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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, 2017 to March 31, 2018 – referred to as 2017–2018 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.

Cover Photo: Jackie Paquet, a resident at Harbour View Hospital in Sydney Mines, Nova Scotia, plays shuffleboard in Harbour View's new family space.

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Message From the President and Chair

In 2017–2018, as governments and healthcare organizations across the country strove to efficiently deliver high-quality services that improve the health of their populations, CFHI was by their side supporting many of their improvement journeys.

his was a year of growth – both for our organization as we enhanced our capacity to collaborate with our partners, and of our impact as we worked with more improvement teams across all sectors of our health systems to achieve even better outcomes for Canadians. We were particularly pleased to contribute to advancing shared federal, provincial and territorial priorities and to successfully forge partnerships with governments across the country to further scale proven innovations on these key issues. Throughout this annual report, you will find many examples of the outputs produced and outcomes achieved as we worked shoulder-to-shoulder with our partners to meet our objectives.

With governments at all levels emphasizing innovation, CFHI works with health system leaders to champion the shift from providing services in hospital to meeting the needs of patients and families at home and in the community. Our Connected

Medicine collaborative – a partnership with Canada Health Infoway, The College of Family Physicians and Surgeons of Canada and the Royal College of Physicians and Surgeons of Canada – is assisting interprofessional teams from seven jurisdictions to implement proven models of remote consult that will speed timely patient access to specialist advice. This is an area where Canada scores lowest compared to other high-income countries.

Through our EXTRA Executive Training Program, a cohort of health system leaders worked as teams to incubate innovations that provide integrated care closer to home. And, after spreading the INSPIRED hospital-to-home outreach model for patients with chronic diseases such as chronic obstructive pulmonary disease, this year we began to assist six health systems that had sustainably reduced emergency department visits and hospital readmissions for COPD to scale their outreach programs to more providers, sites and patients.

Likewise, for palliative and end-of-life care, a cohort of EXTRA teams focused on developing and implementing innovations on this shared priority. We also launched an open call for innovations, asking innovators across the country to share with us their emerging and demonstrated innovations in palliative and end-of-life care. From that open call, we have been collaborating with several of the selected innovators. In partnership with the Canadian Partnership Against Cancer we have also launched a collaborative to expand access to palliative services provided by paramedics in the home.

Nine of 11 teams in our Connected Medicine collaborative have included psychiatry in their remote consult service to date. Also, with health regions in the Northern and Remote Health Network, along with our Indigenous partners, we have worked closely to build a new suicide-prevention collaborative called Promoting Life Together.

CFHI partnered with additional provincial and territorial governments to further scale the appropriate use of antipsychotic medications. Our Appropriate Use of Antipsychotics (AUA) collaborative entered the second phase of its scale across New Brunswick nursing homes, providing more person-centred dementia care that reduces reliance on these medications. Reducing the inappropriate use of antipsychotics decreases falls and does not increase aggressive behaviour among patients.

The success of the AUA approach prompted Quebec stakeholders, including the health and social services ministry, to launch a province-wide rollout of AUA across all their Centres d'hébergement et de soins de longue durée (long term care homes). We were pleased to be asked to partner and support their work. As the year ended, we celebrated the further spread of this initiative with a new AUA collaborative that will scale this approach across long term care (LTC) homes in Newfoundland and Labrador, Prince Edward Island and other sites across North America.

With all this activity and so many teams demonstrating significant improvements in quality within their organizations and systems, it is worth celebrating positive nationwide trends. In 2012–2013, rates for potentially inappropriate use of antipsychotics in LTC across Canada were at 31.3 percent. Since then, they have fallen significantly, and in 2016–2017 stood at 20.4 percent nationwide. This tremendous improvement results from the strenuous efforts of stakeholders across the country; nonetheless, there are still improvements to be made.

None of this work would have been possible without the increased and stable funding announced in federal budgets 2016 and 2017. We took time this year to celebrate several years of growth for our collaboratives by bringing patients, families and healthcare teams to Parliament Hill to share their success with the Minister of Health and other parliamentarians. And we marked a new chapter in CFHI's scale as an organization, moving into a new office in downtown Ottawa that gives us the space we need to evolve and meet new opportunities.

Looking to the future, we asked health leaders across the country for their advice on the best ways to improve healthcare and accelerate health system transformation, as well as to identify new opportunities for collaboration. They told us that CFHI is recognized as having unique expertise in spreading and scaling innovations and building capacity for system-level transformation. We also heard that shifting care from hospital to home and community, primary care reform and integration are their key priorities. Their contributions were invaluable as we consider future programming.

As the year ended, an external review of the eight federally funded pan-Canadian health organizations (PCHOs) recommended ways of enhancing the collective impact of the PCHOs.





"CFHI identifies proven innovations to known deficiencies in Canadian healthcare and, working with willing innovators, we spread these better ways of working. In 2017–2018, we were pleased to begin to scale many of these innovations across jurisdictions so that they benefit more Canadians."

Maureen O'Neil, O.C.
President

"This year was marked by enhanced stakeholder engagement as CFHI began the important work of renewing our corporate strategy to deliver even greater impact on shared health priorities. We see a bright future working closely with governments, PCHOs and other stakeholders to transform our health system for the 21st century and meet the needs of all Canadians"

R. Lynn Stevenson
Chair, Board of Directors

Spreading and scaling innovation across Canada



Results by the numbers



PROGRAMS AND COLLABORATIVES REACHED

13	Canadian provinces and territories
1**	Country outside Canada
58%*	Improvement teams reported making improvements to efficiency of care
73%* >	Improvement teams reported making improvements in patient experience
71%*	Improvement teams reported making improvements in patient health

 $[\]hbox{\it *of those teams who completed their QI project and submitted data}\\$

^{**} St. Andrew's Village, Presbyterian Senior Living Community, Pennsylvania, Appropriate Use of Antipsychotics Initiative

Our strategy



 Resident and nurse of St. Patrick's Mercy Home, review the best options for a more person-centred approach to care.

This is CFHI's current strategy. Work to refresh our corporate strategy began this year. Our new strategy will inform the 2019-2020 workplan.

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 and improvement to scale, including analysis of policy changes to enable the scaling of innovation across jurisdictions.
- 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 jurisdictionspecific scale.
- Identify and receive revenue from sources beyond governments (e.g. private sector, foundations).

CFHI also has several focus areas which are highlighted in each section.





Project Aims Pr

Milest





Alignment WITH CFHI STRATEGY:

- Scale
- Partnerships
- Transformation
- · High risk, high cost
- · Palliative, home and end-of-life care
- · Right care, right place

Alignment WITH SHARED EPT PRIORITIES:

- Shifting care into the home and community, including palliative care
- Innovation



"The COPD outreach program has really improved my life. I wanted to take charge of my condition, so I worked with the team to learn strategies to manage my disease."

Sue JohnsonINSPIRED patient

Improving care, creating value

People who suffer from chronic obstructive pulmonary disease (COPD) are among the highest users of hospital resources in Canada. Approximately one in four Canadians will develop the disease in their lifetime.

Many patients with advanced COPD visit emergency departments (EDs) to manage their symptoms and acute exacerbations. ED admissions, inpatient hospitalizations and readmissions together mean that advanced COPD costs the Canadian healthcare system approximately \$1.5 billion each year.

In 2014–2015, CFHI partnered with 19 healthcare teams from all 10 provinces to spread the INSPIRED COPD Outreach Program™ developed by the Nova Scotia Health Authority in Halifax.

With an INSPIRED approach to care, teams identify patients who visit EDs or are hospitalized with moderate to advanced COPD and invite them into a supportive program that equips them to better manage their illness. The program includes written action plans; telephone, as well as in-home self-management education and support; and advance care planning when needed.

The majority of the 1,011 patients enrolled in the program during the spread collaborative reported greater self-confidence in managing symptoms, an increased return to daily activities and enhanced function overall. System benefits included reductions of 40 to 50 percent in ED visits and hospital readmissions within the first six months of the program.

CFHI commissioned a RiskAnalytica report that showed if the INSPIRED approach were scaled up across Canada, it could prevent 68,500 ED visits, 44,100 hospital visits and 400,000 hospital bed days over five years. RiskAnalytica estimated total savings at \$688 million, or an average of \$34,000 per COPD patient. For every \$1 invested in INSPIRED, \$21 in healthcare costs could be prevented.

"Dr. Rocker and his colleagues did something that's not done often enough in Canadian health care: They asked patients how their care could be improved, and then implemented the advice."

André PicardThe Globe and Mail.

CFHI's INSPIRED scale collaborative

CFHI selected six teams from across Canada to participate in a second INSPIRED collaborative. This 18-month program, which began in October 2017, is designed to assist jurisdictions to scale the COPD INSPIRED approach to more providers, sites and patients. Collectively, teams aim to reach up to 39 hospitals, 13 primary care networks and an additional 2,300 people living with moderate to advanced COPD.

CFHI is providing \$1.4 million in funding and significant support to the six regional and provincial teams. The teams are coalitions of hospitals and health regions, primary care organizations and community partners that have come together to better meet the needs of people living with COPD. Teams in Ontario and New Brunswick have also built partnerships to leverage telehomecare and virtual care solutions, which will support further scaling of their INSPIRED programs.

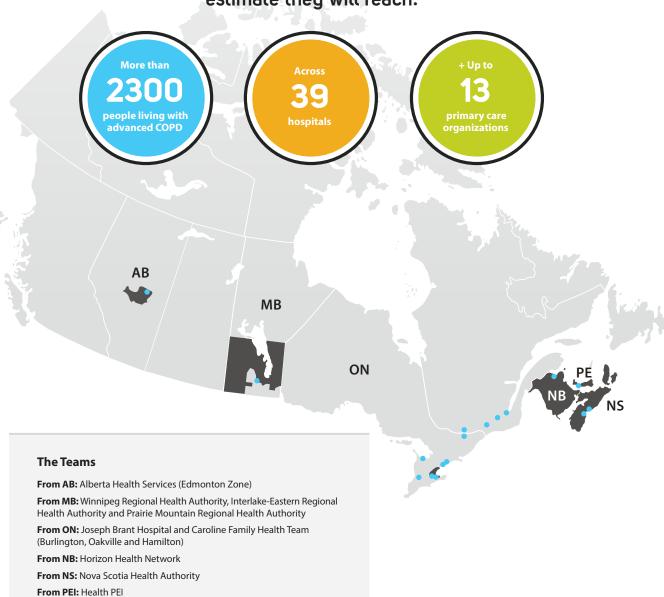
By the end of 2017–2018, CFHI had delivered webinars to participating teams on topics such as measurement and change management; held site visits with all teams as well as a face-to-face trainthe-trainer meeting; and hosted a two-day workshop, which brought all six teams together to learn from each other as they continue on their scale journey.



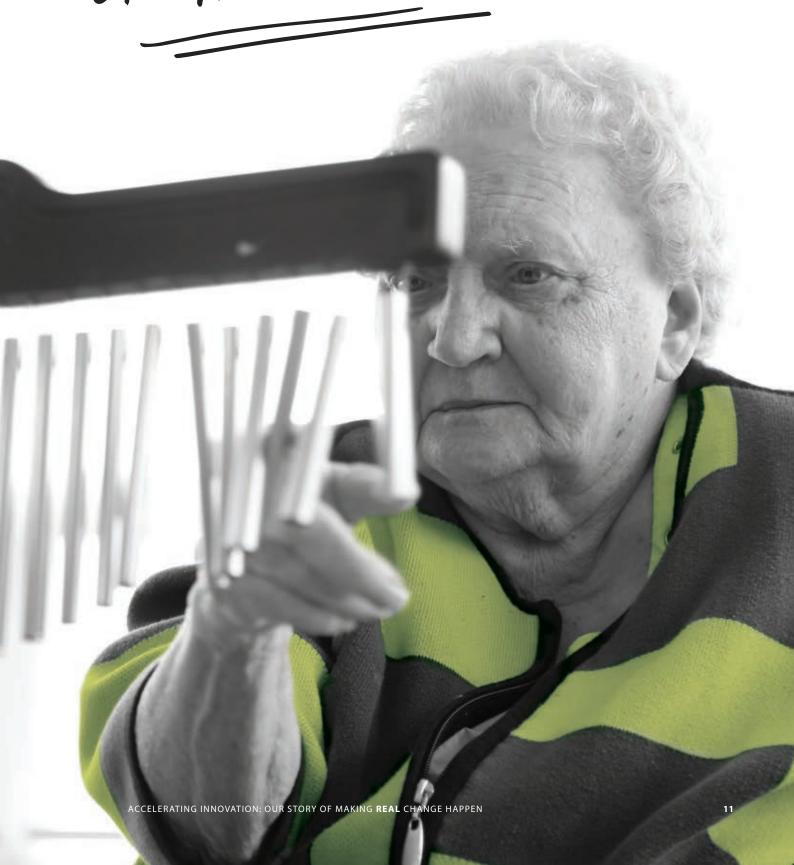




By March 2019, teams from this collaborative estimate they will reach:



APPROPRIATE USE OF ANTIPSYCHOTICS



Alignment WITH CFHI STRATEGY:

- Scale
- Partnerships
- · Cost-sharing
- · High risk, high cost
- Appropriateness
- · Right care, right place

Alignment WITH SHARED EPT PRIORITIES:

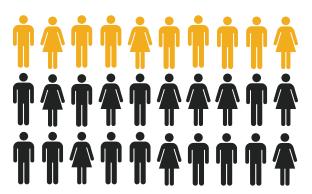
- · Appropriate use of pharmaceuticals
- Innovation

Person-centred dementia care and fewer medications

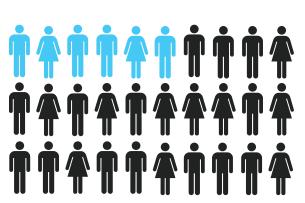
About one in five long term care (LTC) residents in Canada is on an antipsychotic medication without a diagnosis of psychosis. The best evidence tells us that only 5 to 15 percent of residents should be receiving these medications.

Antipsychotics are routinely prescribed to LTC residents to help manage challenging behaviours related to dementia and overcome residents' resistance to care. The medications are sedating and often minimally effective; at worst, they can cause harmful side effects and contribute to falls.

In direct response to the high use of antipsychotics in Canada, CFHI has created programming that not only helps improve the care and health of LTC residents with dementia, but also, because falls are reduced, lowers costs to the health system.



In 2012-13, 1 in 3 LTC residents in Canada was on an antipsychotic



In 2016-17, 1 in 5 LTC residents in Canada was on an antipsychotic

A FOUNDATION IN CFHI'S EXTRA PROGRAM

In 2012, Joe Puchniak and Cynthia Sinclair, who at the time worked with the Winnipeg Regional Health Authority Personal Care Home Program, designed an initiative to help healthcare providers identify residents who could benefit from non-drug therapies to treat behavioural issues. Their work, much of which they developed under CFHI's EXTRA: Executive Training Program, evolved into the Appropriate Use of Antipsychotics, or AUA, approach.

In 2014–2015, a CFHI collaborative to spread the AUA approach resulted in a 54 percent reduction in the use of antipsychotic medications at 56 LTC homes across seven provinces and territories. Aggressive behaviours by residents in these homes were significantly reduced, and falls were reduced by 20 percent. Meanwhile, there was no increase in the use of physical restraints.

SUCCESSFUL SCALE ACROSS EASTERN CANADA

New Brunswick

With these encouraging results, CFHI partnered in 2016 with the New Brunswick Association of Nursing Homes and the Government of New Brunswick on a two-year bilingual collaborative to scale the AUA approach across all nursing home organizations in the province. The first phase, which involved 15 organizations, is complete: 43 percent of residents had their antipsychotics reduced or discontinued, with falls decreasing by one third and with no associated increases in aggressive behaviour. Phase 2 continued through 2017–2018 and brought the AUA approach to the province's remaining 43 nursing home organizations.

Quebec OPUS-AP program

In 2017, the CEOs of all Quebec health and social service regions that provide LTC, in conjunction with Quebec's Ministry of Health and Social Services, agreed to launch an integrated AUA collaborative across Quebec called Optimizing Practices, Use, Care and Services – Antipsychotics (OPUS-AP). The collaborative is based on CFHI's AUA initiative and operates in close partnership with CIUSSS de l'Estrie-CHUS, CIUSSS de la Mauricie-et-du-Centre-du-Québec, and the ministry. OPUS-AP began by implementing the AUA approach in 24 LTC homes known as CHSLDs – one for every institution involved in the collaborative. Additional phases through 2021 will add 293 homes to the roster of participating facilities.

Newfoundland and Prince Edward Island

In early 2018, CFHI and the governments of Newfoundland and Labrador, and PEI partnered on a new AUA collaborative that will scale resident-centred dementia care across these provinces and beyond. Regional workshops launched this collaborative consisting of 39 LTC facilities in Newfoundland and nine facilities in PEI. These workshops included education about the collaborative and dementia and antipsychotic use in LTC and promoted cross-team sharing.

Also involved in this collaborative is the Seniors Quality Leap Initiative (SQLI), a community of practice comprising 14 high-performing LTC and post-acute care organizations and 10 strategic partners across Canada and the United States. In the initial phase of its participation, SQLI is implementing the AUA approach at eight facilities.



Staff from Victoria Glen Manor who participated in the New Brunswick Appropriate Use of Antipsychotics (NB-AUA) collaborative.

Growing a culture of improvement and person-centred care

The AUA approach involves interprofessional teams in regular medication reviews that help them identify which residents could benefit from non-drug therapies for managing their behaviour. The teams provide appropriate person-centred care so that antipsychotics are no longer needed, and apply specific de-prescribing protocols to guide their work. Teams also collect and monitor data on the residents' behaviour, cognitive patterns and much more, which enables them to gain valuable knowledge that leads to better decision making and more appropriate care.

Victoria Glen Manor in New Brunswick reports that the introduction of AUA has been a positive experience for all staff. Staff have changed the way they interact with residents, sitting, listening and getting to know them, and then working to understand their behavioural and psychological symptoms of dementia. Before AUA, staff would have walked away from an episode, told a nurse that the resident was agitated, recommended that the resident be medicated, or simply ignored the problem. Now, staff listen and take a different approach.



Alignment WITH CFHI STRATEGY:

- · Palliative, home and end-of-life care
- Partnerships
- · High risk, high cost
- · Incubating innovations
- Spread and scale
- · Right care, right place

Alignment

- Shifting care into the home and community, including palliative care
- Innovation

Addressing the need for integrated care

Today in Canada, improving access to palliative and end-of-life care and integrating a palliative approach across the continuum of care for people with life-limiting conditions is a priority. Of the approximately 220,000 Canadians who die each year, an estimated 70 percent do not have access to palliative care services – and for many, a palliative approach or referral is initiated only within the last weeks of life. There is widespread acknowledgment that we need to strengthen palliative care resources and services for Canadians.

CFHI is supporting integrated models of palliative care that are consistent with a patient's values, wishes and beliefs, and delivered in a location that the patient chooses. Fully integrating palliative approaches into the continuum of care would support earlier access to palliative care services, allowing palliative approaches to be delivered concurrently with other therapies and adapted to the individual needs of patients and families over the trajectory of their illness.

EXTRA COHORT 12 - A PALLIATIVE FOCUS

The 12th cohort of CFHI's EXTRA Executive Training Program had a special focus on palliative care. five teams in the cohort worked shoulder-to-shoulder with CFHI to improve palliative care and end-of-life support for clients, with a focus on improving early access, integrating care and providing care closer to home.

CEO FORUM ON PALLIATIVE AND END-OF-LIFE CARE

In April 2017, CFHI launched a call for innovations in palliative and end-of-life care. The call yielded 69 applications. A merit review panel selected six of the innovations to highlight at a June 2017 CEO Forum in Toronto organized by CFHI on the theme of palliative and end-of-life care. Another 20 were shared at the forum using storyboards. The presentations included work by acute and primary care, clinicians, researchers, long term care, hospice, home and community care providers, and provincial and national associations. Innovations included pediatric palliative care, creating compassionate communities, telemedicine and much more.

More than 130 people from across Canada attended the forum.

PALLIATIVE CARE MATTERS INITIATIVE

At a 2016 conference supported by CFHI, a partner-ship of 14 health-related organizations, healthcare experts and members of the public developed a consensus statement that included 20 specific recommendations for improving Canadians' access to palliative care at the right time and in the right place. In 2017, CFHI assisted in the development and publication of a special issue of the *Journal of Palliative Medicine* about the Palliative Care Matters initiative to more broadly disseminate the consensus statement and related work.

CFHI also supported a face-to-face stakeholder engagement meeting in February 2018 to look at the recommendations, and resulting actions and next steps from the consensus statement.

THE EMBEDDING PALLIATIVE APPROACHES TO CARE COLLABORATIVE (EPAC)

EPAC is a model of care developed by Jane Webley, of Vancouver Coastal Health, that improves end-of-life care for residents in LTC, their families and surviving residents. The model supports early identification of residents likely to benefit from a palliative approach to care, ensures that residents have timely, supportive discussions with providers and others about their goals for care, supports care provision in the location of the resident's choice, and ensures psychological and social support for all those affected by a resident's death.

Vancouver Coastal Health spread this model across 48 LTC homes from 2012 to 2017, leading to fewer transfers to the emergency department, fewer residents dying in acute care, and positive feedback from families and staff. In 2017–2018, CFHI began work on a pan-Canadian EPAC collaborative that included development of the prospectus and call for applications.



Members from different organizations coming together to participate in the Palliative Care Matters conference.

 Participants collaborate and share perspectives at the Palliative Care Matters conference.



PARAMEDICS PROVIDING PALLIATIVE CARE COLLABORATIVE

Of the innovations showcased at the CEO Forum, a program where paramedics provide palliative care currently being delivered in Alberta, Nova Scotia and PEI, was the top-ranked innovation with great interest from healthcare leaders, partners and stakeholders.

In 2017–2018, CFHI and the Canadian Partnership Against Cancer (CPAC) partnered to support the spread of Paramedics and Palliative Care: Bringing Vital Services to Canadians. This will improve access to palliative care supports regardless of location and time of day; improve paramedic comfort and competence in the provision of palliative care; and bridge support for patients and families until their usual care team can take over. CFHI and CPAC will invest up to \$5.5 million over the next four years on the scale and spread of Paramedics Providing Palliative Care at Home.

Responding to the call

In 2017–2018, CFHI supported further development of several of the innovations in palliative care identified through our call. These included:

Enhanced mHOMR Tool – University Health Network and Mount Sinai Hospital

The enhanced mHOMR tool is an emerging innovation that identifies in-patients at elevated risk of dying in the next year using administrative data, such as diagnosis, collected at the time of admission. The tool notifies admitting teams so that they can assess for and address any unmet needs for palliative care.

Whole Person Approach to Medical Assistance in Dying – Hamilton Health Sciences (HHS)

In 2016 HHS implemented an interprofessional team model to meet the needs of patients requesting medically assisted dying. Supported by CFHI, HHS undertook an analysis comprising a mixed-methods evaluation of the Assisted Dying Resource and Assessment Services interprofessional team and model of care created at HHS in 2016.

Canadian Virtual Hospice Paramedics Grief Support

Canadian Virtual Hospice has created education tools and resources about grief to support paramedics. These tools will be mobilized through the Paramedics and Palliative Care: Bringing Vital Services to Canadians collaborative, a partnership between CFHI and the Canadian Partnership Against Cancer.



Alignment WITH CFHI STRATEGY:

- · Spread and scale
- Partnerships
- · Right care, right place
- Transformation
- Appropriateness



- Innovation
- · Mental health

Remote consult services promote physician learning and better care

Canadians often wait too long for appointments with specialist physicians. Among 11 high-income countries compared by the Commonwealth Fund in 2017, Canada has the worst performance with the highest percentage of patients who report they wait two months or more for a specialist appointment. CFHI's Connected Medicine Collaborative, in partnership with the College of Family Physicians of Canada (CFPC), Canada Health Infoway (Infoway), and the Royal College of Physicians and Surgeons of Canada (The Royal College), is facilitating swifter access to specialist advice by primary care providers through digital technology and telephone services.

The 15-month collaborative, which began in June 2017, includes 11 healthcare teams from across Canada. The teams are adapting and adopting two proven Canadian innovations that facilitate rapid communication between primary care and specialists: Rapid Access to Consultative Expertise (RACE™), and Champlain BASE™ eConsult Service (BASE™). RACE is a British Columbia telephone-based consult service and BASE is a secure web-based eConsult service that began in Ontario.

Within the collaborative, three teams have begun scaling their remote consult service across their province, seven teams are scaling across their regions or service area, and one team is scaling across Canada. All are focused on improving access to specialists across urban and rural areas, where patient travel to see a specialist is an added barrier to timely care.

Every team is adding specialties into their remote consult service based on local priorities, often informed by which specialties have the longest waits, according to requests from primary care, and which specialists have expressed interest. Adult psychiatry is available in nine of the consult services, followed closely by internal medicine and nephrology, each available in seven services.

TEAM-TO-TEAM LEARNING

In November 2017, all teams attended a workshop in Montreal. They also participated in monthly webinars beginning in September on topics that ranged from strategies to sustain remote consult services, to how remuneration works under remote consult models, to the best ways to engage patients in the process.

 Heidi Scott participating at the Connected Medicine workshop in Montreal, QC, November 2017



Team-to-team learning was a key feature of these highly interactive forums; each service is at a different stage of implementation and the teams reflect many geographical areas across the country. Every team, no matter where they are in implementation, had an opportunity to share their own successes, challenges and lessons learned so that all teams could benefit.

LEARNING FROM PATIENTS

All teams in the collaborative engaged patient partners as core members to ensure the patient voice was adequately reflected in their remote consult service. For example, patient members regularly provided input at team meetings, co-designed surveys, and actively participated in webinars, coaching calls and the all-team workshop.

During one webinar, patient partners co-designed the session, provided input on targeted questions about their engagement in the collaborative to date, and shared their thoughts on how physicians could improve their service to be more patient centred. During the Montreal workshop, a group of patient partners co-designed a standard survey for teams to administer to patients who use remote consult services across the collaborative.

"I feel that (the Montreal workshop) has been a poster child for respectful engagement and respecting our time."

Heidi Scott,

Patient and Community Advisor, Interior Electronic Access to Specialist Expertise, British Columbia "CFHI's involvement gave us legitimacy and the ability to connect at a very different level of government. We feel adopted by CFHI, which has been incredibly helpful. We were invited to tables that would have been too hard to access on our own."

Dr. Clare Liddy,BASE™ eConsult Service co-founder

An interview with the physician founders of Champlain BASE™ eConsult Service

As founders of Champlain BASE, Drs. Clare Liddy and Erin Keely – Lead Faculty for the Connected Medicine Collaborative – provide a physician perspective on the benefits of this ground-breaking model for physician communication.

Q. HOW DOES USING CHAMPLAIN BASE COMPARE WITH FACE-TO-FACE SPECIALIST CONSULTS?

"Champlain BASE is an eConsult model that enables asynchronous communication between primary care physicians and specialists. That means primary care can ask targeted questions and have a virtual conversation with a specialist without running into scheduling problems or delays. We've found that the quality and detail of the questions asked is much higher than in a usual referral request. This raises specialists' respect for primary care and helps reinforce a collegial relationship."

Q. HOW DOES THE MODEL IMPROVE HEALTH OUTCOMES?

"Better communication with a specialist provides the patient with a more accurate diagnosis and a more precise treatment plan. It means either the patient gets better faster or is reassured that their health is better than they thought. You can almost hear the patient's sigh of relief. People feel cared for within an appropriate timeframe."

"Also, being able to avoid face-to-face visits is a real benefit for patients who have mobility issues or face geographical barriers. Some of those patients would never travel to see a specialist because they simply don't have the means to make it happen."

Q. WHAT ARE THE BENEFITS OF THE

"Because our communication is more detailed using Champlain BASE, specialists are able to attach clinical pearls that we wouldn't have before. This means we're building capacity in primary care; the physician can apply the learning to the next patient they see. From the specialist's perspective, because the questions we receive are of such high quality, they prompt us to learn more before we give the answers. It's been a rich learning experience in that way."

• HOW ARE THE PARTICIPATING HEALTHCARE TEAMS REACTING TO CONNECTED MEDICINE?

"Really passionate people are coming into this collaborative. Whether they're from northern BC, Newfoundland or Alberta, whether they're the primary care lead, patients or from government, people see Connected Medicine as a real opportunity to make a difference. Canada's geography means some teams are really remote and in need of this model."

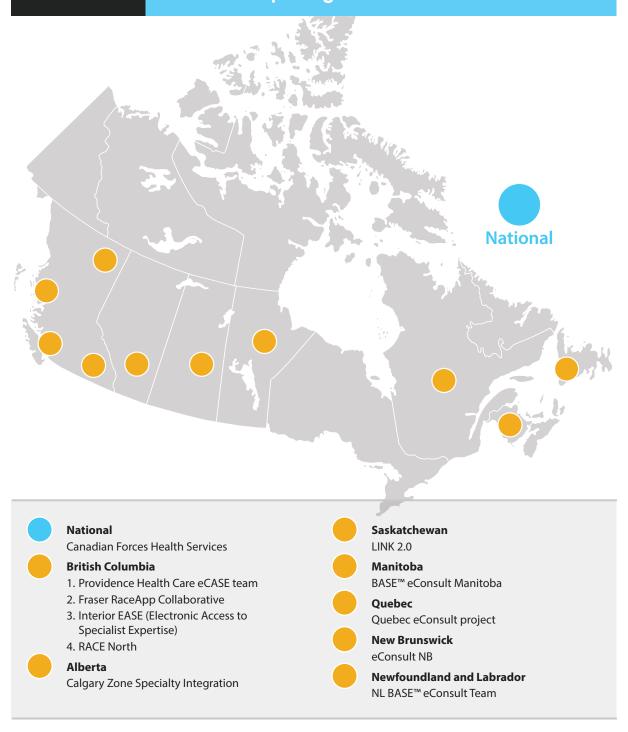
• HOW HAS THE PATIENT PERSPECTIVE INFORMED THIS COLLARORATIVE?

"The involvement of patients and the patient voice at the table has been fascinating. It's good to see the teams are really committed to patient engagement. It's not just patient representation, but real listening."

"One of our most powerful interactions with patients has been about privacy issues. Patients of course want due diligence with respect to privacy. However, their attitude in general is: 'We trust you. What are you waiting for and why are you letting privacy concerns get in the way of my care?' Patients have shifted the conversation from being about risk aversion to being about risk management and practicality. They want the service."

11

Connected Medicine Collaborative Participating Teams



NORTHERN AND INDIGENOUS HEALTH

Alignment with CFHI STRATEGY:

- · Indigenous health
- · Building capacity
- · High risk, high cost
- Partnerships
- · Northern and remote health
- Mental health



- Mental health
- Innovation
- · Indigenous health

Innovators and decision makers improving care together

CFHI recognizes the unique opportunities and challenges associated with delivering health services in Canada's northern and remote areas. In 2014, we established the Canadian Northern and Remote Health Network to provide an opportunity for senior decision makers, policy makers and practitioners to share innovative solutions and success stories with the goal of improving the health of people living in these regions. The network has grown steadily over the years and today includes 11 healthcare organizations.

2017 EXECUTIVE COMMITTEE ROUNDTABLE

CFHI held the annual Northern and Remote Roundtable from May 24 to 26, 2017, in Yellowknife, Northwest Territories. The event's 52 executive committee members, speakers and invited guests represented 22 organizations, six provinces and two territories. Over three days, the network shared wise practices to support healthcare delivery in northern and remote regions.

On the first day, presentations and group discussions focused on what meaningful stakeholder engagement means in a healthcare delivery and policy context. Day two focused on responding to crises in northern and remote regions, and related issues of technology and access. Day three consisted of a halfday session to discuss issues of mental health and wellness. It also provided opportunity to share ideas to develop a collaborative that addresses a shared priority of the network related to suicide prevention and life promotion.

The roundtable concluded with a visit to the community of Behchoko, the largest First Nation in the Northwest Territories. Staff from the Tłįchǫ Community Services Agency shared their wise practices and innovations in healthcare, education and social services following the settlement of the Tłįchǫ land claim and the realization of self-government.

THE PROMOTING LIFE TOGETHER COLLABORATIVE

One important outcome from the roundtable was the development and launch of the Promoting Life Together collaborative, which addresses life promotion and suicide prevention in these regions. Northern health and Indigenous health represent two streams of work at CFHI, and this collaborative is where they intertwine.

Northern and Remote Health Network members identified the need to work within Indigenous communities to address issues of suicide for the collaborative. This led CFHI to enhance relationships with Indigenous leaders and organizations so they could lead in the design, delivery and evaluation of a collaborative focused on life promotion.

Leaders from the First People's Wellness Circle, the First People's Committee of the Canadian Association for Suicide Prevention and the Thunderbird Partnership Foundation have been instrumental in providing support, content expertise and delivery for the Promoting Life Together collaborative.



Sonia Isaac-Mann, Vice President, Programs & Services, First Nations Health Authority, speaks to participants at the Canadian Northern and Remote Health Network (CNRHN) Roundtable.

A STRONG BEGINNING

To date, six of a possible 11 organizations from the Canadian Northern and Remote Health Network are participating in the collaborative. In October 2017, CFHI hosted an orientation workshop in Ottawa for all team members, including Indigenous community members. Currently, teams in the collaborative represent health authorities, provincial governments, First Nations and Métis organizations, and rural and remote communities.

Following the workshop, teams understood the importance of continuing to build relationships with their communities, and working alongside them to develop a project plan that focuses on needs identified within the communities. Indigenous coaches have been identified for each team. The coaches provide guidance and mentor the teams, and foster collaborative relationships between health authorities and Indigenous communities.

CFHI is committed to modelling these same principles of relationship building and mentorship and is asking collaborative teams to work closely with Indigenous leaders and organizations to learn from and with each other. CFHI has established a group that will provide guidance on the curriculum and evaluation approach, as well as on the design and delivery of the collaborative overall. Members of the Guidance Group include those with varying perspectives and expertise related to life promotion, suicide prevention, First Nation models of wellness, mental health and wellness, and quality improvement and evaluation.

Working together toward sustainable solutions

With a CFHI program team focused first and foremost on listening and learning from First Nations organizations and partners, these organizations set out together to establish closer, more engaged relationships based on mutual trust and respect.

"Our goal was to find the best ways to establish a pan-Canadian collaborative that is appropriate and productive for Indigenous partners on the team," said Brenda Restoule, Board Chair for the First People's Wellness Circle and a psychologist.

Restoule said that for the collaborative to succeed, it needed to be co-created and co-owned with Indigenous partners, who bring in muchneeded expertise and knowledge. Developing such partnerships has also enabled new thinking within CFHI on our approach to the issue of suicide prevention. Renaming the collaborative Promoting Life Together is an indication of how this work has been reframed.

"The discussions allowed us to bring in our Indigenous frameworks and evidence as valid and real," said Restoule. "We were able to bring best practices to the table that will engage Indigenous partners because the practices are based on their evidence and their knowledge. This will be far more effective than imposing CFHI's evidence and knowledge base on an Indigenous community."

Dr. Ed Connors is a psychologist, Board Member of the First People's Wellness Circle, Board member of the Canadian Association for Suicide Prevention and Chair of the First Peoples Committee. He said the CFHI team was receptive to creating a contract for how the organizations would work together and that reflects their discussions and new understandings. The contract sets out, for example, precisely what aspects of Indigenous knowledge CFHI can adopt as its own – and what it may not claim as its own.

"The process of drafting the legal basis for our work has created the foundation for a relationship that is safe for all parties," said Connors. He said the contract speaks to the concepts of honouring and respecting sacred Indigenous knowledge. "This is significant because the work we will do is holistic in nature and spiritually based. What's unfolding is exciting because it applies and puts into action work that our Indigenous organizations have done over many years. This is the first time we've succeeded in drafting a contract of this nature with non-Indigenous partners."

Restoule said the contract between CFHI and its Indigenous partners has been well received in the Indigenous community. "It has set a foundation for mutual learning and a respectful relationship moving forward." Connors agrees. "The process we went through and the resulting contract speak to important issues of reconciliation and respecting Indigenous knowledge. We've worked toward this for many years and now it's being put into action through the Promoting Life Together Collaborative."

PATIENT AND FAMILY ENGAGEMENT



- · Patient and family engagement
- Partnerships
- Transformation



Innovation

Working toward a new status quo

Since 2010, CFHI has established itself as an international leader in patient and family engagement. We have led a series of collaboratives, supported patient and family engagement initiatives, created and procured a large suite of resources as we developed the Patient Engagement Resource Hub in partnership with the Canadian Partnership Against Cancer and the Canadian Patient Safety Institute, and spearheaded a successful Canadian campaign to strengthen the voices of patients and families in policy change and family presence.

In 2017–2018, our Patient and Citizen Engagement Team concentrated their efforts to further embed patient and family involvement in all our programming and activities across CFHI. We want to "walk the talk" of engagement both within and outside the organization, and continue to build partnerships with patients and their caregivers to make engagement part of our everyday work.

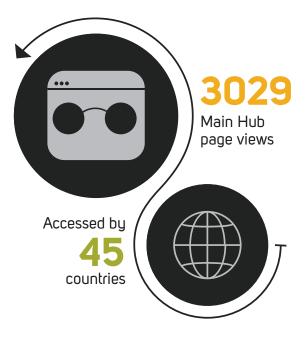
We recognize that patient and family engagement is a journey that leads to a change in culture. It is a way of being that considers, respects and listens intently to others' perspectives, and that welcomes diverse voices to create something new and to learn from those who have a lived experience.

As part of our ongoing journey, Angela Morin was brought onto our team as CFHI's Patient Partner in November 2017. Angela has expertise as an advisor and partner at all levels of the health system – local, regional, provincial and national – and provides insights into engagement practices and perspectives critical for improvement. Angela supports, coaches and mentors CFHI staff as they deepen their knowledge about how best to engage with patients and families in the design, implementation, evaluation and dissemination of their programs and activities.

THE BETTER TOGETHER CAMPAIGN AND POLICY ROUNDTABLE

December 2017 marked the end of the Better Together Campaign that began in 2015. CFHI recognizes that when families are welcomed as partners in care through family presence policies, staff, patients and families, and the organization itself stand to gain. The benefits of adopting family presence include improved experience and outcomes, fewer 30-day readmissions and improved coordination of care.

300 resources and tools



CFHI led the Canadian Better Together effort in concert with a campaign led by the Institute for Patient-and Family-Centered Care in the United States. The 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. CFHI received 52 pledges across the two years of the campaign from individual organizations as well as entire regions and provinces committed to family presence. We have celebrated this work in a series of impact stories that demonstrate the value of welcoming families and caregivers as partners in care and as members of improvement teams.

To build on the momentum of the campaign, CFHI also convened the Better Together Policy Roundtable in September 2017 with 49 participants from 12 provinces and territories. The goal was to learn from provinces that have implemented family presence policies across their jurisdiction. Fourteen patients were involved in the roundtable, which gave government and organization leaders a fresh perspective. The presence of patients created a palpable shift in the dynamic at the roundtable and the discussions that ensued.

The event delivered clear, actionable steps for participants to begin adopting and implementing patient and family policies across their jurisdictions. The roundtable was the first CFHI event to receive the #PatientsIncluded designation, having demonstrated active patient involvement in the design and delivery of the event as well as the inclusion of additional patient and caregiver voices at the roundtable by providing three patient scholarships.

SUPPORTING LEADERS ACROSS CANADA

In September 2017, CFHI assumed a secretariat role for the National Health Engagement Network, a community of practice that has grown to over 100 patient and family engagement leaders. Membership consists of patient engagement practitioners, patient engagement leaders, and patient and family advisors from healthcare organizations across Canada.

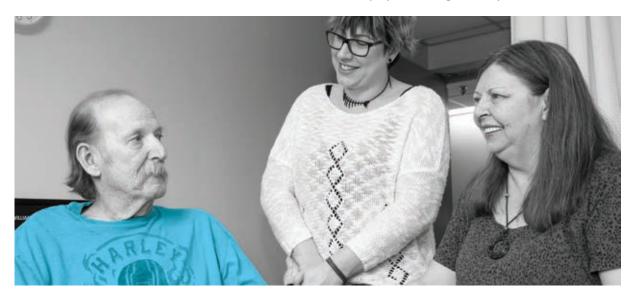
In its secretariat role, CFHI coordinated and hosts the group's monthly meetings on an online platform, shares resources and manages the membership database. This community of practice leads its own efforts, and membership continues to expand to anyone interested in patient engagement.

LEVERAGING OUR RESOURCE HUB

The Patient Engagement Resource Hub, available on CFHI's website, provides more than 300 resources and tools to support those doing engagement work. It has been a go-to resource for CFHI staff as we continue to involve patients and families in our work. We will continue to seek and add sources over time.

This year we also created tip sheets about engagement and added them to the resource hub. We based the tip sheets on findings from patients and families, as well as providers and leaders who worked together on our Partnering with Patients and Families in Quality Improvement collaborative.

Client Peter Primeau, along with his wife Linda and daughter Kira spend the open hours enjoying each other's company and relaxing as a family.



BUILDING ON WHAT WE KNOW – AND LOOKING TO THE FUTURE

This past year marked a period of reflection on what we have learned from our efforts supporting 51 teams from across Canada in four patient and family engagement initiatives and collaboratives since 2010. It also afforded us an opportunity to consider what comes next.

To inform future programming in patient engagement, we consulted over several months with more than 120 patient and family advisors, healthcare leaders and practitioners, and academics. This culminated in a patient and family engagement think tank in December 2017 in Toronto with 18 thought leaders from across Canada who helped shape a patient engagement collaborative on the topic of transitions in care. The new collaborative, called Bridge-to-Home Spread Collaborative: Partnering with Patients and Caregivers to Improve Quality and Patient Experience through Care Transitions, is to be launched in May 2018 with a call for applications to healthcare teams – including patients and their caregivers – from across Canada.

"Patient engagement is about building relationships, about trust, about respect and about action. As an organization, CFHI is aiming to be the gold standard in patient engagement and they are listening, learning and partnering with patients and families to be just that."

Angela MorinCFHI Patient Partner

"You don't really know the other perspective. This gave patients a voice. This was empowering – when you go into a role so dependent... [This] was a way to give back and to gain autonomy, and to share what was meaningful."

Debbie Brennick

Harbour View Hospital Patient & Family Advisory

Harbour View Hospital, located in Sydney Mines, Nova Scotia, was part of the Better Together: Partnering with Families e-Collaborative

EXTRA: EXECUTIVE TRAINING PROGRAM



Alignment WITH CFHI STRATEGY:

- EXTRA program
- · Home, palliative and end-of-life care
- · Right care, right place
- · Building improvement capacity
- · Incubating innovations

Alignment WITH SHARED EPT PRIORITIES:

- Innovation
- Shifting care into the home and community, including palliative care

Building a cadre of improvement leaders

CFHI's EXTRA Executive Training Program supports teams of healthcare executives as they design and implement innovative healthcare projects and then evaluate the projects' effectiveness. Using a 14-month, bilingual, curriculum-based approach, EXTRA teams learn the critical skills they need to build their leadership competencies, put their evidence-informed solutions into practice and improve the health of the populations they serve.

In 2017–2018, EXTRA graduated its 12th cohort of Fellows, with a focus on palliative care projects – many of which were featured at CFHI's 2017 CEO Forum. Six of the participating healthcare teams were from Quebec. For EXTRA's 13th cohort, six teams were once again from Quebec, and many focused on integrating care closer to home. CFHI issued a call for applications for cohort 14, which will begin in June 2018.

Since the program's inception, 411 healthcare professionals from 151 organizations have participated in EXTRA, completing a total of 232 improvement projects.



Linda Eagen, President and CEO, the Ottawa Regional Cancer Foundation, talks to Cohort 13 Fellows at the EXTRA workshop.

IMPROVING CANCER TREATMENTS IN BRITISH COLUMBIA

The BC Cancer Agency oversees the development, delivery and evaluation of systemic therapy (chemotherapy) in the province and is responsible for funding all cancer drugs. But the care situation is complex. While systemic therapy is delivered in part by the BC Cancer Agency, between 40 and 50 percent of treatments are administered by the province's regional health authorities through the Community Oncology Network (CON).

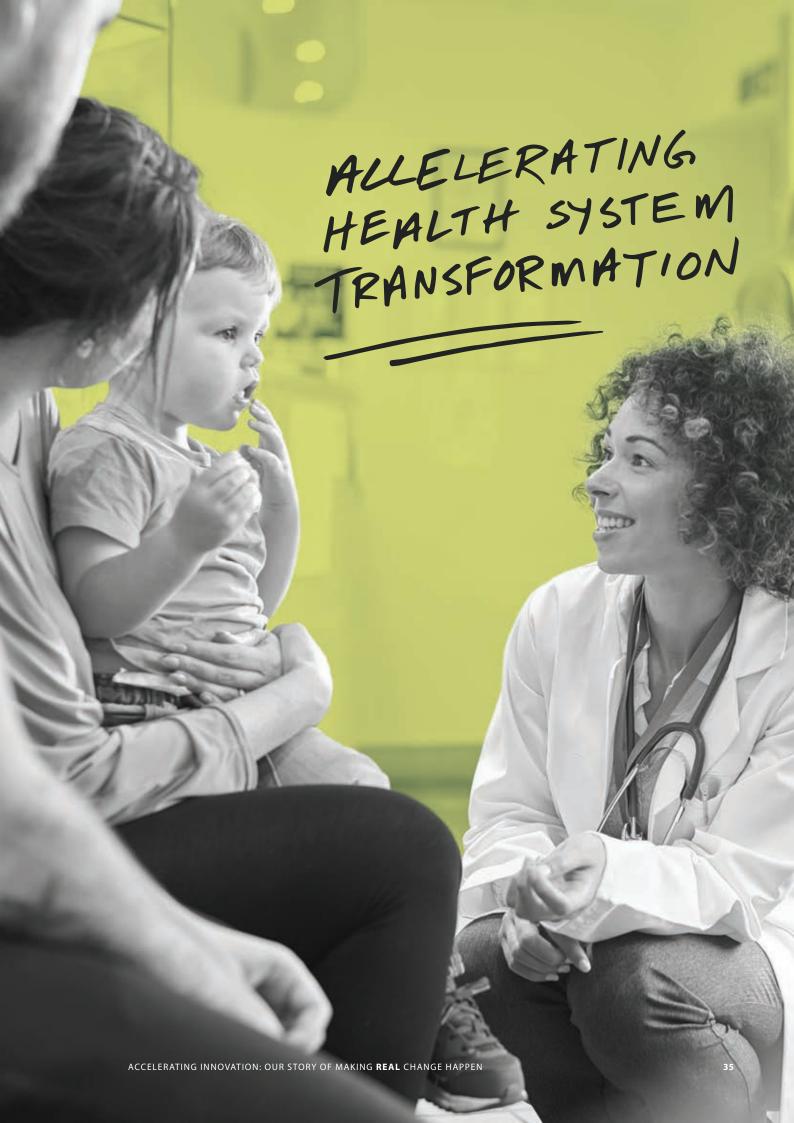
A healthcare team from the BC Cancer Agency is working with cohort 13 of the EXTRA program to address issues related to resources, effective delivery, quality and coordination of cancer care. The team's goal is to develop a provincially adopted and recognized "tiers of service" framework that will inform future and regional local planning for CON within the

province. The work will improve the quality of the patient experience, help measure and monitor the performance of the regional health authorities, allow for a comparison to other organizations and help ensure operational excellence. It will also provide common language among the BC Cancer Agency and regional health authorities for future planning and organization of cancer care in the province.

"EXTRA has given us an effective structure to keep the work moving forward," said Marie Hawkins, Executive Director of Primary Health Care, Chronic Disease Management and Medicine Clinical Network with BC's Fraser Health Authority. "For our team, it's helped with the realization of how many component parts there are to doing a quality improvement project. We've gained a far greater appreciation for the tools you need and who your stakeholders are."

EXTRA BY THE NUMBERS

15	Years Running
151	Canadian Organizations Have Participated
232	Improvement Projects
411	Healthcare Professionals



Alignment with CFHI STRATEGY:

Transformation

Alignment WITH SHARED EPT PRIORITIES

Innovation

Propelling change at the system level

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

Although there are examples of jurisdictions and organizations in Canada 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, these innovations remain isolated pockets of excellence. Many strive to improve healthcare; but it takes time and close collaboration between healthcare partners to identify shared priorities and coordinate efforts.

Canada needs to move from conducting isolated, innovative pilot projects to projects designed to support large-scale change; from focusing on acute care to strengthening home, community and primary care; and from accepting the status quo to creating a sustained culture of improving quality across Canada.



Through our 2017 stakeholder consultation, we heard that CFHI is recognized as having unique expertise in spreading and scaling innovations and building capacity for system level transformation. We also validated the importance of shifting care from hospital to home and the community, and identified a new priority: primary care reform and integration.

This stakeholder input informed our strategic planning process last year, leading to a new stream of work focused on accelerating health system transformation. We are convening interested jurisdictions to share strategies and innovations that work for reforming and integrating primary care, and exploring opportunities for policy-focused primary care collaboratives.

PRIMARY CARE REFORM AND INTEGRATION

Primary care reform and integration has been talked about in Canada for decades – from the landmark 1974 Lalonde report through to the 2000s when multiple health accords included elements to improve primary care. In recent years, there is growing consensus that every Canadian should have a clearly identifiable primary-care provider or team for preventive care, sickness care, and support and follow-up when acute care is needed. Provincial and territorial governments are pursuing a variety of initiatives to improve their primary care systems in this regard.

This past year, CFHI commissioned papers on primary care reform and integration and planned a cross-jurisdictional knowledge exchange roundtable with jurisdictions engaged in changes to primary care to take place in April 2018.

VALUE-BASED HEALTHCARE

Under our collaborative approach to transformation, we worked closely with our expert faculty and advisors and undertook stakeholder analysis to pinpoint lessons learned, opportunities and barriers to value-based healthcare (VBHC) innovation in Canada. As part of this work, in 2017–2018 we:

- commissioned an executive briefing on VBHC and several VBHC case profile examples from within Canada and internationally.
- co-sponsored a VBHC summit in March 2018 to explore the best ways to support pan-Canadian health organizations and regulators interested in VBHC principles in strategic planning and service delivery.

FELLOWSHIPS

CFHI supported two emerging Canadian healthcare leaders to participate in the Canadian Harkness/ CFHI Fellowships in Health Care Policy and Practice program, in collaboration with the Commonwealth Fund's International Program in Health Policy and Innovation. Through this initiative, Dr. Danielle Rodin (Resident, Department of Radiation Oncology, University of Toronto) and Mr. Matthew Herder (Director, Health Law Institute and Associate Professor, Faculties of Medicine and Law, Dalhousie University) received support to spend a year in the United States studying healthcare delivery system reforms and critical issues on the health policy agenda common to the U.S. and Canada. Their research focused on value-based healthcare in cancer control and better controlling pharmaceutical prices. Canadian Harkness Fellows brought these lessons back to Canada and continue to work with CFHI (as faculty, speakers, attendees at key thought-leadership events) to inform and develop programming to accelerate health system transformation.

In addition, CFHI collaborated with the Canadian Institutes of Health Information in support of the Health System Impact Fellowship program, which provides highly qualified individuals with a doctorate degree in health services and policy research the unique opportunity to apply their research and analytic talents to critical challenges in health system and related organizations outside of the traditional scholarly setting. Through this support, CFHI engaged Dr. Ania Syrowatka (University of Toronto) in an applied research project to examine CFHI's programming efforts to improve palliative care in Canada.

As our strategic planning process continues – and our healthcare transformation program area continues to evolve – we are proud to note that CFHI's incremental work to support the spread and scale of healthcare innovations has led to measurable change at the provincial systems level. We will continue to develop this program area, working to simultaneously accelerate improvement at scale of the experience and outcomes of care while also tackling systems-level issues.

KNOWLEDGE TRANSLATION AND POLICY

Alignment WITH CFHI STRATEGY:

- · Disseminate results
- · Policy analysis

Accelerating healthcare transformation through knowledge translation and policy

In 2016–2017, CFHI developed a formal knowledge translation and policy (KTP) strategy with three principal goals:

- 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.
- 2. 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 organizations in Canada and internationally.

In 2017–2018, we refined our KTP approach following the development of a KTP Strategy to amplify making best practices more common as well as sharing lessons for leading health systems transformation. Our focus on repositioning CFHI in the KT and policy landscape vis-à-vis lessons learned from CFHI's improvement collaboratives resulted in us working with program teams to deliver 251 KTP products and activities including primers, patient stories, blogs, research articles, and workshops.

At a two-day workshop in June and a half-day workshop in October 2017, CFHI staff received training to improve their capacity to plan, develop, implement and evaluate effective, high-quality KTP products and activities. A post-workshop survey showed that participants gained new knowledge for how to apply KT and implementation methods to support their work. We also co-designed, with leaders from AHS and Kaiser Permanente, and hosted workshops with more than 200 delegates from Alberta Health and Alberta Health Services to enhance capacity for the successful spread, scale and sustainability of health-care quality improvement initiatives.

Our 2017–2018 work has prepared CFHI to enhance cross-program evaluation. This will help deepen our understanding of important healthcare transformation questions such as: What are the winning conditions for spreading and scaling up healthcare innovations across the country? What we learned in 2017–2018 also informed CFHI's new logic model (see page 41).

251 KTP products



A scholarly contribution

CFHI staff and faculty produced four publications on the process and outcomes evaluative results of our quality improvement collaboratives:

- Physician Remuneration for Remote Consults: An Overview of Approaches across Canada
 October 2017
- New models of care for respiratory disease: a thematic edition

October 2017

- Improving care for advanced COPD through practice change: Experiences of participation in a Canadian spread collaborative
 February 2018
- Spreading improvements for advanced COPD care through a Canadian spread collaborative.
 July 2017

Additional publications

CFHI also commissioned a series of policy papers. Two were commissioned from the North American Observatory on Health Systems and Policies as a foundation for identifying jurisdictions across Canada that have improved primary care and the policy levers that may be suitable for spread to other areas of the country. A third paper was commissioned from Jean-Louis Denis – a professor of health policy and management at the School of Public Health-Université de Montréal and senior scientist at the Research Center of the Centre hospitalier de l'Université de Montréal – on spread, scale and sustainability.

INSPIRED Approaches to COPD: Shifting care closer to home

 New Brunswick Repo Man Looks to Take Back his Health After COPD Diagnosis*

January 2018

 For Edmonton COPD Patients, INSPIRED Offers "Model for the Future" of Care*

January 2018

Appropriate Use of Antipsychotics: AUA

- Success in reducing antipsychotic medication leads Revera to spread approach across four provinces*
 April 2017
- Success at three long term care homes prompts Sienna Senior Living to spread antipsychotic reduction initiative to all of its 34 facilities*
 April 2017
- Success of New Brunswick long term care home's push to reduce antipsychotic use leads to creation of a province-wide initiative*

April 2017

 Target for reducing antipsychotic use in long term care extended to acute care facilities at Newfoundland's Central Health Regional Health Authority*

April 2017

Palliative and End-of-Life

- Special Issue in the Journal of Palliative Medicine
 February 2018
- Recognizing Innovations in Palliative Care, from East to West*

December 2017

Patient and Family Engagement

- Report of the Better Together Policy Roundtable*
 January 2018
- The Great Canadian Healthcare Debate Issue Briefs Top 6 Motions www.nhlc-cnls.ca/

June 2017

EXTRA Executive Training Program

 Front-Line Care Support Services for Cancer Patients*

March 2018

 Nova Scotia Hospital Thinks Home First for Complex Senior Patients*

January 2018

Knowledge Translation and Policy

Policy innovations in primary care across Canada:
 A rapid review prepared for the Canadian
 Foundation for Healthcare Improvement Institute of Health Policy, Management and Evaluation,
 University of Toronto

March 2018

 Workshop Report: Building Capacity for Healthcare Quality Improvement: Spread, Sustainability, Scale & the Quadruple Aim*

March 2018

 Value-Based Healthcare: Executive Brief and Case Profiles

March 2018

 Co-created, Co-delivered, Co-lived: Toward Better Health and Care for Inner-City Populations*

March 2018

 Spreading and scaling best practices: Developing a knowledge translation & policy (KTP) strategy to accelerate healthcare quality improvement

June 2017

^{*} published on the Canadian Foundation for Healthcare Improvement's website

EVALUATION AND PERFURMANCE MEASUREMENT

Alignment WITH CFHI STRATEGY:

- · Evaluate results
- · Disseminate results

AN EVERGREEN APPROACH TO EVALUATION AND PERFORMANCE MEASUREMENT

In 2017–2018, we continued to assess and refine our adaptive and responsive approach to evaluating CFHI's performance. Guided by our corporate Performance Measurement Framework for 2017–2018 (logic model shown on page 41 also available alongside a detailed Performance Measurement Report at cfhi-fcass.ca), we have evaluated the process and outcomes of our collaboratives and programs in their efforts to accelerate health systems transformation.

We have demonstrated successful implementation in forming interprofessional teams, collaboratives and programs. Furthermore, evaluation results indicate that teams and collaboratives have been supported with various knowledge products and exchange activities, which have enabled them to successfully carry out their work.

Sustaining, spreading and scaling best practices have been demonstrated alongside other outcomes, such as improving patient, resident and family experiences of care; the cultures of participating organizations; and the knowledge and skills of healthcare leaders.

In 2017–2018, we co-created evaluation frameworks (program logic model, measurement matrix, and data collection manual) with each collaborative and program to better understand the winning conditions for spreading and scaling healthcare innovations across the country.

Learning modules were developed and delivered to CFHI staff and CFHI program participants, including how to develop evaluation plans, identify appropriate indicators, perform evaluations, and articulate and disseminate results. This work is critical so improvement teams can apply their custom-built frameworks to monitor implementation and document the success of their efforts.

CFHI Program Logic Model

LONGER TERM OUTCOMES

Contribute to improved healthcare system performance and the health of Canadians

INTERMEDIATE OUTCOMES

Best practices are sustained, spread, and/or scaled within and across organizations, regions, and provinces/territories

Improvements are made to: patient, resident, and family experience of care; health of patients and residents reached; value for money (efficiency and ROI); and work life of healthcare providers

IMMEDIATE OUTCOMES

Healthcare leaders are knowledgeable and skilled in carrying out healthcare improvements Patients, residents, family members, communities, and others with lived experience are engaged in healthcare improvement and co-design

The cultures of participating organizations have improved through changes in healthcare practices, delivery models, and related policies

The target patient and resident populations have been reached directly

OUTPUTS

Knowledge products (e.g., improvement tools and training materials)

Knowledge exchange activities (e.g., workshops and forums)

Inter-professional teams, collaboratives, and programs

ACTIVITIES

INPUTS

Build leadership and skill capacity

Apply improvement methodologies

Enable patient, family, and community engagement Create collaboratives to spread and scale proven innovations

Incubate emerging innovations

UTS Financial Resources

Human Resources

External Resources

For a complete list of final indicators, please see CFHI's Performance Measurement Report (https://www.cfhi-fcass.ca/AboutUs/corporate-reports)

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 and 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 2017–2018, we cultivated broader engagement with patients, residents, family members, caregivers, community members and patient advisors, whose valuable perspectives continued to enrich our initiatives, programs and events.

Partners in the Connected Medicine: Access to Specialist Consult spread and scale collaborative

- R.A.C.E. (Rapid Access to Consultative Expertise)
 Providence Health and Vancouver Coastal Health
- BASE (Building Access to Specialist Expertise)
 Champlain LHIN, Bruyère Continuing Care and
 Winchester Memorial Hospital District, ON
- · Royal College of Physicians and Surgeons of Canada
- · College of Family Physicians of Canada
- · Canada Health Infoway

Partners in the New Brunswick Appropriate Use of Antipsychotics (NB-AUA) collaborative

- New Brunswick Association of Nursing Homes
- New Brunswick Department of Social Development
- Canadian Institute for Health Information (CIHI)

Partners in the Newfoundland, PEI and SQLI Appropriate Use of Antipsychotics Spread Collaborative

- Newfoundland and Labrador Health and Community Services
- · Health PEI
- · Seniors Quality Leap Initiative
- Canadian Institute for Health Information (CIHI)

Partners in Optimizing Practices, Use, Care and Services – Antipsychotics (OPUS-AP)

- Ministère de la Santé et des Services sociaux (MSSS)
- CIUSSS de l'Estrie CHUS (representative) et les CISSS et CIUSSS du Ouébec
- L'Institut national d'excellence en santé et en services sociaux (INESSS)
- Réseaux universitaires intégrés de santé (RUIS) du Québec
- · Regroupement provincial des comités des usagers
- · Fédération québécoise des Sociétés Alzheimer

Partners in the INSPIRED Approaches to COPD Care scale-up collaborative

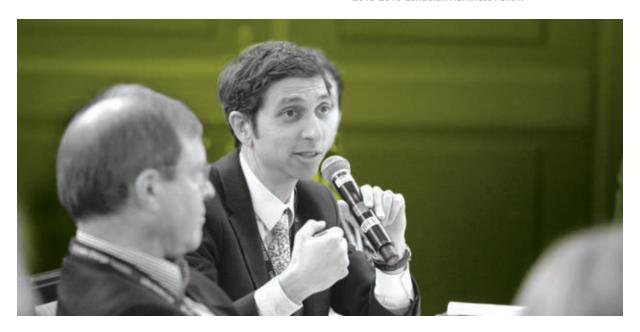
• Canadian Institute for Health Information (CIHI)

Partners in the INSPIRED Approaches to COPD Care roundtables

• Boehringer Ingelheim (Canada) Ltd.

Supporting organizations for the EXTRA: Executive Training Program

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



Supporting organizations for CFHI fellowships

- · The Commonwealth Fund
- Canadian Institutes of Health Research, Institute of Health Services and Policy Research
- The Ottawa Hospital
- · Healthcare Improvement Scotland

Better Together Campaign Supporting Organizations:

- Manitoba Institute for Patient Safety
- · Canada Health Infoway
- · Health Quality Council of Alberta
- · Saskatchewan Health Quality Council
- · Canadian Patient Safety Institute
- · Patients Canada
- · Canadian College of Health Leaders
- BC Patient Safety & Quality Council
- Registered Nurses Association of Ontario
- Patients for Patient Safety Canada
- · Accreditation Canada
- IMAGINE Citizens Collaborating for Health
- The Academy of Canadian Executive Nurses

Partners in Community Actions and Resources Empowering Seniors (CARES)

· Fraser Health Authority, BC

Supporting organizations in the Canadian Northern and Remote Health Network and Promoting Life Together Collaborative

- · Northern Health, BC
- First Nations Health Authority, BC
- Health and Social Services, Government of Yukon
- · North Zone, Alberta Health Services
- Department of Health and Social Services, Government of Northwest Territories
- Department of Health, Government of Nunavut
- · Saskatchewan Health Authority SK
- Northern Regional Health Authority, Winnipeg Regional Health Authority (WRHA), MB
- Churchill Health Centre Division, WRHA, MB
- North East Local Health Integration Network, ON
- First Nations and Inuit Health Branch, Indigenous Services Canada
- · Western Regional Health Authority, NL

Supporting organizations in the Acute Care for Elders (ACE) spread collaborative summative evaluation

- · Canadian Frailty Network
- · Sinai Health System

Partners in CFHI's knowledge translation and policy activity:

KTP Training

- Mental Health Commission of Canada (MHCC)
- Centre for Addiction and Mental Health (CAMH)

Spread and scale workshop

- Alberta Health Services (AHS)
- · Alberta Health
- · Alberta's Strategic Clinical Networks
- Kaiser Permanente (KP), KP Northwest Region and KP Centers for Health Research

Toward Better Health, Care and Value for Innercity Marginalized Populations

- Institute for Healthcare Improvement
- St. Michael's Hospital (Toronto)

EvidenceNetwork.ca

University of Winnipeg

Partners and collaborators in accelerating health system transformation

- Primary care Roundtable:
 - Primary care leads from Provincial/Territorial Governments and Pan-Canadian Health Organizations
 - North American Observatory on Health Systems and Policies, University of Toronto (policy syntheses)

- Value-based Healthcare Canada Summit:
 - Co-sponsors: CFHI and Canadian Institute for Health Information
 - Supporters: CADTH, Canada Health Infoway, Medtronic Canada, Amgen, and Rotman Centre for Health Sector Strategy
- Partners in building capacity for quality improvement in primary care
 - College of Family Physicians of Canada

Partners in palliative care programming

- Call for innovations:
 - Canadian Hospice and Palliative Care Association
 - Pallium
- · Innovation Award Winners:
 - Canadian Virtual Hospice
 - Hamilton Health Sciences
 - Island Health Services (PEI) & Nova Scotia Health Authority
 - University Health Network
 - Vancouver Coastal Health
 - Hamilton Health Sciences
- Paramedics Providing Palliative Care Collaborative
 - Canadian Partnership Against Cancer
 - Alberta Health Services
 - Island Health Services (PEI) & Nova Scotia Health Authority
- Embedding Palliative Care Collaborative (EPAC)
 - Vancouver Coastal Health
- Palliative Care Matters:
 - Covenant Health

Challenges and Risks

Working to manage health system challenges

In 2017–2018, CFHI's specific challenges included building our capacity to engage with health sector leaders to make change, and aligning our priorities with federal, provincial and territorial priorities. Our ongoing engagement with healthcare policy makers and institutions across Canada will facilitate that alignment. Meanwhile, we continue to develop programming that goes beyond spreading and scaling innovation to accelerate health system transformation and to work to enhance alignment with other PCHOs to achieve greater collective impact for people and systems.

Although CFHI has a modest capacity relative to Canada's performance gaps, the stable, ongoing funding announced in Budget 2017 will enable us to plan over the longer term, giving us and our partners confidence that success is within reach. While CFHI is realizing greater success in some areas thanks to our stable funding, with that success and growth come organizational challenges as we scale our operations to achieve the greatest possible impact.

In 2017–2018, we began to refresh our corporate strategy to ensure we meet the challenges ahead.

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 program 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 has introduced monthly reviews of expenditures and programming to ensure Health Canada and the Board are alerted to these issues in a timely manner. In 2017–2018, work began on a new project management solution that will be fully implemented in 2018–2019.

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.

Ongoing funding announced in Budget 2017 set stable funding for CFHI. A more robust and transparent approach to priority setting was initiated in 2017–2018 and will expand in 2018–2019 as CFHI's corporate strategy is refreshed, supporting optimal decisions on programs to pursue.

TYPE OF RISK

MITIGATION STRATEGIES

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, mitigates this risk. CFHI anticipates signing an amendment to extend our current contribution agreement, which ends March 31, 2019.

Coordinated, corporate, evidenceinformed 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 KPMG), and our Performance Measurement Framework also contributes to a culture of continuous improvement.

CFHI must communicate its mission and programming clearly, in order to fulfill its strategic objectives in partnership with key stakeholders.

CFHI has managed this challenge in many ways over several years. These include a 2012 rebranding exercise, which produced CFHI's new name; the allocation of significant resources to communicate CFHI's mission and programs; and efforts 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.

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. We continue to enhance this template and our process to address issues over intellectual property.

To achieve the greatest impact, CFHI needs to align its programming with FPT priorities while still managing our own strategic priorities and ensuring that our programs remain relevant.

The articulation of shared health priorities by FPT governments has greatly facilitated program alignment with these priorities. CFHI currently has federal and provincial representation on its Board of Directors and engages with FPT governments and other stakeholders to inform its priorities and programming. As well, our programs are currently being implemented across the country.

INFORMATION 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.

TYPE OF RISK

MITIGATION STRATEGIES

FINANCIAL RISKS

Rising program costs could prevent CFHI from meeting its obligations to fully implement programming.

CFHI follows a rigorous financial planning process 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 enables greater transparency and access to financial information for staff, which affords 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 a stringent set of procurement and expenditure policies in place, and 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. In addition, our Finance and Audit Committee and the Board of Directors oversee all expenditures.

HUMAN RESOURCES RISKS

Inability to retain highly qualified staff with the potential loss of corporate memory, reducing CFHI's capacity to run projects and programs effectively.

CFHI implemented an organizational energy survey and is responding to the findings. We are also developing an employee engagement survey. We have already implemented several retention initiatives, including: permanent contracts, a compensation review, onsite coaching/mentoring, alternate work arrangements and more.

CFHI uses exit interviews for all departing staff, which inform detailed checklists for handover. We have made contact relationship management software a priority, 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.

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 March 31, 2018, 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 March 31, 2018.

We expressed an unmodified audit opinion on those financial statements in our report dated June 28, 2018.

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 year ended March 31, 2018 are a fair summary of those financial statements, in accordance with the basis described in note 1.

Chartered Professional Accountants, Licensed Public Accountants

Ottawa, Canada June 28, 2018

KPMG LLP

Summary Statement of Financial Position

March 31, 2018, with comparative information for 2017 (In thousands of dollars)

	2018	2017
ASSETS		
Cash	749	2,587
Accounts receivable	377	453
Prepaid expenses	116	187
Partner funding deposits	477	-
Short-term investments	2,500	4,000
Tangible capital and intangible assets	2,835	1,196
Employee future benefits	994	1,188
Investments – Reserve	11,081	8,586
	19,129	18,197
LIABILITIES AND DEFERRED CONTRIBUTIONS		
Accounts payable and accrued liabilities	1,512	2,011
Deferred revenue	-	62
Obligations under capital lease	33	-
Deferred lease inducement	176	-
Deferred capital contribution	487	-
Deferred contributions:		
Restricted – Operations	5,840	5,431
Restricted – Reserve	11,081	10,693
	19,129	18,197

See accompanying notes to summary financial statements.

Summary Statement of Operations

Year ended March 31, 2018, with comparative information for the three months ended March 31, 2017 (In thousands of dollars)

	2018	2017
REVENUE		
Recognition of deferred contributions relating to operations of the current period	14,487	3,616
Program support revenue	-	20
Other revenue	498	157
Recognition of deferred contributions relating to leasehold improvements	37	-
Recognition of deferred contributions relating to tangible capital and intangible assets	520	54
	15,542	3,847
EXPENSES		
Collaborating for Spread and Scale	5,007	1,252
Building Capacity for Improvement and Transformation	2,272	560
Enhancing Evaluation, Analytical and Knowledge Translations Capacity	1,938	417
Corporate Strategy and Program Development	1,603	-
Improving Access to Healthcare for People Living in Northern, Rural, Remote & Indigenous Communities	959	443
Partnering with Patient and Family Members in Healthcare Improvement	748	365
Communications and Stakeholder Relations	1,752	553
Corporate Services and Governance	1,267	254
Investment management fees	37	10
Employee future benefits	(41)	(7)
	15,542	3,847
Excess of revenue over expenses	-	-

See accompanying notes to summary financial statements.

Notes to Summary Financial Statements

Year ended March 31, 2018

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)(I) 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. On March 22, 2017 the government announced, as part of the 2017 budget statement, that CFHI was to receive funding of \$17 million per year beginning in 2019 and a \$17 million in funding in each subsequent year. CFHI holds the unused deferred contributions from agreements prior to March 2016 in reserve.

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 March 31, 2018.

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 66 full-time employees and 10 part-time employees by CFHI is \$5,940,788 for the year ended March 31, 2018.

	Salary	Taxable benefits	Total
President	304,801	1,000	305,801
Vice-President - Programs	216,611	-	216,611
Vice-President - Corporate Services	228,104	1,000	229,104
Corporate Secretary	78,562	27	78,589

Job level	Min	Max	No of FTE
Vice-President	160,000	240,000	2
Director	106,400	159,600	11
Specialist/Management	81,600	122,400	17
Professional	61,600	92,400	25
Operational Support	48,000	72,000	10

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.

Board of Directors

Board members from April 1, 2017 - March 31, 2018



Dr. R. 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
Centre intégré universitaire de
santé et de services sociaux de la
Mauricie-et-du-Centre-du-Québec
(CIUSSS MCQ)
Trois-Rivières, Québec



Deborah Delancey
Former Deputy Minister
Health and Social Services (HSS)
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)



Abby Hoffman Assistant Deputy Minister Strategic Policy Branch Health Canada Ottawa, Ontario



Dr. Murray N. RossVice President
Kaiser Foundation Health Plan, Inc.
Oakland, California, USA



Erik Sande President Medavie Health Services Dartmouth, Nova Scotia



Constance Sugiyama
Corporate Director
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

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