospitalization rates for self-harm among youth.
- The Mental Health Commission also issued a release to show their support for the initiative.
- The report also generated public discussion at the community level, particularly in communities with higher than average self-injury rates, such as those in New Brunswick, Waterloo and Hamilton.

**Obesity in Canada**
- The Obesity report sparked debate across Canada, spurring people to assess the factors causing obesity and the action that can be taken. The newspaper L'Acadie Nouvelle reported that a New Brunswick cabinet minister said the report confirmed more investments are needed in the province to promote physical activity and healthy living.
- In Ontario, the report spurred opposition parties to declare they would make obesity part of their fall election campaign.
Improved Understanding and Use

**Data Request Activity (DaRT)**
The following data are obtained from DaRT, CIHI’s internal data request tracking system launched in 2008-2009.

CIHI staff handled 144 data requests in Q1, the same volume compared to Q1 of last year (n=145). Of these, 72% (n=104) were third party requests from not-for-profit agencies, universities and other clients, and 31% of these were 3rd party, record-level requests (the latter type of requests generally involve more customization, documentation, and privacy review).

This chart shows open and complete requests in Q1, by turnaround time categories. Of the 102 requests completed in Q1, almost all requests (94%) were completed within 90 days, which represent maximum service timeframes established by the Data Request Working Group. Seventy five percent (75%) were completed within one month. Of the open requests, 25% have been open for more than 90 days and therefore once completed, will fall outside the turnaround time standard. Factors that may contribute to extended turnaround times include delays in responses from clients, multiple iterations with client to finalize specifications, the need for special approvals or background work, etc.

* Turnaround time measured as time elapsed from Date of Formal Request to Date of Release (or Q1 end for open requests); standard releases by agreement excluded from these calculations.
Evaluation of Education Sessions

This chart illustrates the percentage of respondents rating CIHI’s educational offerings as being good or good/excellent for the first quarter in FY2011-12.

<table>
<thead>
<tr>
<th></th>
<th>Workshop</th>
<th>Web-Conference</th>
<th>Self-Study</th>
<th>Overall</th>
<th>FY 2011-12 Baseline Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>96.60%</td>
<td>77.59%</td>
<td>83.68%</td>
<td>83.05%</td>
<td>82.6%</td>
</tr>
<tr>
<td>Relevant</td>
<td>98.94%</td>
<td>86.10%</td>
<td>83.92%</td>
<td>85.84%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Good Use of Time</td>
<td>98.86%</td>
<td>92.86%</td>
<td>97.52%</td>
<td>96.26%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Recommend to others</td>
<td>98.86%</td>
<td>76.61%</td>
<td>81.70%</td>
<td>81.71%</td>
<td>82.1%</td>
</tr>
</tbody>
</table>

Overall, results are slightly above baseline results expected, as set at the start of fiscal year. Slight variances in the percentage of clients rating web conferences as essential and as a good use of time are being monitored in the event they need to be examined more closely or to assess whether other follow up is warranted.

Enabling Resources –Supportive Infrastructure

ITS - Service Desk Response Rates for External Users*
In FY 2010-11, ITS launched the centralized service desk. While refinements are still being made to the service standards and performance measure, below is a first look at some of the volume and response rates to queries by our client/stakeholders.

Incident Tickets
During the 1st Qtr of 2011-12, the ITS Service Desk registered 944 incident tickets for external users. Of these:
- 536 tickets were resolved at the Service Desk
- 316 tickets were triaged to the program areas
- 92 tickets were escalated to functional groups within ITS

Of the 536 tickets resolved at the Service Desk, the average ticket was closed in under 2 hours and 99% were resolved within 1 day.

Of the 92 tickets escalated within ITS, the average ticket was closed within 2 days (most were closed in half a day and 84% were closed within 1 day).

Client Services¹
Also, for the 1st Qtr of 2011-12, 503 service requests for Client Services were fulfilled. The average ticket was closed within 16 hours of the request being submitted and 90% of tickets were closed within 1 day.

*Includes only tickets registered by external users using the Service Desk. It does not include tickets that may have been opened by CIHI staff on behalf of external users. Nor does it include other entry points with which clients may also engage.

¹Client services are requests for modifications and additions to client services and are not specifically incident-related.
Appendix C

Environmental Scan
Environmental Scan
FY2011-2012 1st Quarter

Recent F/P/T Initiatives

Health Canada

- The Minister of Health tabled the 2010 Annual Report of the Patented Medicine Prices Review Board (PMPRB) on June 16th. The PMPRB reports that sales of patented drug products declined to $12.9 billion in 2010, a decrease of 3.4% from $13.3 billion in 2009. Prices of patented drugs (as measured by the Patented Medicines Price Index) fell, on average, by 0.4% between 2009 and 2010, while the Consumer Price Index rose to 1.8% during the same period. Canadian prices ranked fourth of the seven comparator countries, lower than Switzerland, the U.S. and Germany.

Council of the Federation

- Premiers met on July 20-22, 2011 in Vancouver for the summer Council of the Federation meeting. They discussed various topics including the health care. They acknowledged the federal commitment to continuing the 6% escalator on the Canada Health Transfer (CHT) while working collaboratively to renew the Health Accord and to enter into a separate agreement with the Government of Quebec regarding the implementation of the renewed Health Accord. They agreed that increases in CHT funding should not be financed by reducing other major transfers.

- Premiers will meet again early in 2012 on an integrated approach to sustainable health. Discussions will include identifying key principles that should govern a new agreement on health care with the federal government and on innovations to modernize health care services. They also discussed progress on two voluntary initiatives initiated last year; the pan-Canadian alliance for medical equipment and supplies, and for common drugs, and on clinical practice guidelines. They have agreed to collaborate on clinical practice guidelines, focusing on 3 to 5 specific ones where better care and cost savings can be achieved. This winter, interested stakeholder groups and governments will be participating in a summit on improving the evaluation and dissemination of clinical practice guidelines.

British Columbia

- B.C. has launched the $68.7-million Healthy Families BC Strategy, a health-promotion program aimed at helping families make healthy choices. The strategy's first program is the $24-million Prescription for Health Program, which will give doctors tools to conduct medical assessments and work with patients to develop a health promotion and illness prevention plan. The program is available to those with risk factors that include smoking, unhealthy eating and medical obesity.

Alberta

- Alberta Health Services announced modifications to its organization which has been in existence for two years after merging nine regional health authorities and three provincial boards. Now, more decision-making is being transferred back to the regional level and there is to be more physician engagement in AHS affairs. The new organization shares major decision-making authority between a Chief Operating Officer and a Chief Medical Officer, and each of the five geographic zones will have an operational and medical director sharing responsibility.

- The province has launched a new online waiting list registry that tells patients which specialists and hospitals have the shortest waits for knee replacements, chemotherapy or CT scans. The launch of wait times.alberta.ca coincides with the first phase of a $33-million health portal that will one day give patients' access to their X-rays or blood results.

- As part of an "agreement in principle" signed between AHS, Alberta Health and Wellness and the Alberta Medical Association, the province is establishing a task force to examine the effectiveness of its 40 physician-led primary-care networks (PCNs). Officials say the effectiveness of PCNs is unclear and that primary-care programs lack accountability and need to be assessed. About 70% of Alberta's primary-care physicians are involved in PCNs. The review will look at whether 24/7 access to primary care and chronic disease management have been improved with the PCNs.
**Saskatchewan**

- Saskatchewan has reached agreement on a plan to lower generic drug prices. The agreement between the Pharmacists’ Association of Saskatchewan and the Canadian Association of Chain Drug Stores was a key component of the plan. The plan's highlights include lowering the price on most existing generic drugs to 45 per cent of the brand drug by June 1, 2011 and to 35 per cent of the brand drug by April 1, 2012. Generic drug prices in the province are between 50 to 70 per cent of brand name price. The maximum dispensing fee was increased from $9.85 on May 1, 2011 and will be further increased to $10.25 on April 1, 2012.

**Manitoba**

- Manitoba has unveiled a new cancer strategy to streamline services and reduce the wait times for treatment. The $40 million cancer reform strategy will address the patient journey, from when a family doctor first suspects cancer until treatment actually begins. CancerCare Manitoba estimates the full cancer-patient journey currently takes three to nine months and the goal is to reduce this to two months or less. The strategy is modeled after similar initiatives undertaken in England, New Zealand and Australia.

**Ontario**

- eHealth Ontario is embarking on a $72-million plan to create a single electronic health records system for hospitals, long-term care centres and family health teams in the Toronto area. The system, ConnectingGTA, would link 700 health providers from 43 Toronto-area hospitals and 201 nursing homes. That means a doctor at one healthcare facility can see a patient's test result or drug information entered at another facility on the network. The first phase of the project will be completed in 2013.

- The Ontario government has passed a regulatory change that allows eHealth Ontario to create and maintain EHRs while keeping personal health information secure. The change clarifies that eHealth Ontario has the authority to create and maintain EHRs; defines eHealth Ontario’s authority to include the ability to integrate personal health information, conduct data quality assurance tests, and conduct analyses to provide alerts and reminders to health information custodians and defines EHRs.

**Quebec**

- Quebec is offering doctors $340 million in bonuses and incentives to encourage them to accept new patients and work more hours. While doctors are being offered the same salary increases as other publicly paid workers, the deal includes a series of bonuses. Under the proposed deal, doctors would receive $100 for every new patient they accept. Each GP would also receive a $50 bonus per day of work beyond 180 days a year, and then $200 for each additional day worked beyond 200 days. The province's 7,800 general practitioners have until Aug. 6 to vote on the deal.

- Quebec has passed a new health-care governance law. The bill is designed to improve the management of the health and social service network but it has gone through changes since it was introduced last December. The final bill gives the minister the final say on the selection of CSSS executive directors (health and social services centres) and tightens up board operations by introducing new accountability measures. As well, boards will have to produce five-year strategic plans in line with ministry direction.

- Quebec has launched its provincial registry on adverse medical events. It recently began collecting data from some 200 organizations and all hospitals are expected to be contributing information by the fall. The first report, based on six-months data, will be published in December 2011.

**New Brunswick**

- An external review of New Brunswick's electronic health records system has been launched after an internal audit detected possible conflicts of interest with contracts intended to help develop the program. A consultant will be hired to examine more than 300 contracts dating back to 2007, when e-health was announced.

**Newfoundland and Labrador**

- The Newfoundland and Labrador government has recently proclaimed the Personal Health Information Act, which will govern the collection, use and disclosure of personal health information within the provincial healthcare system. The legislation requires custodians of personal health information -- which include healthcare professionals -- to collect only the information required, ensure the information is kept...
confidential and secure and provide individuals with a summary of information-handling practices. The act also provides individuals with the right to know what information is included in their records, who has access to those records and for what reason, as well as the right to ask a custodian not to share their personal health information with other healthcare providers.

**Items of Interest from other Organizations**

**L’Association québécoise d’établissements de santé et de services sociaux (AQESSS)**
- The first evaluation report on the performance of the 95 local health networks in Quebec says they are doing a respectable job providing access to care, but there is considerable variation in the results and not many of them are doing their job efficiently. The centres de santé et de services sociaux (CSSS) were created in 2004 as part of a reorganization of Quebec health care and brought together all locally-delivered care, including primary care and hospitals. The evaluation by AQESSS utilized 161 performance indicators using data from 2008-09. The report gave the CSSS a collective score of 75 per cent for access to care but 29 of the 95 were judged to have weak performance in this area. As well, the CSSS got an overall score of 74 per cent for managing resources productively and efficiently but only 14 were assessed to be very efficient in their use of resources, and just 11 were found to have superior productivity performance.

**Atlantic Health Quality & Patient Safety Learning Collaborative**
- The Atlantic Health Quality & Patient Safety Collaborative was unveiled recently, signalling the beginning of a new era of partnership among the Atlantic Provinces in their efforts to deliver safe care. Comprised of representatives from each of the Atlantic Provinces, the goal of the Collaborative is to develop common strategies that will improve the safety of health care and bring recommendations back to their respective Health Ministries. The Collaborative is the first trans-provincial collaborative of its kind in Canada.

**B.C. First Nations**
- In May, First Nations in British Columbia passed a resolution to assume greater control and decision-making over their health and wellness. 146 of the 167 Chiefs in attendance (87%) voted in favour of making BC First Nations the first in Canada to take over health service delivery from the federal government. The resolution also provides the First Nations Health Council a strong mandate to work with the Province and Health Authorities.

**B.C. Medical Association**
- A report by the B.C. Medical Association says standardized quality-improvement measures should be put in place across the province to improve efficiency and care for patients who undergo surgery. The report says the growing demand for surgery and the added emphasis on quality and safety of care means the time is ripe for all hospitals to share best practices and adopt similar methods to improve surgical services. It asks that the ministry of health set up a panel to identify best practices that would be applied in every hospital in the province.

**Canada Health Infoway**
- Canada Health Infoway has established an Emerging Technology Group to identify and guide the use of information and communications technologies (ICTs) in health care innovation. Through its Tech Watch agenda, the group will identify and evaluate emerging technologies, and mature technologies that haven't been fully applied, that look most likely to bring benefits to the health system.

**Canadian Blood Services**
- Canada’s organ donation system is failing patients, and the solutions include having registries in each province and depending less on the United States for tissue, a new report says. The Canadian Blood Services Call to Action report says implementing its recommendations would result in almost 1,000 more life-saving transplants annually and get patients off costly dialysis. Although the costs of implementation would be high during the first five years, it would decrease to $47.8-million by Year 10. Of particular concern is tissue donation - the report noting "Canada imports approximately 80 per cent of its tissue product - a dependency that could pose risks to Canadian patients."
Canadian Medical Association/Canadian Nurses Association

- According to a new poll conducted for the Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA), an overwhelming majority of Canadians say the country's health care system must be transformed to better meet patient needs. The poll, conducted before the beginning of the annual Council of the Federation meeting in Vancouver, found 89 per cent of Canadians believe the federal government should play a leading role in health care transformation, while (92 per cent) agreed that a First Ministers meeting to deal with the challenges of the health care system should be called as soon as possible. These findings rest on a firm belief (91 per cent agree) that Canada's health care system is in need of transformation to better meet the needs of all Canadians. Nine in ten (87 per cent) also agree that any changes already underway at the regional level should be guided by a common policy so that all Canadians have equitable access to the same quality of health and health care services. A significant majority of respondents (65 per cent) also consider it very important that the health care system have national standards for quality. Only 10 per cent of those polled believe that the system now does a very good job in this area. The poll also found that 90 per cent of Canadians believe that changes to the system must build on the five principles of the Canada Health Act - universality, accessibility, portability, comprehensiveness, and publicly administered. But Canadians also feel the Act should go beyond hospital and physician services, with 86 per cent agreeing that these principles should apply to other aspects of health care such as prescription drugs, home care, and physiotherapy. The online poll of 1,018 adults was conducted by Ipsos Reid on July 18 and 19 and has an estimated margin of error of plus or minus 3.1 percentage points, 19 times out of 20.

Canadian Nurses Association

- The Canadian Nurses Association launched its National Expert Commission on health system improvement, entitled The Health of Our Nation — the Future of Our Health System. The Commission's mandate is to generate policy solutions that contribute to a transformed health system — one that is better equipped to meet the changing health needs of Canada's population. The Commission will consult with nurses, other health-care leaders and the public to weigh evidence and advice on how to accelerate a positive transformation of Canada's medicare system. The Commission will engage in consultations throughout next year and will table its final recommendations in June 2012. Selected appointments to the National Expert Commission on Health System Improvement include Marlene Smadu, Co-chair, Maureen A. McTeer, Co-chair, The Honourable Sharon Carstairs, PC, Thomas d’Aquino, Judith Shamian.

Canadian Partnership Against Cancer

- The Canadian Partnership Against Cancer has developed a web-enabled platform -- the Cancer Risk Management simulation model -- that simulates the demographic characteristics of the Canadian population and projects cancer occurrences. It predicts that if Canada's smoking rates were cut by half to an average national rate of 11% within five years, it would result in 35,900 fewer cases of lung cancer by 2030 and save $656 million in treatment costs. For lung cancer, the developers say it can be used to explore the impact of smoking cessation on such things as downstream treatment costs, life-years gained, the impacts on tax revenue, as well as the impact of introducing a population-based screening program and new systemic treatments for specific populations.

Canadian Patient Safety Institute

- Patient safety and quality improvement information from across Canada and the globe will now be available to patients and healthcare providers in one place. The Improving Care Search Centre, a publicly available web-based search centre developed by the Institute will provide an easy method for searching information on patient safety and quality improvement generated by organizations from across the country and around the world.

Conference Board of Canada

- The Conference Board of Canada launched the Canadian Alliance for Sustainable Health Care (CASHC), a five-year, multi-million dollar initiative that seeks to improve the Canadian health system as a whole - as well as health-care practices within firms and organizations. To launch this five-year initiative, the Conference Board will assess the fiscal sustainability of the publicly-funded health care system nationally, and by province and territory. Subsequent research will include detailed analysis of financial pressures
and reform options in the health care system—identifying implications and enabling discussion of policy options.

**Health Council of Canada**
- Canada’s health care system has made incremental progress toward goals its own leaders set out for it according to the Health Council of Canada, charged with evaluating progress on the 10-year, $41.3-billion health accord enacted in 2004. The Council’s new report *Progress Report 2011: Health Care Renewal in Canada* says that goals for the previous decade have been only half met. Governments have made wait times for certain procedures a priority, and have largely met the goals set out years ago. But the focus on certain procedures has had a troubling side-effect in that wait times in emergency departments seem to be growing. It says progress on providing home care is hampered by a hodgepodge of publicly funded projects that has led to rapid growth of private agencies to fill in the gaps. The council sees some progress in primary health-care reform, but says that Canada has seen only a recent embrace of a team-based approach to providing primary health care. As for the goal of creating a national system of electronic health records, the council finds there has been recent progress, but not enough.
- The Health Council of Canada concludes that the country has more magnetic resonance imaging machines than ever, yet wait times for MRI exams are on the rise. It noted that wait times have increased while the number of MRI machines have doubled and tripled in some provinces, building on evidence that family physicians are overusing diagnostic tests: Between 2003 and 2009, the number of CT scans ordered rose by 58% per year and the number of MRIs ordered annually rose by 100%.

**Health Quality Ontario**
- *Quality Monitor*, Health Quality Ontario’s (HQO’s) annual report, finds there are far too many patients occupying alternative level of care (ALC) beds in the province’s hospitals and wait times for long-term care are still very high. The report also identified achievements, including improvements in primary care access, reductions in wait times for many surgeries and CT scans, as well as better patient outcomes for coronary artery disease and declining smoking rates. Emergency department wait times are also going down, which is encouraging, but they are still far from ideal. The report identifies three system areas that need to be addressed: access to healthcare, chronic disease management and keeping the population healthy.

**New Brunswick Health Council**
- After-hours access to primary care in New Brunswick is an issue for patients, according to a survey of primary care services by the New Brunswick Health Council. The survey of over 14,000 residents was conducted earlier this year and reveals wide variations in the use of services across the province. The overwhelming majority of New Brunswickers have a regular family doctor (93 per cent) but only 30 per cent can get a same or next day appointment and even fewer (22 per cent) have a doctor who has an after-hours arrangement when the office is closed. On both counts, this is well below the national average. As a result, only 62 per cent reported that a personal family doctor was the model of care used most often when sick or in need of care from a health professional. Another 18 per cent said it was an after-hours or walk-in clinic, and fully 12 per cent said it was a hospital emergency department.

**Ontario Hospital Association/Ontario Association of Community Care Access**
- Ontario needs a better planned and more integrated approach to health care if it wants to improve patient services and outcomes while trimming a huge deficit, concludes a special report from hospitals and community care centres. A joint report from the Ontario Hospital Association and the Ontario Association of Community Care Access Centres calls for funding of 3.5 per cent a year plus inflation to beef up community care. Almost 16 per cent of patients in Ontario hospitals should be at home or in an alternate and more appropriate level of care in the community, according to the report. The report says the government should produce and circulate five- and 10-year plans that set goals and objectives.

**PwC**
- A report from PwC (formerly PricewaterhouseCoopers) and the Citizens’ Reference Panel it created earlier this year to come up with ideas for reforming Ontario’s health system outlines 13 recommendations under five themes: improve accountability and incentives for quality care; strengthen community care; improve access and timeliness (including expanded family health teams and use of nurse practitioners); expedite e-health and information sharing; and, step up prevention and promotion activities. PwC said participants
were clear about what was needed to ensure the sustainability of the province’s health system: “more collaboration, more integration and more accountability.”

**Wait Time Alliance**

- The Wait Time Alliance (WTA) warned that as the expiry of the 10-Year Accord draws near, long waits for care still threaten the ability of Canadians to get timely access to quality health care services. The sixth annual WTA report card highlights the detrimental impact alternate-levels-of-care (ALC) stays are having on wait times for both emergency and elective/scheduled care. About one in six hospital beds are occupied by patients who should be receiving care somewhere else. Provinces and territories have shown modest improvement in reducing waits endured by patients in the five clinical areas governments consider a priority. For the five-year period between 2007-2011, governments receive an overall national grade of B for reducing waits for cancer care, heart procedures, diagnostic imaging, joint replacement and sight restoration. However, beyond those five priority areas those grades that could be assigned are very low in most instances.

**International**

**OECD**

- Nations need to improve on their long-term care strategies to accommodate a growing demand for elder care services a new Organization for Economic Co-operation and Development report says. The report told its 34 member countries to consider new policies that would fight high turnover for professional caregivers and help informal caregivers, such as family and friends. Researchers project that by 2050, those who are at least 80 years old will make up 10 per cent of the global population - up from four per cent in 2010. There are about 20 long-term care employees per 100 people over the age of 80 in the country. Government and private-market spending on long-term care is about 1.5 per cent of GDP on average across the OECD's members, but figures will double or even triple by 2050, the report noted.

- The Organisation for Economic Co-operation and Development reported that despite relatively high health expenditures in Canada there are fewer physicians per capita here than in most other OECD countries. The comment came in a country report on Canada as part of the general release of Health Data 2011. The Canadian report acknowledged the fact that over the past five years the number of doctors per capita in Canada has increased quite rapidly: from 2.1 per 1,000 population in 2004 to 2.4 physicians per 1,000 population in 2009 although this remains well below the OECD average of 3.1. The report also said that Canada still lags behind other countries in the supply of MRI and CT machines. This is despite dramatic increases in the number of units in place.

**US**

- The US Supreme Court has ruled that prescribing data can be used without physician consent by pharmaceutical companies to market their drugs. The court ruled 6-3 that a Vermont law barring data companies such as IMS Health from selling that information to drug companies violated the First Amendment.

**Selected Transitions**

**Government**

- Dr. David Butler-Jones has been reappointed Chief Public Health Officer of Canada effective September 24, 2011.

- Deputy Auditor General John Wiersema appointed to serve as interim Auditor General, replacing outgoing Auditor General, Sheila Fraser.

**Other Organizations**

- Tom Closson to step down as President and CEO of the Ontario Hospital Association in January 2012.

- Dr. Philippe Couillard to Chair of the Board of Directors for Rx&D's Health Research Foundation.

- Wendy Harris appointed to CEO, Cancer Research Society.
Appendix D

Upcoming Reports and Conferences
The following contains a listing of upcoming reports as well as recent and upcoming conferences of interest.

Recent and Upcoming Reports

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Product Description</th>
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| Obesity in Canada  | *Obesity in Canada* was a joint report developed with the Public Health Agency of Canada. The report examined how obesity varies across Canada, who’s most at risk and possible actions to address it. Highlights included:  
  - Physical inactivity had the strongest association with obesity for both men and women. The equivalent of 646,000 cases of obesity in women and 405,000 cases of obesity in men could be altered or averted if inactive populations became active.  
  - Eliminating the consumption of a poor-quality diet, as measured by the frequency of low fruit and vegetable consumption, could result in the equivalent of 265,000 fewer men being obese and 97,000 fewer women being obese.  
  - Based on measured height/weight, more than 1 in 4 adults and just less than 1 in 11 children are considered obese.  
  - In 2008, 17% of non-Aboriginal adults self-reported being obese, compared with 26% of off-reserve Aboriginal adults. Obesity was also found to vary between First Nations, Inuit and Métis populations. Among children age 6 to 14, for example, 20% of off-reserve First Nations, 25.6% of Inuit and 17% of Métis were estimated to be obese.  
  - The report release elicited an exceptionally strong media and public response, with 224 mentions in the six days following the release (print, radio, television across Canada).  
  - CIHI has been commended by the acting CEO of the National Aboriginal Health Organization, who stated that the report’s chapter on obesity among First Nations, Inuit and Métis populations was a “breath of fresh air” and should be an example for how information is reported on Aboriginal health issues.  
  - Internationally, WHO featured the report on their Twitter (over 200,000 followers); the Pan-American Health Organization posted a link to the report on its website; the Government of Alaska and the University of Tennessee’s Obesity Research Centre shared the findings among their subscribers. | June 20, 2011 |
### Trauma

- A broadly covered media release was issued on summer injuries. The focus was on injuries which are most common in summer months and associated with outdoor activities. Motor vehicle collisions, cycling and water-related injuries were highlighted. The report demonstrated that the number of cycling injuries remains stable over the past decade but head injuries are on the decline. Other highlights included:
  - During June, July and August, an average of 194 deaths occurred every year in Canada from all motor vehicle collisions, all-terrain vehicle (ATV) collisions and summer sports and recreational activities.
  - The number of serious injuries involving ATVs is growing faster than that for any other major type of wheel- or water-based activity. In 2009–2010, there were 3,386 hospitalizations for ATV injuries across Canada—a 31% increase since 2001–2002. Those at highest risk of injury were young men age 15 to 24.
  - Motor vehicle collisions still represent the number two cause of injury in Canada, second only to falls, with 18,964 hospitalizations in 2009–2010. However, this number has declined significantly (21%) from 2001–2002. The summer months, August in particular, and the Christmas season represent peak periods for motor vehicle collisions.
  - The number of water-related injuries has remained relatively stable since 2001–2002, with 331 injuries occurring in 2009–2010.

### Mental Health

- This report examined the use of restraints and other control interventions for mental health inpatients in Ontario. Some of the highlights included:
  - Nearly one in four individuals admitted to a designated mental health bed in Ontario experienced at least one type of control intervention during their hospitalization.
  - Difficulty communicating and violent behavior greatly increase chances of patients experiencing control interventions.
  - More than 40% of mental health inpatients who experienced a control intervention had been diagnosed with schizophrenia and psychotic disorders.

### Advanced Maternal Age (AMA)

- CIHI has been looking at the association between maternal age and pregnancy and labour complications and interventions and health outcomes for mothers and newborns age 35 and over. Several outcomes are associated with age, and risks are greatest for those 40 and over who are first time mothers. We are targeting to release an analysis in brief on September 8.

### Sparsely Populated Health Regions

- This report entitled *Inpatient Acute Care Use by Patients From Sparsely Populated Health Regions in Western Canada* will profile acute inpatient care for people who live in sparsely populated health authorities in Western Canada and the contribution of sparsely populated health authorities to the provision of this care.
### Recent and Upcoming Reports

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<th>Product Name</th>
<th>Product Description</th>
<th>Availability Date</th>
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<tr>
<td><strong>Cancer</strong></td>
<td>• This report entitled <em>Surgery for Pancreatic and Esophageal Cancer in Canada: Hospital Experience and Care Centralization</em> examines the degree of centralization of surgery for pancreatic and esophageal cancer, and the extent to which centralization to high-volume hospitals varies by province.</td>
<td>September 2011 (with media product)</td>
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<tr>
<td><strong>Health Workforce</strong></td>
<td>• Annual reports for seven health workforce databases will be released (electronically) between September and December 2011. This year, for the first time, releases for the Occupational Therapist Database (OTDB) and Pharmacist Database (PDB) will feature five-year trend data. Work is underway on the development of a more interactive e-Reporting tool that will be used for future releases.</td>
<td>September to December 2011 (with media products)</td>
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<td><strong>Stroke</strong></td>
<td>• The Pathways of Care for Stroke Patients in Ontario study examines pathways of care for stroke patients by following them from their first encounter with the health care system until the end of their care. It further examines the key factors that may influence a patient's pathway and related outcomes.</td>
<td>October 2011 (with media product)</td>
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<tr>
<td><strong>National Health Expenditures (NHEX)</strong></td>
<td>• The NHEX report is to be released in early November 2011 in conjunction with the release of the synthesis report on Health Care Cost Drivers.</td>
<td>November 2011 (with media product)</td>
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<tr>
<td><strong>Health Care in Canada 2011</strong></td>
<td>• Health Care in Canada 2011 (HCIC 2011) will focus on seniors and aging in Canada. This report examines whether the Canadian health care system is meeting the needs of the aging population now and into the future. It also highlights how the system may need to adapt to meet future needs. HCIC 2011 has six chapters that look at: the healthcare systems sustainability, how healthy Canadian seniors are, primary care and prescription drugs, caring for seniors in the community and in residential care as well as the care needs of seniors when they are acutely ill.</td>
<td>December 2011 (with media product)</td>
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Recent Conferences of Interest

**e-Health 2011: Enabling Healthy Outcomes**

E-Health 2011 was successfully held in Toronto, May 29 to June 1, 2011. CIHI co-hosted this event in collaboration with COACH: Canada’s Health Informatics Association. Program tracks and topics for the 2011 Conference include: Models of Care, Using Evidence to Affect Change, Health 2.0.

**2011 National Health Care Leadership Conference**

This year’s National Health Care Leadership Conference “Rising to the Challenge: Resources, Realities and Relationships” was held June 6-7, 2011 in Whistler, BC. Participants at the conference represented health regions, hospitals, long-term care organizations, public health agencies, community care and mental health services and social services. At this conference, a poster on CIHI’s Patient Cost Estimator was presented.

Upcoming Conferences of Interest

**Data Users’ Conference 2011 (CIHI and Statistics Canada)**

Planning for the 2011 Data Users’ Conference is progressing. This event will be held in Ottawa from September 22-23, 2011. The goal of this annual conference series, which is sponsored by CIHI and Statistics Canada, is to promote and facilitate the exchange of information between data users from across Canada. The lead organization alternates each year. This year Statistics Canada is the lead organization for planning the event.

**27th Annual Patient Classification Systems International (PCSI) Conference**

This fall, CIHI will be hosting an international case mix event— the 27th annual Patient Classification Systems International (PCSI) Conference, in Montreal.

**2011 World Conference on Social Determinants of Health**

The upcoming 2011 World Conference on Social Determinants of Health will be held in Rio de Janeiro, Brazil, October 19-21, 2011. One output will be a Rio Declaration. The Canadian Reference Group (CRG) will be looking for input on a technical paper and the identification of country examples that highlight lessons learned.