Canadian Institute for Health Information (CIHI)

President’s Quarterly Report
and
Review of Financial Statements
as at December 31, 2009

Board Report

February 2010
Table of Contents

Introduction ................................................................................. 1
President’s Report ........................................................................ 2
Financial Highlights and Statements .............................................. 14
Appendix A - Health Environmental Scan ...................................... A-1
Appendix B - Recent and Upcoming Reports and Conferences ....... B-1
Appendix C - Performance Indicators ........................................... C-1
Introduction
This document provides an overview of some of the significant accomplishments achieved during the third quarter of fiscal 2009/2010 (i.e. October 1 to December 31, 2009), as well as a review of CIHI’s financial statements as at December 31, 2009. 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 third quarter of fiscal 2009-2010, as well as other items of interest.

➢ Financial highlights and statements – presents CIHI’s financial situation as at December 31, 2009.

➢ Appendix A – our regular external environmental scan.

➢ Appendix B – a list of recent and upcoming reports and conferences of interest.

President’s Report

Corporate Highlights

Human Resources and Corporate Administration

- Jeremy Veillard will be joining CIHI in the Toronto office on May 1st as the Vice-President, Research and Analysis. He has extensive professional experience in the health industry in Europe and in Canada. Jeremy is currently the Regional Adviser for Health Policy and Equity at the World Health Organization Regional Office for Europe and is the lead for health system performance assessment. Previously, he worked at the Ontario MOHLTC as the Lead, Health Results Team for Information Management, Measuring Performance for Change and with the WHO as Policy Adviser in charge of Hospital Reforms, WHO Regional Office for Europe. He is currently a PhD Candidate and his thesis is on Health System Performance Management. Jeremy is fluent in French, English and Spanish.

- The campaign for 360 degree feedback for Managers is currently underway. The tool provides managers with feedback on their strengths, how their people management skills impact others as well as areas for development. Confidential reports will be sent to managers and they will have the opportunity to explore their results with the help of a trained coach to provide additional insights into the feedback and identify strengths, areas to capitalize on and future development.

- The Talent Management Communication Strategy, promoting the awareness of the HR Strategy has been developed and is expected to help employees understand and personalize the strategy as well as build employee interest and excitement. The HR Strategy is focused on how the organization can successfully plan and manage talent through the employee “life cycle” of recruitment, development, career transition and retention.

Outreach and Partnerships

- We partnered with the Economic Club of Canada to hold a successful event in Ottawa, including a keynote speech by our Board Chair that also tied into the release of the National Health Expenditures and Health Care in Canada reports.

- We continued building the Speaker’s Bureau, developing new case studies, including our first video case study to be featured in our new intranet and web site, as well as in presentations. While the Speakers Bureau won’t be officially launched until the new intranet is released, we have already used it to help people with more than 40 presentations, with overwhelmingly positive feedback.

- We collaborated with our Program colleagues to develop marketing communications and outreach campaigns for various CIHI initiatives: Patient Cost Estimator, Business Process Management, Canadian Hospital Reporting, First Nation Inuit and Metis, Intranet, eCJRR, eCORR and Web/ECM.

- We coordinated/supported two international delegations from China and Kazakhstan.

Privacy and Security Compliance at CIHI

- CIHI adopted and implemented a Mandatory Privacy and Security Training Policy as a result of an Ontario Information Privacy Commissioner (IPC) recommendation flowing from the 2008 Review of our Prescribed Entity status under the Personal Health Information Protection Act (PHIPA). The mandatory training was carried out across the organization in January 2010 and included the annual renewal, by all staff, of their individual commitment to privacy and security. The renewal was done electronically for the first time. One hundred percent compliance was achieved successfully and in short order – making privacy and security a corporate priority.
Vulnerability Testing

- At the November 2009 meeting of the Finance and Audit Committee (FAC), the results of IBM’s network vulnerability testing were reviewed. It was noted that several mitigation strategies were in place or are being developed to address the issues uncovered.

By-law Review

- At the November 2009 Board meeting, Board members agreed to have a By-law review completed. One of the reasons was to incorporate any required regulations emanating from the new Not-for-Profit Corporations Act that received royal assent in June 2009. After consulting with CIHI’s lawyer, the By-law review will be held off until mid-2010 or early 2011, once the new act comes into force.

Evaluation and Performance Audit

- CIHI released the Request for Proposal (RFP) for the independent evaluation and performance audit in November 2009. A proposal by KPMG was selected. Initial work has begun, including conducting interviews with management and several Board members.
- KPMG will be outlining their plan for the evaluation and performance audit to management on February 19, 2010 and a verbal report will be provided at the March 2010 Board meeting.

More and Better Data

National Ambulatory Care Reporting System (NACRS)

- One hundred and twenty-six pay-for-results Ontario facilities have successfully submitted ED Level 1 data to NACRS for November and December. In January, the data was successfully delivered to Ontario using the ERNI (ER NACRS interim) solution. This is the successful result of a joint project with Ontario which began in 2008. All of the project goals have been accomplished including the elimination of duplicate data collection for hospitals, and reducing reporting turnaround time from 4 months to 1 month. Ontario reporting of Level 1 ED data will be fully integrated with the 2010-2011 NACRS system as of April 1, 2010.
- We have started receiving Level 1 ED data from 6 of the 7 facilities in Winnipeg Regional Health Authority. The remaining facility is on schedule to submit Level 3 ED data on March 1, 2010. The WRHA hospitals represent approximately 75% of the ED visits in Manitoba.
- Vendor and facility testing was made available on February 1, 2010 for the 2010-11 NACRS production system. This is 6 weeks earlier than in previous years and provides vendors and clients with more time to implement the updates and be ready to submit data earlier in the data year. Level 1 facilities are expected to begin submission of ED Level 1 data as early as mid April 2010.
- The NACRS team continues to partner with the Quebec regional office to work towards submission of SIGDU data to NACRS. This includes a comparison of the edits between the SIGDU and NACRS and development of the mapping rules between data elements. The successful outcome of this project will result in the submission of comparable ED wait time data by Quebec.
• The implementation of data submission to NACRS for all Alberta ambulatory data continues to be on track for 2010-2011. Education sessions are in progress an 4 face-to-face workshops and 2 web conferences have been delivered.

• Discussions are ongoing with several facilities in Saskatchewan and British Columbia.

Discharge Abstract Database (DAD)
• Vendor and facility testing were made available on February 1, 2010 for the 2010-11 DAD production system. This is 6 weeks earlier than in previous years and provides vendors and clients with more time to implement the updates and be ready to submit data earlier in the data year.

• An accelerated plan is in place to roll the most recent 3 years of Quebec data (2006-07, 2007-08 and 2008-09) into the DAD_HMDB database. By April 16, 2010 the 3 years of Quebec data will be appended to the DAD and will complete DAD pan-Canadian coverage up to the 2008-09 data year.

• Work continues to migrate the DAD off the mainframe. The DAD mainframe application will be retired in 2011/12. This project will result in significant improvements to current processes and security of the data as well as introduce automation of current manual and paper-based practices.

• The DAD team is working with the Quebec office and Portal team to provide education to four facilities in Quebec who will use the Portal for some key analytical work. This will be the first time any clients in Quebec access DAD data and use the Portal.

National Prescription Drug Utilization Information System (NPDUIS)
• CIHI is actively working with Ontario to evaluate the ability to incorporate their existing third party drug claim file layout into the NPDUIS database and to explore the potential to incorporate additional data elements to meet Ontario’s information needs.

National System for Incident Reporting (NSIR)
• After conducting the National System for Incident Reporting (NSIR) Pilot Test and the external field review, the conclusion is that NSIR should meet the medication incident reporting needs of Canadian hospitals. Further, data from the evaluation process has provided direction for improvement of both the technical system and the minimum data set. Changes to the minimum data set and the system are ongoing and will be ready for implementation in the spring of 2010.

• CIHI is establishing a relationship with the Canadian Association of Provincial Cancer Agencies (CAPCA) to explore information requirements for national cancer chemotherapy incident reporting.

National Unique Identifier (NUI) Feasibility Study
• In 2009, CIHI completed its role to facilitate the examination of the feasibility of a NUI, in collaboration with external stakeholders. A NUI would help track career paths and migration across jurisdictions. CIHI presented a final report to the Advisory Committee on Health Delivery and Human Resources (ACHDHR) (a committee that reports to the Conference of Deputy Ministers of Health (CDM)) on the regulatory, professional education, and privacy and legislative reviews as well as the NUI’s potential costs and benefits. The ACHDHR has tasked its Planning & Partnerships Subcommittee to prepare a readiness assessment tool for jurisdictions. This will allow them to assess themselves against the proposed business model and to discuss options for governance, a funding model, and a potential NUI organization. ACHDHR intends to use this information to make a decision on whether to implement a NUI and to present a proposal to the CDM for approval.
Physician-Level Alternative Payment Plan (APP) Data
- CIHI will continue to build on recent success with individual jurisdictions to assist them in submitting as much physician-level APP data to the National Physician Database (NPDB) that is available, over the next several years. The objective is to integrate APP data with the fee-for-service information currently being submitting so that ultimately CIHI will have more comprehensive data on total physician remuneration.

Patient-Level Billing Data
- CIHI has begun preliminary discussions with select jurisdictions to access physician billing data at the patient-level to demonstrate its utility for primary healthcare use, complement inpatient cost data, and other uses. CIHI has formally requested this information from the ministries of health in Ontario and the Northwest Territories.

National Physician Survey
- CIHI is partly funding and working with the College of Family Physicians of Canada, the Canadian Medical Association, and the Royal College of Physicians and Surgeons of Canada to develop the 2010 National Physician Survey (NPS). Health Canada also funded the 2004 and 2007 surveys and is expected to contribute support for the 2010 survey.

National Physicians Database Economic Indicator Review
- CIHI has started a 2-year examination of the use and relevancy of the NPDB economic indicators (National Grouping System, Physician Services Benefit Rates, Physician Full Time Equivalence, and Average Payments). This project will include extensive external consultation.

Health Human Resources (HHR) Databases Development Project
- This project has developed supply-based HHR databases for five professions: occupational therapists, pharmacists, physiotherapists, medical laboratory technologists, and medical radiation technologists. CIHI released first-year data for the remaining two professions (medical laboratory technologists, and medical radiation technologists) in January 2010. This project has been funded separately by Health Canada until March 2010. As of fiscal 2010-11, the continued maintenance and reporting of these data and information will be incorporated into CIHI’s operational funding structure.

Mental Health Information
- Prototype comparative reports using Newfoundland and Labrador pilot interRAI community mental health data were recently presented to stakeholders in the province and well received.
- New quarterly comparative reports for the Ontario Mental Health Reporting System, which includes significant enhancements in peer comparisons, outcome scales and quality indicators, were released in Q2.

Continuing Care Reporting System (CCRS)
- There has been strong growth in the Continuing Care Reporting System. Data are now being received from 727 facilities (hospitals and residential care) in 5 jurisdictions, including 196 new facilities in Q2. All Ontario facilities will be submitting by Q4 bringing the total to approximately 800. In addition, CCRS has over 700 registered users for eReports.
- Better data quality by bringing together researchers and clients: A recent CCRS WebEx Quality Series on coding of restraints, featuring Dr. John Hirdes from University of Waterloo, attracted more than 700 attendees, logging in from every jurisdiction in Canada.
Home Care Reporting System (HCRS)
- CIHI released the Canadian version of the interRAI Contact Assessment (CA), which captures intake and screening data on individuals referred to home care, for assessment in hospitals, emergency rooms or in the community. This information will shed new light on Alternate Level of Care (ALC) patients, short term home care clients, and transitions between hospital and community services. The new CA reporting module, planned as part of the vision for HCRS in 2005, is now under construction.

Primary Health Care (PHC) Information
- CIHI continued to make progress on its approach to strengthen primary healthcare (PHC) information in Canada. Based on directions received at the November 2009 Board meeting, CIHI is advancing work for each of the three approved streams of work including: 1) EMR Content Standards, 2) Voluntary Reporting System and 3) Analysis, Indicators, Reporting and Surveys.
- CIHI successfully launched the EMR Content Standards Jurisdictional Advisory Group with representation from 13 out of 14 ministries. This group will guide the refinement of version 2.0 pan-Canadian EMR Content Standards slated for release in 2010. These EMR standards will support jurisdictions in their efforts to support the use of better PHC EMRs.
- CIHI continued to make progress on the Voluntary Reporting System (EMR database) by increasing the collection of priority data from select primary care clinics. In addition to working with individual sites on a voluntary basis, Alberta and Manitoba have expressed an interest in participating in the next phase of the Voluntary Reporting System. In October 2009, CIHI hosted a face-to-face meeting with PHC pilot sites to share lessons learned, validate data quality and provide input on provider feedback reports.

Health System Use (HSU) of Electronic Medical Records/Electronic Health Records (EMR/EHR)
- The Strategy Working Group has engaged two external consultants to develop communications and messaging around the health system use of information, a responsible use doctrine, and an engagement strategy. Each of these will be informed by focus group and survey research among the general population and physicians.
- In early fall, the Technical Advisory Committee agreed to focus initial efforts on the following activities, pending additional funding from Infoway: vision/business requirements, primary healthcare EMR data content standards, data de-identification, pan-Canadian governance standards and a knowledge exchange network. Work is underway in all projects.
- The HSU Knowledge Exchange Network (KNEX) has been established, with the inaugural meeting held January 14th, 2010. The KNEX has representation from 11 jurisdictions/organizations. The chair of the KNEX is the Director, IM Strategy & Policy Branch from the Ontario Ministry of Health & Long-Term Care.

First Nations, Inuit and Métis (FNIM) Health Information
- A preliminary strategy related to the First Nations, Inuit and Métis health information has been developed. It focuses on building collaborative relationships, enhancing data, and developing analytic opportunities.
- In November, CIHI presented at the national conference hosted by the National Aboriginal Health Organization (NAHO), addressing the topic of data availability concerning First Nations, Inuit and Métis people in Canada.
- Possible short and longer term approaches to First Nations, Inuit and Métis-specific analysis and research are being assessed. Several short-term analytic projects are currently being evaluated for feasibility.
• Negotiations to obtain drug prescription data from the First Nations and Inuit Health Branch (FNIHB) of Health Canada are proceeding.

MIS and Costing

• Much improvement in the timeliness of the data will be achieved this year with the release of the final 2008/09 MIS data in June 2010 (four months in advance). The 2002/03 to 2006/07 Canadian MIS Database included in the Portal will be updated with 2007/08 data in February and 2008/09 data in June.

• We completed the development of ten (10) new financial indicators to be introduced in the new CIHI Pan-Canadian Hospital Report next summer. Three of the financial indicators will be calculated at the health region level (Current ratio, Total margin and Average age of equipment); the rest will be hospital level financial indicators. We are currently finalizing the review of the methodologies for each indicator, with the guidance of an Expert Stakeholder Group. The preliminary results of the financial indicators will be available for review by the participating jurisdictions in March 2010.

• Following the successful launch of the Patient Cost Estimator in November 2010, CIHI is currently developing a strategy to improve the use of the costing data already available, including a patient cost dataset to support internal analysis.

Medical Isotopes

• Late November 2009, after consultation with Health Canada and the provincial/territorial Ministries of health, CIHI made the decision to proceed with a one-time electronic voluntary survey and focused discussions with health professionals to gather data that would shed light on the impact of the supply and disruption of Technetium-99 (Tc-99m) to patients, with a focus on measures of throughput. This is after the shutdown of the Chalk River National Research Universal Reactor (NRU) for repairs, in May 2009, as well as the shutdown of the Petten nuclear reactor in the Netherlands from July 18 to August 18, 2010. The survey and focused discussions will help investigate key areas of interest such as, effect on patient throughput, change in practice, change to examinations, impact on other modalities, and impact on health human resources. Under guidance from an Expert Advisory Group established in early December 2009, a survey tool was developed. The electronic voluntary survey was distributed to approximately 400 respondents (public and private facilities with nuclear medicine and MRI technologies). The survey was available to be completed for a period of 3 weeks in February 2010. The preliminary results will be available early April 2010 with a presentation to Federal, Provincial and Territorial representatives.

Health Expenditures

• Efforts continue to complete the Labour Rate Adjustment Study. The purpose of the study is to generate an index that will adjust for labour compensation differences among provinces/territories for the Hospital and Physician categories of the National Health Expenditure Database. This will support our understanding of the variation in provincial/territorial health expenditures. We are currently finalizing the data analysis for the physician portion. The analysis for the hospital portion will be completed by mid-February 2010. A draft report is expected for the end of February 2010, which will include some shortcomings and limitations of the proposed approach using both National Physician Database (NPDB) and Canadian MIS database (CMDB) data. The project will be completed on March 31, 2010 with the delivery of the final report in the first quarter of 2010/11.
More Relevant and Actionable Analysis

2009 HSMR Public Release
- The 2009 hospital standardized mortality ratios (HSMR) for eligible hospitals and regions across Canada were released in December 2009. As in the previous year, this was a web-only release. A brief national analysis of sepsis – an important cause of hospital mortality - was included with the electronic release, and resulted in extensive media coverage across the country.
- CIHI’s HSMR results are also included in the set of indicators mandated for public reporting in Ontario. They are posted by the Ministry of Health and Long Term through a direct link to CIHI’s website.

Canadian Hospital Reporting Project
- Nine jurisdictions have confirmed their participation in the 2010 pilot of the Canadian Hospital Reporting Project (CHRP). These include Newfoundland and Labrador, Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia and Northwest Territories. Work is progressing well, and definitions and methods have been finalized with the expert group. The initial private release is scheduled for June 2010, in an e-reporting format.
- As previously reported this year, clinical quality and financial indicators will be included in the e-reports. Opportunities to include indicators related to patient experience and system integration and change are currently being explored for potential inclusion in the following or subsequent years.
- In addition, an information needs survey has been disseminated to participating jurisdictions that have forwarded appropriate contacts. This survey (being more strategic and focused on information priorities) has been targeted at Ministry, regional and hospital level representatives. The survey has currently been disseminated to 93 representatives from participating jurisdictions and will provide insight on potential indicator categories and future project direction.

Health Indicators 2010
- Health Indicators 2010 will be released in the spring. This year, the report will include regional-level health indicators for all provinces and territories including the most recent data for Quebec, which was not available in recent years. The focus of the report will be on disparities in health and health system use, including an analysis of socio-economic gradients in selected health status and health system indicators.
- Disparities were one of the key areas identified as a priority for future indicator development at the 3rd Consensus Conference on Pan-Canadian Health Indicators, held in 2009. The conference report has now been publically released.

Canadian Population Health Initiative
- A CIHI-authored article based on analyses prepared for the CPHI report Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada has been published in the January 2010 issue of Canadian Nurse. The article focuses on ambulatory care sensitive conditions (ACSC) and is the result of an invitation for CIHI to submit to a special issue on chronic disease.
- CIHI, in collaboration with the Addictions and Mental Health Services department of the New Brunswick government and the department of Wellness, Culture and Sport, is planning an invitational workshop on positive mental health and mental health promotion. The event will take place on May 20, 2010 in Moncton, New Brunswick and will bring together policy-makers, researchers and practitioners from across Canada to engage in facilitated discussion, share current research and explore promising practices.
• CIHI presented a poster on leveraging standardized data and information to advance a Mental Health Strategy. The poster presentation was part of the Into the Light: Transforming Mental Health in Canada conference hosted by the Mental Health Commission of Canada (MHCC), Simon Fraser University and Vancouver Coastal Health. CIHI staff also participated on a discussion panel that included representatives of the Public Health Agency of Canada (PHAC). The conference convened more than 700 attendees and was a platform for the release of the MHCC’s framework for a mental health strategy for Canada and their launch of the campaign titled, “Partners for Mental Health”.

• CIHI is continuing to develop an eLearning course that will provide an overview of information related to mental health, delinquency and criminal activity. The eLearning course will include different learning techniques, using the breadth of CPHI’s work in this area (report, webcast, and workshop proceedings report), developing exercises to encourage the application of information to research, policy and practice activities and explore the use of dialogues on promising practices. This eLearning course is scheduled for release in May/June 2010.

• CPHI will be undergoing an evaluation which will feed into CIHI’s broader evaluation initiatives and builds on the organization’s over-arching commitment to forward-thinking, responsiveness to emerging trends and stakeholder needs. The CPHI Evaluation Framework – Measuring Progress and Impact 2007-2012 is a guiding tool to help increase our understanding of the impact of CPHI’s reports and products among stakeholders and inform the strategic planning process. A verbal update will be provided at the Board meeting.

Cancer Cross-Cutting Theme

• Following the signing of a letter of agreement in December 2009 between CIHI and the Canadian Partnership Against Cancer (CPAC), work has begun on developing a multi-year joint program of work on cancer analysis. At the same time, the Registrars of the provincial Cancer Registries are being approached to discuss the possibility of CIHI having access to the national Cancer Registry data.

Clinical Data Standards, Quality and Methodology

• Jurisdictional data quality reports were disseminated on November 30, 2009 – one month earlier than previous years, easing pressures in DM offices over the holidays. The 2009 reports include data quality assessments on eight CIHI data holdings and three from Statistics Canada.

• CIHI’s Data Quality Framework 2009 has been extensively revised and is now posted on CIHI’s external web. The Framework includes a data-holding assessment tool, which is the model adopted by many Canadian and international organizations—the Canada Revenue Agency is the latest organization making inquiries about the Framework.

• The reports from data quality studies of CIHI’s inpatient database have now been posted on the web. These reports cover 2005-2006 and 2006-2007 data years of the Discharge Abstract Database. A third report is expected in early spring on the 2007-2008 data.

• CIHI’s metadata repository of data quality documents for all of CIHI’s data holdings continues to grow and be updated. Currently 27 out of 30 data holdings are included.

• At the recent World Health Organization – Family of International Classifications (WHO-FIC) Annual meeting, 61 out of 70 proposed changes to ICD-10 were approved, the Update and Revision Committee’s revised terms of reference were ratified, the work plan for 2010 was developed, and international consensus on the coding of H1N1 influenza was achieved. A bulletin was distributed to all hospitals on the coding of H1N1 immediately following the WHO meetings.
Education workshops to support the new “Case Mix Decision-Support Guide: CMG+” have been rolled out across the country to assist hospital stakeholders in their use of case mix information for decision support purposes. Ten sessions have taken place and stakeholders have been very satisfied.

**Improved Understanding and Use**

Corporate Communications & Outreach

- Our Education and Classifications teams collaborated in Q3 to enhance our Classifications workshops to focus more on problem-solving skills versus knowledge dissemination, receiving very positive feedback from customers.
- The services of Deloitte have been engaged to develop a new education strategy for the next three to five years. The strategy will: clarify the education mandate and accountabilities in alignment with CIHI priorities and external realities; include progressive new curriculum and approaches; and be cost-effective and revenue-generating where opportunities exist.

CIHI Portal

- The CIHI Portal pilot with the Ontario Ministry of Health and Long Term Care has moved into the evaluation phase with a decision regarding an Ontario provincial deployment expected by April 1, 2010. The first phase of the CIHI Portal pilot for 4 pediatric hospitals participating in the Canadian Association of Pediatric Health Centers (CAPHC) community of practice has been completed with a 3 day instructor lead training session held in Montreal February 3-5, 2010.
- Negotiations are underway for a provincial deployment in Nova Scotia, as well as negotiations with Alberta Health and Wellness and Alberta Health Services regarding their ongoing participation. CIHI Portal has been deployed in the Yukon and in the North West Territories.
- There are currently 236 Portal users in 44 organizations including 4 Ministries of Health, 2 Territories, 23 Regional Health Authorities and 15 facilities.
- Available data and functionality within CIHI Portal is enhanced on a regular basis. Recent enhancements to CIHI Portal include the availability of an ad hoc reporting environment for MIS data (Oct 2009), monthly data releases for NACRS data (August 2009), a recent upgrade to the newest version of MicroStrategy (January 2010) and the introduction of 54 prompted metrics to facilitate analysis (December 2009).

Web Site

- At the November 2009 Board meeting, plans were presented for a new web site. At that time, we anticipated a launch of the new site in January 2010. A key element of the new site is a single sign-on capability, which requires the implementation of a new Identity Management (IDM) technical solution. IDM lies at the heart of the new web site, and must be integrated with approximately 40 web-based offerings including all of our e-Reports, the Portal, and other offerings currently undergoing redevelopment, which include a Learning Management System (LMS), our electronic data submission system (eDSS), and our e-Commerce engine. The complexities involved in completing and testing all of these integration and various redevelopment activities in a well-coordinated fashion have proven much more challenging than originally anticipated. We have engaged the services of an industry expert to help us manage this integration work and expect to provide a verbal update with a firm launch date at the time of the March 2010 Board meeting. We will be proceeding with the launch of our new intranet site, which uses the same technologies, in March 2010. This will give us a good “test bed” for working out any kinks before the launch of the external site, and will facilitate a smooth roll-out.
Regional Updates

Western Office

- CIHI and the Saskatchewan Ministry of Health signed a formal data sharing agreement in November 2009. Work continues on an overall data sharing agreement with British Columbia. The introduction of new pharmaceutical legislation in BC has presented challenges in moving forward in acquiring National Prescription Drug Utilization Information System (NPDUIS) data from BC.

- The BC Ministry of Health had provided $500,000 in funding to help develop and improve indicators. Over the past few months, the Western Office has been working with the Provincial Health Officer and the ministries which provide services to children to develop child health indicators. A background paper was developed and in November 2009 a workshop was held in Victoria with representatives from the various Ministries. At that time, an indicator framework was agreed upon and the next step in the process (i.e. identifying indicators) will proceed. These indicators will form the basis of a report by the Provincial Health Officer on child health to be released in 2011-2012.

- CIHI continues to work with both Alberta Health and Wellness and Alberta Health Services Authority on improving the flow of data in long-term care and ambulatory care.

- National Ambulatory Care Reporting System (NACRS) Level 1 is being implemented in Manitoba with data submission scheduled to start in Q4 of 2009-2010. Manitoba has plans for moving to NACRS Level 2 in 2010-2011.

- A Knowledge Exchange forum in November 2009 brought together over 100 executives, researchers and clinical champions to showcase nursing home data (MDS 2.0) from Saskatchewan with Continuing Care Reporting System (CCRS) data from across the country. The province is working toward regular data submissions to CCRS. CIHI also presented the first analysis of Alberta long-term care data (MDS 2.0) along with other CCRS data from across Canada to key Alberta stakeholders. The province is working towards regular data submissions to CCRS.

Ontario Office

- The trial of the CIHI Portal concluded on December 31, 2009. An evaluation of the Portal has been completed by the 15 pilot program participants. The Ministry of Health and Long-term Care (MOHLTC) is currently evaluating the results. Preliminary findings suggest that most of the participants have found the Portal to be of significant value to their analytic requirements. The MOHLTC and CIHI staff will continue to jointly evaluate the survey results and define a course of action during March 2010.

- NPDUIS Claims Submissions - Numerous communications have occurred over the past three months between the Ontario Drug Program staff and CIHI in an effort to resolve any barriers that the Ontario Drug Program staff perceive may exist in the submission of drug claims data. CIHI believe that all of the concerns have been addressed. However there has been limited progress in moving this file forward, specifically in receiving a claims data file layout for evaluation by CIHI as promised over 6 months ago by the by the MOHLTC Drug Program staff. It appears that in order resolve the MOHLTC’s position on the matter, the next step will require a meeting with the MOHLTC Assistant Deputy Minister of the Drug Program Division to determine if Ontario will submit claims data to NPDUIS.

- The Ontario Health Quality Council (OHQC) has released the quality indicators for long term care (LTC) and home care (HC) services, based on the new risk-adjusted interRAI quality indicators for Chronic Care and Home Care Reporting Systems. This is the first public publication of the interRAI quality indicators for LTC facilities and home care services.
Over the past several years, there has been a proliferation of health system performance indicators issued by several organizations and various program areas within the MOHLTC. In order to address this issue, the Ontario Hospital Association has suggested that the principal organizations developing indicators participate in a process to attempt to reconcile the definitions and methods of similar performance indicators (e.g. re-admission indicators, alternative level of care definitions with the objective of reaching a common definition and methodology). The MOHLTC will assume leadership for this process with input from CIHI, the Ontario Health Quality Council, the Ontario Hospital Association and various organizations in the health sector.

CIHI provided risk-adjusted quality indicators, based on CCRS and HCRS data to the Ontario Health Quality Council for reporting on the quality of home and facility-based long-term care in Ontario. CIHI also released new CCRS RUG-Weighted Patient Day reports for Ontario long-term care homes to support the Ontario Ministry of Health and Long-Term Care in their transition to a new funding formula.

**Quebec Office**

- CIHI accepted two significant requests for changes presented by Québec in the Folio product. New functionalities are expected to improve the workflow processes for coders, and ultimately improve data quality. One functionality will be pilot tested in Québec and if successful, deployed later in the rest of Canada.
- CIHI’s CEO and Vice President, Programs met with the Québec Health Minister and staff to discuss the reasons for partial absence of Québec’s data in CIHI productions. Commitment was expressed on both parts to increase the presence of Québec data. For the Ministry, this means improving the data transmission processes and timelines and for CIHI, increased analytical efforts to understand data differences in order to improve comparability and presence.
- M. Robert Salois, the Quebec Health Commissioner, and Dr. Jean-Frédéric Levesque visited CIHI in Ottawa to present to senior management on the role and mandate of the Quebec Health and Welfare Commission, as well as high-level results from recent reports. Discussions included possible collaborations between our two organizations.
- The Québec Ministry assigned AETMIS staff (Agence d’évaluation des technologies et modes d’intervention en santé) to work with CIHI to resolve data comparability issues in relation to cardiac angioplasty procedures. Increased presence of Québec data is expected in the upcoming Health Indicators report and other cardiac care indicators.
- CIHI staff held a meeting with the Ministry to resolve comparability issues with physician-related data. As a result, a request was presented to the Collège des médecins du Québec to obtain required data to improve comparability between CIHI and ministry numbers. Also, a data quality study will be performed to identify all potential sources of data variation.
- The Québec office analytical team provided support to CIHI program areas in order to include Québec raw data into upcoming analyses: H1N1, palliative care, advanced maternal age and newborn outcomes, out-of-province report and bariatric surgeries.
- Required documentation finalized for trauma data transmission (April 1, 2005 to March 31, 2009). Required work to create the data file has commenced at the ministry.
Atlantic Office

- Three of the four Atlantic provinces have agreed to participate in the Canadian Hospital Reporting Project pilot. New Brunswick has opted not to participate at this time.
- CIHI continues to work with Nova Scotia and Newfoundland & Labrador ministries of health to successfully license the CIHI Portal product for province-wide use in both jurisdictions. PEI has indicated that it is awaiting additional functional enhancements to the Portal prior to acquiring a license. New Brunswick has held a provincial Portal license since March 2009.
- Progress continues to be made with the Atlantic End of Life study. As of the end of this quarter, data request forms for each province have been drafted, and where required, provincial research ethics approval has been sought.
Financial Highlights and Statements

The following section provides an overview of the key financial considerations and results with regards to recent developments and accomplishments achieved during the nine months of the fiscal year.

Last year, the Board approved for the FY 2009/2010 Operational Plan and Budget (Plan) up to $115.7 million consisting of an annual operating budget of up to $111.6 million and $4.1 million in capital expenditures. Health Canada is the primary source of funding through the Health Information Initiative ($81.7 million) and the Roadmap carry-forward ($8.2 million).

Based on Management’s latest review, the overall year-end projection of $115 million ($107.6 million – operating, $3.8 million – capital and $3.6 million CIHI Pension Plan) reflects no significant deviation from the total approved budget, with the exception of some reallocations between budget elements as explained below.

The following table provides a comparative summary of CIHI’s key budget elements.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Budget</td>
<td>$115.0 million</td>
<td>$115.7 million</td>
</tr>
<tr>
<td>Operating</td>
<td>$107.6 million</td>
<td>$111.6 million *</td>
</tr>
<tr>
<td>Capital</td>
<td>$3.8 million</td>
<td>$4.1 million</td>
</tr>
<tr>
<td>CIHI Pension Plan</td>
<td>$3.6 million</td>
<td></td>
</tr>
</tbody>
</table>

* includes a provision for the CIHI Pension Plan element

Management continues to effectively deliver on its core programs and functions while making solid progress on new strategic initiatives that are designed to further achieve CIHI’s strategic directions and address priority health information needs. Refer to Appendix C of this document for highlights of progress against established performance targets for FY2009-2010. 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.

Capital expenditures are proceeding well, with some minor delays relating to Information Technology and Telecommunication acquisitions. The year-end projected capital expenditures of $3.8 million reflect an under-spending of $300,000 relating primarily to revised priority projects and budget estimates. As a result, the equivalent funding amount was reallocated from the capital budget to the operating budget. For more details, refer to capital expenditures table on page 18.

Management has recently received a letter from Health Canada confirming that the Health Information Initiative funding can be used to fulfill legal obligations such as the financing of CIHI Pension Plan related employer cash contributions as well as other operational requirements. Approximately $3.6 million\(^1\) was set aside to finance the current service costs, as well as special payments towards the actuarial deficits based on the January 1, 2009 actuarial valuation prepared by independent actuaries.

\(^{1}\) The $3.6 million required to finance CIHI’s employer contributions towards the current service costs (9.3% of pensionable earnings) and the special payments ($1.8 million including retroactive payments for January – March 2009) is over and above the accumulated cash inflows generated over time from the difference between the financing and accounting of the CIHI Pension Plan related costs. The total employer contributions are estimated at $6.3 million in FY 2009/2010.
Of note, at the time the annual operational plan and budget was developed, a provision for these payments had been included in the operating budget, more specifically on the compensation line item. For greater clarity, Management has reduced the projected operating budget to reflect this financial consideration as a separate budget element, similar to the capital budget.

The financial statements included on pages 16-18 present CIHI’s financial position as at December 31, 2009, and the results of its operations for the nine months of the fiscal year, including an updated projection to year end. The notes to the financial statements, presented on pages 19-21, provide details related to specific lines of the Balance Sheet and the Statement of Revenue and Expenses.

The following provides more details of the significant changes from the approved budget not previously highlighted. Unless noted specifically, the amounts are in line with those reported in the previous quarter.

Revenue

- CIHI Portal sales shortfall of $100,000 from an original budget of $600,000 as a result of lower take up than anticipated;
- lower external data requests related sales of $100,000 as a result of the revised pricing policy effective April 1, 2009 (simplified pricing model based on an hourly rate fee as opposed to multi-level structure including, administration/production and per record fee);
- additional Roadmap carry-forward funding of $100,000 relating to CPHI activities due to year-end under-spending from last fiscal year;

Expenses

- under-spending of $600,000 (reported $200,000 at Q2) for CIHI activities funded by the Roadmap carry-forward funding;
- under-spending of $500,000 (reported $420,000 at Q2) relating to projects funded by provincial governments special contributions;
- additional occupancy costs of $450,000 for the Ottawa office resulting from an overall recent municipal property assessment of the building value. This variance is partly offset by the amortization of $180,000 of additional free rent and other lease inducements recognized last fiscal year for the new Toronto lease;
- increased corporate provision to $1 million primarily to offset year-end adjustments (i.e. revenue shortfall, benefits/pension costs).

Finally, the recent review indicates that CIHI will use all of Health Canada’s Health Information Initiative annual funding allocation of $81.7 million.

Other Financial Considerations:

The working capital ratio, which measures CIHI’s ability to discharge its current liabilities in a timely manner, remains positive and satisfactory at 1:1 (1.2:1 as at September 30, 2009). The closing balance of the Balance Sheet accounts on page 16 is reasonably in line with the Institute’s operating cycle.

Interest, net of investment fees, on Roadmap funds yielded approximately 0.1% (as opposed to 1.1% included in the approved budget) during the first three quarters resulting in lower investment revenue by $140,000. The most recent analysis indicates that the Roadmap investment revenue for the current year will be $187,000 below the original estimate of $203,000 primarily due to lower interest rates than anticipated. These results were taken into consideration when Management updated the multi-year financial plan, which is presented in the FY 2009/2010 Operational Plan and Budget.
## Balance Sheet ($, 000)
as at December 31, 2009

<table>
<thead>
<tr>
<th></th>
<th>December 31, 2009</th>
<th>March 31, 2009 (audited)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Short Term Investments</td>
<td>$ 19,053</td>
<td>$ 12,170</td>
<td>1</td>
</tr>
<tr>
<td>Receivables - Operating</td>
<td>6,423</td>
<td>1,693</td>
<td>2</td>
</tr>
<tr>
<td>Receivables - Funding</td>
<td>430</td>
<td>1,261</td>
<td>3</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>1,231</td>
<td>2,159</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT ASSETS</strong></td>
<td><strong>27,137</strong></td>
<td><strong>17,283</strong></td>
<td></td>
</tr>
<tr>
<td><strong>LONG TERM ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Assets</td>
<td>19,570</td>
<td>21,968</td>
<td>5</td>
</tr>
<tr>
<td>Investments - Roadmap</td>
<td>19,425</td>
<td>24,476</td>
<td>6</td>
</tr>
<tr>
<td>Accrued Pension Benefit Asset</td>
<td>1,124</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL LONG TERM ASSETS</strong></td>
<td><strong>40,119</strong></td>
<td><strong>46,444</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$ 67,256</strong></td>
<td><strong>$ 63,727</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable and Accrued Liabilities</td>
<td>$ 4,599</td>
<td>$ 10,502</td>
<td>8</td>
</tr>
<tr>
<td>Unearned Revenue</td>
<td>9,930</td>
<td>2,682</td>
<td>9</td>
</tr>
<tr>
<td>Deferred Funding - Health Information Initiative</td>
<td>12,113</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT LIABILITIES</strong></td>
<td><strong>26,642</strong></td>
<td><strong>13,184</strong></td>
<td></td>
</tr>
<tr>
<td><strong>LONG TERM LIABILITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued Pension Benefits Liability</td>
<td>-</td>
<td>2,468</td>
<td>7</td>
</tr>
<tr>
<td>Deferred Funding - Roadmap</td>
<td>16,131</td>
<td>21,300</td>
<td>11</td>
</tr>
<tr>
<td>Deferred Funding - Capital Assets</td>
<td>16,440</td>
<td>18,436</td>
<td>12</td>
</tr>
<tr>
<td>Lease Inducements</td>
<td>3,240</td>
<td>3,600</td>
<td>13</td>
</tr>
<tr>
<td><strong>TOTAL LONG TERM LIABILITIES</strong></td>
<td><strong>35,811</strong></td>
<td><strong>45,804</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NET ASSETS</strong></td>
<td>4,803</td>
<td>4,739</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
<td><strong>$ 67,256</strong></td>
<td><strong>$ 63,727</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Operating Budget ($,000)**
for the Nine-Month Period Ending December 31, 2009

<table>
<thead>
<tr>
<th></th>
<th>Actual YTD</th>
<th>Year-end Projection (12 months)</th>
<th>Approved Budget (12 months)</th>
<th>Variance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales</td>
<td>$1,382</td>
<td>$1,620</td>
<td>$1,928</td>
<td>$(308)</td>
<td>14</td>
</tr>
<tr>
<td>Core Plan</td>
<td>11,918</td>
<td>15,892</td>
<td>15,892</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Funding - Health Information/Roadmap</td>
<td>59,101</td>
<td>86,579</td>
<td>89,692</td>
<td>(3,113)</td>
<td>16</td>
</tr>
<tr>
<td>Funding - Other</td>
<td>2,342</td>
<td>3,374</td>
<td>3,874</td>
<td>(500)</td>
<td>17</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>101</td>
<td>118</td>
<td>201</td>
<td>(83)</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL REVENUES</strong></td>
<td>74,844</td>
<td>107,583</td>
<td>111,587</td>
<td>(4,004)</td>
<td></td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation</td>
<td>47,887</td>
<td>65,546</td>
<td>69,084</td>
<td>(3,538)</td>
<td>19</td>
</tr>
<tr>
<td>External and Professional Services</td>
<td>7,886</td>
<td>14,847</td>
<td>15,283</td>
<td>436</td>
<td>20</td>
</tr>
<tr>
<td>Travel and Advisory Committee Expenses</td>
<td>3,459</td>
<td>5,149</td>
<td>6,581</td>
<td>1,432</td>
<td>21</td>
</tr>
<tr>
<td>Office Supplies and Services</td>
<td>9,106</td>
<td>12,256</td>
<td>12,135</td>
<td>(121)</td>
<td>22</td>
</tr>
<tr>
<td>Computer and Telecommunications</td>
<td>6,018</td>
<td>7,328</td>
<td>6,764</td>
<td>(564)</td>
<td>23</td>
</tr>
<tr>
<td>Research Grants and Contributions</td>
<td>424</td>
<td>1,457</td>
<td>1,240</td>
<td>(217)</td>
<td>24</td>
</tr>
<tr>
<td>Corporate Provision</td>
<td>-</td>
<td>1,000</td>
<td>500</td>
<td>(500)</td>
<td>25</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td>74,780</td>
<td>107,583</td>
<td>111,587</td>
<td>4,004</td>
<td></td>
</tr>
<tr>
<td><strong>SURPLUS (DEFICIT)</strong></td>
<td>$ 64</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(1) The compensation line in the annual budget includes a provision of $3.6M for CIHI’s employer contributions to the CIHI Pension Plan in excess of the annual accounting related pension expense. For presentation purposes, this element is excluded from the year-end projection.
### Capital Budget ($,000)
for the Nine-Month Period Ending December 31, 2009

<table>
<thead>
<tr>
<th></th>
<th>YTD Actual</th>
<th>Year-end Projection</th>
<th>Approved Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniture and Office Equipment</td>
<td>$ 50</td>
<td>$ 265</td>
<td>$ 450</td>
<td>$ 185</td>
</tr>
<tr>
<td>Leasehold Improvements</td>
<td>223</td>
<td>435</td>
<td>550</td>
<td>115</td>
</tr>
<tr>
<td>Information Technology and Telecommunication</td>
<td>865</td>
<td>3,100</td>
<td>3,100</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><strong>$ 1,138</strong></td>
<td><strong>$ 3,800</strong></td>
<td><strong>$ 4,100</strong></td>
<td><strong>$ 300</strong></td>
</tr>
</tbody>
</table>

Note: The above excludes $308,000 of commitments up to February 8, 2010.
Notes to Financial Statements
for the Nine-Month Period Ending December 31, 2009

Balance Sheet
1. Cash and short-term investments are presented net of outstanding cheques as at December 31, 2009, and include $9.5 million in term deposits with a yield of 0.4%, which all mature before the end of February.
2. Receivables – Operating are accounts related to the sale of products and services including the provision of the Core Plan through provincial/territorial bilateral agreements. The balance includes $3.9 million of pre-billed Q4 Core Plan subscriptions. Subsequent to quarter end, approximately $2.5 million of Receivables - Operating have been received.
3. Receivables - Funding relates to special purpose funding contributions such as $300,000 from Health Canada for the Health Human Resources Database Development Project and $130,000 from Statistics Canada for various transferred programs.
4. Prepaid expenses are payments that have yet to be recognized as expenses and consist of $216,000 rent deposits to landlords for office space, $38,000 advance payments to recipient agencies for CPHI research projects and $977,000 prepaid software/equipment support and maintenance as well as other expenses.
5. Capital assets net of accumulated amortization include $7.8 million of computers and telecommunications equipment, $3.6 million of furniture and $8.2 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 using only half of the applicable term.
6. Investments - Roadmap investments consist of pooled funds which include low risk financial instruments, such as GICs, treasury bills and commercial papers. These investments are in compliance with CIHI’s treasury investment policy.
7. The 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, 2009 actuarial valuation.
8. Accounts payable and accrued liabilities are operational in nature. The accounts payable of $1.3 million are mostly current (less than 30 days). The accrued liabilities represent an estimate of $3.3 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.
9. Unearned revenue relates to either sales that will be recognized as revenue when the service is rendered or funding contributions that will be recognized as revenue in the same period as the related expenses are incurred. The unearned revenue includes $5.8 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, $3.9 million for the Q4 Core Plan subscriptions and $200,000 of funding contributions from the Ontario Ministry of Health and Long-term Care for the Ontario Mental Health Reporting System Project and the Ontario Trauma Registry.
10. The Health Information Initiative related funding is recognized as revenue in the same period as the related expenses are incurred. Contributions received from Health Canada but not yet recognized as revenue are recorded as Deferred Funding – Health Information Initiative. Funding recognized but not received at the end of the period would be recorded as Receivable – Health Information Initiative.

11. The deferred funding - Roadmap consists of contributions received under previous restricted grants with Health Canada. The funding is recognized as income to match the occurrence of expenditures for projects and activities specifically identified in the approved Operational Plan and Budget.

12. The deferred funding – Capital assets represents 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.

13. The lease inducements represent the leasehold improvement allowances, other inducements and free rent received/provided over the years for Edmonton, Toronto, Ottawa and Montreal offices. The allowances and free rent are amortized over the period of their respective leases.

**Statement of Revenue and Expenses**

14. Sales include products and services of CIHI over and above those sold as part of the Core Plan (i.e. fee-for-service basis). As reported at Q2, the annual variance relates primarily to the sales of CIHI Portal and external data requests being lower than anticipated by approximately $200,000 (original budget of $870,000).

15. Core Plan subscriptions represent revenue from the bilateral agreements with provincial/territorial governments.

16. The projected variance of $3.1 million of Funding – Health Information/Roadmap reflects anticipated under-spending with the planned program of work. Approximately $600,000 of this amount reflects an anticipated annual under-spending for projects and activities specifically funded by the Roadmap carry-forward funds from previous funding arrangements with Health Canada and as identified in the approved Operational Plan and Budget. In addition, as previously reported at Q2, some funding was reallocated from the operating budget to accommodate the financing of the CIHI Pension Plan.

17. 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 such as British Columbia special studies/projects, Health Human Resources Database Development project, Ontario Mental Health Reporting System, and Ontario Trauma Registry. These funding contributions are recognized as revenue in the same period as the related expenses are incurred. A review of the planned expenditures for the remainder of the fiscal year indicates an annual under-spending of $500,000, therefore lower funding being recognized for some provincially funded projects.

18. Other revenue includes interest income generated from the bank accounts and ad hoc short-term investments as well as miscellaneous income. The annual variance reflects the significant decrease in interest rates over the past year.

19. The projection for compensation reflects the anticipated costs to be incurred for the filled positions as well as any other known changes to year end. The annual 10% attrition/vacancy factor incorporated in the approved budget remains a valid assumption. The year-end projection reduction from budget reflects primarily the reallocation of the CIHI Pension Plan financing provision originally included in the approved operating budget. Please refer to the financial highlights on page 14 for more details.
20. The external professional services include accruals for services rendered to date. The recent review indicates budget adjustments as required for some program/project. At the end of Q3, the unrecorded contractual commitments pertaining to this fiscal year are in the order of $2.8 million.

21. The annual favourable variance confirms some over-estimation of travel/meeting resources requirements in some areas.

22. Office supply and services include printing/translation, postage/courier/distribution, professional development, recruitment, office equipment and supplies, insurance, rent and related operating costs, taxes and maintenance as well as depreciation of leasehold improvements and furniture. The recent review indicates an annual unfavourable variance of $120,000 explained by additional occupancy costs of $450,000 for the Ottawa office resulting from a municipal property assessment of the building value. This variance is partially offset by the amortization of $180,000 of additional free rent and other lease inducements recognized last fiscal year for the new Toronto lease as well as some reductions in printing budget.

23. 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 annual variance confirms an annual increase of $565,000 primarily due to revised budget estimate relating to software/hardware support and maintenance as well as depreciation.

24. Research grants and contributions relate to contributions to researchers in support of various population health research projects. In addition, it includes contributions to Statistics Canada for some collaborative work in areas such as primary health care and indicator and performance measurement. The revised annual projection reflects an increase of $217,000 resulting from revised plans/estimates associated with anticipated collaborative work with third party agencies.

25. The corporate provision set aside by Management, which is essentially a contingency, is earmarked to offset year-end adjustments (e.g. benefits/pension costs, revenue shortfall, etc).
### Program/Project Resources by Strategic Directions ($,000)
for the Nine-Month Period Ending December 31, 2009

<table>
<thead>
<tr>
<th></th>
<th>Actual YTD</th>
<th>Year-end Projection</th>
<th>Approved Budget (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MORE AND BETTER DATA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Services</td>
<td>$13,860.4</td>
<td>$19,346.3</td>
<td>$20,255.8</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>1,559.2</td>
<td>3,032.0</td>
<td>4,162.0</td>
</tr>
<tr>
<td>Health Human Resources</td>
<td>3,526.2</td>
<td>4,657.2</td>
<td>4,859.0</td>
</tr>
<tr>
<td>Clinical Registries</td>
<td>2,079.0</td>
<td>2,931.1</td>
<td>2,633.7</td>
</tr>
<tr>
<td>Health Expenditures</td>
<td>2,204.7</td>
<td>3,447.6</td>
<td>3,309.1</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>2,512.6</td>
<td>3,272.7</td>
<td>3,693.0</td>
</tr>
<tr>
<td>Standards</td>
<td>3,806.3</td>
<td>5,400.6</td>
<td>5,166.7</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>29,548.5</strong></td>
<td><strong>42,087.5</strong></td>
<td><strong>44,079.4</strong></td>
</tr>
<tr>
<td><strong>MORE RELEVANT AND ACTIONABLE ANALYSIS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Indicators</td>
<td>2,565.0</td>
<td>3,691.8</td>
<td>3,745.9</td>
</tr>
<tr>
<td>Hospital Performance Indicators</td>
<td>1,753.7</td>
<td>2,498.7</td>
<td>2,867.1</td>
</tr>
<tr>
<td>Canadian Population Health Initiatives (CPHI)</td>
<td>2,024.6</td>
<td>3,324.1</td>
<td>3,995.5</td>
</tr>
<tr>
<td>Health Reports, Special Studies and Analysis</td>
<td>13,013.3</td>
<td>18,129.3</td>
<td>20,176.5</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>19,356.7</strong></td>
<td><strong>27,644.0</strong></td>
<td><strong>30,785.0</strong></td>
</tr>
<tr>
<td><strong>IMPROVED USE AND UNDERSTANDING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Support Services</td>
<td>6,418.3</td>
<td>8,841.1</td>
<td>8,007.9</td>
</tr>
<tr>
<td>National Conferences/Education</td>
<td>10,817.8</td>
<td>15,570.3</td>
<td>16,102.7</td>
</tr>
<tr>
<td>Outreach and Other Activities</td>
<td>8,639.3</td>
<td>12,396.7</td>
<td>12,112.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>25,875.4</strong></td>
<td><strong>36,851.1</strong></td>
<td><strong>36,222.6</strong></td>
</tr>
<tr>
<td>Corporate Provision</td>
<td></td>
<td>1,000.0</td>
<td>500.0</td>
</tr>
<tr>
<td><strong>Total Operating Expenses / Resources</strong></td>
<td>$74,780.6</td>
<td>$107,582.7</td>
<td>$111,587.0</td>
</tr>
</tbody>
</table>

(1) The annual budget includes a provision of $3.6M for CIHI’s employer contributions to the CIHI Pension Plan in excess of the annual accounting related pension expense. For presentation purposes, this element is excluded from the year-end projection.

Indirect Costs included in this analysis are allocated to programs/projects on the basis of direct costs. These indirect 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.
Appendix A

Health Environmental Scan
**Recent F/P/T Initiatives**

A *Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications* has been agreed to by the federal government, provinces and territories. It will tell foreign-trained workers within one year of submitting an application whether their qualifications will be recognized. It applies first, by December 31, 2010, to medical laboratory technologists, occupational therapists, pharmacists, physiotherapists and registered nurses. Physicians will be in the next group, two years’ later.

**Medical Isotopes**

Canada has been told to build a new billion-dollar multipurpose reactor to secure its isotope supply for the next several decades and to prevent another global isotope shortage. An expert-panel report commissioned by the federal Department of Natural Resources also recommended adopting supplementary production methods such as cyclotron technology that would allow small-scale, on-site isotope production and investment in new gamma camera technology and PET scans for health-care facilities that would use radioactive materials more efficiently.


**British Columbia**

The B.C. Supreme Court will hear a lawsuit claiming the province’s health insurance laws are unconstitutional. The suit was launched by five clinics and the Canadian Independent Medical Clinics Association. It alleges the province is depriving patients of their rights under the Charter of Rights to timely and adequate medical care, the same argument that was used in the June 2005 Supreme Court of Canada decision that forced Quebec to amend its health insurance laws. No date has yet been set for the trial. (Canadian Press, November 17, 2009)

**Alberta**

The Alberta Ministry of Health’s Advisory Committee on Health issued its report, *A Foundation for Alberta’s Health System* [http://www.ministersadvisorycommitteeonhealth.ca](http://www.ministersadvisorycommitteeonhealth.ca)

It recommends a new Alberta Health Act built around core principles and calls for a patient charter and strong support for evidence-based decision making. Among its six principals are:

- Be committed to safety and quality
- Ensure equitable access to timely and appropriate care
- Enable decision-making using best available evidence
- Be focused on wellness and public health

**Saskatchewan**

Saskatchewan is setting up a new agency to handle the recruitment and retention of physicians. The government has a target of increasing the number of Saskatchewan medical school graduates who stay and practice in the province by 10 per cent over the next four years. It aims to increase the proportion of Canadian-trained doctors working in Saskatchewan by 10 per cent as well. The agency is expected to be operational in the spring of 2010.

**Ontario**

Ontario has announced that seven more new nurse practitioner-led clinics are on the way with a total of 25 operating by 2011-12. And nurse practitioners, pharmacists and other Ontario health professionals are getting expanded scopes of practice after Bill 179 was passed which changes the rules for administering, prescribing, dispensing, selling and using drugs for a number of professionals including pharmacists.
Ontario has announced firm targets for its diabetes strategy. They include ensuring all people with diabetes have a regular primary health care provider, and that 80 per cent of people with diabetes, age 18 and older, have all three key diabetes tests completed. To help meet these targets, the government is creating 51 new diabetes education teams across the province and up to 14 regional coordination centres to help better organize and manage local diabetes programs.


Quebec
Quebec is re-examining the standards which private surgical clinics will have to follow when new regulations come into force March 31, 2010. There are some 50 services which these clinics, to be designated as Centres Medicaux Specialises or CMS, will be able to perform. Some of these will be done on contract to public hospitals. (Le Devoir, November 17, 2009)

A Quebec legislative committee has begun hearings on a bill to set up a new health quality institute patterned after the U.K. National Institute for Health and Clinical Excellence (NICE). Creating an Institut national d’excellence en santé et services (INESSS) was one of the recommendations of a February 2008 report from the Claude Castonguay working group.

New Brunswick
A radiation registry will be developed in New Brunswick by the National Research Council to track people’s accumulated radiation exposure from medical tests. The Dose Registry and Radiation Exposure Monitor project will track and study radiation exposure caused by repeated medical tests, such as X-rays and CT scans. The information will be used to weigh the possible benefits of a scan against the risk of more radiation exposure. The first of its kind in Canada, the registry will also help the medical community re-evaluate its current guidelines for thresholds and appropriate levels of radiation.

Nova Scotia
Personal health information legislation has been tabled in Nova Scotia addressing how health information is collected, used, disclosed, retained and destroyed. The proposed law includes provisions for privacy breach notification, audit reports to track who has had access to electronic health records, and requests for people to access to their health information.


PEI
A new agency has been created to oversee health care delivery in Prince Edward Island. The arm’s length body called Health P.E.I. will be responsible for the delivery of front-line health care services, including pharmacy and dental programs. It will come into effect on April 1, 2010.

Atlantic Provinces
A new multi-province agreement will ensure cancer patients from the four Atlantic Provinces are able to access radiation therapy within eight weeks. Officials from New Brunswick, Nova Scotia, Newfoundland and Labrador, and Prince Edward Island signed a memorandum of understanding recently that states the provinces will support each other in the provision of radiation therapy if the patient’s home province is unable to provide the service within eight weeks.
Items of Interest from other Organizations

Angus Reid
According to an Angus Reid poll, the number one health care concern for Canadians is hospital wait times. Yet, almost half of all Canadians said they're willing to wait up to three weeks to receive test results. The study also showed that close to 50% of respondents feel the most important thing for their doctor was to have a comprehensive view of their medical history, however, one third of Canadians don’t know if they have an electronic health record. Other findings:

- Females are more likely than males to say that the quality of care received at a hospital/healthcare facility is their biggest concern (26% vs. 17%). Males are more likely than females to worry about hospital wait times (43% vs. 34%).
- Atlantic Canadians and Ontarians are the most adamant about not paying for private healthcare just to avoid wait times (76% and 62%, respectively), whereas 45% of Quebecers reveal they would be willing to pay up to one thousand dollars for private healthcare.


Canadian Diabetes Association
An estimated one-in-ten Canadians are expected to have diabetes by 2020 creating an economic burden on the country of almost $17 billion. The number of Canadians with the disease is expected to double between 2000 and 2010 and triple by 2020. Aboriginal Canadians are also three- to five-times more likely than the general population to develop type 2 diabetes. This report calculates that an annual two per cent reduction in current incidence rates plus better disease management could shave nine per cent off direct costs and seven per cent from indirect costs yielding an estimated saving of $1.3 billion. An Economic Tsunami: The Cost of Diabetes in Canada
http://www.diabetes.ca/economicreport

Canada Health Infoway
A report by the Auditor General of Canada concluded that Canada Health Infoway is making the best use of its funds for Electronic Health Record (EHR) projects and has established appropriate governance mechanisms and management controls as well as a risk management strategy. The report includes eight recommendations for improvement including strengthening controls for improved public reporting, contracting goods and services, better documentation of project deliverables, as well as a recommendation related to ensuring conformance to standards.

Canadian Medical Association (CMA)
The CMA is developing a blueprint for transforming health care “to put patients first.” This will include a Patient Quality Charter “that sets out a clear vision for quality care and what that means for individual patients.” http://www.cma.ca/index.cfm/ci_id/89937/la_id/1.htm

The College of Family Physicians of Canada (CFPC)/Canadian Medical Association (CMA)
A poll of Canadians shows that public concern over the country’s shortage of family doctors continues to run high. The poll, by Ipsos for CFPC and the CMA, looked at a variety of issues concerning Canadians’ views on front-line physician care. The survey found:

- 84% of respondents are either "very" or "somewhat concerned" about the length of time it takes to see a specialist upon referral from a family doctor; and the same percentage are also either "very" or "somewhat concerned" about the length of time it takes to receive treatment following consultation with a specialist doctor.
The CFPC and CMA also released the final report of the Primary Care Wait Time Partnership, *The Wait Starts Here*. The report contains recommendations that build on wait time efforts to date including that Canada must achieve the target of having 95% of the population with a family doctor by 2012. It also recommends that should wait time benchmarks for primary care be developed, they must be used as guides to drive improvements in timely access to care and not as targets.
http://www.cma.ca http://www.cfpc.ca

**Deloitte**

Canadians increasingly want to be treated as consumers rather than as patients. They want improved service, personalized programs, greater access to their health records, and more education and options for health self-management. These findings are the result of Deloitte’s 2009 *Canadian Health Care Consumer Survey* report which surveyed 2,304 Canadian adults. The survey examined Canadian’s interactions and experiences with physicians, hospitals, prescription medications, insurance companies, and government. It focused on six major areas of health care consumer activity - health policy, health insurance, traditional health services, information resources, alternative health services, and wellness and health management. Among the findings:

- Although three-quarters (75%) of Canadians report having private health insurance, only one-quarter (25%) feel well-insured across their public and private insurance plans and only 39% feel they are well-prepared to handle future health care costs.
- More than half (56%) of respondents indicate they support increasing private care services if there is no impact on the current publicly-funded health care system, while half (50%) of Canadians support increasing private care services if it resulted in an overall reduction in wait times for public care.

http://www.deloitte.com/ca/patientsasconsumers

**eHealth Ontario**

The identification of the 906,577 Ontario patients living with diabetes and linking them with their 9,000 family physicians has been accomplished, using eHealth Ontario’s *Baseline Diabetes Dataset Initiative*. Results show that just one in three Ontarians with diabetes are getting cholesterol and blood sugar levels tested and eyes examined at regular intervals. Knowing the number of Ontarians living with diabetes - and the test and exams they are receiving - will assist physicians to provide improved care. Also identified:

- 55 per cent of Ontarians with diabetes received an A1C test in the last six months;
- 68 per cent of Ontarians with diabetes received an LDL test in the last year;
- 64 per cent of Ontarians with diabetes received a retinal exam in the last two years.

**The Fraser Institute** - *Waiting Your Turn: Hospital Waiting Lists in Canada.*

Canadians looking to undergo surgery can expect to wait a total of 113 days in 2009, a slight improvement over last year, the Fraser Institute’s annual report on hospital wait times has found. Median wait time for Canadians seeking surgical or other therapeutic treatment is 16.1 weeks in 2009, down from 2008’s 17.3 weeks. For total time spent waiting between GP referral and treatment, Ontario performed best with an average wait of 12.5 weeks, followed by Manitoba (14.3 weeks) and Quebec respectively (16.6 weeks). Newfoundland recorded the longest wait at 27.3 weeks, followed by P.E.I. (26.7 weeks) and New Brunswick (25.8 weeks).

http://www.fraserinstitute.org
Frontier Center for Public Policy/Health Consumer Powerhouse
The second annual Canada Health Consumer Index (CHCI) ranks health care system performance in each province by assessing the extent to which it meets the needs of users. In the study, the ten provincial health care systems are compared across five different “sub-disciplines:” patients’ rights, problem prevention, wait times, patient outcome and range and reach of services. For the second straight year, Ontario finishes with the highest overall score, driven primarily by good patient outcomes and shorter-than-average wait times. British Columbia, New Brunswick, Alberta and Nova Scotia finish in second through fifth place respectively. The authors of the report did not find a significant relationship between per capita healthcare spending and healthcare performance. Some low-performing provinces are among the biggest healthcare spenders; some high-performing provinces have relatively low per capita spending.
http://www.fcpp.org/publication.php/3078

Mental Health Commission of Canada
The Mental Health Commission of Canada (MHCC) released its framework for Canada’s national mental health strategy. The document Toward Recovery and Well-Being outlines the Commission’s vision for changes needed to address the mental health needs of Canadians. Its seven goals will provide direction in creating a transformed mental health system where:
- Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
- People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are integrated around their needs.
http://www.mentalhealthcommission.ca/english/pages/default.aspx

Ontario Medical Association
The Ontario Medical Association (OMA) has launched a not-for-profit corporation dedicated to improving the quality of healthcare services. The Institute for Quality Management in Healthcare (IQMH) offers accreditation, proficiency testing, knowledge transfer and facilitation and expertise services to medical laboratories and other healthcare organizations.

Public Health Agency of Canada
Growing Up Well – Priorities for a Healthy Future, a report by the Chief Public Health Officer of Canada is the second annual report to Parliament on the state of public health in Canada. It focuses on the lifelong impact of exposures and influences that occur early in life and explores the current state of children’s health in Canada. Efforts to address negative health trends among sub-populations include a range of targeted community-level interventions and nationwide universal programs.

The Wait Time Alliance/CAPS
The Wait Time Alliance welcomed the Canadian Association of Paediatric Surgeons (CAPS) as its 14th member. CAPS has been working in collaboration with paediatric surgeons on the Canadian Paediatric Surgical Wait Times (CPSWT) Project to develop acceptable wait times for all paediatric surgical subspecialties. Current CPSWT Project data shows that one third of paediatric patients received surgery past acceptable wait times. Common standards for wait times were developed by expert panels of over 100 paediatric surgeons from children’s teaching hospitals across the country. This methodology has been implemented at 24 hospitals across 8 jurisdictions. The resulting database contains mature wait time data and trends for 150,000 paediatric surgical cases from key facilities across Canada.
http://www.waittimealliance.ca
International

The Commonwealth Fund


This report analyzes the provisions of the health reform bills passed by the U.S. House of Representatives and Senate that seek to expand and improve health insurance coverage. It focuses on: the number of people who would likely gain coverage; under which program or plan they would be covered, and the consequences for federal financing; the estimated insurance premium and out-of-pocket costs for families; the consequences for employers; and the degree to which the reorganization and regulation of insurance markets has the potential to stimulate price competition and lower costs.


The Institute of Medicine

In *Patient Safety At Ten: Unmistakable Progress, Troubling Gaps* and to coincide with the tenth anniversary of the Institute of Medicine report on medical errors, *To Err Is Human*, Robert M. Wachter examines where things stand today in 10 patient-safety domains, as a follow-up to a similar analysis he made in 2004. He finds progress, even though hard evidence of improved outcomes remains elusive because of rudimentary measurement capacity in safety. Most changes have constituted real progress, and even missteps have yielded valuable lessons. Moreover, in a further sign of the field’s maturation, previously unaddressed areas (such as diagnostic errors) are being placed on the safety field’s agenda, as well as the study of how to prioritize safety interventions.


OECD - Organization for Economic Cooperation and Development

Rising public health care spending remains a problem in virtually all OECD and EU member countries. As a consequence, there is growing interest in policies that will ease this pressure through improved health system performance. This report examines selected policies that may help countries better achieve the goal of improved health system efficiency and thus better value for money. Drawing on multinational data sets and case studies, it examines a range of policy instruments. These include: the role of competition in health markets; the scope for improving care coordination; better pharmaceutical pricing policies; greater quality control supported by stronger information and communication technology in health care; and increased cost sharing. *Achieving Better Value for Money in Health Care*

http://www.oecd.org/document/42/0,3343,en_2649_33929_44043754_1_1_1_37407,00.html

U.S. Department of Health and Human Services

Health spending in the U.S. grew in 2008 at the slowest pace in 48 years as the recession affected health costs. Health spending topped $2.3 trillion in 2008, up 4.4 percent from the previous year. But the rate of growth in 2008 was down from 6 percent in 2007 and an average increase of 7 percent a year in the decade from 1998 to 2008. Health care accounted for 16.2 percent of the gross domestic product in 2008, up from 15.9 percent in 2007. National health spending averaged $7,681 a person in 2008, up 3.5 percent from the previous year.

http://www.nytimes.com/2010/01/05/health/policy/05health.html?hp
Selected Transitions

Government
- In a federal cabinet shuffle, **Stockwell Day** was named Treasury Board President.
- **Jim Rondeau** is the new Minister of Healthy Living in Manitoba.
- Alberta’s new health minister is **Gene Zwozdesky**.
- **Jay Ramotar** was announced as the new Deputy Minister of Alberta Health and Wellness effective Friday January 15, 2010.
- In PEI, **Carolyn Bertram** is the new Minister of Health and Wellness (including Aboriginal Affairs). **Tracey Cutcliffe** will assume the post of Deputy Minister, Health and Wellness and **Keith Dewar**, the former Deputy Minister of Health will assume the post of Interim Chief Executive Officer, Health PEI.
- **Kevin McNamara** is the new Deputy Minister of Health in Nova Scotia. He had been acting deputy minister since July.
- Following the resignation of Ron Sapsford, **Dawn Ogram**, ADM Corporate and Direct Services has been named Ontario’s Acting Deputy Minister of Health until a permanent replacement is named.
- **David Hallett** is the new Associate Deputy Minister of Health in Ontario.

Other Organizations
- **Raymond Hession** has been nominated chairman of eHealth Ontario’s board of directors.
- **Michael Fenn**, a former deputy minister in Ontario is the new interim president and CEO of eHealth Ontario, until the end of February 2010.
- **Kevin Smith** to Chair of the Ontario Hospital Association.
- **Dr. David M.C. Walker**, chair, Board of The Ontario Agency for Health Protection and Promotion.
- **Dr. Terrence Sullivan**, vice-chair, Board of The Ontario Agency for Health Protection and Promotion.
- **Hugh MacLeod** was selected as the new President and CEO of the Canadian Patient Safety Institute.
- **Michael Howlett** is stepping down from his position as President and CEO of the Mental Health Commission of Canada, effective March, 31, 2010.
Appendix B

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

**Recent and Upcoming Reports**

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Product Description</th>
<th>Availability Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Human Resource (HHR)</td>
<td>In December 2009 a number of reports focused on health human resources were released, including: - Workforce Trends of Occupational Therapists - Workforce Trends of Physiotherapists - Workforce Trends of Pharmacists - Workforce Trends of Registered Nurses/Licensed Practical Nurses and Registered Psychiatric Nurses in Canada - Workforce Trends of Medical Laboratory Technologists (inaugural report) – released in January 2010 - Workforce Trends of Medical Radiation Technologists (inaugural report) – released in January 2010</td>
<td>December 2009</td>
</tr>
<tr>
<td>Hospital Standardized Mortality Ratio (HSMR)</td>
<td>The third public reporting of Hospital Standardized Mortality Ratios was released on December 10, 2009. The special focus of the report included an analysis on sepsis, a recognized cause of in-hospital death. In 2008–2009, almost one-quarter (23.6%) of all sepsis patients were diagnosed with sepsis after being admitted to hospitals. CIHI’s data found these patients were 56% more likely to die than patients diagnosed with sepsis before their admission to hospital.</td>
<td>December 10, 2009 (including media release)</td>
</tr>
<tr>
<td>Organ Donor Activity in Canada, 1999 to 2008</td>
<td>On December 22, 2009, CIHI released a report regarding organ donations in Canada, which provided information on the supply and demand of organ donations in Canada over a ten year period. In summary, the report indicated that the supply rose by over one quarter (28%), but that the supply is not keeping up with the demand.</td>
<td>December 22, 2009</td>
</tr>
<tr>
<td>Seniors’ Use of Emergency Departments</td>
<td>This report provides a focused look at changes in seniors’ ED visit volumes, triage levels and acute care admission rates from 2004–2005 to 2008–2009.</td>
<td>February 18, 2010 (including media product)</td>
</tr>
<tr>
<td>Distribution and Internal Migration of Canada’s Health Care Workforce</td>
<td>This report will examine the distribution of Canada’s health care workforce and their movement within provinces or territories or from one province or territory to another.</td>
<td>March 2010 (including media product)</td>
</tr>
<tr>
<td>Wait Times Tables - A Comparison by Province</td>
<td>The Reports in the series Wait Times Tables - A Comparison by Province provide an annual update of wait time data and information reported on provincial websites. The series includes a province-by-province summary of approaches used to report on wait times such as definitions, summary measures and time frames.</td>
<td>March 2010 (including media product)</td>
</tr>
<tr>
<td>Drug Use Among Seniors on Public Drug Programs in Canada: 2002 to 2008</td>
<td>In March 2010, the Drug Use Among Seniors on Public Drug Programs in Canada: 2002 to 2008 report will begin to address several questions regarding seniors’ drug use and expenditures based on data from the National Pharmaceutical Drug Utilization Information System (NPDUIS).</td>
<td>March 2010 (including media product)</td>
</tr>
</tbody>
</table>
## Appendix B – Recent and Upcoming Reports

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Product Description</th>
<th>Availability Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Putting Away the Stethoscope for Good? Toward a New Perspective on Physician Retirement</td>
<td>This study will examine what the available data says about how physicians actually retire.</td>
<td>April 2010 (including media product)</td>
</tr>
<tr>
<td>Drug Expenditures in Canada, 1985 to 2008</td>
<td>This annual report updated trends in retail drug spending grouped by public and private payers, and by type of drug (prescribed and non-prescribed). Provincial and territorial comparisons are included, along with international using Organization for Economic Co-operation and Development (OECD) data.</td>
<td>May 2010 (including media release)</td>
</tr>
<tr>
<td>Health Indicators</td>
<td>The Health Indicators 2010 report will contain data tables and regional tool kits</td>
<td>May 2010 (including media product)</td>
</tr>
</tbody>
</table>
Recent Conferences of Interest

CIHR-IHSPR PHC Summit 2010
This conference is a collaboration between the Canadian Institutes of Health Research - Institute of Health Services and Policy Research (CIHR-IHSPR) and the Canadian Institute for Health Information (CIHI). It was held on January 18-19, 2010 in Ottawa, Ontario. The goal was to foster multidisciplinary primary care collaboration among decision makers, administrators, clinicians, researchers and patient representatives in conducting and using research. The Summit also provided Canadian and international stakeholders with an opportunity to exchange best practices in implementing primary care initiatives.

ICES-CIHI-MOHLTC Data Symposium 2010
The Institute for Clinical Evaluative Sciences (ICES)-CIHI-Ministry of Health and Long Term Care in Ontario Healthcare 2010: Evidence, Evaluation and Engagement, was held in Toronto on February 1, 2010. CIHI was a co-sponsor and active participant in this annual event. Mr. Jean-Marie Berthelot, Vice President, Programs, co-presented the opening remarks and many other staff presented.

Upcoming Conferences of Interest

Canadian Association of Health Policy and Research (CAHSPR) Conference 2010
The 2010 Canadian Association of Health Policy and Research (CAHSPR) Conference will be held in Toronto from May 10-13, 2010. As in previous years, CIHI will be one of the co-sponsors for this event and provide in-kind support through participation on the Program Planning Committee. CIHI will present results from several analytical studies and provide updates on our data holdings at this event. Dr. Luc Boileau, Quebec non-government representative is also scheduled to provide a plenary session at this event.

e-Health 2010: From Investment to Impact
CIHI will be co-hosting e-Health 2010 which will be held in Vancouver from May 30 to June 2, 2010. Program tracks and topics for the 2010 Conference include: New Models of Care, Developing Capacity, and Measuring and Accelerating Impact.

2010 National Health Care Leadership Conference
CIHI will be hosting a breakfast presentation at this year’s Health Care Leadership Conference “Transforming Health: From Silos to Systems”, that will be held June 7-8, 2010 in Winnipeg, Manitoba. Participants at the conference represent health regions, hospitals, long-term care organizations, public health agencies, community care and mental health and social services.

CHIMA 2010 Annual Conference
CIHI will be sponsoring the 2010 the Canadian Health Information Management Association (CHIMA) Conference that will be June 10-12, 2010 in Halifax. The theme of the event is Charting your Course in Changing Winds.

CPHA 2010 Conference
The Canadian Public Health Association (CPHA) Centenary Conference is taking place June 13 to 16, 2010 in Toronto. CIHI’s contribution includes the review of abstract submissions and participation on both of the Conference’s Steering and Scientific Review Committees. In collaboration with the Propel Centre for Population Health Impact and CIHR’s Strategic Training Program in Public Health Policy, a one-day workshop will be presented titled “Strategic Training in Population Intervention Science and Practice: “Integrated KT” and “Engaged Scholarship” approaches”. CPHI will also present an abridged version of the full-day Introduction to Population Health Planning workshop titled “Addressing Social and Economic Determinants of Health-Practical Strategies for Developing Programs to Promote Health and Reduce Inequalities”.

Appendix C

Operational Plan and
Quarterly Performance Indicators
Introduction

After the 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.

This corporate performance indicator framework aligns with the strategic directions and CIHI’s corporate performance indicators have been aligned around them through their respective strategic actions and priorities. In addition, in support of the Board’s role in monitoring CIHI’s progress in achieving its strategic objectives, a number of performance targets were identified in the FY2009-10 operational plan and budget document to assess progress against specific priority initiatives.

As part of CIHI’s quarterly reporting, the chart on the following page illustrates CIHI’s progress in moving forward on these priority objectives. Overall, the results demonstrate good progress, with many of the targets well on their way to being achieved and in some cases the targets have already been met. In addition to the reporting of the performance measures, is the regular quarterly reporting of select performance indicators.
<table>
<thead>
<tr>
<th>Strategic Priorities/Initiatives</th>
<th>Performance Measures</th>
<th>Targets/Key Deliverables for 2009–2010 (as of March 31, 2010)</th>
<th>2009–2010 Update to 3rd Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase emergency department (ED) data</td>
<td>Number of sites/facilities/jurisdictions submitting ED abstracts to NACRS (by reporting level)</td>
<td>Maintain current level of participation in submission of Level 3 ED abstracts</td>
<td>No change in current level of participation in submission of Level 3 ED abstracts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At least 20 new sites/facilities from two different jurisdictions will submit ED abstracts (Level 1 data only)</td>
<td>Ontario: 128 sites from 83 corporations will be submitting Level 1 data starting in January 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of sites/facilities/jurisdictions submitting ED abstracts to NACRS (by reporting level)</td>
<td>Manitoba: seven sites will be submitting Level 1 data and one site will be submitting Level 3 data beginning in mid-February 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% of all ED visits having submitted an abstract to NACRS (level 1 or 3 data)</td>
<td>New and existing clients submitting level 1 or 3 data to NACRS will be reporting 40% of all ED visits</td>
</tr>
<tr>
<td>Increase home care data</td>
<td>Number of P/T jurisdictions participating in HCRS</td>
<td>5 jurisdictions participating in HCRS</td>
<td>5 jurisdictions (B.C., Manitoba, Nova Scotia, Ontario, Yukon)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 RHAs/LHINs submitting RAI-HC data to HCRS</td>
<td>24 RHAs/LHINs</td>
</tr>
<tr>
<td>Increase continuing care data</td>
<td>Number of P/T jurisdictions participating in CCRS</td>
<td>6 jurisdictions participating in CCRS</td>
<td>5 jurisdictions (B.C., Manitoba, Nova Scotia, Ontario, Yukon)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>800 facilities/LTC homes submitting RAI-MDS 2.0 data to CCRS</td>
<td>727 regularly submitting facilities/LTC homes (does not include non-production/historical data submissions)</td>
</tr>
<tr>
<td>Increase pharmaceutical data</td>
<td>Number of jurisdictions submitting data to NPDUIS Database</td>
<td>At least one new jurisdiction will submit drug utilization data to NPDUIS Database</td>
<td>No change in current level of participation. Active discussions towards establishing data sharing agreements with FNIHB, BC and ON. Newfoundland and Labrador is actively working with CIHI to meet claims data submission specifications.</td>
</tr>
<tr>
<td>Address data gaps in community mental health</td>
<td>No performance measures established (see key deliverables for 2009–2010)</td>
<td>Complete specific project designed to explore options/opportunities to address information needs in the area of community mental health</td>
<td>Public report now scheduled for release in Q2 2010-2011.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop prototype database for one or two jurisdictions to demonstrate the types of reports, indicators and quality process that could be implemented with a community mental health reporting system</td>
<td>Internal working group to explore options for prototype database in context of Ontario pilot</td>
</tr>
<tr>
<td>Improve quality and use of financial/cost data</td>
<td>No performance measures established (see key deliverables for 2009–2010)</td>
<td>Develop analytical data sets to support analysis and third-party data requests</td>
<td>Project charter and business case have been finalized for development of new SRCDB application</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop web-based interactive data tables that would provide cost estimates for specific diagnosis and intervention groups</td>
<td>Completed data mart to be used in the creation of MicroStrategy tool to estimate average costs by CMG, age group and jurisdiction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Initiate development of patient-specific case-cost database (with expected go-live date of April 2011)</td>
<td>Changed database name to Canadian Patient Costing Database (CPCD)</td>
</tr>
</tbody>
</table>
### Strategic Priorities/Initiatives

**Increase overall depth, breadth and relevance of analytical products**

- **Number of regular annual reports produced**
  - 19 regular annual reports produced
  - 16 regular annual reports produced

- **Number of special/topical reports produced**
  - 12 special/topical reports produced
  - 4 special/topical reports produced

- **Number of Analyses in Brief produced**
  - 15 Analyses in Brief produced
  - 10 Analyses in Brief produced

- **Overall measure of reach and impact—to be developed**
  - Measures of reach and impact (TBD)

**Develop new comparative health indicators in areas such as hospital performance, patient safety, quality and access to care and public/population health**

- **Number of health indicators produced**
  - Health Indicators 2009 report will contain at least three new/additional CIHI-produced indicators (likely AMI, stroke and hip fracture event rates)
  - In the 2009 publication, three new indicators that were developed at national, provincial and regional levels were published. These were hospitalized stroke event, hospitalized AMI event and hospitalized hip fracture event.
  - Health Indicators 2010 report will contain two new measures for disparity. These measures will provide rates/ratios at provincial and national levels.

**Develop pan-Canadian hospital performance reports**

- **Number of health indicators produced**
  - Health Indicators 2009 report will contain at least three new/additional CIHI-produced indicators (likely AMI, stroke and hip fracture event rates)
  - In the 2009 publication, three new indicators that were developed at national, provincial and regional levels were published. These were hospitalized stroke event, hospitalized AMI event and hospitalized hip fracture event.
  - Health Indicators 2010 report will contain two new measures for disparity. These measures will provide rates/ratios at provincial and national levels.

**Continue work on redevelopment of CIHI’s website**

- **Launch redesigned external website with improved navigation and more comprehensive, up-to-date and easier-to-retrieve content**
  - Completed website visual design, structure has been generated
  - Internet content and application mapping complete
  - Conceptual Design of IDM complete
  - File structure and Metadata complete

**Develop (and provide access to) new eReporting tools/reports/indicators**

- **Number of eReporting applications available to clients**
  - Addition of three new eReporting applications
  - Six new eReporting applications were added:
    - The HSMR Indicator Dashboard
    - NACRS ED Wait Times eReporting solution
    - NRS eReporting solution
    - MIS ad hoc eReporting in CIHI Portal
    - The Patient Cost Estimation Dashboard
    - HCRS eReporting Solution

**Increase adoption/uptake of CIHI Portal**

- **Number of participating sites**
  - 60 participating sites
  - As of the end of December 2009, 46 sites and 238 registered (named) users in 9 provinces and 2 territories

**Increase number of data offerings in CIHI Portal**

- **Number of data marts available in CIHI Portal**
  - Addition of one new data mart
  - Review of existing NRS data mart underway to establish scope of work to integrate an ad hoc NRS reporting environment
  - Access to MIS ad hoc environment had to be disabled due to problem with data; Data to be available to Portal users in January and February 2010.

**Increase number and reach of educational offerings**

- **Number of face-to-face educational workshops offered**
  - 200 face-to-face workshops offered
  - 139 face-to-face educational workshops delivered

- **Number of registrations (for all education offerings)**
  - 12,000 registrations (for all education offerings)
  - 16,525* registrations (for all education offerings)
  - Target exceeded due to a greater than expected take-up of our web-based offerings
The charts above provide an overview of those key deliverables—that support progress against CIHI’s strategic priorities—that are being monitored through CIHI’s 2009–2010 production schedule. These deliverables include items related to data releases, information products and/or other deliverables that improve our clients’ use of CIHI products and services.

In Q1, 75.6% (31 of 41) of key deliverables were released within 30 days of their target date, while in Q2 and Q3, 67.6% (23 of 34) and 88.2% (30 of 34) were completed according to target. As of the end of Q3, 77.1% of deliverables were completed according to the 30-day target, while 95.4% of all deliverables were completed to date.

Note: This performance indicator is aligned with all three of CIHI’s strategic directions.

### Improved Understanding and Use

#### Education Sessions/Products – Q3

<table>
<thead>
<tr>
<th></th>
<th>Total Planned</th>
<th>Delivered</th>
<th>Cancelled</th>
<th>Rescheduled</th>
<th>Registrations</th>
<th>% Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web-Conference</td>
<td>43</td>
<td>41</td>
<td>2</td>
<td>0</td>
<td>1185*</td>
<td>95%</td>
</tr>
<tr>
<td>Workshop</td>
<td>108</td>
<td>84</td>
<td>22</td>
<td>2</td>
<td>2281</td>
<td>78%</td>
</tr>
<tr>
<td>e-Learning Courses</td>
<td>62</td>
<td>62</td>
<td>--</td>
<td>--</td>
<td>949</td>
<td></td>
</tr>
<tr>
<td>Self-learning Products</td>
<td>19</td>
<td>19</td>
<td>--</td>
<td>--</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>232</strong></td>
<td><strong>206</strong></td>
<td><strong>24</strong></td>
<td><strong>2</strong></td>
<td><strong>4448</strong></td>
<td><strong>83%</strong></td>
</tr>
</tbody>
</table>

*In addition there were 100 registrants for archived resources.

This table illustrates the number and type of education workshops (core and custom) that were planned and delivered during Q3 of 2009–2010, as well as the percentage of sessions delivered. In Q3 of 2009–2010, 125 courses were delivered out of the 151 courses that were originally planned (this includes seven web-conferences and six workshops added to the schedule after March 31, 2009, due to program area and
provincial requests). Of the 26 sessions not delivered in Q3, two web conferences were cancelled, one due to low registration numbers and one due to program area request. As well, 22 workshops were cancelled; two at jurisdiction request, 17 due to low registration numbers, two due to program area request, and one session was cancelled as the associated part 1 session was cancelled due to low numbers. The higher than normal number of cancellations may be attributed to several factors including the economic climate and travel restrictions as well as implementation of newer data holdings (e.g. Home and Continuing Care) is at a different stage in the data submission life cycle.

### Media Coverage – Q3

This quarter saw a significant increase in the total number of CIHI mentions in all media categories (print, web and broadcast), with 80% more mentions over Q3 of last year, and more than double the total reach. This is likely a reflection of several factors:

- **More news releases this quarter:** There were seven media releases and eight media advisories in the third quarter of this year, compared to six media releases and two advisories in Q3 of 2008-2009. Releases are generally of broader public interest, and typically get more coverage than advisories.

- **Broad appeal of CIHI releases:** The quarter saw a series of releases with wide appeal to the general public for example CPHI’s study of children and healthy weights and the CORR analysis on organ donor availability.

- **Integration with other major news events:** The economy and H1N1 continued to dominate news headlines this quarter. The economic slowdown heightened interest in CIHI’s annual report on health spending, generating many news stories as well as editorial coverage. And while H1N1 continued to compete with other health news stories in general, questions over flu vaccination costs prompted unsolicited mentions of CIHI health spending data as well.

- **New angles for old “blockbusters”:** This year’s HSMR release included CIHI’s first national analysis on sepsis hospitalization rates and mortality rates, lending a new angle to a three-year-old indicator, and attracting significant news coverage as a result. In addition, our annual report on the supply of physicians received considerable attention by highlighting for the first time a consistent upward trend in the rate of physicians working in Canada.

- **Growing online presence:** CIHI’s presence is growing outside of traditional media, for example in online news aggregators (Yahoo and Google News), blogs, and healthcare newsletters. Although these mentions can be difficult to isolate and capture, the media team has been testing and using various methods to improve measurement of these web mentions. The media team has also been striving to communicate our releases in easy to understand and compelling language, in order to make the transition from release to web copy as seamless as possible. As a result, the majority of CIHI quotes in electronic news stories have been lifted directly from our news releases.
For the third quarter of 2009–2010, there were seven media releases and eight advisories (compared to six releases and two advisories in Q3 of 2008–2009). There were 369 CIHI print mentions, an increase from 2008–2009’s 262 articles. There were 198 broadcast items which featured data from CIHI in the third quarter of 2009–2010, compared to 167 in 2008–2009. There were 458 online mentions this quarter versus 138 in 2008–2009, indicative of the continuing and growing use of this technology for communication.

CIHI also received a significant number of unsolicited mentions this quarter, with nearly four times more mentions than the same quarter last year. The media used CIHI data to support a variety of news stories. In particular, CIHI data was used in a variety of stories about Ontario’s health spending deficit as well as a Canadian Press story about pollution’s effect on health costs. CIHI spending data was also cited in light of the H1N1 pandemic health strategy. CIHI was also cited in a series of articles about Quebec wait times.

Audience reach numbers displayed in this chart indicate an increase in both print and broadcast audience and a still growing trend to online communications.

The total number of web mentions in Q3 of 2009–2010 almost tripled over last year. In all media categories, audience reach more than doubled.

When analyzing mentions, the closer the name of an organization is to the headline, the better the branding. For this quarter, it is noted that 263 mentions (31%) were found at the top of the published story, which is in line with other quarters. In addition, twenty five articles (3%) included CIHI’s name in the headline.
Website Activity – Q3

CIHI’s website is another important vehicle in the measurement of the public dissemination and use of our data and reports. In Q3 of 2009–2010 there were 562,038 visits to the website as compared to 442,114 in Q3 of 2008–2009, indicative of the continuing popularity of online technology for communication.

Top 10 Downloaded Analytical Reports – Q3

This chart illustrates the top 10 downloaded analytical reports in Q3 of 2009–2010.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Report</th>
<th>Total Download Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health Care in Canada 2009</td>
<td>3,677</td>
</tr>
<tr>
<td>2</td>
<td>Impact of Poverty on Health June 2003</td>
<td>2,097</td>
</tr>
<tr>
<td>3</td>
<td>Health Indicators 2009</td>
<td>2,009</td>
</tr>
<tr>
<td>4</td>
<td>Health Care in Canada 2008</td>
<td>1,517</td>
</tr>
<tr>
<td>5</td>
<td>National Health Expenditure Trends 1975-2009</td>
<td>1,131</td>
</tr>
<tr>
<td>6</td>
<td>Wait Times Tables Analysis in Brief April 2009</td>
<td>1,042</td>
</tr>
<tr>
<td>7</td>
<td>Drug Expenditure in Canada 1985-2008</td>
<td>998</td>
</tr>
<tr>
<td>8</td>
<td>Exploring the 70/30 Split: How Canada’s Health Care System Is Financed</td>
<td>951</td>
</tr>
<tr>
<td>9</td>
<td>HSMR – Hospital Mortality Trends in Canada 2007</td>
<td>857</td>
</tr>
<tr>
<td>10</td>
<td>National Health Expenditure Trends 1975-2008</td>
<td>809</td>
</tr>
</tbody>
</table>
Data Request Activity (DaRT) – Q3

The following data are obtained from DaRT, CIHI’s internal data request tracking system launched in 2008-2009. DaRT captures information on all data requests from external clients via department-level spreadsheets and compiled by the Programs Division on a quarterly basis.

In Q3 of fiscal year 2009-10, CIHI staff handled 102 data requests in various stages. Of these, 21% were own data requests, and 79% were from third party data requestors such as not-for-profit agencies, universities and other clients. Third party requests generally involve more customization, consultation and privacy review. Fifty-five percent of requests were for custom data tables (aggregate) and 44% were for record-level data.

This chart illustrates that own data requests were mostly for record–level data (76%), while third party requests were mainly for aggregated data (63%). The “Other” category consisted of contextual data requests that could not be classified as record-level or aggregate.

This chart shows open and complete requests in Q3, by turnaround time categories. Of the 56 requests completed in Q3, most requests (73%) were completed within 90 days, which represent maximum service timeframes established by the Data Request Working Group. Fifty-two percent (52%) were completed within one month.

Of the open requests, 23% have been open for more than 90 days and therefore once completed, will fall outside the turnaround time standard. Factors that may have contributed to extended turnaround times for these requests include: multiple iterations with client to finalize specifications, the need for special approvals or background work, etc.

Note
*Turnaround time measured as time elapsed from date of formal request to date of release (or Q3 end for open requests).