Canadian Foundation for **Healthcare Improvement**

Fondation canadienne pour **l'amélioration des services de santé**

CFHI ANNUAL REPORT 2016–2017

BETTER HOW?

INNOVATING TO TRANSFORM HEALTHCARE FOR CANADIANS

The Canadian Foundation for Healthcare Improvement works #shoulder2shoulder with you to improve health and care for all Canadians.

The Canadian Foundation for Healthcare Improvement identifies proven innovations and accelerates their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements in patient care, population health and value for money.

CFHI is a not-for-profit organization funded by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

This annual report covers the period from April 1, 2016 to March 31, 2017 – referred to as 2016–2017 in this document.

Highlights of CFHI's performance, including outputs and outcomes, are found throughout this report. A detailed Performance Measurement Report is included as an appendix to this document and is available at cfhi-fcass.ca.

150 Kent Street, Suite 200
Ottawa, ON K1P 0E4
Canada

info@cfhi-fcass.ca

cfhi-fcass.ca

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MESSAGE FROM THE PRESIDENT AND CHAIR

In 2016–2017, CFHI experienced a pivotal year in which we moved from a position of financial uncertainty to a position where we now have the capacity to plan well into the future. In the federal government's Budget 2017, CFHI welcomed a $51 million commitment over three years starting when our current funding was scheduled to end in 2019–2020, and $17 million ongoing thereafter, ensuring stability for our organization.

That stability is already enabling us to build more durable relationships with healthcare providers, governments, policy-makers and others, in pursuit of better health, better care and better value for Canadians.

This annual report describes how CFHI met its goals and objectives as set out in our 2016–2017 Strategy (see page 3), and highlights our success at identifying and supporting innovations that can scale across jurisdictions.

As one example, CFHI's Appropriate Use of Antipsychotics (AUA) collaborative provided seed funding and training to help 56 long term care facilities across Canada reduce the use of antipsychotics among elderly residents with dementia who had been prescribed these drugs inappropriately. Together with the New Brunswick Association of Nursing Homes, and financed by the provincial government, we began implementing the AUA initiative in 15 nursing home organizations this year, with plans to further scale the innovation across the province's remaining 43 nursing home organizations in the coming year. We are in discussions with three other provinces to scale this AUA collaborative across their jurisdictions.

Throughout 2016 and 2017, we continued to align our work with federal, provincial and territorial health priorities. This included our work on palliative and end-of-life care, where in March 2017 we issued an open call for innovations. Palliative care was also the focus of the call for EXTRA: Executive Training Program's 12th cohort (2015–2016). For the call for the 13th cohort of EXTRA in October 2016, we requested applications with a special focus on the integration of care closer to home looking for innovative projects that integrate care across services, sectors and providers to deliver high-quality care in the patient's home or community. To that end, our work continued with INSPIRED, a model of care that provides care and services at home and in the community for patients with advanced Chronic Obstructive Pulmonary Disease, thus drastically reducing their need for emergency care and hospital admission. This transformational approach not only improves quality of care, but could also save $688 million in hospital costs over the next five years.

As well, we continued our important work to further Indigenous health through such events as the We Belong International Forum for Indigenous Life Promotion to Address Suicide, co-hosted with the Thunderbird Partnership Foundation and the International Initiative for Mental Health Leadership. In February 2017, CFHI and Fraser Health in B.C. announced we would fast-track the regional spread of a simple and highly effective communication tool called PREVIEW-ED© in 79 Fraser Health long term care homes. The tool helps staff identify early health decline in elderly residents in long term care, avoiding disruption and expensive visits to the emergency room.

On the patient and family front, we started to see real change this year resulting from our focus on engagement activities – in particular through Better Together, where we are midway through a campaign that is starting to shift how leaders and healthcare organizations view the benefits of family presence in hospitals. We were invited to make dozens of presentations on the issue of family presence this year – an indication that CFHI continues to be seen as a leader in this realm.

We also took important steps to lay the groundwork for policy development. CFHI collaborated with partners to evaluate the role of paramedics in providing palliative care in three provinces, and we completed a 10-month e-collaborative to support organizations interested in using remote-consult initiatives (either telephone or web-based consults) to provide patients with better access to specialist care.

Throughout a busy and productive year, we have continued to foster a close working relationship with our funder, Health Canada. With a renewed capacity to plan ahead, we are confident that CFHI will continue to build strong partnerships and forge ahead with new and exciting initiatives to improve the health and well-being of all Canadians. Our future is indeed bright.

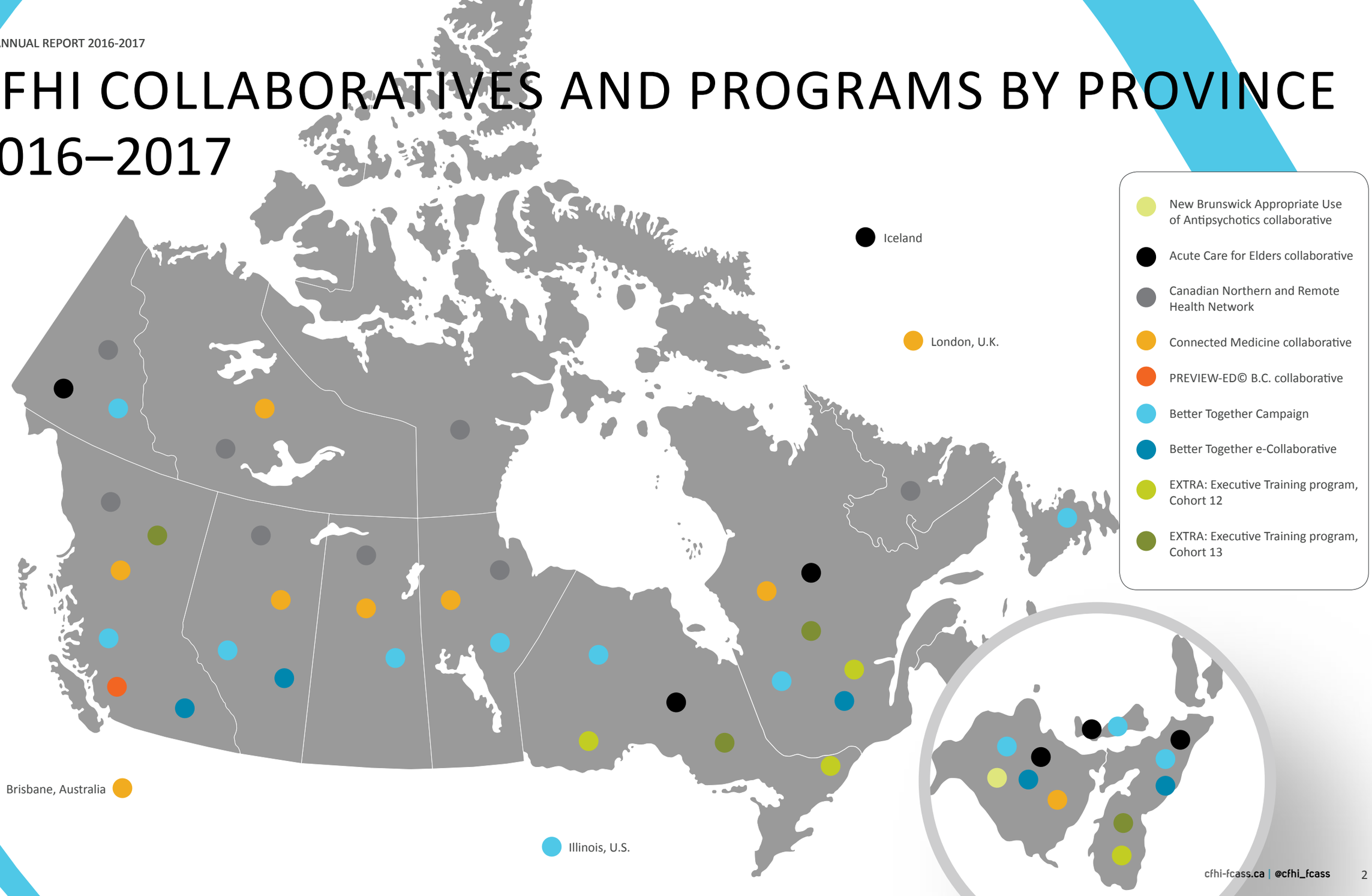
"Stable, ongoing funding will enhance our ability to plan for the long term and achieve even greater impact with our partners."

Maureen O'Neil, O.C.,
President

"CFHI is working creatively to find new partners across sectors, and examining existing partnerships to ensure that our priorities are strongly aligned."

R. Lynn Stevenson,
Chair, Board of Directors

CFHI COLLABORATIVES AND PROGRAMS BY PROVINCE 2016–2017



RESULTS BY THE NUMBERS: 2016-2017

6 collaboratives + **2** programs + **1** EXTRA cohort

191 improvement teams

1,375 healthcare leaders trained

28,327 patients directly reached

Programs and collaboratives reached

10 Canadian provinces

2 territories

3 international

76% * of improvement projects contributed to improvements in efficiency of care

60% * of improvement projects contributed to improvements in patient experience

58% * of improvement projects contributed to improvements in patient health

*Reported as a percentage of the projects that aimed to generate improvements in these domains.

Credit: GBP Creative

CFHI'S STRATEGY 2016–2017

Goals and objectives

- Execute, analyze, evaluate and communicate widely the results of CFHI's improvement collaboratives.
- Create opportunities and strategic partnerships to move from spread of improvement to scale up, including analysis of policy changes to enable the scale up of innovation.
- Deliver CFHI's EXTRA program. Analyze, evaluate and disseminate widely improvement project results. Identify EXTRA projects for potential future spread collaboratives.
- Improve care for, and well-being of, Indigenous people in Canada.
- Enhance CFHI's leadership role in patient, family and citizen engagement for improvement.
- Continue to seek new funding from the federal government as well as funding from provinces, territories and/or regions to support jurisdiction-specific scale.
- Identify and receive revenue from sources beyond governments (e.g., private sector, foundations).

APPROPRIATE USE OF ANTIPSYCHOTICS: AUA

Alignment with strategy goals and focus areas:

- Scale
- Identifying revenue
- Partnerships
- Frail elderly
- Appropriateness

The need

Across Canada, one in four long term care (LTC) residents is on antipsychotic medication without a diagnosis of psychosis – yet the best health evidence says that only 5 to 15% of residents should be on these medications. Antipsychotics are often prescribed in a bid to reduce challenging behaviours and resistance to care, but they have a sedating effect. For many seniors, antipsychotic medication can be minimally effective at best. At worst, it can cause harmful side effects and contribute to falls and hospitalizations.

In 2014 and 2015 CFHI led a pan-Canadian quality improvement collaborative to support the appropriate use of antipsychotic medication, working with 15 teams spanning 56 LTC facilities in seven provinces and one territory. CFHI continues to work with healthcare organizations across Canada to scale this remarkably successful program for reducing the use of these medications and provide safer, more appropriate care for seniors with dementia.

Our work had its roots in the EXTRA: Executive Training Program. In 2012, Joe Puchniak and Cynthia Sinclair – at the time both managers with the Winnipeg Regional Health Authority Personal Care Home Program – designed an initiative to help healthcare providers use the data collected in long term care to identify residents who could benefit from non-drug therapies to treat behavioural issues associated with dementia. This initiative has evolved into the Appropriate Use of Antipsychotics, or AUA, approach.

> “Dementia is a debilitating condition that affects the quality of life of many Canadians and their families. This program will help improve the appropriate use of medication to treat seniors and their health.”
>
> The Honourable Jane Philpott, federal Minister of Health, 2015–2017

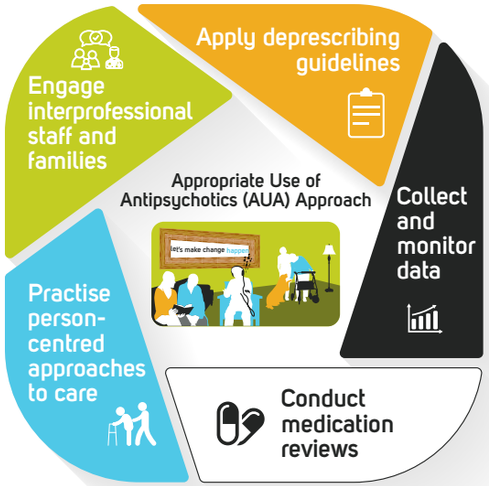
Residents of New Brunswick nursing homes participating in person-centred recreation activities as part of the AUA approach

Significant results

The results of the collaborative were astounding. Of the 416 LTC residents who participated, 54% had their antipsychotic medication either discontinued or reduced. Results showed significant reductions in abusive behaviours by residents – even though antipsychotics are prescribed to reduce challenging behaviours – as well as a 20% reduction in falls. Just as important, there was no increase in the use of physical restraints on residents who participated.

What this means

If antipsychotic reduction programs were spread nationally over five years, 35,000 LTC residents per year would have their antipsychotic medications reduced or discontinued. Canada could save $194 million over five years and prevent 91,000 falls, more than 19,000 emergency room visits, and 7,000 hospitalizations.



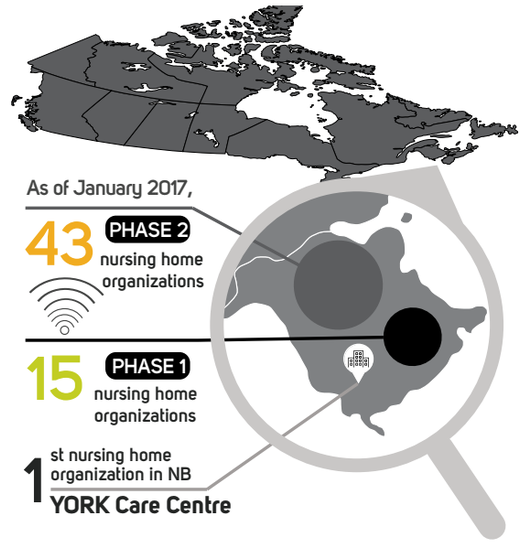
The New Brunswick collaborative: Moving to spread and scale

The success of the 2014–2015 pan-Canadian collaborative laid the groundwork for spread and scale. In May 2016, CFHI, the Government of New Brunswick and the New Brunswick Association of Nursing Homes took the first step toward province-wide scale by announcing Phase 1 of the New Brunswick AUA Collaborative. The first phase of this two-year bilingual collaborative involves 15 nursing home organizations adapting and adopting the AUA approach to improve care for residents with dementia. The remaining 43 nursing home organizations in Phase 2 joined in early 2017.

In their first year, the 15 homes participating in Phase 1 have identified 272 residents on antipsychotics without a diagnosis of psychosis – roughly 15% of all residents inappropriately prescribed these medications in the province. Of the 204 residents still participating at the nine-month mark, 43% had their antipsychotics safely reduced or discontinued, and among these residents:

- The number of falls decreased by one-third
- Social engagement, wakefulness and the ability to self-manage care have significantly improved
- Aggressive behaviours and use of other psychotropic medications have not increased

Appropriate Use of Antipsychotics (AUA): Spreading innovation to improve the quality of life for New Brunswick's seniors



Scaling AUA across Canada

As 2016–2017 came to an end, CFHI was in discussions with three other provinces interested in collaborating to implement the AUA approach. These additional provincial scale collaboratives are an exciting development that will provide better care and quality of life for older Canadians, as well as value for money for health systems.

> "Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime. Rather than just giving once and handing off, CFHI shared with us the tools we needed to be successful in the longer term. And with those tools, we can make anything happen."

Kevin Harter, CEO, York Care Centre, NB

ACUTE CARE FOR ELDERS (ACE) COLLABORATIVE

Alignment with strategy goals and focus areas:

- Spread
- Building capacity
- Partnerships
- Frail elderly
- Coordination and transitions

The need

Although older adults today account for only 16% of Canada's population, they represent 42% of hospitalizations, 58% of hospital days and 60% of hospital-related expenditures. Older Canadians often present at hospitals with multiple inter-related, chronic, acute and social issues, yet this increasingly frail population is not well served by hospital-based models of care. Meanwhile, the number of people aged 65 years and older is expected to double over the next 20 years.

Under the Acute Care for Elders (ACE) Strategy, Mount Sinai Hospital (Sinai Health System) in Toronto has become one of Canada's leading elder-friendly hospitals. ACE uses a seamless model of care that spans the continuum of the emergency department, inpatient, outpatient, and community care.

> "We have seen positive change since the inception of the collaborative and feel that a major driver in this change was the structure and support we have been receiving from CFHI staff [and faculty]."
>
> ACE collaborative team member, Geraldton District Hospital, ON

The CFHI collaborative

CFHI, working with the Canadian Frailty Network, launched a 12-month quality improvement collaborative from March 2016 to March 2017 aimed at supporting the spread of Sinai's elder-friendly models of care and practices to 18 improvement teams: 17 from across Canada and one internationally. Each team received coaching, educational materials and tools to help adopt Sinai's models to their local contexts. Each of the 17 Canadian teams was eligible for up to $40,000 in funding.

Learning opportunities included an online learning platform, educational webinars, an in-person workshop, coaching calls and ongoing support from the ACE collaborative faculty and CFHI staff.

Our intention was to support teams to build capacity in healthcare practices that benefit older patients, as well as improve experiences for patients and families. Another aim was to improve the coordination of care from the emergency room to inpatient care, and to home and community care. Ultimately, the goal of the ACE collaborative was to produce better system outcomes for older Canadians such as reduced hospital stays and fewer complications resulting from hospital stays.

Some participants in our collaborative made significant headway in 2016–2017 in implementing some of the interventions from Sinai's ACE model. Five participating teams opened ACE units in their organization.

Teams selected for CFHI's ACE Collaborative had to have already implemented at least 2 interventions out of the 18 in Sinai's ACE Strategy and commit to implementing 1 more. On average, teams were already doing 6 of the ACE strategy interventions, and then implemented 3 more during the collaborative. Overall, teams planned to implement 35 interventions, but gained momentum and ended up implementing 59 collectively.

18 teams across

4 provinces

1 territory

1 international site

Teams participating in the ACE collaborative

- Whitehorse General Hospital, YN
- Geraldton District Hospital, ON
- Halton Healthcare, ON
- Hamilton Health Sciences, ON
- London Health Sciences Centre, ON
- Montfort Hospital, ON
- Orillia Soldiers' Memorial Hospital, ON
- Queensway Carleton Hospital, ON
- Quinte Health Care, ON
- Scarborough and Rouge Hospital, ON
- Thunder Bay Regional Health Sciences Centre, ON
- University Health Network, ON
- William Osler Health System, ON
- CISSS Chaudière-Appalaches, QC
- Horizon Health Network, NB
- Nova Scotia Health Authority - South Shore, NS
- Nova Scotia Health Authority - Central Zone, NS
- National University Hospital of Iceland

> I am delighted to share Sinai Health System's approach to addressing the needs of our older patients through this innovative ACE collaborative. Transformative change in healthcare is always fueled by strong partnerships committed to improving outcomes and I am deeply proud of being able to be part of this effort.

Samir K. Sinha, MD, DPhil, FRCPC, Director of Geriatrics, Sinai Health System
and the University Health Network, Toronto, ON

Knowledge, skills

The most popular interventions to implement were elder-friendly order sets; inpatient behavioural management; high-risk screening tools in the ED; the Geriatric Emergency Model (GEM) nurse model; an ACE tracker; and the opening of an ACE Unit.

Participants reported that they gained knowledge and skills in four areas:

- problem identification and baseline data
- design, implementation and evaluation
- leading change and communicating results
- enabling conditions for improvement

Most teams reported changes in culture as a result of the ACE collaborative, including changes in how data collection and measurement is perceived; greater compassion for the needs of elderly patients with dementia; and adjustments in daily practices. The shift in culture resulted in improved patient outcomes and more knowledgeable staff.

CONNECTED MEDICINE: ENHANCING ACCESS TO SPECIALIST CONSULT

Alignment with strategy goals and focus areas:

- Emergency Department avoidance
- Spread
- Scale
- Partnerships
- Primary care
- Access
- Patient- and family-centred care

The need

Among the most significant challenges facing the healthcare system is that of long wait times for specialty care. This issue can be particularly concerning to patients and families earlier on in the care process, before their problem is properly diagnosed and a treatment plan is in place.

According to a 2017 report by the Commonwealth Fund, Canada ranks 11th out of 11 countries when it comes to the number of people who wait two months or longer for a specialist appointment.

Remote consultation

Remote consults consist of connecting primary healthcare providers with specialists electronically or over the telephone. Two proven Canadian remote consult innovations have demonstrably improved primary healthcare access to specialist consultation.

- Rapid Access to Consultative Expertise (RACE™) is a telephone-based consult service first developed by Providence Health Care and Vancouver Coastal Health in British Columbia.
- Champlain BASE™ eConsult Service (BASE™) is a web-based e-consult service launched within the Champlain Local Integration Health Network in Ontario.

International cohort of 10 teams (from Canada, Australia and England) participating in the 2016–2017 Access to Specialist Consult e-Collaborative

- Department of Health & Social Services, NT
- Providence Health Care, BC
- Alberta Health Services, AB
- Saskatchewan Ministry of Health, SK
- Manitoba eHealth, MB
- McGill University Health Centre, QC
- Department of Health, NB
- St. Mary's University, NS
- MonMedical/NHS, London, U.K.
- Mater Health Service, Brisbane, AU

The CFHI collaborative

From May 2016 to January 2017, CFHI delivered a nine-month Enhancing Access to Specialist Consult e-collaborative to address the problem of long wait times. This e-collaborative supported organizations interested in using remote consult services to improve primary care provider access to specialists. The College of Family Physicians of Canada, Canada Health Infoway, and the Royal College of Physicians and Surgeons of Canada were partners for this initiative.

Our expectation was that each team would build toward implementing a RACE or BASE model – or both – that fits its local context. The collaborative's first phase, which ended in 2017, focused on enabling participants to build a business plan and project charter for a remote consult initiative. Ten teams from Canada, Australia and the U.K. participated in six CFHI-led webinars. The collaborative culminated in an in-person workshop, where teams presented their business cases and received feedback from an expert-led "Innovation Den."

Pre- and post-collaborative surveys showed the teams' knowledge and understanding of remote consult expanded considerably. The overarching message was that participants valued the interactions with other teams, specifically regarding the ability to share knowledge and learn about the barriers and best practices for setting up a remote consult service.

The collaborative's second phase launched in March 2017, when CFHI made a call for applications to teams interested in implementing and evaluating remote consult services in their local region, or even across an entire jurisdiction. The 15-month collaborative begins in June 2017 and ends in September 2018.

Alberta Health Services

88% resulted in continuation of primary care for the patient

Of **25** calls

12% led to a face-to-face visit with a specialist

Saskatchewan Health

Of **65** calls

50% avoided a referral

21% avoided a visit to the emergency department

18% avoided a prescription

14% avoided treatment

> "The information on a business case was certainly important, but the most important impact was the legitimacy and raised profile within our own province. Being part of an international collaborative gave our project the attention and support of key stakeholders."
>
> Connected Medicine collaborative participant

PREVIEW-ED©: AVOIDING TRANSFERS TO EMERGENCY

Alignment with strategy goals and focus areas:

- Test for spread
- Scale
- Policy analysis
- Partnerships
- Frail elderly
- High-risk, high-cost populations
- Emergency Department avoidance

The need

Across Canada, one in three emergency department (ED) transfers by seniors living in long term care (LTC) is potentially avoidable. PREVIEW-ED© (Practical Routine Elder Variants Indicate Early Warning for ED) is a simple and easy-to-use communication tool that helps staff in LTC homes keep seniors out of hospital.

Developed by senior healthcare executive Marilyn El Bestawi through CFHI's EXTRA: Executive Training Program, the tool helps staff in LTC identify early health decline related to four conditions responsible for nearly half of potentially avoidable hospitalizations: pneumonia; urinary tract infections; dehydration; and congestive heart failure.

The tool is administered in just 10 to 15 seconds by personal support workers (who make up more than 70% of LTC staff and provide most of the direct care for residents). If the tool score is zero, the resident's condition is normal. If the score is greater than zero, the support worker informs a registered clinical staff member (registered nurse or registered practical nurse).

Successful pilots lead to spread

After an initial three-month pilot in 2012 involving 66 residents at a University Health Network LTC facility in Toronto, El-Bestawi's results showed a 57% decrease in ED visits.

The tool was also pilot tested by Fraser Health in British Columbia in four of its LTC facilities from February to June 2016.

After seeing the reduction in transfers to the ED in the four pilot homes, in September 2016 Fraser Health partnered with CFHI to spread the innovation to all 79 homes in the health authority. The fast-tracked rollout was undertaken in two phases, starting with 40 homes in September and to the remaining residential care homes within Fraser Health in January 2017. The results and lessons learned through this spread initiative in Fraser Health will enable CFHI to launch a pan-Canadian collaborative to further spread this innovation.

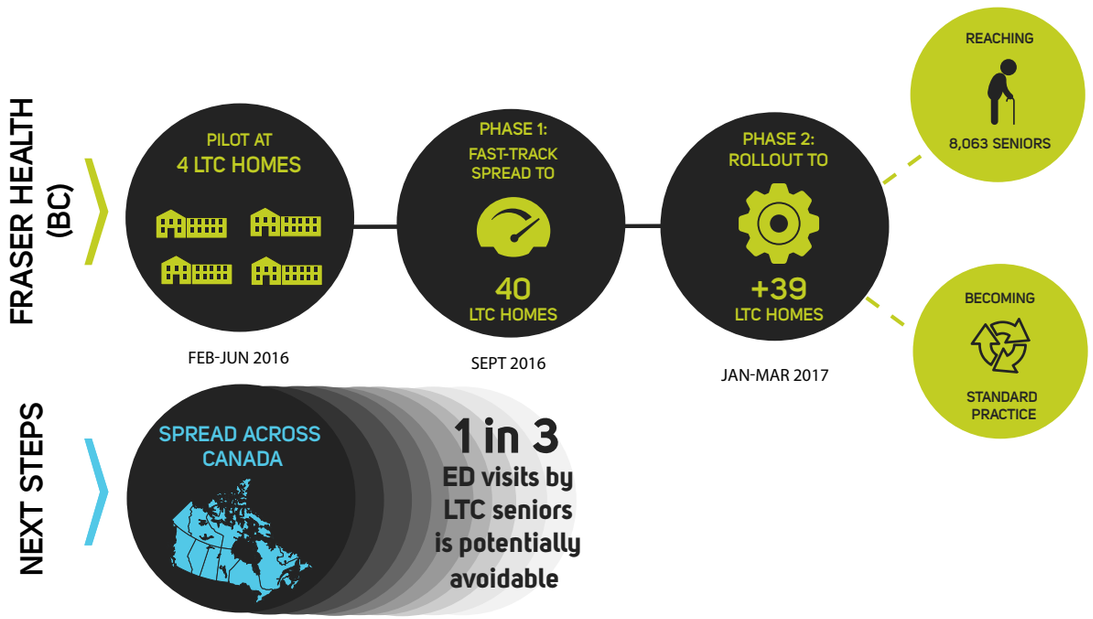
CFHI's support to date has included face-to face-workshops, regular monthly webinars and education support. CFHI also entered into a partnership with Interior Health Authority in British Columbia that involved spreading PREVIEW-ED to three of its residential care homes. Other organizations in other provinces have also shown great interest in adopting PREVIEW-ED.

Staff using the PREVIEW-ED tool at Harmony Court, Fraser Health, B.C.

> "We have been fortunate to be part of a wonderful project. Through the workshops and webinars, we've come to see this as a system issue that needs a system change. CFHI helped us sort out our process issues, and it's been very helpful to have a Canadian perspective."
>
> Catherine Kohm, Director, Fraser Health

PREVIEW-ED©

SPREAD



Feedback from direct care staff suggested that an electronic version of the tool would reduce paperwork, making it more efficient. In February 2017, Fraser Health received $50,000 in funding from the Centre for Aging and Brain Health Innovation, to support the development of an electronic version of the PREVIEW-ED© tool.

Sites using the PREVIEW-ED© tool in B.C.

COMMUNITY ACTIONS AND RESOURCES EMPOWERING SENIORS: CARES

Alignment with strategy goals and focus areas:

- Test for spread
- Frail elderly
- High-risk, high-cost populations
- Partnerships
- Spread
- Primary care

Discussing CFHI and CARES at the Canadian Geriatrics Society 2017 Annual Scientific Meeting in Toronto, ON, in April 2017

The need

Frail seniors have poor quality of life and increasingly rely on healthcare resources. Evidence shows that comprehensive geriatric health assessments (CGA), coupled with long term coaching in the community, are associated with better health outcomes for pre-frail seniors. Frailty can be slowed down or even reversed.

The Community Actions and Resources Empowering Seniors (CARES) approach connects pre-frail seniors (identified through the CGA) with primary care providers and community-trained wellness coaches. Using this approach, seniors receive coaching before they become frail – delaying and sometimes preventing frailty.

In 2014, the Fraser Health Authority (B.C.) partnered with Nova Scotia Health Authority and Shannex Inc. (N.S.), through CFHI's EXTRA program, to implement an inter-provincial CARES initiative – the first of its kind.

Results were extremely promising: seniors participating in CARES saw considerable improvements in their well-being and quality of life in areas such as walking independently, exercising frequently, and becoming more socially engaged.

Since the pilot, Fraser Health has been working to spread the approach.

Going paperless

In 2016–2017, as part of our partnership with Fraser Health, CFHI supported the development of an electronic version of the CGA that can be embedded into electronic medical records. Like the paper version, it generates a frailty score for each patient.

Support from CFHI for this project also included education for teams, evaluation of the initiative, and communication and dissemination of results.

Nine physicians working with Fraser Health are currently using the e-CGA with the aim of enrolling 70 pre-frail patients in the program. Patients will be connected with community health coaches as part of the wellness plan and will receive free, over-the-phone health coaching for up to six months to address nutrition, exercise and social engagement.

> "It's really a good example of how patients and providers work together to provide meaningful improvements for seniors."
>
> Joyce Sandercock, Patients Voices Network

> "It gave me encouragement which I really need. Sometimes it's hard to give yourself encouragement. […] I'm feeling a little bit stronger [...], but I know it'll take time to get stronger."
>
> Barbara Dyce, CARES Participant

COLLABORATING TO IMPROVE NORTHERN AND INDIGENOUS HEALTH

Alignment with strategy goals and focus areas:

- Indigenous Health
- High-risk, high-cost populations
- Building capacity
- Access
- Partnerships
- Leadership development
- Northern and remote health
- Mental health

The need

Indigenous Canadians – including First Nations, Inuit and Métis – endure more health challenges than other Canadians, including higher rates of chronic diseases, infectious diseases, suicide, and a gap in life expectancy. This is more marked in northern and remote regions due to issues such as lack of access to health and social services. As well, services for Indigenous Canadians are delivered from multiple jurisdictions, so partnerships between providers and leaders are essential for the delivery of effective services.

CFHI is committed to supporting partners to contribute to closing the gap in Indigenous health, by supporting healthcare organizations to better meet the needs of their Indigenous populations.

Northern and Remote Health Network

In 2016–2017, CFHI's Northern and Remote Health Network continued its work to improve the health of people living in northern and remote regions in Canada by addressing the barriers they encounter in accessing healthcare. This year, the collaboration expanded to 13 members, welcoming the North East Ontario Local Health Integration Network.

Annual Roundtable for members

In May 2016, CFHI held its third Northern and Remote Roundtable in Saskatoon, Saskatchewan. Close to 50 participants attended the two-day event, representing 25 organizations and 10 provinces and territories across Canada's northern and remote regions. The goal was to further the network's sharing of wise practices that support healthcare delivery improvements in northern and remote Canada.

On the first day, Roundtable participants were encouraged to define what cultural competence means at the individual and organizational levels. Cultural competence, in its broadest sense, is the ability of a system to deliver healthcare services that meet the needs of specific cultural groups of patients, such as social, cultural and linguistic needs.

Participants concluded that, for an organization to be culturally competent, strong leadership is needed to initiate and sustain change, and that "everyone must play a role and shoulder part of the responsibility." Participants also discussed the importance of listening to Elders and patients, and "indigenizing" healthcare access points, so that access to healthcare is solidly under the influence and control of the Indigenous populations it serves. Keynote speaker Dr. Vianne Timmons, President and Vice Chancellor of the University of Regina and member of the Bras d'Or Mi'kmaq First Nation in Nova Scotia, challenged participants to take the first step.

The Roundtable's second day focused on Indigenous suicide prevention and wise practices across mental health systems. Carol Hopkins and Brenda Restoule, both nationally renowned experts in Indigenous mental health and suicide prevention, were the day's plenary speakers. Participants spent much of the day working in groups to discuss:

- approaches to case management in teams for mental health
- successes and approaches in culturally based healing
- approaches to prevent secondary trauma in employees
- wise practices in evaluating client and community outcomes
- wise practices in reducing suicide clusters
- integration in mental health

The Roundtable concluded with a commitment from CFHI to develop and share stories on life promotion, community wellness, and resiliency, and to coordinate an Indigenous suicide prevention conference.

We Belong

In November 2016, CFHI, the Thunderbird Partnership Foundation and the International Initiative for Mental Health Leadership co-hosted the We Belong International Forum for Indigenous Life Promotion to Address Suicide in Vancouver, B.C.

The We Belong forum brought together 150 Indigenous leaders from across Canada and six other countries to validate what is known about suicide prevention in Indigenous communities; celebrate successes in community wellness and resilience; deepen understanding about holistic Indigenous ways of life that promote belonging, hope and purpose; and raise public awareness about resilience in Indigenous culture and knowledge.

Indigenous youth – the generation most affected by suicide – were engaged across all stages of preparation and delivery of the forum. They also participated in a two-day wellness and leadership event in advance of We Belong that helped identify the youths' collective needs and priorities, and built their capacity to share their messages.

Of the participants who provided feedback on the forum, 100% rated their overall experience as either "good" or "excellent" and many said it was "life-changing." Delegates noted the extent of youth involvement and the diversity of participants from Indigenous communities across Canada and around the world as among the forum's key strengths. Many participants said they would share the knowledge they learned via youth strategies, life-promotion planning and programming, and in providing Elders and youth opportunities to connect.

Winning photo from CFHI's We Belong photo contest

> "Inuit, First Nation and Métis youth came together to tackle a real issue that we are trying to eliminate in our communities. That is special."
>
> Youth Delegate, We Belong

> "By preventing child abuse we are promoting life. This has to be done at a family and community level, and cultural interventions must be at the front of practices."
>
> Delegate, We Belong

Indigenous cultural competence

CFHI believes that cultural competence, and the capacity of health systems to incorporate cultural competence, safety and humility into their practices, are necessary steps towards reconciliation and closing the gap in health outcomes for Indigenous populations.

Following the Truth and Reconciliation Commission's Calls to Action, CFHI offered a new learning opportunity in Indigenous cultural competence (ICC). The course was designed to help teams and organizations learn more about how history – including residential schools – can affect health outcomes today. The goal of ICC is to support teams and organizations to strengthen individual and organizational cultural competence, and consider ways to reduce racism towards Indigenous peoples in health and mental health systems.

Between April 1, 2016 and March 31, 2017, CFHI delivered 22 ICC sessions to groups and organizations across Canada, including three sessions for CFHI staff. We also delivered three train-the-trainer sessions with the Government of Nunavut.

Graduates of Indigenous Cultural Competency train-the-trainer session, Government of Nunavut

PATIENT AND FAMILY ENGAGEMENT: PARTNERING FOR IMPROVEMENT

Alignment with strategy goals and focus areas:

- Patient and family engagement
- Building capacity
- Partnerships
- Transformation

Supporting patients and families

CFHI is emerging as an international leader in the transformative realm of patient and family engagement, helping organizations build capacity and implement practices and strategies to support partnerships with patients and families.

From 2010 to 2015, CFHI led a series of pan-Canadian initiatives that supported 44 healthcare teams in harnessing the potential of patients and families to help drive quality improvements.

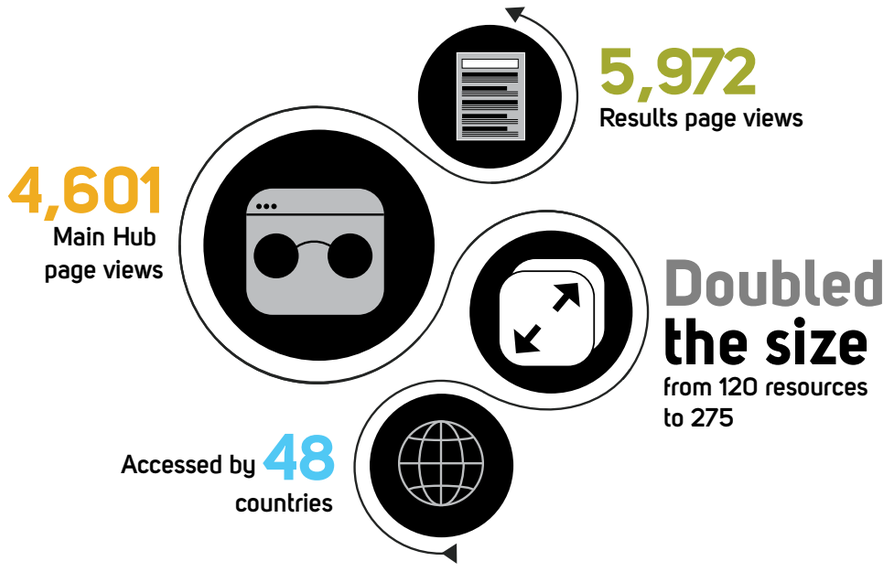
In 2016–2017, we continued to develop partnerships designed to spread family presence policy innovations, while also taking time to reflect on the outcomes of our previous work and begin planning for future patient and family engagement programming.

Patient Engagement: Catalyzing Improvement and Innovation in Healthcare

In 2015, CFHI was commissioned by the Federal Advisory Panel on Healthcare Innovation to provide an analysis of successful Canadian and international approaches to patient and family engagement. The project was undertaken in collaboration with G. Ross Baker of the Institute of Health Policy, Management and Evaluation, University of Toronto. Drawing on existing research, we conducted key informant interviews to identify compelling patient engagement initiatives and analyzed the components necessary to create engagement-capable environments.

Informed by this work, in 2016, we published a book called Patient Engagement: Catalyzing Improvement and Innovation in Healthcare, and hosted a Breakfast with the Chiefs event as well as a public On Call webinar to share key insights.

CFHI's online Patient Engagement Resource Hub: Expansion and growth in 2016–2017



Patient Engagement Resource Hub

Over several years, CFHI has built a comprehensive online collection of international, open-access tools and resources that support organizations in their efforts to engage patients and their families. Resources in the Patient Engagement Resource Hub include patient surveys; checklists and templates; engagement frameworks; and toolkits to help organizations assess, design, implement and evaluate patient and family engagement activities.

In 2016, the Canadian Patient Safety Institute partnered with CFHI to expand the Hub to include resources focusing on patient engagement to improve patient safety.

> "CFHI is helping to build a national dialogue around what person-centred care looks like in practice. Central to the work ahead is the need to integrate the direct voices of patients and their loved ones. This is how we guide change forward in a way that is meaningful."
>
> Michael Decter, Board Chair, Patients Canada

Patient Engagement Toolkit

In one major addition to the Hub, CFHI was one of 20 organizations involved in the production of a new document called Engaging Patients in Patient Safety – a Canadian Guide.

Designed for a broad audience that includes patients, caregivers, and healthcare leaders, the toolkit provides information on what we know works well in the field, along with supporting evidence, evaluation strategies, links to helpful resources and tools, and pan-Canadian practice examples.

The initiative was led by the Canadian Patient Safety Institute. As a key partner, CFHI worked with national and provincial governments and organizations to shape the content and delivery of this uniquely Canadian toolkit.

Better Together: Partnering with Families

The need

When families are welcomed as partners in care, staff, patients and families, and the organization itself, stand to benefit. Benefits of adopting family presence include improved experience and outcomes, fewer 30-day readmissions and improved care coordination.

However, Commonwealth Fund statistics show that, as of 2014, Canada ranked 8th out of 11 countries in patient and family-centred care. As well, a November 2015 study by CFHI found that fewer than one in three Canadian hospitals had accommodating visiting policies, and fewer offered 24/7 access to designated family members.

Formally adopting and implementing family presence policies is a practical step organizations can take to deliver more, and better, patient- and family-centred care.

The campaign

Better Together is a campaign spearheaded by the Institute for Patient- and Family-Centered Care in the U.S. CFHI has led Canadian efforts with widespread success.

The campaign encourages healthcare organizations to review their visiting policies with patients and families and develop and implement new policies that recognize the key roles families play in supporting their loved ones and improving patient outcomes. Changing visiting policies aims to eliminate the barrier of access to family members, viewing them not merely as visitors, but rather as partners in care and allies for quality and safety.

CFHI's work in leading the Canadian Better Together campaign encouraged healthcare organizations to take the Better Together Pledge and publicly demonstrate their commitment to review and implement family presence policies in their own organizations. To support those organizations who wanted to make policy changes, we offered a suite of programming and resources.

One such program was a free, 17-month e-collaborative that supported organizations across Canada to develop and implement new policies on family presence. The 12 healthcare teams that joined our e-collaborative – some of which represent entire provinces – worked collaboratively and in partnership with patients and families to assess, plan, implement, evaluate and sustain family presence policies.

50 organizations

8 provinces

1 territory

Better Together Pledging Organizations

- Alberta
  - » Pincher Creek Health Centre
  - » South Health Campus
- British Columbia
  - » Interior Health
  - » Northern Health
  - » Providence
- Manitoba
  - » Victoria General Hospital
  - » Winnipeg Regional Health Authority
- New Brunswick
  - » Horizon Health Network
  - » Hôpital régional d'Edmundston (Vitalité)
- Newfoundland and and Labrador
  - » Eastern Health
  - » Western Health
- Nova Scotia
  - » Nova Scotia Health Authority Harbour View Site
  - » IWK Health Centre
- Ontario
  - » Hotel Dieu Grace Healthcare
  - » Parkwood Mennonite Home
  - » Orillia Soldiers' Memorial Hospital
  - » Markham Stouffville Hospital
  - » Norfolk General Hospital
  - » Ross Memorial Hospital
  - » North York General Hospital
  - » St. Thomas Elgin General Hospital
  - » Hotel Dieu Shaver Health and Rehabilitation Centre
  - » Royal Victoria Regional Health Centre
  - » Humber River Hospital
  - » Headwaters Health Care Centre
  - » The Ottawa Hospital
  - » St. Joseph's Healthcare Hamilton
  - » Michael Garron Hospital
  - » The Scarborough Hospital
  - » Huron Perth Healthcare Alliance
  - » Stevenson Memorial Hospital
  - » Hamilton Health Sciences
  - » Arnprior Regional Health
  - » Lake of the Woods District Hospital
  - » Red Lake Margaret Cochenour Memorial Hospital
  - » St. Michael's Hospital
  - » North Bay Regional Health Centre
  - » Deep River and District Hospital
  - » William Osler Health System
  - » Kemptville District Hospital
  - » Saint Elizabeth Health Care
  - » Kingston General Hospital
- Prince Edward Island
  - » Health PEI
- Quebec
  - » Centre intégré de santé et de services sociaux de l'Outaouais
  - » Centre hospitalier de l'université de Montréal
  - » CISSS de la Montérégie Est
  - » CIUSSS Mauricie-et-Centre-du-Québec
- Saskatchewan
  - » Whole province moved to family presence in March 2016
- Yukon
  - » Yukon Continuing Care
- United States
  - » Methodist Hospitals, Inc. (Illinois)

* The whole province of Saskatchewan moved to family presence in March 2016

> "Being away from home and family can be devastating. Realizing that family is still welcome – day or night – goes a long way toward relieving that stress."
>
> Charlene Guraluick, family member of patient at Bengough Health Centre, SK

International leadership

In 2016–2017, CFHI was invited to make 26 presentations on lessons learned and impacts of engaging patients and families in improving healthcare, including for the Institute for Patient- and Family-Centered Care; the Lung Association; Accreditation Canada, which asked us to present to their more than 400 surveyors; and Health Quality Ontario, at its annual Health Quality Transformation conference.

In July 2016, the Institute for Patient- and Family-Centered Care hosted the biennial international conference on patient- and family-centred care. Called "Partnerships in Care, Inter-professional Education," the conference showcased patient and family engagement programs that are creating real transformation in organizations by improving the quality and safety of care for patients and families.

The Canadian contingent was a major presence at the conference. Of the 22 teams that were part of CFHI's Partnering with Patients and Families for Quality Improvement Collaborative, 12 were accepted as presenters.

Calgary Zone took the pledge for making family presence a priority

Better Together: Results

By March 2017, 50 healthcare organizations across Canada had taken the Better Together Pledge and were shifting their policies to support family presence and do away with visiting hours for designated family members. Saskatchewan had already started on its journey and, in March 2016, became the first province to fully move to family presence. New Brunswick and Prince Edward Island also committed to developing province-wide family presence policies, including 24/7 visiting hours for designated partners in care.

CFHI continues to focus on seeking out innovations and partnerships that will support us in our efforts to expand the pan-Canadian spread of family presence policies. Our plans include bringing together government leaders for a roundtable discussion on how family presence policies could be implemented on a broader scale.

Participants confer and share their experiences at the Choosing Wisely Canada Co-design workshop, February 2017 in Calgary, AB

Choosing Wisely Canada

Choosing Wisely Canada is a campaign that helps physicians and patients engage in conversations about unnecessary tests, treatments and procedures. The goal is to help physicians and patients make smart and effective choices that ensure high-quality care.

CFHI partnered with Choosing Wisely Canada in 2016–2017 to explore how they could further engage with patients and the public in their campaign.

A one-day co-design workshop, held on February 28, 2017 in Calgary, was attended by 46 individuals from coast to coast and with a broad range of backgrounds and perspectives. Participants included patients, families and caregivers; patient advisors; researchers; clinicians; and representatives from patient, public and professional organizations from seven provinces and territories.

In all, patients and patient representatives constituted 33% of participants, which was essential to the support of the concept of patient engagement in co-design.

The workshop identified four key opportunities for Choosing Wisely Canada to pursue:

- Advance shared decision-making
- Create learning opportunities for providers
- Engage with other organizations to enhance reach of the campaign, and
- Facilitate multi-pronged awareness campaigns.

COMMUNITY CARE AND POPULATION HEALTH IMPROVEMENT FOR INNER-CITY AND MARGINALIZED POPULATIONS

Alignment with strategy goals and focus areas:

- Patient and family engagement
- Population health
- High-risk, high-cost populations
- Partnerships
- Access
- Spread

Participants at the Toward Better Health and Care for Inner-City Populations roundtable in Toronto, ON, March 2017

The need

Healthcare organizations are eager to accelerate improvements for those who need it most. Such populations, often referred to as “high risk, high cost,” are the 5% of Canadians who rely on upwards of 60% of healthcare services and costs. Meanwhile, marginalized or inner-city populations may be referred to as “high risk, high need/no cost” as they live with healthcare needs that the system is unable to address in isolation and which demand cross-sectoral approaches to maximize health outcomes, care and value.

> “The exciting thing is that health systems are partnering with people in community to coordinate and wrap around care to meet unmet social and health needs. We’re bearing the cost.”
>
> Roundtable participant

Toward better strategies

CFHI identified a common interest among the organizations it works with to explore and develop strategies for providing better community care for “high risk/high cost” and “high risk, high need/no cost” populations. To address the issue and learn from Canadian best practices, CFHI and St. Michael’s Hospital (Toronto) co-hosted a two-day roundtable in March 2017 that brought together individuals and organizations working in community care with marginalized populations.

The aims of the “Toward Better Health and Care for Inner-City Populations” roundtable were to:

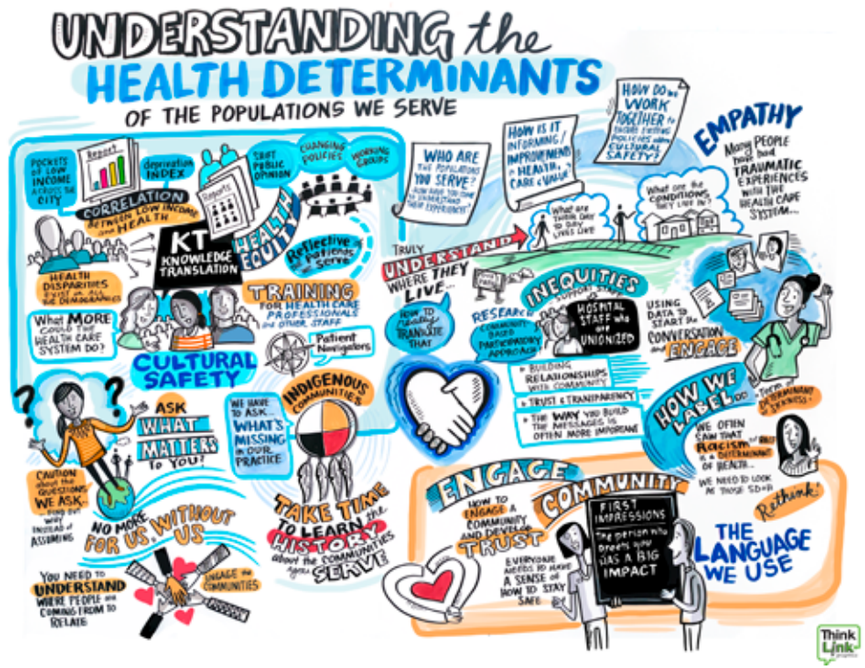
- better understand “inner-city” and “marginalized” populations and their care needs (but being mindful of how such terms may be both used and perceived)
- explore examples of how cross-sectoral action is working to enhance care, health, and value (known as the “Triple Aim”)
- discuss ways to sustain, spread and scale community care examples that work
- build networks, share expertise and promote collaboration

More than 60 individuals from within and outside the healthcare system – including several Institute for Healthcare Improvement international fellows, and people with lived experiences – attended the roundtable, sharing successful programs, experiences and tactics for increasing health equity and getting Triple Aim results with marginalized populations.

In conjunction with the event, CFHI commissioned a series of Canadian case studies of leading practices in community and population health with marginalized and inner-city populations.

The roundtable and case studies will inform future CFHI work aimed at supporting the sustainability and spread of specific examples of community care that yield measurable improvements for marginalized populations.

TOWARD BETTER HEALTH AND CARE FOR INNER-CITY POPULATIONS



INNOVATIONS IN PALLIATIVE AND END-OF-LIFE CARE

Alignment with strategy goals and focus areas:

- Patient- and family-centred care
- Access
- Partnerships
- Incubating innovation
- Coordination and transition
- Home care
- Palliative and end-of-life care
- High-risk, high-cost populations

CFHI's Maria Judd, second from right, was part of Canada's delegation at an international dialogue on rethinking end-of-life care in Salzburg, Austria.

The need

An estimated 70% or more of the 220,000 Canadians who die each year do not receive any hospice, palliative or end-of-life care – and often these services or a referral to palliative care are initiated only within the last days or weeks of life. In 2016–2017, CFHI took a number of important steps in developing our palliative care programming to help meet this pan-Canadian need.

One involved our 2016 call for applications to the EXTRA program, in which we made a specific appeal for teams to focus on the shared federal/provincial/territorial priority of palliative and end-of-life care. More than half of the teams chosen for EXTRA in 2016-2017 focused their improvement projects on these subjects.

As well, palliative and end-of-life care was the theme for our annual CEO Forum event, scheduled for June 2017. In keeping with our commitment to patient engagement, the Forum's steering committee includes several patient advisors and their families and caregivers who continue to add their expertise and perspectives to planning the day-long event.

Learning from the best

CFHI brought a Canadian delegation to Salzburg, Austria to be part of an international dialogue on rethinking end-of-life care. The conference was an opportunity for us to work shoulder-to-shoulder with organizations at the leading edge of palliative care and learn from the best models internationally to inform palliative care programming for Canada.

In February 2017, we issued an open call for innovations in palliative and end-of-life care practices in Canada, with the goals of deepening our understanding about the Canadian context and identifying models, programs and tools – both demonstrated and emerging – for potential pan-Canadian spread.

By April 1, we had launched the call, hosted a live webinar about the call that included over 100 participants, and were accepting applications with 69 received by the end of the fiscal year.

Many organizations, including the Canadian Nurses Association, Canadian Hospice Palliative Care Association, and the Canadian Society of Palliative Care Physicians, were instrumental in promoting our call for innovations.

These and other new partnerships – including those with patients and their families/caregivers – are being continually forged through our emerging work on palliative and end-of-life care. These partnerships provide valuable perspectives and continue to enrich our planning for future programming.

Palliative Care Matters conference

A partnership of 14 health-related organizations (including CFHI), healthcare experts and members of the public, led by Covenant Health, came together in November 2016 for the Palliative Care Matters Consensus Development Conference. The goal was to make recommendations for the future of palliative care in Canada.

The conference yielded a consensus statement that includes 20 specific recommendations for improving Canadians' access to palliative care – at the right time and in the right place.

CFHI was a major sponsor of the conference, serving on the steering committee and working group and providing expertise in the conference's evaluation phase. CFHI also supported patients and families/caregivers to plan, attend and help deliver the conference. This ensured that conference participants heard the voices and experience of those with first-hand knowledge of palliative care.

Recommendations from the conference will inform future CFHI programming in palliative and end-of-life care.

> "My wife is not a health care consumer. She is a person and she has a name. And people who care for her genuinely in my estimation are noble. It is the ancient, archetypal expression of human solidarity that one should care for another. And it is the measure of what is best in us as people and as a country."

Jim Mulcahy, family advisor, in opening remarks at the November 2016 Palliative Care Matters Consensus Development Conference, Ottawa, ON

Evaluating return on investment for paramedics providing palliative care

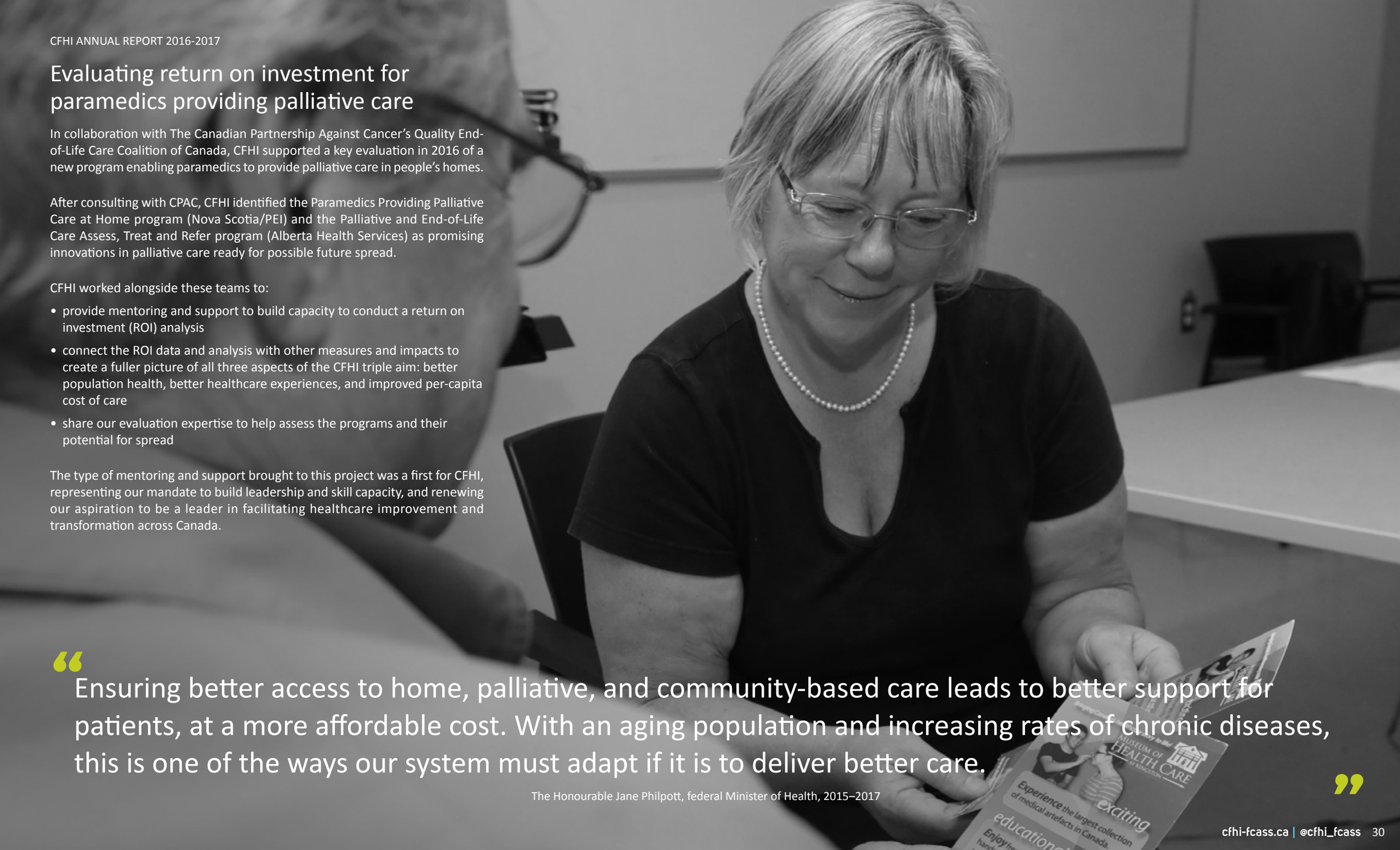
In collaboration with The Canadian Partnership Against Cancer's Quality End-of-Life Care Coalition of Canada, CFHI supported a key evaluation in 2016 of a new program enabling paramedics to provide palliative care in people's homes.

After consulting with CPAC, CFHI identified the Paramedics Providing Palliative Care at Home program (Nova Scotia/PEI) and the Palliative and End-of-Life Care Assess, Treat and Refer program (Alberta Health Services) as promising innovations in palliative care ready for possible future spread.

CFHI worked alongside these teams to:

- provide mentoring and support to build capacity to conduct a return on investment (ROI) analysis
- connect the ROI data and analysis with other measures and impacts to create a fuller picture of all three aspects of the CFHI triple aim: better population health, better healthcare experiences, and improved per-capita cost of care
- share our evaluation expertise to help assess the programs and their potential for spread

The type of mentoring and support brought to this project was a first for CFHI, representing our mandate to build leadership and skill capacity, and renewing our aspiration to be a leader in facilitating healthcare improvement and transformation across Canada.



> "Ensuring better access to home, palliative, and community-based care leads to better support for patients, at a more affordable cost. With an aging population and increasing rates of chronic diseases, this is one of the ways our system must adapt if it is to deliver better care."
>
> The Honourable Jane Philpott, federal Minister of Health, 2015–2017

EXTRA: EXECUTIVE TRAINING PROGRAM

Alignment with strategy goals and focus areas:

- EXTRA
- Disseminate results
- Building capacity
- Partnerships
- Leadership development
- Incubating innovation

About the program

Since 2004, CFHI's EXTRA: Executive Training Program has supported healthcare leaders as they design and implement critical improvements within organizations and evaluate the difference they make.

EXTRA is a unique, fully bilingual 14-month pan-Canadian improvement fellowship customized to support teams as they build leadership and quality improvement skills and put evidence-informed solutions into practice. EXTRA frequently acts as an incubator for improvement projects that are sustained and spread – often through CFHI pan-Canadian collaboratives.

EXTRA adheres to adult-learning principles and is delivered using a balance of in-person and virtual learning exchanges such as interactive webinars, affinity calls (opportunities for Fellows and faculty to discuss key topics of interest and best practice approaches), and an online learning platform called the CFHI Desktop. EXTRA is tailored to the unique needs of its Fellows.

EXTRA:

- Enhances the capacity of individuals and teams to make change happen.
- Builds the capacity of organizations to achieve and sustain improvement.
- Creates a pan-Canadian community of leaders dedicated to innovation

EXTRA by the Numbers

14 Years Running	**136** Canadian Organizations Have Participated
220 Improvement Projects	**372** Healthcare Professionals

Enhancing the EXTRA curriculum

In April 2016, CFHI launched a refreshed EXTRA program. The new EXTRA has kept the focus on evidence-informed decision-making – a core element of this proven program – while enhancing and integrating new core curriculum including patient and family engagement, greater emphasis on improvement methods and tools, and an introduction to Indigenous cultural competence.

> "This is a very efficient, effective investment. In a short time, you can realistically expect to implement a sustainable and breakthrough innovation."
>
> Isabelle Legault, Assistant to the President - Director General Assistant, Integrated Health and Social Services Centre (CISSS), Laval, QC

Clinical intake nurse Johanne Riseling with Hector MacMillan, a patient at Kingston General Hospital. KGH was one of the EXTRA Cohort 12 teams that focused its improvement project on palliative care.

Cohort 12: A focus on palliative care

In an effort to address unmet end-of-life needs across Canada, our call for proposals for EXTRA's 12th cohort made a specific appeal for teams to focus on the shared federal/provincial/territorial priority of palliative and end-of-life care.

Ten teams, involving 13 organizations, joined Cohort 12 in 2016. Here are a few:

- Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Ouest in Quebec developed an approach to better support palliative care in a home setting.
- Le Centre intégré universitaire de santé et de services sociaux Saguenay-Lac-St-Jean created a shared understanding among healthcare professionals of the transition to palliative care based on patient experiences.
- The Nova Scotia Health Authority implemented a palliative care approach in primary healthcare settings across the province.

Six EXTRA teams were from organizations in Quebec, where the program has become recognized as a key vehicle for advancing important healthcare initiatives and building professional careers. Four of these organizations had CEOs who were EXTRA alumni.

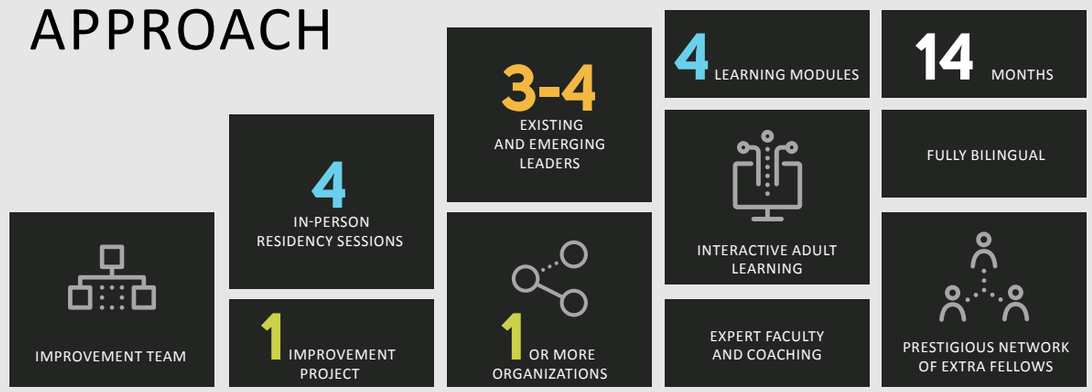
Cohort 13: A focus on integrated care

In October 2016, the EXTRA program launched a call for applications for its 13th cohort on the sub-theme of Integration of Care Close to Home. The focus is on integrating care across services, sectors and providers to deliver high-quality care in the patient's home or community. Projects aim to improve transitions between services, organizations or jurisdictions, and to explore ways to successfully shift the delivery of care from acute to home or community settings.

Nine teams, involving 10 organizations, were selected in March 2017 to participate. Six teams will focus on improving services and policies to support more Canadians in accessing quality integrated care close to home.

1. Centre intégré de santé et de services sociaux (CISSS) Montérégie Ouest (Quebec): Innovating to Establish Care and Services in the Community for Stroke Patients.
2. Centre intégré universitaire de santé et de services sociaux (CIUSSS) Centre-Sud-de l'île-de-Montréal (Quebec): The Transition Between Hospital Care and Community Care at Notre-Dame Hospital.
3. Centre intégré de santé et de services sociaux (CISSS) de Chaudière-Appalaches (Quebec): The personal support worker: FOR the user, FROM a logistics perspective.
4. Centre intégré universitaire de santé et de services sociaux (CIUSSS) Saguenay-Lac-St-Jean (Quebec): Quality, Accessibility and Proximity of Pediatric Palliative Care Services.
5. Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Est (Quebec): Involving Patient Advisors in Analyzing Serious Adverse Events.
6. Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Centre (Quebec): Public Health Control Room: Better Performance to Improve Citizens' Health.
7. Ottawa Regional Cancer Foundation (Ontario): Improving and Spreading Cancer Coaching.
8. BC Cancer Agency and Fraser Health (British Columbia): Enhancing the Community Oncology Network in B.C.
9. Nova Scotia Health Authority: There is No Place Like Home: Building a "home first" philosophy in NSHA and beyond.

THE EXTRA APPROACH



The EXTRA team from the Canadian Armed Forces of Cohort 12, with CFHI President Maureen O'Neil, second from right, and Terry Sullivan, Lead Faculty with EXTRA

Fit to serve

The Canadian Armed Forces' (CAF) Health Services Group participated in the EXTRA program for the first time in 2016 with the goal of improving the armed forces' Periodic Health Assessment (PHA). The PHA is administered to CAF members every few years to ensure they're fit to serve, and to screen them for occupational and environmental health hazards.

The team started with the premise that the existing PHA is cumbersome and not as patient-centred or effective as it needs to be.

Over two project phases, the armed forces team refined the PHA process by consulting closely with patients and other stakeholders and by reviewing best practices and evidence. The team then evaluated the refined PHA to gauge whether it was meeting its core requirements.

Determining that it was not feasible to address the PHA all at once, the team chose to focus on colorectal cancer (CRC) screening – a much simpler project that supported the project's overall goal to reduce the morbidity from preventable diseases for CAF personnel by 10% by June 2020.

The improvement project's aim is to ensure that 100% of CAF personnel over age 50 years are offered the CRC screening according to evidence-based guidelines by December 2018.

The CAF chose EXTRA for its interactive blended-learning model and because EXTRA enabled the team to join a pan-Canadian community of leaders dedicated to improvement. At the end of the 14-month EXTRA program, team members report that:

- There is interest within the CAF in future cohorts of this training
- Consideration is being given to establishing a collaborative
- It has helped reinforce the need for performance measurement
- It has started to shape a new way of thinking to achieve and sustain improvements

> "The delivery of EXTRA is unlike most other quality improvement projects. The interactive blended-learning model and expert Canadian faculty the program offers is an experience second to none."
>
> Shoba Ranganathan, Chief Quality and Patient Safety Officer, Canadian Armed Forces

ON CALL AND QUALITY IMPROVEMENT PRIMERS

Alignment with strategy goals and focus areas:

- Disseminate results
- Building capacity
- Leadership development

Building Improvement Capacity

Healthcare leaders and their teams achieve better results faster when they are equipped with appropriate knowledge, strategies, tools and evidence for their improvement projects. CFHI provides this via focused, expert-led webinars, on-demand videos and fellowships.

On Call webinars

CFHI's On Call webinars include single-event educational experiences, as well as a series on key healthcare topics. Now in its 10th season, On Call continues to engage participants from across Canada and internationally in live webinars that feature clinicians, managers and healthcare leaders who are accelerating healthcare improvement. Each session provides participants with concrete strategies, lessons, and results that can be applied to their own care settings.

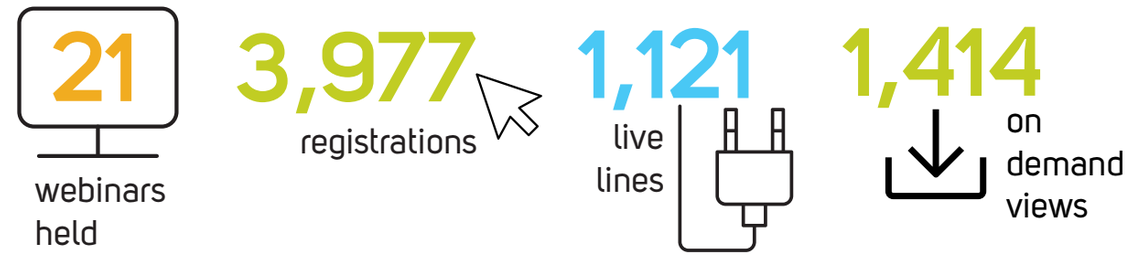
Quality improvement primer series

In 2016, CFHI developed quality-improvement primers on topics central to our quality improvement approach. Each primer takes the form of an on-demand video with an accompanying PDF document.

The primers deliver an introduction to a specific core curriculum issue and can be used as a complement to more intensive curriculum delivery. For example, improvement teams can view the primers either as background for more detailed information sessions or as refreshers when they participate in CFHI programs. To date, we have produced five primers:

- Team effectiveness
- Achieving successful improvement
- Highly adoptable improvement
- Driver diagrams
- Plan-do-study-act cycles

On Call by the numbers



who participated?

what participants had to say

"This webinar increased my knowledge..."

"I learned something new..." **"Excellent content and presenters."**

"...good amount of information from a variety of speakers..."

EVALUATION AND PERFORMANCE MEASUREMENT

Alignment with strategy goals and focus areas:

Evaluate results

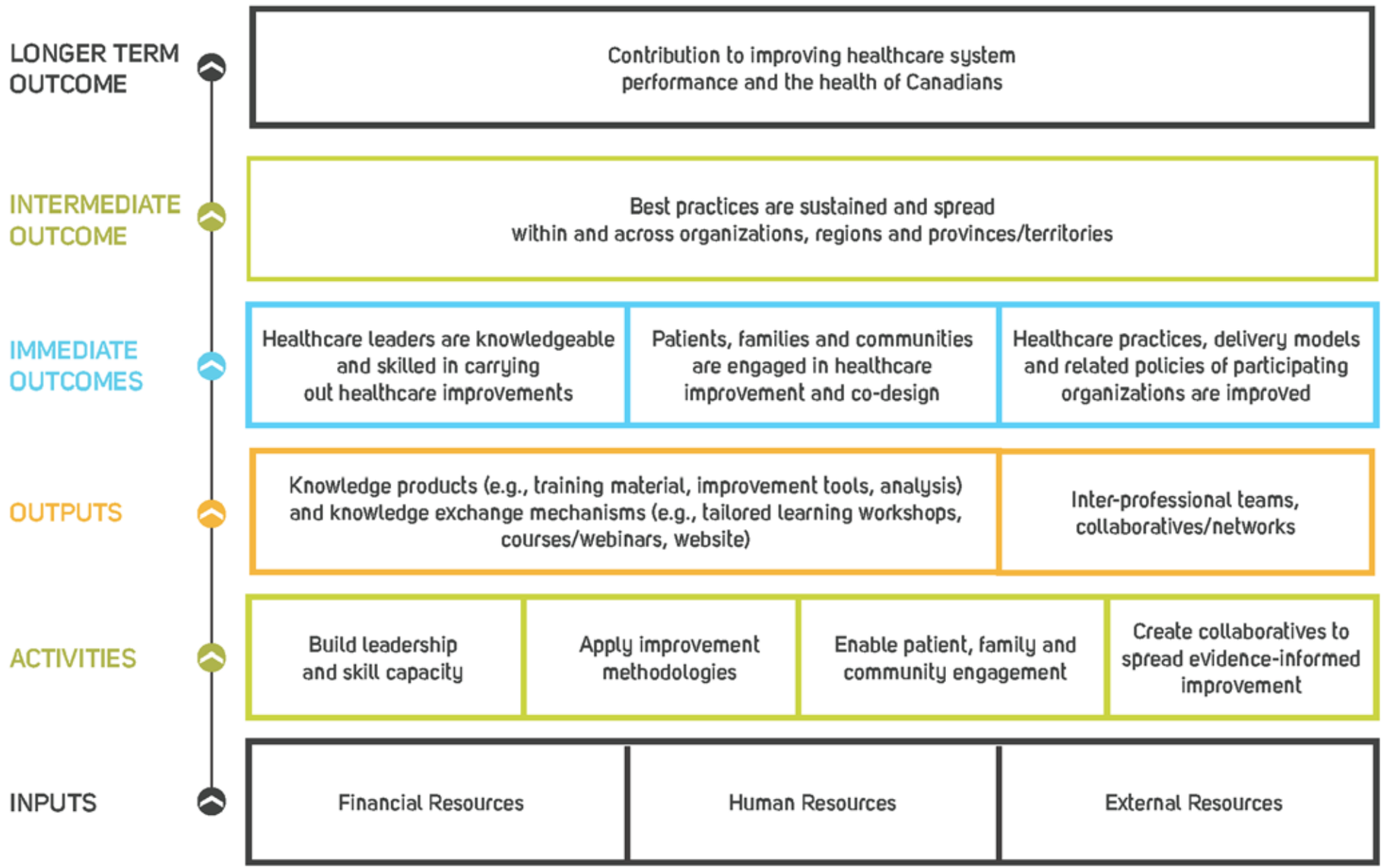
Disseminate results

LOGIC MODEL

CFHI builds the evaluation and performance measurement capacity of our staff and the improvement teams we support. The purpose of our evaluation activities is to demonstrate the impacts our work has on health outcomes, experiences of care for patients and families, and on return on investment for our programs.

CFHI offers tailored online learning sessions and performance measurement topics to participants in our collaboratives. Our evaluation practices are designed to be flexible and responsive to improvement teams' unique capacity, needs and infrastructure.

A detailed Performance Measurement Report is included as an appendix to this annual report and is available at cfhi-fcass.ca.



KNOWLEDGE TRANSLATION AND POLICY

Alignment with strategy goals and focus areas:

- Policy analysis
- Evaluate results
- Disseminate results

A knowledge translation and policy (KTP) strategy to accelerate healthcare quality improvement

To help make best practices more common and to share lessons for leading healthcare transformation, CFHI developed a formal KTP strategy in 2016–2017.

Goals of CFHI's KTP Strategy

- Develop CFHI's expertise and reputation as the "go-to" organization for healthcare improvement in Canada, particularly as it relates to spread, scale, and sustainability of quality improvement, healthcare transformation and related policy considerations.
- Build our organizational KTP leadership capacity and expertise, equipping CFHI staff with the necessary KT and implementation skills to support improved delivery of CFHI's priorities.
- Refine our evaluation processes to better demonstrate the reach and impacts of our KTP work, and continually improve, while learning from other high-performing KTP organizations within Canada and internationally.

How we developed our strategy

We applied a mixed-method approach over a four-month period (January – April 2017) to inform the strategy's development.

Key informant interviews and focus groups:

37 **interviewees** with 21 internal and 16 external participants

Document analysis:

85 **products** reviewed across CFHI teams

Environmental scan:

14 **Canadian and international organizations**

Literature review:

11 **relevant articles** including systematic, scoping and other reviews

Results

Recommendations focused on four areas to drive spread and scale of healthcare improvement.

Process

- Build CFHI staff KT capacity
- Align planning and evaluation efforts across programs and teams
- Disseminate the CFHI Improvement Model

Activities

- Prioritize approaches based on sound evidence of effectiveness, reach and impact
- Deliver policy and practice briefs

Target audiences

- Reach across the spectrum of CFHI's stakeholders and partners (end-users, clinicians, senior leadership/ boards, and policy-makers)

Resources

- Embed KTP capacity across the organization

CFHI ON THE ROAD

In 2016–2017, CFHI was invited to conferences and events across Canada and around the world, where we shared our work, the results of our initiatives, and the benefits of our improvement approach.

Here are a few of the key events we attended.

- Canadian Association for Health Services and Policy Research (CAHSPR)
- National Health Leadership Conference (NHLC)
- BC Patient Safety and Quality Council, annual quality forum
- Canadian Home Care Association Summit
- Canadian Nursing Students Association (MB)
- Better Breathing (Canadian Lung Association)
- International meeting on Indigenous Child Health (Canadian Paediatric Association)
- Canadian Collaborative Mental Health Conference
- Advanced Learning in Palliative Medicine Conference
- Rural Physicians Summit
- Partnerships in Care, Inter-professional Education session (Institute for Patient- and Family-Centred Care)
- National Forum on Patient Experience
- Médécins francophone du Canada

PARTNERSHIPS

CFHI works with governments and other healthcare partners to promote better care, value and health. These partners and clients include healthcare delivery organizations spanning the continuum of care, regional health authorities, provincial-territorial departments of health and agencies, and other national and international organizations.

Collaboration is at the heart of our programming; each initiative seeks to match unique local priorities, needs and capacity with CFHI's coaches, faculty, resources and tools.

In 2016–2017, we welcomed an increased collaboration with patients, residents, family members, caregivers, community members, and patient advisors, whose valuable perspectives continue to enrich our initiatives, programs and events.

The following are supporting organizations to the Better Together campaign:

- Accreditation Canada
- British Columbia Patient Safety and Quality Council
- Canadian College of Health Leaders
- Canada Health Infoway
- Canadian Patient Safety Institute
- Health Quality Council of Alberta
- IMAGINE Citizens Collaborating for Health
- Manitoba Institute for Patient Safety
- Patients Canada
- Patients for Patient Safety Canada
- Registered Nurses Association of Ontario
- Saskatchewan Health Quality Council

The Acute Care for Elders (ACE) collaborative is offered in partnership with:

- Canadian Frailty Network (formerly Technology Evaluation in the Elderly Network)
- Sinai Health System (Toronto)

Partners in the Appropriate Use of Antipsychotics (AUA)

- Government of New Brunswick
- New Brunswick Association of Nursing Homes
- York Care Centre
- interRAI
- CIHI

Partners in "CARES"

- Fraser Health Authority, B.C.
- Nova Scotia Health Authority
- Shannex Inc. (Nova Scotia)
- Canadian Geriatrics Society

Partners in Palliative and End-Of-Life Care

- Covenant Health
- Canadian Nurses Association
- Canadian Hospice Palliative Care Association
- Canadian Society of Palliative Care Physicians
- Canadian Partnership Against Cancer

Partners in Community Health and Marginalized Populations

- St. Michael's Hospital, Toronto

Partners in PREVIEW-ED©

- Fraser Health Authority, B.C.
- Interior Health Authority, B.C.

Supporting organizations for the EXTRA: Executive Training Program, Cohort 13

- Canadian Nurses Association
- Canadian Patient Safety Institute
- Canadian College of Health Leaders
- BC Patient Safety and Quality Council
- The College of Family Physicians of Canada
- Canadian Health Leadership Network
- Health Quality of Council of Alberta

The Connected Medicine collaborative is offered in partnership with:

- The College of Family Physicians of Canada
- Canada Health Infoway
- Royal College of Physicians and Surgeons of Canada

Partners in collaborating to improve Northern and Indigenous Health

- First Nations Health Managers Association
- Thunderbird Partnership Foundation
- National Collaborating Centre for Aboriginal Health
- The Circle of Philanthropy with Aboriginal Peoples
- International Initiative on Mental Health Leadership

Members of the Canadian Northern and Remote Health Network

- Alberta Health Services, North Zone
- First Nations Health Authority (British Columbia)
- North East Ontario Local Health Integration Network (Ontario)
- Northern Health Authority (British Columbia)
- Northern Regional Health Authority (Manitoba)
- Northwest Territories Department of Health and Social Services
- Nunavut Department of Health
- Prince Albert Parkland Health Region (Saskatchewan)
- Western Health (Newfoundland and Labrador)
- Winnipeg Regional Health Authority, Churchill Health Centre Division (Manitoba)
- Yukon Department of Health and Social Services

Co-chairs/Partners in the Delivery of We Belong

- Thunderbird Partnership Foundation

CHALLENGES AND RISKS

Working to manage health system challenges

Canada continues to face persistent challenges in achieving efficient, coordinated, patient-and family-centred healthcare in all provinces and territories. Our health system places in the middle of the pack, or worse, in international comparisons, and has done so for many years. Indigenous health outcomes are of particular concern.

Examples do exist in Canada of aligning structures and incentives to provide appropriate care closer to home to the patients who need it most, including people with multiple chronic conditions and the frail elderly. However, these innovations remain isolated pockets of excellence. Too often, these innovative ways of meeting healthcare challenges are not shared and implemented across the country.

Many organizations are striving to improve healthcare, but identifying shared priorities and coordinating efforts requires time and collaboration between healthcare partners.

In 2016–2017, our specific challenges included aligning our priorities with federal, provincial and territorial priorities and building our capacity to engage with health sector leaders to make change. The latter includes finding effective ways to identify innovations that are most likely to spread and scale and, as a result, benefit the most Canadians. As we work to spread these innovations across the country, we must also ensure that each is adequately evaluated, not only for its impact, but also for its likely impact when it is spread farther.

Within these realities, an opportunity emerges for CFHI to assert its unique role as a flexible and responsive leader in health system transformation. We can take the lessons we have learned about spread at the micro and meso levels and apply that experience and knowledge to macro-level challenges – bundled payment and primary care reform, for example.

Our excellent engagement with healthcare policy-makers and institutions across the country will facilitate the alignment of our priorities with those of the federal, provincial and territorial governments.

Although CFHI has a modest capacity relative to Canada's performance gaps, the stable, ongoing funding announced in Budget 2017 will allow us to plan over the longer term, giving us and our partners confidence that success is within reach.

Mitigating risks

	Type of risk	Mitigation strategies
Operational risks	CFHI and its partners could experience delays in implementing programs – for example, delays in finalizing agreements with partners — which could reduce their relevance and strain CFHI's ability to spend its annual funding.	CFHI management has implemented structured, ongoing monitoring of all programs (including through our Performance Management Framework) to ensure programs' progress. We have also reorganized program portfolios, revised the MOU template, and revamped our model for collaboratives and the EXTRA program so that programs are relevant and timely. Senior management is re-profiling the monies in appropriate ways to reduce the risk of underspending, and has introduced monthly reviews of expenditures and programming to ensure these issues are alerted to Health Canada and the Board in a timely manner.
	CFHI's financial and human resource limitations could result in us being unable to respond to demands for more programming, as more organizations approach us to work with them on their particular issues and challenges.	Robust and transparent approaches to priority-setting can support the appropriate decisions on programs to pursue.
Financial risks	Rising program costs could prevent CFHI from meeting its obligations to implement programming.	CFHI follows a rigorous financial planning mandate that includes, among other things, quarterly forecasting and review of financial statements with senior staff, monthly budget meetings, and a mid-year financial review of our progress against our program of work. Our new finance system will allow for greater transparency and access to the finances for staff, which will allow greater oversight.
	In keeping with sound financial management practices, CFHI needs to apply a consistent approach to all aspects of managing expenditures related to corporate infrastructure, and to identify and address issues that may arise during the fiscal year.	CFHI has in place a stringent set of procurement and expenditure policies, and this year has revised its procurement policy and practices to clearly distinguish sole source contracting and single source contracting. We contract auditors to undertake annual audits and reviews of our expenditures, and will be introducing an internal audit function for 2017–18. In addition, our Finance and Audit Committee and the Board of Directors oversee all expenditures.
Strategic risks	An inability to secure funding could prevent CFHI from meeting its current and future obligations.	Ongoing federal funding for CFHI, announced in Budget 2017, ensures long term financial stability.
	Coordinated, corporate, evidence-informed decision-making is needed for CFHI to make sound decisions that lead to continuous improvements in quality.	CFHI is committed to a program of continuous quality improvement in which we perform formative and summative evaluations across all programs on a regular basis, and use inputs such as event surveys and website analytics to improve quality. Other organizations have conducted independent analyses and evaluations of our work (e.g., a five-year evaluation by RiskAnalytica), and our Performance Measurement Framework also contributes to a culture of continuous improvement.

	Type of risk	Mitigation strategies
Strategic risks	CFHI must communicate its mission and programming clearly, in order to fulfill its strategic objectives and ensure its mission and role are clearly defined.	CFHI has managed this challenge in a many ways over several years. These include a 2012 re-branding exercise, which produced CFHI's new name; the allocation of significant resources to communicate CFHI's mission and programs; and a committed program to steadily increase reach and engagement across communications channels. These activities, combined with recent increases in funding and the current development of a new strategy document, have created momentum toward greater awareness and recognition of CFHI's mission and work. CFHI's work plan focuses on the organization's specific niche, which our 2012 branding exercise clarified. Our continued engagement with other organizations, including through the Interagency Collaborative Group, helps enhance our partnerships and avoid mandate conflicts.
	CFHI works in partnership with other organizations on virtually all its programming. This presents the potential risk that our reputation will suffer should our partners fail to deliver on their work.	We continue to engage with our partners and ensure that all partnerships benefit from careful management oversight. Our revised MOU template, which we share with prospective partners in advance, helps ensure that roles and expectations are clearly understood in advance.
	To achieve the greatest impact, CFHI needs to align its programming with F/P/T priorities while still managing our own strategic priorities and ensuring that our programs remain relevant.	CFHI currently has F/P/T representation on its Board of Directors, and engages with F/P/T governments and other stakeholders to inform its priorities and programming. As well, our programs are currently being implemented in 10 Canadian provinces and two territories.
Information and technology management risks	CFHI, like other organizations, manages a great deal of protected corporate information and intellectual property (IP). There is an inherent risk that these elements could be inappropriately disseminated.	CFHI has written new, protective IP clauses into its MOUs, agreements and contracts; improved its security firewall and other aspects of its IT infrastructure; introduced security audits; and trained all staff on document security. In addition, CFHI seeks trademarks and other IP protections, as appropriate. In the past year, we migrated our Office 365 environment from U.S. data centres to Canadian data centres.
Human resources risks	Corporate memory could be lost due to employee turnover, reducing CFHI's capacity to run projects and programs effectively.	CFHI uses exit interviews for all departing staff, which inform detailed checklists for handover. We have made contact relationship management software a priority for 2017, as well as new IT strategies to ensure we retain key documents when employees leave. We identify turnover risks within carefully monitored work plans and have documented a formal replacement plan and succession plan.
Human resources risks	CFHI faces a potential inability to recruit highly qualified staff.	CFHI has successfully recruited and retained key staff for all major roles in the organization. We use talent mapping, allowing the organization to determine skill sets of staff and to redeploy staff to new projects requiring those skills. We also enhance the capacity of our staff by using external experts. CFHI places a priority on encouraging work-life balance, healthy living and workplace mental health initiatives. We provide permanent contracts to staff, review their compensation regularly, and provide coaching and mentoring. Greater certainty about our funding has improved our attractiveness to current and potential staff.
	As a growing organization, CFHI faces the risk of being unable to onboard the highly-qualified employees it requires.	CFHI's management has monitored and slowed the pace of recruitment to facilitate onboarding. Our Monday morning all-staff huddles and updated orientation, training and development programs include a new 'buddy' system. These actions have the combined effect of ensuring new staff feel oriented, welcome and included.

REPORT OF THE INDEPENDENT AUDITORS ON THE SUMMARY FINANCIAL STATEMENTS

To the Directors of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé

The accompanying summary financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé, which comprise the summary statement of financial position as at December 31, 2016, the summary statement of operations for the year then ended, and related notes, are derived from the audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations, of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé as at and for the year ended December 31, 2016.

We expressed an unmodified audit opinion on those financial statements in our report dated March 23, 2017.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations applied in the preparation of the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé.

Management's Responsibility for the Summary Financial Statements

Management is responsible for the preparation of the summary financial statements in accordance with the basis described in note 1.

Auditors' Responsibility

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, "Engagements to Report on Summary Financial Statements."

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé as at December 31, 2016 and for the year then ended are a fair summary of those financial statements, in accordance with the basis described in note 1.

Chartered Professional Accountants, Licensed Public Accountants
March 23, 2017
Ottawa, Canada

Summary Statement of Financial Position

December 31, 2016, with comparative information for 2015
(In thousands of dollars)

	2016	2015
Assets		
Cash	$ 1,653	$ 1,939
Accounts receivable	627	381
Prepaid expenses	166	120
Investments	3,800	8,355
Employee future benefits	1,006	618
Tangible capital and intangible assets	296	92
Investments - Wind-Up Reserve	8,537	–
	$ 16,085	$ 11,505
Liabilities and Deferred Contributions		
Accounts payable and accrued liabilities	$ 1,414	$ 1,033
Deferred revenue	124	–
Capital lease obligations	–	10
Deferred contributions - Operations	3,903	10,462
Deferred contributions - Wind-Up Reserve	10,644	–
	$ 16,085	$ 11,505

See accompanying notes to summary financial statements.

Summary Statement of Operations

Year ended December 31, 2016, with comparative information for 2015
(In thousands of dollars)

	2016	2015
Revenue		
Program support revenue	$ 377	$ 391
Other revenue	240	445
Recognition of deferred contributions relating to operations of the current year	10,399	10,507
Recognition of deferred contributions relating to tangible capital and intangible assets	108	79
	$ 11,124	$ 11,422
Expenses		
Collaboration for Innovation and Improvement	$ 3,183	$ 3,397
Patient Engagement for Healthcare Improvement	1,124	1,821
Education and Training	1,565	2,086
Evaluation and Performance Management	791	549
Northern and Indigenous Health	1,869	948
Communications	1,759	1,486
Administration	692	1,045
Amortization of tangible capital and intangible assets	109	79
Investment management fees	34	37
Employee future benefits	(2)	(26)
	11,124	11,422
Excess of revenue over expenses	$ –	$ –

See accompanying notes to summary financial statements.

Notes to Summary Financial Statements

Year ended December 31, 2016

The Canadian Foundation for Healthcare Improvement ("CFHI") is dedicated to accelerating healthcare improvement and transformation for Canadians. As such, it collaborates with governments, policy-makers, and health system leaders to convert evidence and innovative practices into actionable policies, programs, tools and leadership development. CFHI changed its name from the Canadian Health Services Research Foundation effective April 5, 2012.

CFHI is a registered charity and accordingly, is exempt from income taxes under paragraph 149(1)(l) of the Income Tax Act (Canada). The organization became operational in fiscal 1997 and is incorporated under the Canada Corporations Act. Effective June 17, 2014, CFHI was continued under the Canada Not-for-profit Corporations Act.

Under the Federal Budget 1996, the Government authorized Health Canada to pay $55,000,000 to CFHI (then CHSRF) over a five-year period. As part of the same agreement, the Medical Research Council agreed to contribute $10,000,000 and the Social Sciences and Humanities Research Council of Canada agreed to contribute $1,500,000 over the same five-year period. In 1999, the Federal Government granted $35,000,000 to CFHI for participation in the Canadian Institutes of Health Research (this partnership led to the development and implementation of the Capacity for Applied and Developmental Research and Evaluation (CADRE) program), and another $25,000,000 to support a ten-year nursing research fund. In 2003, the Federal Government provided $25,000,000 for the implementation of the Executive Training for Research Application (EXTRA) program over a thirteen-year period.

In 2009, CFHI entered into a Comprehensive Funding Agreement with Health Canada. This agreement supersedes the previous agreements. Under this agreement CFHI was directed to hold all investments in fixed income securities within a single investment portfolio. The agreement enabled CFHI to report their operations under a single program. On March 16, 2016, CFHI signed a contribution agreement with Health Canada, providing $14 million of funding to CFHI to continue its operations until March 2017. On November 10, 2016, CFHI signed an amendment to the contribution agreement, providing an additional $39 million of funding to CFHI for eligible expenditures up to March 31, 2019. The new agreement allows CFHI to reserve its unused deferred contribution balance as at December 31, 2015 in the event of a possible wind-up. In response to this, the Board of Directors approved a revised investment policy on October 20, 2016 with the objective to protect the reserve from undue risk and to enable growth where appropriate.

1. Summary financial statements:

The summary financial statements are derived from the complete audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations, as at and for the year ended December 31, 2016.

The preparation of these summary financial statements requires management to determine the information that needs to be reflected in the summary financial statements so that they are consistent, in all material respects, with or represent a fair summary of the audited financial statements.

These summary financial statements have been prepared by management using the following criteria:

(a) whether information in the summary financial statements is in agreement with the related information in the complete audited financial statements; and

(b) whether, in all material respects, the summary financial statements contain the information necessary to avoid distorting or obscuring matters disclosed in the related complete audited financial statements, including the notes thereto.

Management determined that the statements of deferred contributions and cash flows do not provide additional useful information and as such has not included them as part of the summary financial statements.

2. Remuneration:

The total remuneration, including any fees, allowances or other benefits, paid to its 59 full time employees by CFHI is $5,525,819 in 2016.

	Salary	Taxable Benefits	Total
President	302,836	300	303,136
Vice President - Programs	200,533	1,360	201,893
Vice President - Corporate Services	200,986	1,697	202,683
Corporate Secretary	77,070	552	77,622

Job Level	December 31, 2016		
	Min	Max	No of FTE
Senior Director	92,400	171,600	5
Director	78,400	145,600	4
Senior Advisor	75,200	112,800	15
Program Officer	48,800	96,000	29
Assistant	41,600	62,400	2

The complete audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé are available upon request by contacting the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé.

REPORT OF THE INDEPENDENT AUDITORS ON THE SUMMARY FINANCIAL STATEMENTS

To the Directors of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé

The accompanying summary financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé, which comprise the summary statement of financial position as at March 31, 2017, the summary statement of operations for the three months then ended, and related notes, are derived from the audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations, of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé as at and for the three months ended March 31, 2017.

We expressed an unmodified audit opinion on those financial statements in our report dated June 19, 2017.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations applied in the preparation of the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé.

Management's Responsibility for the Summary Financial Statements

Management is responsible for the preparation of the summary financial statements in accordance with the basis described in note 1.

Auditors' Responsibility

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, "Engagements to Report on Summary Financial Statements."

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé as at and for the three months ended March 31, 2017 are a fair summary of those financial statements, in accordance with the basis described in note 1.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants
June 19, 2017
Ottawa, Canada

Summary Statement of Financial Position

March 31, 2017, with comparative information as at December 31, 2016
(In thousands of dollars)

	2017	2016
Assets		
Cash	$ 2,587	$ 1,653
Accounts receivable	453	627
Prepaid expenses	187	166
Short-term investments	4,000	3,800
Employee future benefits	1,188	1,006
Tangible capital and intangible assets	1,196	296
Investments - Wind-Up Reserve	8,586	8,537
	$ 18,197	$ 16,085
Liabilities and Deferred Contributions		
Accounts payable and accrued liabilities	$ 2,011	$ 1,414
Deferred revenue	62	124
Deferred contributions - Operations	5,431	3,903
Deferred contributions - Wind-Up Reserve	10,693	10,644
	$ 18,197	$ 16,085

See accompanying notes to summary financial statements.

Summary Statement of Operations

Three months ended March 31, 2017, with comparative information for the year ended December 31, 2016
(In thousands of dollars)

	2017	2016
Revenue		
Recognition of deferred contributions relating to operations of the current year	$ 3,616	$ 10,399
Program support revenue	20	377
Other revenue	157	240
Recognition of deferred contributions relating to tangible capital and intangible assets	54	108
	$ 3,847	$ 11,124
Expenses		
Collaboration for Innovation and Improvement	$ 1,252	$ 3,183
Patient Engagement for Healthcare Improvement	365	1,124
Education and Training	560	1,565
Evaluation and Performance Management	417	791
Northern and Indigenous Health	443	1,869
Communications	553	1,759
Administration	200	692
Amortization of tangible capital and intangible assets	54	109
Investment management fees	10	34
Employee future benefits	(7)	(2)
	3,847	11,124
Excess of revenue over expenses	$ –	$ –

See accompanying notes to summary financial statements.

Notes to Summary Financial Statements

Three months ended March 31, 2017

The Canadian Foundation for Healthcare Improvement ("CFHI") is dedicated to accelerating healthcare improvement and transformation for Canadians. As such, it collaborates with governments, policy-makers, and health system leaders to convert evidence and innovative practices into actionable policies, programs, tools and leadership development. CFHI changed its name from the Canadian Health Services Research Foundation effective April 5, 2012.

CFHI is a registered charity and accordingly, is exempt from income taxes under paragraph 149(1)(l) of the Income Tax Act (Canada). The organization became operational in fiscal 1997 and is incorporated under the Canada Corporations Act. Effective June 17, 2014, CFHI was continued under the Canada Not-for-profit Corporations Act.

Under the Federal Budget 1996, the Government authorized Health Canada to pay $55,000,000 to CFHI (then CHSRF) over a five-year period. As part of the same agreement, the Medical Research Council agreed to contribute $10,000,000 and the Social Sciences and Humanities Research Council of Canada agreed to contribute $1,500,000 over the same five-year period. In 1999, the Federal Government granted $35,000,000 to CFHI for participation in the Canadian Institutes of Health Research (this partnership led to the development and implementation of the Capacity for Applied and Developmental Research and Evaluation (CADRE) program), and another $25,000,000 to support a ten-year nursing research fund. In 2003, the Federal Government provided $25,000,000 for the implementation of the Executive Training for Research Application (EXTRA) program over a thirteen-year period.

In 2009, CFHI entered into a Comprehensive Funding Agreement with Health Canada. This agreement supersedes the previous agreements. Under this agreement CFHI was directed to hold all investments in fixed income securities within a single investment portfolio. The agreement enabled CFHI to report their operations under a single program.

On March 16, 2016, CFHI signed a contribution agreement with Health Canada, providing $14 million of funding to CFHI to continue its operations until March 2017. On November 10, 2016, CFHI signed an amendment to the contribution agreement, providing an additional $39 million of funding to CFHI for eligible expenditures up to March 31, 2019. The new agreement allows CFHI to reserve its unused deferred contribution balance as at December 31, 2015 in the event of a possible wind-up. In response to this, the Board of Directors approved a revised investment policy on October 20, 2016 with the objective to protect the reserve from undue risk and to enable growth where appropriate.

1. Summary financial statements:

The summary financial statements are derived from the complete audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations, as at and for the three months ended March 31, 2017.

The preparation of these summary financial statements requires management to determine the information that needs to be reflected in the summary financial statements so that they are consistent, in all material respects, with or represent a fair summary of the audited financial statements.

These summary financial statements have been prepared by management using the following criteria:

(a) whether information in the summary financial statements is in agreement with the related information in the complete audited financial statements; and

(b) whether, in all material respects, the summary financial statements contain the information necessary to avoid distorting or obscuring matters disclosed in the related complete audited financial statements, including the notes thereto.

Management determined that the statements of deferred contributions and cash flows do not provide additional useful information and as such has not included them as part of the summary financial statements.

2. Remuneration:

The total remuneration, including any fees, allowances or other benefits, paid to its 58 full time employees by CFHI is $1,740,777 for the three months ended March 31, 2017.

	Salary	Taxable Benefits	Total
President	81,316		81,316
Vice President - Programs	53,846	217	54,063
Vice President - Corporate Services	54,169	329	54,498
Corporate Secretary	20,643	131	20,774

Job Level	March 31, 2017		
	Min	Max	No of FTE
Senior Director	93,786	174,174	5
Director	79,576	147,784	3
Senior Advisor	76,328	114,492	15
Program Officer	49,532	97,440	29
Assistant	36,540	63,336	2

The complete audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l'amélioration des services de santé are available upon request by contacting the Canadian Foundation for Healthcare Improvement/ Fondation canadienne pour l'amélioration des services de santé.

2016–2017 CFHI BOARD OF DIRECTORS

LYNN STEVENSON, CHAIR

Associate Deputy Minister, Health Services
British Columbia Ministry of Health
Victoria, British Columbia

TOM R. CLOSSON, VICE-CHAIR

Former President and CEO
Ontario Hospital Association
Toronto, Ontario

MARTIN BEAUMONT

President and CEO of Centre intégré universitaire de santé et de services sociaux de la Mauricie-et-du-Centre-du-Québec (CIUSSS MCQ)
Trois-Rivières, Québec

LINDSAY CROWSHOE

Associate Professor
Department of Family Medicine
University of Calgary

DEBBIE DELANCEY

Deputy Minister, Health and Social Services
Government of the Northwest Territories
Yellowknife, Northwest Territories

VINCENT DUMEZ

Co-director, Center of Excellence on Partnering with Patients and the Public (CEPPP)
Faculty of Medicine, Université de Montréal
Research Centre of the Centre hospitalier de l'Université de Montréal (CRCHUM)

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Distinguished Visiting Scholar, Ryerson University Law Research Centre
Former Chair, Board of Trustees, Hospital for Sick Children,
Toronto, Ontario

Canadian Foundation for **Healthcare Improvement**

Fondation canadienne pour **l'amélioration des services de santé**

150 Kent Street, Suite 200
Ottawa, Ontario K1P 0E4
Canada

T: 613-728-2238
info@cfhi-fcass.ca