President's Quarterly Report and Review of Financial Statements

As at June 30, 2016

Final report

Canadian Institute for Health Information
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Introduction

This document highlights some of the significant accomplishments of the first quarter of fiscal year 2016–2017 (i.e., April 1 to June 30, 2016), and also reviews CIHI’s financial statements as at June 30, 2016. This document includes the following sections:

- **President’s update:** Recent developments and updates affecting CIHI’s corporate services and goals for the first quarter of 2016–2017
- **Financial highlights and statements:** CIHI’s financial situation as at June 30, 2016
- **Appendix A:** CIHI’s regular external environmental scan

President's update

Corporate updates

Key accomplishments and achievements

Funding and operations

- CIHI's Strategic Plan launched in April 2016.
- The proposed new Performance Management Framework, including new corporate performance indicators, is supported by Health Canada.
- The Board's direction to renew our provincial and territorial bilateral agreements for 3 years with annual 2% increases is being supported by the provinces and territories.
- Discussions with Health Canada about how CIHI can best contribute to the implementation of a new health accord will continue into the fall.

Commitment to stakeholders

- The renewed Communications and Stakeholder Engagement Strategy is being implemented. The executive search for the position of Vice President, Strategic Communications and Stakeholder Relations, is expected to generate a first-class pool of applicants.

Outreach and partnerships

- CIHI co-chaired the first World interRAI Conference, held in Toronto from April 11 to 14, 2016. The conference was very successful and included CIHI sponsorship of a well-received session, The Road Ahead: What Is the Future of Evidence for Health Care Decision-Makers?
- David O'Toole, President and CEO, travelled to Atlantic Canada in June 2016. He and Stephen O'Reilly, Executive Director, Atlantic Canada and Integrated eReporting, met with several vice presidents from Eastern Health (Newfoundland and Labrador) and with Beverley Clarke, Deputy Minister, Newfoundland and Labrador Department of Health and Community Services. They also met with Catherine Gaulton, VP, Quality and System Performance, and Chief Legal Officer, Nova Scotia Health Authority; Tracy Kitch, President and CEO, IWK Health Centre; and Janet Knox, CEO, Nova Scotia Health Authority.
  - Discussions included CIHI sponsorship of a meeting on primary health care reform models, how to achieve more comprehensive clinical documentation, the potential to develop pediatric outcome indicators and CIHI support for an Atlantic region health quality organization. A similar trip to the Western region is scheduled for October.

Human resources

- CIHI’s Mentoring Program launched on June 9, 2016, to further improve engagement and development of CIHI’s leadership cadre. 12 pairs of program/team leads and members of the management team were identified.
- CIHI’s pension plan windup continues, with pension statements delivered to employees on June 30, 2016.

IT and communications

- CIHI is moving to single sign-on access to all products and services. This improvement will allow access both to the Learning Centre and to other services, such as eQuery and eStore.
- As of May 2016, CIHI’s website is compliant with the *Accessibility for Ontarians With Disabilities Act* (AODA).

Data quality and agreements

- Saskatchewan signed a data-sharing agreement to allow identifiable drug data to flow to CIHI.
- CIHI met with the Ontario Ministry of Health and Long-Term Care (MOHLTC) to discuss an update to the physician billing data agreement to regularize data flow, to possibly extend CIHI’s uses beyond the population grouping methodology and to obtain linkable drugs and narcotics data.

Strategic activities and outcomes

The following are key accomplishments for each of the corporate goals for the first quarter of 2016–2017.

1 Be a trusted source of standards and data quality

Deliver more timely, comparable and accessible data across the health continuum.

Key accomplishments

Outreach and stakeholder activities

- In response to our users' comments, CIHI conducted an open-year Discharge Abstract Database (DAD) reabstraction study. For the first time, study participants were able to interpret the results and make corrections to the DAD data before year-end closure.
- CIHI began developing potential revisions to the *Standards for Management Information Systems in Canadian Health Service Organizations* (MIS Standards) 2019 and 2022. This will ensure that the MIS Standards is current, relevant and timely.
- CIHI presented a plan for incorporating CIHI data standards into hospital information systems (HISs) in Ontario to the MOHLTC. Further work is being completed, in conjunction with eHealth Ontario, to determine the costs and benefits of embedding data standards into these systems. This work has led to recognition that an in-depth analysis and harmonization of data standards is required across both organizations, along with others such as Health Quality Ontario and Cancer Care Ontario, to ensure that the most benefit can be derived from the data that is being collected at the point of care with the least amount of manipulation.

Collaboration and partnership activities

- British Columbia adopted the National System for Incident Reporting — Radiation Treatment (NSIR-RT) standard in its Provincial Incident Reporting System.
- The National Prescription Drug Utilization Information System (NPDUIS) team initiated work with the Canadian Partnership Against Cancer to develop a data standard for oncology drug data.
- CIHI participated in the review of the World Health Organization's ICD-11 Reference Guide and Field Testing Manual.

- In our continuous efforts to improve data accessibility, we are working with
  - Statistics Canada, to confirm logistics for including linked DAD data in the Research Data Centres;
  - The Canadian Institutes of Health Research (CIHR), to enhance access to the high-user cohorts in the Strategy for Patient-Oriented Research (SPOR) support units; and
  - The Canadian Longitudinal Study on Aging, to discuss data partnership opportunities.

Priority themes and populations

- In collaboration with others, CIHI defined new data standards to improve data quality in the area of mental health. These standards will be implemented in 2018–2019 in the DAD and National Ambulatory Care Reporting System (NACRS) and will improve data quality in such areas as transitions between care settings, suicides, use of restraints and electroconvulsive therapy.
- Home care service data has been acquired from B.C. as part of the Seniors in Transition Project.

2 Expand analytical tools to support measurement of health systems

Deliver reporting tools, methods and information that enable improvements in health care, health system performance and population health.

Key accomplishments

Your Health System (YHS) updates

- April 21, 2016: The HSMR (Hospital Deaths) indicator was integrated into YHS: Insight, and the stand-alone products associated with HSMR were retired.
- May 26, 2016: Retired Breastfeeding Initiation indicator; updated Early Development Instrument indicator; added High Users of Hospital Beds indicator.
- June 23, 2016: Added further accessibility enhancements.

Outreach and stakeholder activities

- The Hospital Harm measure data validation web conference was held on April 28, 2016, for stakeholders in anticipation of the release. It was followed by an update web conference on June 14.
- A kick-off meeting was held in June 2016 to lead the assembly of a Surgical Care Safety Indicators Working Group to review and assess current surgical care safety indicators for inclusion in a national priority set.
- CIHI produced preliminary DAD Surveillance Program dashboards and reports, with supporting materials for review by a focus group of Ontario facilities and presented pilot project results to Statistics Canada's Methodology Symposium in March 2016.

Collaboration and partnership activities

- As part of the 2016 e-Health Conference's Hackathon, CIHI collaborated with the BC Renal Agency to develop a prototype of a patient portal app that included the ability to collect and report patient-reported outcome measures (PROMs). The prototype was presented at e-Health and was one of the top 10 projects in the competition. Several other presentations were solely or collaboratively led by CIHI at the 2016 e-Health Conference.
- The population grouping methodology (POP) that is under development has received very positive evaluations (when compared with similar methodologies from Johns Hopkins and 3M) from Ontario, Alberta and Saskatchewan. Each of these jurisdictions intends to start using the POP when v1.0 is released in November.

Priority themes and populations

- The infographic on child and youth mental health in Canada was updated to include 2014–2015 data. It examines the use of hospital services, both emergency department visits and inpatient hospitalizations, for children, youth and young adults from 2007–2008 to 2014–2015. It also includes information on how many youth have received medication for mental disorders.
- In May 2016, Manitoba Health, Seniors and Active Living submitted the first Canadian Patient Experiences Reporting System (CPERS) data, including 2,385 survey records for 2014–2015 discharges, representing 22 facilities from rural health regions in Southern Health and Interlake–Eastern regional health authorities.
- CIHI (as part of the Alberta First Nations Home Care Pilot Implementation team) received the 2016 Canadian Health Informatics Association Award in the Innovation and Care Delivery category for work on using care planning tools to change practice among First Nations communities in Alberta.

3 Produce actionable analysis and accelerate its adoption

Collaborate with stakeholders to increase their ability to use data and analysis to accelerate improvements in health care, health systems and the health of populations.

Key accomplishments

Outreach and stakeholder activities

- CIHI presentations:
  - May 2016: Sepsis Mortality Hospitalization Patterns in Canada, at the Canadian Association for Health Services and Policy Research (CAHSPR) Conference
  - June 2016: Alcohol-Attributable Hospitalizations in Canada, at the Canadian Public Health Association (CPHA) Conference
- *Ambulance Use for Time-Sensitive Conditions: Stroke and Heart Attack* was released on June 30, 2016, revealing the proportions of stroke and heart attack patients who arrive at the hospital by ambulance, and the characteristics of patients who don't use an ambulance to get to the hospital.
- A report on health system efficiency and a companion description of methods were released on June 14, 2016. To support the release, a web conference was held on June 27 with guest speakers Janet Knox, CEO, Nova Scotia Health Authority, and Susan Brown, VP and Chief Operating Officer, Hospitals and Community, Interior Health (B.C.).
- A PROMs Renal Working Group meeting was held on June 27, 2016. This meeting focused on how PROMs data is used to support patient care and performance reporting. At the meeting, CIHI presented an analysis of PROMs data received from the BC Renal Agency for the pilot project in renal care.
- CIHI was invited to deliver a workshop presentation on evaluating quantitative performance indicators to Alberta Health Services (AHS), which targeted individuals practising or influencing aspects of health analytics and business intelligence within AHS. More than 100 people working in analytics attended the session.

Collaboration and partnership activities

- CIHI attended the Paediatric Chairs of Canada's biannual working group meeting. We presented on CIHI's eReporting tools and strategic plan and discussed how we can partner to provide data and information to support their quality and patient safety initiatives.
- At the request of key stakeholders from the Heart and Stroke Foundation, Ontario Stroke Network and Toronto Western Hospital, ad hoc analyses of stroke patient admissions were completed to validate the quality of endovascular clot retrieval reporting in the DAD and NACRS.

- A Stroke Client Support and Collaboration Working Group was established to better address client queries pertaining to Stroke Special Projects and for stroke indicator research and analysis support. Clinician representatives include Dr. Patrice Lindsay (Heart and Stroke Foundation) and Dr. Ruth Hall (Ontario Stroke Network).
- The online database OECD Health Statistics 2016 was released on June 30 using CIHI data. This database offers the most comprehensive source of comparable statistics on health and health systems across countries in the Organisation for Economic Co-operation and Development (OECD).

Priority themes and populations

- In May 2016, CIHI released a *Healthcare Quarterly* article on care for children and youth with mental disorders. This article examines emergency department visits, inpatient hospitalizations and psychotropic medication use among children and youth with mental disorders.
- CIHI supported the planning of and participated in the Mental Health and Addictions Quality Initiative CEO Symposium.

Financial highlights and statements

In March 2016, CIHI's Board of Directors approved the *2016–2017 Operational Plan and Budget* for up to $104.3 million, including $101.5 million for operations, $1.5 million in capital expenditures and $1.3 million as a provision for the windup of the CIHI Pension Plan.

Management is in the early stages of implementing key initiatives to achieve the strategic goals outlined in *CIHI's Strategic Plan, 2016 to 2021*, while continuing to provide important services and achieve improvements in its core program of work.

Known financial variances to the approved budget

The following represents the significant known annual financial variances to the approved budget based on the current review and first quarter results:

- Health Canada approved a carry-forward of $832,000 from fiscal year 2015–2016 for some key projects that were underspent last year due to project delays (e.g., web redevelopment project, update platform of our business process management tool, Learning Management System replacement project, Prescription Drug Abuse project, eQuery project).
- An additional $204,000 will be spent in leasehold improvements for the Ottawa office due to construction delays. The amount will be recovered from the landlord.
- $1.3 million for potential pension windup costs was set aside in the 2016–2017 budget, of which only $307,000 will be required this fiscal year, creating a $993,000 saving.
- There is a projected underspending of $521,000 due to compensation savings.
- Planned information technology and communication capital spending for 2016–2017 has been reduced by $158,000, as certain budgeted capital purchases were accelerated and acquired in 2015–2016.
- In light of the savings identified above and a few other smaller adjustments, management has reviewed the plans and priorities and reallocated $1.9 million to pressure points and key strategic initiatives:
  - Following an organizational review, $575,000 was allocated to augment our human resources capacity. This includes creating a vice president position for Strategic Communications and Stakeholder Relations and new contract positions to integrate work across the organization, as well as seconding 2 staff from the Australian Institute of Health and Welfare as part of an interchange program.
  - $1.2 million was allocated to external and professional services to be spent on several projects to address capacity issues, create efficiencies (e.g., enhance automated patient experience reporting measures) and make some progress on key initiatives (e.g., medical assistance in dying, SPOR).

Known year-to-date financial variances

- Although the actual results for the 3-month period ended June 30, 2016, are slightly different from the approved budget, these differences are largely due to timing. Other than the items listed above, the annual results are expected to be relatively in line with the budget.
- Management will continue to monitor the operating and capital budgets to ensure resources are best allocated between them to meet CIHI’s deliverables and commitments in the current fiscal year, as well as to achieve notable progress toward its strategic goals. CIHI will prepare a thorough year-end projection as part of the mid-year review exercise.

Financial statements

- Financial statements included in the following section present CIHI’s financial position as at June 30, 2016, with detailed results of operations for the first 3 months of the fiscal year.
- Notes to the financial statements provide details related to specific lines of each statement.
- The closing balances of the balance sheet accounts in the following section are reasonably in line with the organization’s operating cycle.

Balance sheet ($000) as at June 30, 2016

Balance sheet	June 30, 2016 $	March 31, 2016 (audited) $
Assets		
Current assets		
Cash and short-term investments *(note 1)*	12,637	10,500
Accounts receivable *(note 2)*	4,378	7,440
Prepaid expenses *(note 3)*	3,628	3,928
Total current assets	**20,643**	**21,868**
Long-term assets		
Capital assets *(note 4)*	7,023	7,570
Accrued pension benefits *(note 5)*	1,320	1,013
Total long-term assets	**8,343**	**8,583**
Total assets	**28,986**	**30,451**
Liabilities and net assets		
Current liabilities		
Accounts payable and accrued liabilities *(note 6)*	5,157	4,507
Deferred contributions — Health Information Initiative *(note 7)*	1,969	—
Unearned revenue *(note 8)*	2,648	5,545
Total current liabilities	**9,774**	**10,052**
Long-term liabilities		
Deferred contributions — expenses of future periods *(note 9)*	2,319	3,070
Deferred contributions — capital assets *(note 10)*	4,707	5,242
Lease inducements *(note 11)*	1,854	1,802
Total long-term liabilities	**8,880**	**10,114**
Net assets	**10,332**	**10,285**
Total liabilities and net assets	**28,986**	**30,451**

Notes to balance sheet as at June 30, 2016

1. Cash and short-term investments: Presented net of outstanding cheques as at June 30, 2016. Short-term investments include $12.2 million in term deposits, which will yield 0.87% and mature within 97 days.
2. Accounts receivable: Relate to the sale of products and services, including the provision of the Core Plan through provincial/territorial bilateral agreements. Also included in receivables are provincial/territorial contributions for specific programs, including $341,000 from the Ontario Ministry of Health and Long-Term Care for the Ontario Trauma Registry, the Ontario Mental Health Reporting System, the Ontario Health Based Allocation Model (including the data surveillance project) and the Ontario Ambulatory Care Collection and Reporting System Proof of Concept project. The government refund receivable as at June 30, 2016, is $256,000. Subsequent to quarter end and up to July 13, 2016, approximately $157,000 of receivables have been received.
3. Prepaid expenses: Represent payments that have yet to be recognized as expenses, consisting of $2.8 million in software and maintenance, $373,000 in rent deposits to landlords for office space and $455,000 in other expenses.
4. Capital assets: Presented net of accumulated amortization, including $3.9 million of computers and telecommunications equipment, $811,000 of furniture and $2.3 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. Assets acquired during the year are amortized beginning in the month of acquisition.
5. Accrued pension benefits: Represent the accumulated cash contributions made by CIHI net of the sum of the current and prior years' accounting pension expense for the registered retirement plan. In November 2014, a decision to wind up the pension plan effective December 31, 2015, was approved by CIHI's Board of Directors. A $307,000 payment to the plan was made in June 2016 to settle the anticipated windup deficit.
6. Accounts payable and accrued liabilities: Operational in nature. The accounts payable amount of $3.0 million is mostly current (less than 30 days). The accrued liabilities represent an estimate of $2.1 million for goods received and services rendered up to the end of the quarter (e.g., external professional services, advisory groups, printing, travel) as well as payroll and benefit accruals. The government remittances payable as at June 30, 2016, are $908,000.

7. Deferred contributions — 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 contributions — Health Information Initiative. Funding recognized but not received at the end of the period is recorded as Receivable — Health Information Initiative.
8. Unearned revenue: Includes contributions received, for which expenses have not yet been incurred. The contributions are recognized as revenue in the same period as the related expenses are incurred. The balance consists of $1.7 million of funding contributions from the B.C. Ministry of Health for special projects and $931,000 in Core Plan and Portal billings related to the second quarter.
9. Deferred contributions — expenses of future periods: Represent unspent restricted contributions. The funding is recognized as income to match the occurrence of specific expenditures for projects and activities.
10. Deferred contributions — capital assets: Represent contributions provided for the purpose of capital assets acquisitions. The deferred contributions are recognized as revenue on the same basis as the amortization of the related capital assets.
11. Lease inducements: Represent leasehold improvement allowances, other inducements and free rent received/provided over the years for the Toronto, Ottawa and Victoria offices. The inducements are amortized over the period of their respective leases.

Operating budget ($000) for the 3-month period ended June 30, 2016

Operating budget	Actual year to date $	Approved budget year to date $	Variance $	Approved budget (12 months) $
Revenues				
Sales *(note 1)*	597	539	58	2,572
Core Plan *(note 2)*	4,348	4,348	—	17,391
Health Information Initiative *(note 3)*	19,836	20,903	(1,067)	78,907
Funding — other *(note 4)*	655	668	(13)	2,485
Other revenue *(note 5)*	46	45	1	180
Total revenues	**25,482**	**26,503**	**(1,021)**	**101,535**
Expenses				
Compensation *(note 6)*	19,729	19,885	156	76,951
External and professional services *(note 7)*	734	1,343	609	4,897
Travel and advisory committee expenses *(note 8)*	839	1,216	377	3,353
Office supplies and services *(note 9)*	140	139	(1)	584
Computer and telecommunications *(note 10)*	1,721	1,641	(80)	6,578
Occupancy *(note 11)*	2,272	2,279	7	9,172
Corporate provision *(note 12)*	—	—	—	—
Total expenses	**25,435**	**26,503**	**1,068**	**101,535**
Surplus (deficit)	**47**	**—**	**47**	**—**

Notes to operating budget for the 3-month period ended June 30, 2016

1. Sales: Include CIHI's products and services over and above those sold as part of the Core Plan (e.g., on a fee-for-service basis).
2. Core Plan: Represents subscription revenue from the bilateral agreements with provincial/territorial governments.
3. Health Information Initiative: Represents Health Canada's current-year funding allocation recognized as revenue to match the operating expenses incurred. As well, it includes deferred contributions received in prior years recognized as revenue to match the capital assets amortization.
4. Funding — other: Represents contributions from provincial/territorial governments and other agencies for special projects (e.g., The Commonwealth Fund International Health Policy Survey, Ontario Ambulatory Care Collection and Reporting System Proof of Concept project, Paediatric Rehabilitation Reporting System project) or specific programs (e.g., Ontario Mental Health Reporting System, Ontario Trauma Registry, Ontario Health Based Allocation Model, including the data surveillance project). The funding is recognized as revenue in the same period as the related expenses are incurred.
5. Other revenue: Includes interest income generated from the bank accounts and ad hoc short-term investments as well as miscellaneous income.
6. Compensation: Includes salaries, benefits and pension expense for both full-time employees and agency/contract staff.
7. External and professional services: Include accruals for services rendered to date. At the end of June, the unrecorded contractual commitments pertaining to this fiscal year are in the order of $1.1 million.
8. Travel and advisory committee expenses: Include travel expenses for staff and for Board of Directors and advisory committee members, as well as facility costs relating to CIHI's education sessions and externally hosted meetings.
9. Office supplies and services: Include printing, postage/courier/distribution, office equipment and supplies, and insurance costs.
10. Computer 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 telecommunication assets.
11. Occupancy: Includes rent, facility maintenance and depreciation of furniture and leasehold improvements.
12. Corporate provision: Set aside by management; essentially a contingency for emerging issues and year-end adjustments (e.g., benefits/pension costs, revenue shortfall).

Capital budget ($000) for the 3-month period ended June 30, 2016

Capital budget	Actual year to date $	Approved budget year to date $	Variance $	Approved budget (12 months) $
Furniture and office equipment	3	—	(3)	50
Leasehold improvements	133	120	(13)	240
Information technology and telecommunication	40	199	158	1,204
Total	**176**	**319**	**143**	**1,494**

Note
The above excludes $431,000 of commitments up to July 5, 2016.

Appendix A: Environmental health scan, Q1 2016–2017

Federal/provincial/territorial

Newfoundland and Labrador

$2.5 million telepathology network to connect doctors

In July 2016, the Newfoundland and Labrador government announced a new province-wide telecommunications network that will allow pathologists to consult other doctors for second opinions and for research purposes. The $2.5 million network, jointly funded by the provincial and federal governments, will be installed by the provincial Centre for Health Information and by GE Healthcare. Approximately $1.4 million of the funding will come from the federal government through Canada Health Infoway.

Prince Edward Island

Higher taxes looming for P.E.I. to cover health care costs

According to a study by the Fraser Institute, government health care spending in P.E.I. is projected to be more than 50% of the province's budget in the next 15 years. P.E.I. currently spends 41.1% of its programs budget on health care. The Fraser Institute predicts that the increase, through 2030, will likely trigger higher taxes, larger deficits and/or reduced spending on other services.

Nova Scotia

Nova Scotia government readies plan to address doctor shortage

Nova Scotia's health minister, Leo Glavine, hopes a new short-term strategy to address doctor shortages in certain parts of the province could also have recruitment benefits. In June 2016, Mr. Glavine reported that he would soon release a plan to help bridge the period between now and when the Nova Scotia Health Authority hopes to have collaborative primary care practices established across the province — a transition that could take up to 10 years.

Urgent upgrade requests at Nova Scotia hospitals

According to the province's auditor general, Nova Scotia Health Authority hospitals need $114 million in renovations and equipment. The latest report suggests that the province has more health facilities than it can afford. There are 9 regional hospitals across the province, as well as the QEII Health Sciences Centre in Halifax and 31 other facilities, including collaborative emergency centres. Janet Knox, CEO of the Nova Scotia Health Authority, told reporters that a comprehensive plan for the province would not be ready for "a couple of years."

New Brunswick

Poor health status "urgent matter," warns New Brunswick Health Council

A new report by the New Brunswick Health Council warns that if the New Brunswick health care system does not shift to a more proactive, citizen-centred approach, many people will face a reduced quality of life, and even shortened lifespans.

The report stipulates that the province needs to focus on primary health care — currently the "weakest link" in publicly funded health services — and on prevention rather than treatment. Other government services, such as education, roads, tourism, the environment and social services, will have to be reduced to pay for increased health care costs.

Quebec

Quebec gives $50 million boost to seniors and people with disabilities for home health care

Quebec is giving individual health agencies control over $50 million for people getting medical care at home. Health Minister Gaétan Barrette explained that regional health boards will have autonomy in how they spend the funding, as long as it helps the elderly and those with chronic health care needs receive care at home.

In addition to the annual $50 million in funding, the province will also distribute $60 million among the neediest regions and will spend $1.9 million on creating a home care coordinator bureau to ensure that the level of care provided across the province is equitable.

Ontario

Ontario doctors reach tentative 4-year deal with province

The Ontario government and the province's doctors have reached a tentative 4-year agreement that provides a "predictable and sustainable" budget of $11.5 billion, with annual increases of 2.5%. The agreement also includes funding to increase the number of doctors and a modernization of Ontario Health Insurance Plan fees that will result in $200 million in reductions.

In addition, the government has agreed to one-time payments to doctors of $50 million in 2016–2017, $100 million in 2017–2018, $120 million in 2018–2019 and $100 million in 2019–2020. These payments are an incentive for doctors to stay on budget, as funds will be paid only if physicians adhere to the budget. Both sides will co-manage the physician services budget, and the government has agreed not to unilaterally cut the fees it pays to physicians, as it has in the past.

Ontario increases funding to hospitals

Ontario will increase funding to hospitals this year by more than $345 million province-wide. This is part of a total investment of $51.8 billion in health care, a $1 billion increase over last year. The province also plans to invest $12 billion over 10 years in capital grants to hospitals to build modern infrastructure. About 35 major hospital projects are now under way across Ontario.

Manitoba

Budget 2016

Finance Minister Cameron Friesen tabled Manitoba's 2016–2017 budget on May 31, 2016. The speech from the throne presented a strategic vision aimed at improving results in health care, education and economic innovation while restoring prudent financial management and open, inclusive consultation to the daily operation of government. Overall provincial expenditures are expected to increase by 3.2%, with a projected deficit of $911 million. Health expenditures are expected to increase by 3.8% and will represent 40% of the provincial budget for 2016–2017.

Some health-related initiatives include

- Appointing a wait time task force to consult with front-line health care providers to develop a plan to reduce waits in the health care system (the budget refers to waits for emergency services and personal care home beds; it is unclear what the scope of the wait time task force will include);
- Addressing the shortage of long-term care (LTC) beds by developing a funding model to fast-track the construction of beds in partnership with non-profit organizations, faith-based groups and community leaders in all regions of Manitoba;

- Reducing ambulance fees by 5% this year; and
- Initiating a comprehensive review of health care delivery that engages all stakeholders, including patients and front-line workers, in the search for sustainable solutions.

Saskatchewan

Budget 2016

Finance Minister Kevin Doherty tabled Saskatchewan's 2016–2017 budget on June 1, 2016. The revenue was presented at $14.02 billion, down 1.8% from the 2015–2016 budget, and expenses were tabled at $14.46 billion, up 2.0% from the 2015–2016 budget. The projected deficit for the year is $434 million.

A record $5.17 billion will be invested in health infrastructure, improving access to care and reducing wait times for surgery and diagnostic services for Saskatchewan residents. There has been a 50% increase in the health budget since 2007.

Investments in health include

- $3.38 billion for regional health authorities, up $75.45 million (2.3%) from last year's budget, for base operating funding and regional targeted programs and services;
- $70.5 million to the Saskatchewan Surgical Initiative, a $20 million increase (40%) over last year, to help ensure the shortest wait times in the country;
- $167.1 million for the Saskatchewan Cancer Agency, up $9.8 million from last year's budget, to provide compensation for 15 new drugs that were approved in 2015–2016;
- $386.8 million for the Drug Plan and Extended Benefits program, up almost $15 million from last year due to increased utilization and the addition of treatment for hepatitis C, which was approved in 2015–2016; and
- $239.9 million for capital projects, including the Saskatchewan Hospital North Battleford (which will have an integrated correctional facility), LTC facilities and hospital infrastructure updates.

Privacy legislation to improve protection of health information

Saskatchewan residents will benefit from strengthened protection of personal health records and increased accountability of trustees and employees responsible for protecting those records, effective June 1, 2016.

Amendments to the *Health Information Protection Act* (HIPA) result from the government's support of recommendations from the Health Records Protection Working Group. The group's report, released in 2014, included recommended changes to HIPA to help enforce trustees' responsibilities under the act, to address possible gaps in the legislation and to put a system in place to deal with the discovery of unsecured health records. Amendments to HIPA include

- Making offences strict liability (i.e., "reverse onus");
- Clarifying that offences for willful disclosure of personal information apply to individuals who are employees of trustees (as well as to trustees);
- Establishing a snooping offence; and
- Putting in place a system to take control of abandoned records.

Alberta

Government improving Primary Care Networks for Albertans

The government is acting on the findings of a Primary Care Network review aimed at improving services for Alberta patients. The review showed that Primary Care Networks are delivering patient-focused health care in most cases, but it also showed that there are many inconsistencies.

The review, which focused on a sample of Primary Care Networks, assessed financial practices and service delivery approaches. It found inconsistencies in accountability and reporting structures, service levels and approaches to team-based care and planning. There were also instances of inappropriate use of government funding.

Alberta Health will consult with stakeholders as it looks for ways to expand after-hours access for patients and develops a new funding model that promotes more team-based care.

Yukon

Government of Yukon funds Mental Health Association of Yukon executive director position

At the recent Mental Wellness Summit, Minister of Health and Social Services Mike Nixon announced additional funding for the Mental Health Association of Yukon to support a part-time executive director position.

The contribution agreement, which will end in March 2018, will enable the association to support specific projects and further its work. The contribution agreement calls for specific deliverables, work plans and reports, and will cover delivery of the Living Life to the Full program and the Mental Health Works program.

Northwest Territories

Northwest Territories averaging 1 fentanyl-related death per year, study finds

According to a study by the Northwest Territories coroner's office, there have been 5 fentanyl-related deaths in the Northwest Territories in the past 5 years. The study, published in collaboration with the Office of the Northwest Territories' Chief Public Health Officer, reviewed narcotic-related hospital visits and deaths in the territory from 2009 to 2014. It found that 27 people died from narcotic use in the territory during that time. 4 of those deaths — all between 2011 and 2014 — were from fentanyl use. A fifth person died from fentanyl use in 2015.

The majority of fentanyl-related deaths in the territory happened before the spike in fentanyl overdoses in Canada that made headlines in mid-2015, which means the drug was being used — and killing people — in the North years before the majority of the public knew it existed.

Trends and innovation

Most Canadians want, but do not use, digital health tools

While nearly 90% of Canadians said that they want digital health technologies — believing they lead to better health care — only a small percentage are actually taking advantage of tools, according to a recent survey.

The survey of 1,009 Canadian adults, conducted by Maru/VCR&C and commissioned by Telus Health, found at least 85% of Canadians are not taking advantage of the digital tools available, such as accessing their electronic medical records via a portal. At least half of them were not even aware that such services were already available at medical offices, clinics or pharmacies in some parts of the country.

The majority of Canadians (80%) surveyed agreed that electronic records provide accurate information to their doctors. Three-quarters of them believe that electronic health records (EHRs) help doctors diagnose more effectively and allow for safe and secure sharing of information with patients, pharmacists, other doctors and specialists. Canadians' attitudes toward EHRs are overwhelmingly positive, but more than half of respondents couldn't say whether their family doctor used one.

Pharmacare

New paper calling for a national public drug plan

The Canadian Health Coalition is launching a policy brief titled *A National Public Drug Plan for All*, bringing together a variety of academic studies that show the financial savings, improved drug safety and increased equality that would occur under a national public drug plan.

Canada remains the only country with a universal health system that does not include prescription medicines. According to an Angus Reid poll conducted in 2015, 23% of Canadians did not fill a prescription in the past 12 months due to the cost of medicines.

Naloxone now available without a prescription in Ontario pharmacies

Following a decision by the National Association of Pharmacy Regulatory Authorities, Ontario is making naloxone available in pharmacies across the province without a prescription and at no cost to eligible Ontarians to help reduce opioid overdoses across the province.

Seniors

Harmful medication prescribing to Canadian seniors costs $419 million a year

Health policy researchers from the University of British Columbia have reported that more than 1 in 3 Canadian seniors fills a prescription for a risky medication that should be avoided in older patients, estimating that $419 million a year is spent on such drugs. Many medications are appropriate to take before age 65 but, as a person's metabolism changes, can become riskier compared with other available treatments. Inappropriate prescribing to seniors can result in hospital admissions and increased risk of death.

Research on Australia's national strategy on quality prescribing suggests that funding public education to empower doctors, pharmacists and nurses to help patients substitute long-term use of sedatives with other approaches, for example, costs about $47 million and generates direct savings to drug plans of $67 million.

First Nations

New report outlines actions needed to reduce chronic disease in Aboriginal communities

There is an urgent need for system-level interventions that reduce the high burden of chronic disease faced by First Nations, Inuit and Métis and that encourage healthy behaviours, according to a new report titled *Path to Prevention — Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis*, released by Cancer Care Ontario. The report provides the Government of Ontario with evidence-based policy recommendations to reduce exposure to 4 key chronic disease risk factors in Aboriginal communities: commercial tobacco use, alcohol consumption, physical inactivity and unhealthy eating. It is also a key deliverable of Cancer Care Ontario's third Aboriginal Cancer Strategy.

The policy recommendations address the social determinants of Aboriginal health and were informed by First Nations, Inuit and Métis communities, health system representatives, health data and literature reviews. They were guided by the Joint Cancer Care Ontario–Aboriginal Cancer Committee, and they aim to reduce inequities by focusing on the highest-priority needs.

Although the emphasis of the report is on policy actions for the Government of Ontario, implementation will involve the full participation of key stakeholders, including First Nations, Inuit and Métis partners, other organizations and the government. Moving forward, Cancer Care Ontario will create a collaborative structure that includes First Nations, Inuit and Métis communities and other key partners to develop, plan, implement and evaluate progress.

Pan-Canadian and other organizations

Centre for Addiction and Mental Health to open 3 youth mental health walk-in clinics in Toronto

Toronto's Centre for Addiction and Mental Health (CAMH) is opening 3 mental health walk-in clinics aimed at youth age 11 to 25. The walk-in clinics have been designed in part by young people to offer them the mental health services they need. The clinics provide access to brief solution-focused therapy, peer support, system navigation, access to internet-based tools and onsite access to psychiatric services.

CAMH estimates the prevalence of mental health and addiction disorders is as high as 20% among young people, yet as few as 1 in 6 youth affected by mental health issues will access appropriate treatment.

Taking seniors off antipsychotics shows dramatic improvement in care

In May 2016, the Canadian Foundation for Healthcare Improvement (CFHI) released results from a pan-Canadian initiative to reduce the inappropriate use of antipsychotic medication among seniors in LTC — leading to fewer falls, less aggressive behaviours and resistance to care, and an improved quality of life for residents and their families.

Available health evidence shows that 5% to 15% of seniors in LTC facilities should be on antipsychotic medication, yet the national average is much higher.

CFHI is calling for

- LTC homes and provincial/territorial governments to step up efforts to change the culture of over-medicating seniors with dementia, and to increase access to alternate behavioural support programs;
- Health care providers to take better patient histories, conduct more regular medication reviews and work as care teams with family members; and
- Front-line staff in LTC to tailor services — including music, pet or recreation therapy that can replace strong medications — to support quality of care and quality of life for residents.

International

Australian government commits $186 million to e-health record system

The Northern Territory in Australia has announced plans to spend $186 million on a jurisdiction-wide, integrated EHR system. Implemented as part of the 2016 budget, the investment will be spread over 5 years as part of the Core Clinical Systems Renewal Program.

The e-health program will replace 4 existing clinical information systems with a single end-to-end clinical information system at the point of care for all public health facilities, including all Northern Territory public hospitals and more than 50 health clinics. It will improve efficiency; eliminate outdated, manual systems of patient support; and ultimately improve health outcomes.

New Zealand Health Strategy update

An update to the New Zealand Health Strategy has been released for 2016. In 2015, the Ministry of Health consulted on the draft update to the strategy and a road map of actions. The strategy was last updated in 2000. The new strategy sets a clear direction for the health system over the next 10 years.

It covers 5 strategic themes: people-powered, closer to home, value and high performance, 1 team, and smart system. A road map of actions identifies 27 areas for action over the next 5 years to put the strategy in place. It will be updated annually and serves as a practical guide for district health boards, primary health organizations, non-governmental organizations and the wider sector to support their planning and prioritization of work to deliver the strategy. To support the strategy's implementation, the Ministry of Health is currently reorganizing the way it operates.

Selected transitions

- **Avi Orner** to President, Canadian Society of Medical Evaluators (Toronto, Ontario)
- **Barb Shellian** to President, Canadian Nurses Association (Ottawa, Ontario)
- **David M. Kaplan** to Provincial Clinical Lead, Primary Care, Health Quality Ontario (Toronto, Ontario)
- **Elaine Campbell** to Interim President, Innovative Medicines Canada (Ottawa, Ontario)
- **Kimberly Williams** to President, Resident Doctors of Canada (Ottawa, Ontario)
- **Neil Fraser** to Chair, MEDEC Board of Directors (Toronto, Ontario)
- **Paul Kubes** to Executive Chair, Canadian Institutes of Health Research College of Reviewers (Ottawa, Ontario)
- **Susan (Sue) Owen** to Chair, Board of Directors, Canadian College of Health Leaders (Ottawa, Ontario)
- **Trina Larsen-Soles** to President, Doctors of BC (Vancouver, British Columbia)

Government

- **George Hickes** to Health Minister, Nunavut Ministry of Health (Iqaluit, Nunavut)
- **Glenda Yeates** to Member, Order of Canada (Ottawa, Ontario)
- **Hon. Anne McLellan** to Chair, Task Force on Marijuana Legalization and Regulation, Government of Canada (Ottawa, Ontario)
- **Kevin Goertzen** to Minister of Health, Seniors and Active Living, and Government House Leader, Government of Manitoba (Winnipeg, Manitoba)

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