SPREADING BEST PRACTICES ACROSS CANADA
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1565 Carling Avenue, Suite 700
Ottawa, Ontario, Canada K1Z 8R1

t (613) 728-2238 | f (613) 728-3527 | info@cfhi-fcass.ca

cfhi-fcass.ca
# Table of Contents

2  MESSAGE FROM THE PRESIDENT AND CHAIR

7  COLLABORATING ACROSS JURISDICTIONS
   8  Spreading the Appropriate Use of Antipsychotic Medication in Long Term Care
   10  Spreading an INSPIRED Approach to COPD Care
   12  Atlantic Healthcare Collaboration: A Collaborative Approach to a Chronic Care Problem
   14  Northern and Aboriginal Health: Collaborating for Better Health

17  PATIENT AND FAMILY ENGAGEMENT: PARTNERING FOR QUALITY IMPROVEMENT
   18  Putting Patients at the Centre of Care

23  BUILDING CAPACITY
   24  The EXTRA Program: Putting Healthcare Leaders on the Map
   26  Education and Training: Building Improvement Capacity

29  DEMONSTRATING RESULTS
   30  Evaluation and Performance Measurement: Demonstrating Results

33  IHI TRIPLE AIM COLLABORATIVES: Healthier Populations, Better Care, Lower Costs
   34  Optimizing Health System Performance

37  FINANCIALS AND PARTNERSHIPS

45  2014 CFHI BOARD OF DIRECTORS
The Canadian Foundation for Healthcare Improvement continued in 2014 to support new ways of spreading healthcare innovations across the country. We worked closely with healthcare providers, governments, policy-makers and other leaders to bring about real improvements in the quality and efficiency of patient care, and ensure the spread of these improvements. In undertaking this work, we were guided by three strategic priorities:

- accelerating evidence-informed improvements in healthcare delivery
- engaging patients and families
- promoting policy analysis and facilitating dialogue for improvement.

Improvement and innovation were rallying cries for governments and healthcare organizations at all levels this year. The Council of the Federation Healthcare Innovation Working Group continued its work, focusing on how innovation can enable the provinces and territories to better meet their healthcare challenges, while the federal Advisory Panel on Healthcare Innovation is working to identify the five most promising areas of healthcare innovation in Canada and internationally.

This annual report explains some of the ways CFHI met its objectives in 2014. It highlights our work leading pan-Canadian initiatives to spread evidence-informed innovations, including a project implemented by the Winnipeg Regional Health Authority to reduce the use of antipsychotic medication in long term care facilities, which is now spreading to seven provinces and one territory. An innovative approach to improving care for patients with chronic obstructive pulmonary disease (COPD), originating in Halifax, is being spread to every Canadian province. Another major collaborative was partnering healthcare professionals with patients and families to improve health services drawing from what was learned from the 17 healthcare institutions we worked with in the previous Patient Engagement Projects initiative.

Our expanded Northern and Remote Collaboration continued to address the barriers faced in accessing healthcare in remote communities, particularly by First Nations.

Initiatives like these brought together multidisciplinary teams to work together on common priorities, across regions and jurisdictions. These “coalitions of the willing” are made up of committed professionals who believe innovation is possible and want to emulate the positive change achieved elsewhere. By focusing on implementation and rigorous evaluation, CFHI has built a track record of leading change processes that make a difference in communities across Canada. Our programming has helped our partners make progress towards our common goals of:

- healthcare efficiency
- patient- and family-centred care
- coordinated healthcare.

In 2014, we began to see solid results from our first pan-provincial collaboration, the Atlantic Healthcare Collaboration, which united teams from across the provinces to improve care for patients living with chronic disease. The EXTRA program graduated its largest ever cohort of improvement leaders, whose projects continued to generate measurable improvements in patient care. And we further cemented our relationship with the Institute for Healthcare Improvement (IHI), supporting a second cohort of Canadian organizations in IHI’s Triple Aim collaboratives, which simultaneously improve the health of populations and patient experiences while reducing per capita healthcare costs.

At CFHI, we strive to identify innovations, build productive pan-Canadian collaborations, and enable improvement champions and environments. We apply a proven and rigorous process, and then communicate and spread success. We work with provincial quality councils and health ministries so that innovations spread further and may be scaled-up. We look forward to taking this work further in 2015 for the benefit of Canadians across the country.

Maureen O’Neil, O.C.,
President

Leslee J. Thompson,
Chair, Board of Directors
In 2014, CFHI supported:

799 healthcare leaders

141 improvement teams

10 collaborations

2 EXTRA cohorts
Our Work

Spreading Innovation Across Canada

When it comes to improving healthcare, we’re all over the map. And that’s a good thing.

Programs

- Antipsychotic Medication in Long Term Care
- INSPIRED Approaches to COPD
- Atlantic Healthcare Collaboration
- Northern and Remote Collaboration
- Partnering with Patients and Families for Quality Improvement
- EXTRA Cohort 10
- EXTRA Cohort 11
- IHI’s Better Health, Lower Costs for Patients with Complex Needs
- IHI’s Triple Aim Improvement Community
Ontario

IHI's Better Health, Lower Costs for Patients with Complex Needs

IHI's Triple Aim Improvement Community

EXTRA Cohort 10

EXTRA Cohort 11

Atlantic Healthcare Collaboration

Antipsychotic Medication in Long Term Care

Partnering with Patients and Families for Quality Improvement

INSPIRED Approaches to COPD

Northern and Remote Collaboration

Programs
Collaborating Across Jurisdictions

CFHI brings together healthcare professionals from across jurisdictions and disciplines to solve persistent healthcare problems. We apply our proven approach, supporting health teams to assess their challenges, articulate clear improvement objectives, design solutions, implement improvements and evaluate outcomes. The teams are made up of senior executives, managers, physicians, nurses, allied health professionals, and patient experience advisors.
Spreading the Appropriate Use of Antipsychotic Medication in Long Term Care

THE INNOVATION

In 2011, the Winnipeg Regional Health Authority sent a team into CFHI’s EXTRA program to uncover whether the use of antipsychotics in long term care (LTC) facilities could be reduced without bringing about adverse changes in the residents’ behaviour. The health authority made use of quarterly assessment data to implement more personalized approaches to resident care. These approaches included creative solutions such as tailored recreational activities, which greatly reduced staff reliance on antipsychotics. Within six months, 27 percent of residents in the pilot were off these medications with no increase in behavioural symptoms or use of physical restraints.

THE CFHI COLLABORATIVE

CFHI launched a 16-month quality improvement collaborative in June 2014 in which interprofessional healthcare teams are adapting and implementing WRHAs proven approach. Teams are collecting interRAI data on a range of measures, such as residents’ moods and cognitive status, and the incidence of falls, and using that information to tailor alternative approaches to care. By the end of 2014, most teams had provided the first of four major submissions of their data and, in 2015, CFHI will further support teams in collecting data on the quality of care experience for staff and family members.

Working with Dr. John Hirdes, Senior Canadian Fellow for interRAI at the University of Waterloo and lead member of the Seniors Quality Leap Initiative (a network of LTC homes in Canada and the US dedicated to identifying and spreading best practices in the reduction of antipsychotic medications), we will also compare the performance of facilities participating in the collaborative to those that have not participated.

Teams consist of a variety of healthcare providers, including administrators, physicians, nurses, evaluation specialists, pharmacists and others. Since the collaborative began, CFHI has supported teams by providing them with nine webinars on improving the quality of care in LTC homes, an in-person workshop, teleconference coaching, training and templates, and access to an online learning community platform.

The collaborative is supported by a strong faculty that includes Cynthia Sinclair—now with the East Gate Lodge personal care home—and Joe Puchniak, who co-led the original EXTRA project, and Lori Mitchell of the Winnipeg Regional Health Authority as well as Dennis Cleaver, Executive Director of the Seniors Health Strategic Clinical Network in Alberta.

ENCOURAGING RESULTS

Teams are already demonstrating success with their interventions, including discontinuing antipsychotics without any negative effects on residents. Some teams have engaged families in identifying techniques that do not involve medications for managing residents’ behaviours. Others are reporting changes from a culture of prescribing antipsychotics to a culture of finding alternative approaches.

“CFHI’s Reducing Antipsychotic Medication Use in Long Term Care is one of the most interesting and exciting quality initiatives to have happened in Canadian healthcare recently.”

– Dr. John Hirdes, Professor, School of Public Health and Health Systems, University of Waterloo
Problem: Inappropriate Use of Medication in Long Term Care

Solution: Reducing Antipsychotic Medication Use in Long Term Care Collaborative

1 in 3 long term care residents in Canada is on antipsychotic medication without a diagnosis of psychosis.

That’s more than 10,000 Canadians.

CFHI’s collaborative includes a wide range of organizations and approaches to spread and scale. Edmonton’s Good Samaritan Society, above, serves 7,500 people in Alberta and British Columbia, has launched their project from a single site and plans to spread the approach to an additional five LTC facilities in Alberta. Staff and residents are shown engaging in tailored recreational activity, which is reducing reliance on medication. Central Health in Newfoundland and Labrador is implementing an initiative across four long-term care facilities simultaneously. Revera is implementing its initiative in 15 LTC homes across two provinces: British Columbia and Ontario and plans to spread it across 58 sites in Canada.
Spreading an INSPIRED Approach to COPD Care

THE INNOVATION

In 2010, a healthcare team at Capital Health’s Queen Elizabeth II Health Sciences Centre in Halifax, Nova Scotia developed the INSPIRED COPD Outreach Program™ to better care for patients living with advanced chronic obstructive pulmonary disease (COPD), a primary cause of hospital admissions in Canada. Typically, patients suffering from an “acute exacerbation of COPD” or AECOPD would present at the emergency department, receive treatment and undergo a lengthy hospital stay and then be discharged—only to be readmitted when the next AECOPD struck.

The healthcare team developed the INSPIRED program to locate the gaps in COPD care and deliver an individualized experience for each patient and family. Within six months, patients and their families experienced improved care and patients’ emergency department visits fell by 60 percent, hospitalizations fell by 63 percent, and days in hospital fell by 62 percent. The reduction in hospitalizations translates into an estimated $977,000—more than three times the annual operating costs of the INSPIRED program.

THE CFHI COLLABORATIVE

Following Capital Health’s success, CFHI, with support from Boehringer Ingelheim (Canada) Ltd. (BICL), is providing funding, coaching, educational materials and tools, and other support to 19 teams from all 10 provinces to transform care for people living with COPD and support their caregivers by adapting the INSPIRED COPD Outreach Program™ to their own context. Ten improvement teams engaged in the collaborative estimate that more than 11,000 people living with COPD within their vicinities will benefit from this pan-Canadian initiative. Similarly, across the 19 teams, it is estimated that a combined $221 million a year is spent on treating COPD exacerbations in hospital so the potential cost-savings are sizeable. Interventions put in place by these teams will include:

- Improving patient and family caregiver education, self-management and self-efficacy, particularly for patients with advanced COPD;
- Enhancing home-based care;
- Improving continuity of care across the hospital-to-home transition;
- Facilitating effective advance care planning; and,
- Reducing reliance on costly hospital-based care, including emergency department (ED) visits, hospital admissions and lengths of stay.

The collaborative is supported by a faculty that includes Drs. Graeme Rocker and Cathy Simpson, co-founders of the INSPIRED COPD approach. They are joined on the faculty by Dr. Terry Sullivan of the University of Toronto, Dr. Jean Bourbeau of the Department of Medicine and Epidemiology & Biostatistics, McGill University and Jillian Demmons, who works as program coordinator.
Problem: Gaps in COPD Care

COPD will soon be the **third leading cause of death** and is a primary cause of emergency department visits and hospitalizations in Canada.

COPD exacerbations are costing the 19 teams a combined $221,673,196.

Solution: INSPIRED Approaches to COPD: Improving Care and Creating Value

- **19 teams**
- **214 healthcare professionals**
- across **10 provinces**

**REPRESENTING:**
- **78 Healthcare Sites**

**BENEFITTING:**
- **11,000+ Patients**
Atlantic Healthcare Collaboration
A Collaborative Approach to a Chronic Care Problem

In 2012, CFHI launched its first pan-provincial collaboration to improve the health of Canadians living with chronic disease. The Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease brought together 17 regional health authorities spanning all four Atlantic provinces—a region that reports higher than average rates of chronic disease. CFHI supported eight improvement projects—led by multidisciplinary teams, including front-line clinicians and managers—that have delivered tangible improvements for people living with mental illness, diabetes and chronic obstructive pulmonary disease.

COMMON CHALLENGES—AND SUCCESSES—ACROSS MULTIPLE PROGRAMS

The organizations that participated in the Atlantic Healthcare Collaboration faced several challenges common to this region: escalating rates of chronic disease among the elderly and declining healthcare budgets at a time when these care deficits persist. The teams achieved positive results by prioritizing patient needs at the outset of a project, educating healthcare providers on the importance of enabling patients to self-manage their disease, and have, in turn, developed important skills in areas such as community engagement, multidisciplinary teamwork, project management and evaluation.

Key improvements included: Horizon Health Network’s (NB) success in enhancing the quality of life of young adults living with mental illness, decreasing their use of formal crisis services, which includes visits to the emergency room and use of community mobile mental health services; Central Health’s (NL) redesign of an asthma outpatient clinic into a new Respiratory Ambulatory Care Centre (filling a previously under-serviced need); and Health PEI’s success in helping healthcare providers to more actively involve patients in the decision-making and goal-setting around the management of their own health and wellness.

One important meeting was a symposium convened by Capital Health (NS) in which all Nova Scotia health authorities (and some out of province teams) discussed system-level approaches to better coordinate care for people living with chronic conditions. More than 150 participants attended, including notable guests, such as Dr. Ed Wagner of the MacColl Centre and Dr. Martin Fortin of the University of Sherbrooke.

“We are used to silos; [the in-person workshops] opened boundaries. It took us to this shared space. We learned a lot from other teams.”

– AHC participant
**IMPROVING HEALTH: MY WAY**

Western Health, located in Newfoundland and Labrador, has among the highest rates of diabetes in the country: nine percent of the population in 2010, projected to rise to 14 percent by 2020. Their initiative engaged providers in improving self-management support for patients with chronic conditions.

**Key Results**

**Central Health (NL)**
Redesigned an asthma outpatient clinic into a Respiratory Ambulatory Care Centre
New standing orders and improved care pathways provide standardized and evidence-informed care

New COPD outreach program uses telehealth and home-based support to provide:

- self-management education
- action plan development
- psychosocial support
- advance care planning

60 Patients
in just 2 months

**Western Health (NL)**
Implemented:

- Depression-screening tool for people living with type 2 diabetes
- Physician, team and staff self-management education

Patients report:
- Convenient appointments
- Helpful diabetes management plans and education sessions
- Confidence in diabetes self-management

**Health PEI**

**Current:**

- 101 healthcare providers completed self-management training

**In 3 years:**

- 1,000+ healthcare providers will be trained

Providers report greater confidence in their self-management ability and likelihood to implement self-management

**Horizon Health Network (NB)**

Youth report improvement in concerns about:

- mental health
- work
- relationships
- money

Decrease in:
- Emergency room visits
- Hospital admissions for a mental health diagnosis
- Use of community mental health services
Northern and Aboriginal Health
Collaborating for Better Health

Of all Canadians, First Nations, Métis, and Inuit peoples face some of the greatest barriers to accessing healthcare and, at the same time, have among the worst healthcare outcomes. The delivery of healthcare services to all people in northern and remote areas in Canada presents a unique set of challenges and CFHI is bringing together healthcare leaders to solve them.

NORTHERN AND REMOTE COLLABORATION

In May 2014, CFHI’s Northern and Remote (formerly the Northern, Rural or Remote) Collaboration was launched to appropriately and effectively meet the needs of Canadians living in northern and remote areas. It held a pan-Canadian invitational roundtable of more than 50 healthcare leaders from 19 organizations. It was the second such roundtable to take place and the first since CFHI established its focus on Northern and Aboriginal Health programming. The meeting’s overarching goal was to encourage dialogue about the best ways to collaborate across northern and remote regions. At the meeting, primary care, cultural capacity (healthcare providers’ ability to understand and respond effectively to First Nations’ cultural needs), and mental health and addiction services were identified as priorities for collective action.

In October, CFHI launched new programming for the Collaboration that consists of two Community of Practice streams: an Information Sharing Network that offers a series of webinars, and an Improvement Team stream that offers tailored improvement planning webinars and coaching to help healthcare teams develop improvement project plans that will be ready for implementation in their communities. Seven teams from three territories and four provinces joined the expanded Collaboration. The participating organizations include the Departments of Health and Social Services from the Yukon and the Northwest Territories, the Department of Health from Nunavut, Alberta Health Services, Northern Health Region in Manitoba, Northern Health Authority and First Nations Health Authority in British Columbia, and the Cree Board of Health and Social Services of James Bay, Québec.

A GROWING CHORUS OF VOICES

Following the May roundtable, the Collaboration’s executive committee expanded to include all three territories and the First Nations Health Authority of British Columbia. The executive committee members set priorities to ensure the programming addresses the quality improvement gaps in their regions. In addition, the executive committee members provide executive-level support to the quality improvement teams for successful implementation of their improvement initiatives. The executive committee members are mostly CEOs of their respective regions, including one deputy minister of health and social services.
Collaborating with the North Shore Tribal Council

In 2014, CFHI worked closely with the North Shore Tribal Council (NSTC) to facilitate the design of an evidence-informed, community-driven, holistic model of primary healthcare. NSTC serves a population of 12,000 people living in the 307 km stretch between Sudbury and Sault Ste. Marie. The model, inspired by the Southcentral Foundation of Alaska’s Nuka System of Care, focuses on physical, mental, emotional and spiritual wellness, as well as principles of community relationships, innovation and quality improvement.

CFHI assisted NSTC in developing a collaboration framework and workplan that included a community engagement plan to inform the design of a new primary care model. The community’s participation has been key to developing a healthcare model that identifies ineffective delivery practices and focuses on appropriate service delivery that meets the healthcare needs of its members. Over several months, CFHI provided training to key community leaders to become community engagement facilitators in their own communities. The training resulted in a total of eight community engagement workshops, seven of which were delivered in 2014, that will help inform the development of a new primary healthcare delivery model and build capacity for future community engagement.

AN EFFECTIVE ENGAGEMENT

Evaluations from the eight community workshops revealed that 90 percent of respondents agreed the workshops were effective for sharing their experiences about the existing healthcare model, for identifying what is working and what needs to be changed, and for how communities can come together to improve healthcare.

Facilitators from seven northern First Nations (Batchwana, Garden River, Thessalon, Mississauga, Serpent River, Sagamok Anishnawbek, Whitefish Lake) gather to prepare for a community roundtable. In this photo (from centre): Roger Boyer II, Sheila Niganobe, Cheryl Hankard, Gloria Daybutch, Linda Ambeault and Lois Harrop.
Patient and Family Engagement
Partnering for Quality Improvement

Since 2010, CFHI has led three pan-Canadian initiatives and supported 39 teams in harnessing the tremendous potential of patients and families to help drive quality improvement. The projects, which have targeted diverse healthcare issues and settings, have engaged patients and families in the design, delivery and evaluation of health services. Today, CFHI is leading the way in this transformative realm of quality improvement.
Putting Patients at the **Centre of Care**

When healthcare teams work with patients and families to co-design improvements to care, they gain different insights and deliver better results than when teams work on their own. In 2014, CFHI built on the success of its Patient Engagement Projects (2010–2013) by launching the Partnering with Patients and Families for Quality Improvement collaborative. The collaborative provides funding, coaching and other support for 22 teams from healthcare organizations across the country. Teams are partnering with patients and families to improve patient care and outcomes.

Our faculty for the 2014 collaborative includes Patty O’Connor of McGill University Health Centre, Angela Morin of Kingston General Hospital and Lena Cuthbertson of the British Columbia Ministry of Health/Providence Health Care.

**MEET A TEAM**

A team that includes British Columbia’s Vancouver Coastal Health and Fraser Health is participating in the Partnering with Patients and Families for Quality Improvement collaborative. The team will work with patients and families to develop a plan for accessing appropriate services once patients return home following hip fracture surgery.

In this photo: Dolores Langford, Physiotherapy Practice Coordinator, Coastal Community of Care, Vancouver Coastal Health and Kathleen Jackson, patient, ‘Good to Go’ hip project.
Problem: Finding Better Ways to Tap Into Patient Know-how
Solution: Partnering with Patients and Families for Quality Improvement Collaborative

22 teams  99 team members  28 faculty and coaches
across 6 provinces and 1 territory

Team members consist of:

- Patient Experience Advisors: 24
- Administrators and Coordinators: 55
- Academic and Research: 6
- Communications and IT: 3
- Healthcare Providers: 11

Teams are working on improving multiple quality domains:

- Patient Experience: 95%
- Coordination of Care: 23%
- Efficiency: 73%
- Effectiveness and Appropriateness of Care: 50%
- Patient Safety: 23%

Legend:
- Patient Experience
- Coordination of Care
- Efficiency
- Effectiveness and Appropriateness of Care
- Patient Safety

ANNUAL REPORT 2014
SHARING KEY KNOWLEDGE

CFHI has built a substantial collection of tools and resources that help healthcare organizations assess, design, implement and evaluate their patient and family engagement initiatives. Our Resource Hub, funded in part by the Canadian Partnership Against Cancer, provides access to tools, such as guides, checklists and literature reviews. In 2014, we developed and promoted the Resource Hub more actively than ever before. Regular webinars, including a patient and family engagement four-part series, equip organizations with the knowledge to plan, implement and measure their initiatives. In 2014, CFHI worked with Dr. Ross Baker to develop a research paper that reviews research evidence, and Canadian and international case studies—including CFHI-supported Patient Engagement Projects (PEP)—on how patient engagement can contribute to patient care and organizational effectiveness.

RESULTS ACROSS MULTIPLE DOMAINS OF QUALITY

Our PEP teams’ results have demonstrated the significant benefits of working with patients and families as equal partners; as examples, teams have reduced admission rates, improved responsiveness and reduced medication transcription errors. Teams participating in our most recent collaborative continue to build the capacity and culture of organizations to partner with patients and families in quality improvement. As part of the collaborative, teams are working to bring about measureable improvements across multiple domains of quality improvement, such as patient and family experience of care, coordination of care, effectiveness and appropriateness of care, and safety.

“Greater engagement of patients and families in organizational roles and care teams has helped a number of healthcare organizations to improve quality, safety and patient experience.”
– G. Ross Baker, Ph.D.

“I became a Patient and Family Advisor out of frustration with a system that meant well but sometimes missed the mark because it didn’t consult the people it served. So now it’s thrilling for me to be a part of this pan-Canadian endeavour, to see the way that the personal relationships it fosters create a pattern that then extends like a fractal into healthcare across the country.”
– Anya Humphrey
Patient and Family Adviser to Cancer Care Ontario PEP Team
**INTERNATIONAL CONFERENCE IN CANADA FOR THE FIRST TIME**

The Institute for Patient- and Family-Centered Care (IPFCC) is an international leader in advancing the practice of patient- and family-centred care. In 2014, CFHI acted as program partner for IPFCC’s annual conference which showcased innovative collaborative programs among healthcare professionals, patients and families.

The conference, held in Vancouver, British Columbia, included 750 participants (half of them Canadian) from 11 countries and an impressive line-up of plenary speakers, and featured networking opportunities for participants. More than 53 sessions featured presenters from six Canadian provinces, including a keynote presentation from the Chair of our Board of Directors, Leslee Thompson, on meaningful patient and family partnerships. The event generated significant media attention across Canada.
Building Capacity

Building capacity for quality improvement is at the core of CFHI’s work. We deliver in-person learning experiences for healthcare leaders via our EXTRA residency programming and face-to-face workshops, while our On Call webinars and online workshops enable leaders to access knowledge and learning remotely. Across all our education and training activities, we help experts to learn by doing.
The EXTRA Program
Putting Healthcare Leaders on the Map

CFHI’s EXTRA program for healthcare improvement celebrated its 11th year of operation in 2014 with its largest ever cohort: 40 Fellows. The EXTRA program supports teams of healthcare executives in designing and implementing innovative healthcare projects and then evaluating their effectiveness. Using a 14-month 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.

SOLID RESULTS OVER 11 YEARS OF PROGRAMMING

In 2014, EXTRA graduated its 10th cohort—nine healthcare teams from Ontario, Manitoba and Quebec. A project by the Winnipeg Regional Health Authority (building on a previous EXTRA initiative) reduced by 56 percent the use of antipsychotic medications in long term care facilities leading to a better quality of life for the residents, as well as significant savings for the health authority. A project by Peel Public Health, an organization that has participated in the past six EXTRA cohorts, focused on increasing breastfeeding following caesarian section births and created a lasting collaboration between the region’s hospital and its public health department.

The 11th EXTRA cohort includes teams from a mix of hospitals, public health agencies, regional health authorities and continuing care organizations across Canada, including an interprovincial team from Capital Health in Nova Scotia and Fraser Health in British Columbia. The improvement projects range from enhancing the quality of continuing care for the elderly to improving mental health care, and creating integrated approaches to quality, safety and risk management for healthcare leaders. In the continuing care project, seniors are already enrolled in a program that will keep them out of the hospital.

Since 2003, the EXTRA program has had more than 300 Fellows and has supported more than 200 healthcare improvement initiatives across Canada. This flagship offering has generated measurable improvements in key healthcare domains, such as quality, safety, access and efficiency.
A POLICY OF CONTINUOUS QUALITY IMPROVEMENT

EXTRA’s 2014 cohort benefitted from a targeted initiative in which CFHI used focus groups, feedback from former Fellows and the results of a Lean Six Sigma exercise to enhance the program’s coaching model, revise the fee structure, amend the curriculum by integrating national and international expertise on scale and spread, and develop many other program improvements.

MEET A TEAM

A healthcare team led by Agence de la santé et des services sociaux du Saguenay-Lac-St-Jean in Québec, is working to improve the state of health of the region’s population and control costs while doing it. Research indicates that a relatively small number of patients use the majority of clinical services in the region—in particular, emergency services, hospital beds and community health clinics. Despite the fact that a high proportion of patients have family physicians, two out of 10 patients visit the emergency department when they are ill. Moreover, data shows that as little as five percent of the population accounts for 50 percent of the use of hospital beds in the region. The Saguenay-Lac-St-Jean team aims to reconfigure clinical activities between social service centres and local health networks so that patients with chronic diseases are less dependent on hospital resources.

Dr Guy Verrault provides outpatient support.
Education and Training
Building Improvement Capacity

Building capacity for quality improvement is at the core of CFHI’s work. Healthcare leaders and their teams achieve better results faster when they are equipped with appropriate knowledge, strategies, tools and evidence for their improvement projects. CFHI provides focused, expert-led webinars, online workshops and in-person workshops.

LEARNING ONLINE
WEBINARS
CFHI’s On Call webinars include single-event educational experiences, as well as webinar series on key healthcare topics. In 2014, we hosted 16 webinars on diverse topics, such as “Caring for the 5 percent: healthcare for those who need it most” (a webinar series), and “How to keep long term care residents out of the hospital” (a single-event webinar).
Attendance for On Call webinars increased this year, with a total of 2,014 lines, averaging 126 lines per session equal to a 113 percent increase from 2013. Additionally, teams participating in other CFHI programming, such as our quality improvement collaboratives, benefitted from these educational webinars. As one example, all CFHI-supported teams participated in the “Measurement for Quality Improvement” webinar series.

WORKSHOPS
In 2014, CFHI launched the first of its new online workshops: “INSPIRED Approaches to COPD: Improving Care and Creating Value.” Our workshops are designed to provide healthcare teams and individuals with a convenient and affordable way to learn about innovative models of care and best practices, featuring a range of topics including quality improvement, change management, performance measurement, and patient and family engagement. The INSPIRED workshop focused on strategies for planning, designing and implementing improvements to COPD care. The workshop sold out quickly, attracting 115 registrants from 30 organizations across nine provinces and one territory.

“
I have been a strong advocate for self-management support. This webinar reinforced much of our current and proposed priority areas.

– On Call participant
In addition to online offerings, CFHI works with healthcare teams and individuals via face to face workshops. In 2014, we ran two workshops: The Institute for Healthcare Improvement’s “Driving Quality, Lowering Costs” event in October; and “Spreading Healthcare Innovations in a Land of Pilot Projects: From Sustainability to Spread and Scale Up” in June. The workshops attracted attendees from nine provinces and one territory.

We delivered the “Driving Quality, Lowering Costs” workshop in partnership with the BC Patient Safety Quality Council and the Health Quality Council of Saskatchewan. Seventy-seven attendees from diverse healthcare organizations attended the workshop in Vancouver to learn how to lower their operating costs by two to five percent—and improve care while doing it. The “Spreading Healthcare Innovations” workshop in Banff, Alberta provided over 100 participants with crucial knowledge, skills and strategies for spreading innovations across institutions, regions, provinces and territories. The workshop included a stream specifically for teams participating in the antipsychotic medication collaborative (see page 8).
Demonstrating Results

At CFHI, we embed evaluation and performance measurement in all our work, measuring the impact of the improvement projects we lead, as well as the value we bring to these collaborative efforts. By measuring the impact of our initiatives, we can help healthcare leaders make informed decisions about how to use resources more effectively and deliver improved services. These evaluative results are essential to building the case for change within organizations and ensuring the sustainability and scalability of improvement projects.
Evaluation and Performance Measurement
Demonstrating Results

EDUCATING FOR EFFECTIVE MEASUREMENT

Our EXTRA program, healthcare collaborations and workshops all train health leaders in evaluation and performance measurement so they can determine whether the changes they are making are leading to tangible improvements. CFHI led a webinar series in 2014 in which more than 520 individuals and teams from across Canada learned about a range of measurement techniques, from basic to more advanced practices. Topics included:

- data collection and the creation of run charts to track progress
- ways to embed economic parameters on costs in the data collection process
- linking data from quality improvement activities to inform overall system- and organization-level performance.

ENSURING ACCOUNTABILITY AND PERFORMANCE

We also completed significant work on a set of indicators for the CFHI Improvement Model that will guide our own performance reporting. This work will enable us to consistently collect process and outcome data across our collaboratives, and build the capacity in our own operation and among the improvement teams we work with, to measure performance. Also in 2014, we standardized our approach to conducting program evaluation surveys, and built an improvement project database capturing evaluative data for hundreds of projects that CFHI has supported.

“Well run webinar—good flow of answering questions and covering material—excellent presenters!”

– Participant, “Measurement for Quality Improvement” webinar series

One major finding from an independent analysis indicated that CFHI programming from 2006 to 2013 generated significantly more value to Canada than the funds invested in CFHI by government.
AN EVALUATION THAT DEMONSTRATES OUR IMPACT

CFHI undergoes an independent evaluation every five years. In 2013 and 2014, KPMG undertook an evaluation that found clear evidence we have supported substantive positive impacts on the Canadian healthcare system. One major finding from a partial benefit cost analysis indicated that CFHI programming generated significantly more benefits to Canada from 2006 to 2013 than the funding investments made by government. The analysis was based on a number of high-impact EXTRA projects; here are three examples:

1. A project by the Winnipeg Regional Health Authority in Manitoba saved $3.2 million and created better health outcomes for patients by encouraging the use of home dialysis instead of hospital-based dialysis.

2. The Ontario Ministry of Health and Long-Term Care developed a framework for reassessing the value of existing healthcare services. The work has led to the removal of two diagnostic tests from the standard Ontario laboratory test ordering form, resulting in an estimated $39 million per year being redirected to higher value tests. Changes to two other tests could result in more appropriate care and deliver further cost-savings of $20 million per year.

3. A senior healthcare executive developed a tool to help staff working in long term care facilities recognize the early signs of common ailments that result in residents being transferred to hospital emergency departments. Results from a pilot facility showed a 57 percent decrease in resident transfers to the emergency department associated with pneumonia, urinary tract infections, dehydration and congestive heart failure among participating residents. Estimated annual cost-savings if the tool were implemented throughout the Toronto Central Local Health Integration Network would exceed $500,000.

$3.2 million
saved

$39 million
redirected per year

$20 million
more could be saved

57% decrease
in resident transfers to the emergency department
CFHI worked with the Institute for Healthcare Improvement to support Canadian participation in IHI’s Triple Aim collaboratives. The Triple Aim focuses on simultaneously improving the health of populations and experiences for patients, while reducing the per capita costs of care. As one IHI Triple Aim collaborative ended in 2014, a second one began. CFHI is supporting the teams by funding half their registration fee, evaluating their progress, providing networking opportunities and access to resources.
Optimizing Health System Performance

In 2014, CFHI supported nine Canadian healthcare organizations to participate in IHI’s Triple Aim Improvement Community (TAIC). The organizations were part of a larger international cohort that included teams from the United States, Denmark, Sweden and the United Kingdom. Each Canadian team selected a specific population segment and used Triple Aim strategies to realize a particular business objective—for example, reducing the need for emergency care by bringing medically complex patients into a team-based personal care model. Each team also developed a measurement strategy and executed a set of interrelated projects to achieve results.

ENCOURAGING OUTCOMES FOR THE 2014 COHORT

An evaluation of the nine Canadian teams conducted by CFHI revealed the Triple Aim approach to be highly integrative, structured and systematic, as well as effective in the planning, delivery and practice of interprofessional, patient-centred and comprehensive healthcare at a population level. The evaluation also showed that Triple Aim promotes patient-centred care, facilitates partnerships and fosters interprofessional teamwork.

ALBERTA HEALTH SERVICES

Alberta Health Services (Edmonton Zone) is a true Triple Aim champion, focusing on better meeting the needs of a population with addictions, mental health issues and chronic disease that makes frequent use of the emergency department (ED). Providing services such as support for pregnant and parenting women with substance abuse issues, team-based care for complex patients in a new site with all the needed services, and community-based emergency medical service case management for clients who frequently use EMS and ED services, the team estimates it has lowered monthly per capita costs from $7,300 to $4,500 for adults with mental health and addictions issues.

WOMEN’S COLLEGE HOSPITAL

Participation in the Triple Aim collaborative has helped Women’s College Hospital in Toronto roll out a number of successful innovations. A project called 1-800-Imaging has enabled timely, appropriate imaging by providing primary care physicians with a virtual navigation hub for access to specialty care and consultation services. Specifically, the hub enables services for expediting imaging and reports for patients who need these services urgently, arranging physician-to-physician consultations with on-call radiologists (for matters such as appropriate test selection and second opinions). SCOPE 2 (Seamless Care Optimizing the Patient Experience) is a two-year collaborative partnership that offers primary care providers access to community resources and specialist care for high-need patients. PATH (Promoting Access to Team-based Healthcare) brings high-need patients most at risk of avoidable emergency department visits into a team-based primary care practice.
A NEW TRIPLE AIM COHORT FOR 2014

In addition to beginning an evaluation of the original nine Canadian TAIC projects in 2014, CFHI also supported 10 new Triple Aim collaborative teams. Called the “Better Health at Lower Costs for Patients with Complex Needs: An IHI Triple Aim Collaborative”, the initiative commenced in July 2014 and will conclude in June 2015—enabling healthcare teams to transform how their organizations care for patients living with complex health needs. Among groups being targeted by the Canadian teams are children with complex conditions, patients with mental health and addiction issues, the homeless, new Canadians and the frail elderly.

This collaborative reaches many of the most vulnerable individuals whose needs often go unmet by the traditional healthcare service model... IHI welcomes CFHI’s continued funding and networking support for Canadian organizations to help advance our Triple Aim work around the world.

– Maureen Bisognano
President, Institute for Healthcare Improvement

MEET A TEAM

The healthcare team at Belleville and Quinte West Community Health Centre in Belleville, Ontario is focusing its Triple Aim project on individuals with advanced chronic diseases, addiction and mental health needs, and those who require hospice palliative care. The team supports clients in planning their healthcare around what matters most to them.

In this photo: Joanne Fitzgibbon, RN, MSc, Quinte HealthLink Care Coordinator conducting one of many at-home interviews.
Financials and Partnerships

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

The accompanying summary financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l’amélioration des services de santé, which comprise the summary statement of financial position as at December 31, 2014, the summary statement of operations for the year then ended, and related notes, are derived from the audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations, of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l’amélioration des services de santé as at and for the year ended December 31, 2014.

We expressed an unmodified audit opinion on those financial statements in our report dated March 26, 2015.

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 as at December 31, 2014 and for the year then ended. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l’amélioration des services de santé.

MANAGEMENT’S RESPONSIBILITY FOR THE SUMMARY FINANCIAL STATEMENTS

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

AUDITORS’ RESPONSIBILITY

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

OPINION

In our opinion, the summary financial statements derived from the audited financial statements of the Canadian Foundation for Healthcare Improvement/Fondation canadienne pour l’amélioration des services de santé as at December 31, 2014 and for the year then ended are a fair summary of those financial statements, in accordance with the basis described in Note 1.

Chartered Professional Accountants,
Licensed Public Accountants
March 26, 2015
Ottawa, Canada
Summary Statement of Financial Position

DECEMBER 31, 2014, WITH COMPARATIVE INFORMATION FOR 2013
(IN THOUSANDS OF DOLLARS)

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$1,537</td>
<td>$1,570</td>
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<tr>
<td>Accounts receivable</td>
<td>544</td>
<td>1,233</td>
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<tr>
<td>Prepaid expenses</td>
<td>102</td>
<td>180</td>
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<tr>
<td>Investments</td>
<td>19,833</td>
<td>29,303</td>
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<td>Employee future benefits</td>
<td>670</td>
<td>587</td>
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<tr>
<td>Tangible capital and intangible assets</td>
<td>144</td>
<td>143</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$22,830</td>
<td>$33,016</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIABILITIES AND DEFERRED CONTRIBUTIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>$1,723</td>
<td>$1,856</td>
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<tr>
<td>Deferred revenue</td>
<td>476</td>
<td>439</td>
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<tr>
<td>Capital lease obligations</td>
<td>21</td>
<td>31</td>
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<tr>
<td>Deferred lease inducement</td>
<td>—</td>
<td>8</td>
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<tr>
<td>Deferred contributions</td>
<td>20,610</td>
<td>30,682</td>
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<tr>
<td><strong>Total Liabilities and Deferred Contributions</strong></td>
<td>$22,830</td>
<td>$33,016</td>
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</table>

See accompanying notes to summary financial statements.
Summary Statement of Operations

YEAR ENDED DECEMBER 31, 2014, WITH COMPARATIVE INFORMATION FOR 2013
(IN THOUSANDS OF DOLLARS)

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program support revenue</td>
<td>$ 721</td>
<td>$ 514</td>
</tr>
<tr>
<td>Other revenue</td>
<td>558</td>
<td>476</td>
</tr>
<tr>
<td>Co-sponsor revenue</td>
<td>27</td>
<td>306</td>
</tr>
<tr>
<td>Recognition of deferred contributions relating to operations of the current year</td>
<td>10,382</td>
<td>9,254</td>
</tr>
<tr>
<td>Recognition of deferred contributions relating to tangible capital and intangible assets</td>
<td>108</td>
<td>168</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$ 11,796</td>
<td>$ 10,718</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EXPENSES</strong></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration for innovation and improvement</td>
<td>$ 3,669</td>
<td>$ 3,886</td>
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<tr>
<td>Education and training</td>
<td>3,490</td>
<td>3,800</td>
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<tr>
<td>Applied research and policy analysis</td>
<td>—</td>
<td>949</td>
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<tr>
<td>Patient engagement for healthcare improvement</td>
<td>1,776</td>
<td>—</td>
</tr>
<tr>
<td>Business development</td>
<td>366</td>
<td>731</td>
</tr>
<tr>
<td>Administration</td>
<td>821</td>
<td>563</td>
</tr>
<tr>
<td>Communications</td>
<td>1,158</td>
<td>555</td>
</tr>
<tr>
<td>Evaluation and performance measurement</td>
<td>483</td>
<td>293</td>
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<tr>
<td>Amortization of tangible capital and intangible assets</td>
<td>108</td>
<td>168</td>
</tr>
<tr>
<td>Investment management fees</td>
<td>69</td>
<td>88</td>
</tr>
<tr>
<td>Employee future benefits fair value adjustment</td>
<td>(144)</td>
<td>(315)</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$ 11,796</td>
<td>$ 10,718</td>
</tr>
</tbody>
</table>

**EXCESS OF REVENUE OVER EXPENSES**

$ – $ –

See accompanying notes to summary financial statements.
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 (CHSRF) effective April 5, 2012.

CFHI is a registered charity under the Income Tax Act, and accordingly, is exempt from income taxes under paragraph 149(1)(l) of the Income Tax Act (Canada). The organization became operational in fiscal 1997 and is incorporated under Part II of the Canada Corporations Act. Effective June 17, 2014, CFHI continued its articles of incorporation from the Canada Corporations Act to 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. CFHI is transitioning its investments to meet this agreement.
1. SUMMARY FINANCIAL STATEMENTS:

The summary financial statements are derived from the complete audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations, as at and for the year ended December 31, 2014.

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 45 full time employees by CFHI is $4,832,320 in 2014. The ten highest compensation full time positions are as follows:

<table>
<thead>
<tr>
<th>RANGE</th>
<th>NUMBER OF POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250,000 – $299,999</td>
<td>1</td>
</tr>
<tr>
<td>$200,000 – $249,999</td>
<td>0</td>
</tr>
<tr>
<td>$160,000 – $199,999</td>
<td>2</td>
</tr>
<tr>
<td>$120,000 – $159,999</td>
<td>5</td>
</tr>
<tr>
<td>$80,000 – $119,999</td>
<td>2</td>
</tr>
</tbody>
</table>

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.
Partnerships, Cost Sharing and Revenue Generation

PARTNERSHIPS

CFHI works with provinces, territories and other healthcare partners to promote better care, value and health. These partners include national and international organizations, provincial-territorial departments of health and agencies, regional health authorities and healthcare delivery organizations spanning the continuum of care. Collaboration is at the heart of our programming; each partnership is unique, marrying local priorities, needs and capacity with CFHI’s coaches, faculty, resources and tools.

In 2014, CFHI entered into two revenue-generating partnership agreements, including:

- Boehringer Ingelheim Canada (Ltd.) for the INSPIRED Collaborative – $600,000
- Five Atlantic health regions for the Collaboration for Innovation and Improvement in Chronic Disease – $150,500.

Highlights of our programming partnerships are found in the preceding sections and a full list of programming partners for each collaborative can be found on our website.

EXPERIMENTING WITH REVENUE GENERATION

In some cases, our partnerships include a monetary exchange; in all cases, they include human resources from CFHI and its partners. CFHI has continued to expand its program reach and revenues through the continued offering of CFHI workshops and On Call webinars. In 2014, CFHI generated the following revenues:

- On Call webinars and series generated $63,000
- EXTRA program registration fees generated $262,000
- CFHI workshops generated $140,000.

CFHI cost-shared programs and fees for webinars, EXTRA registration and some workshops, generating funds that augment federal funding.
2014 CFHI
Board of Directors