



Legacies & Lessons Learned:

Reflections on the

Child Health Network for the

Greater Toronto Area

(1998-2010)

September 2010

This report is dedicated to the Child Health Network's members, staff and countless supporters who shared the commitment to build a regional system of care for mothers, newborns, children and youth across the Greater Toronto Area. Together, we achieved major milestones that will forever change how we work together and how health care for this population is delivered. The breadth and depth of the partnerships built across the region will continue to be the best measurement and testimony to the Network's success.

Special thanks to Beverley J. Nickoloff and Moya Johnson who were the primary authors of this report and to Sheila Jarvis and Alison Quigley for sharing their thoughts on the legacies and lessons learned from the CHN.

INTRODUCTION

Built on a concept that goes back to the 1970s, the Child Health Network for the Greater Toronto Area (CHN) was established in 1998 as a partnership of hospital and community care providers. For a dozen years, the CHN remained committed to the goal that brought members together initially: to develop a regional system of care to improve the quality of and access to services for mothers, newborns, children and youth.

The Network played a strong and pivotal leadership role that demonstrated the benefits of a regional approach to the delivery of care [see Figure 1]. With the closing of the Network on September 30, 2010, this report is intended to capture the legacies and lessons from this experience. It is hoped that this overview will offer guidance in the future to both the members of the CHN and others involved in the planning and delivery of maternal/child services and perhaps to the participants in other kinds of health networks.

Much of the work undertaken by the CHN focused on putting in place protocols, processes and linkages to support development of a regional system of care for mothers, newborns, children and youth. The CHN cultivated new inter-hospital partnerships and more clearly defined the scope of services for individual hospitals and the linkages required between and among them to better offset demands on the most specialized facilities. It advocated for fewer, stronger centres of excellence to provide a higher level of health care to mothers and children. It looked at new ways for health professionals to work together and to increase their access to and use of evidence-based practice guidelines. It proposed ways in which health dollars, programs and human resources could be better deployed to meet the region's existing and future needs. All in all, the CHN's work tells an impressive story that showcases the value of a regional approach to health care and how this can be implemented.

Figure 1: Benefits of a Regional Approach to the Delivery of Maternal/Child Health Care

- ✓ Strengthen the delivery of hospital-based and ambulatory services across regions
- ✓ Enhance accountability and transparency (e.g., clear scope of service guidelines tied to accountability).
- ✓ Streamline specialty resources and services
- ✓ Facilitate development of stronger linkages and continuity between hospitals and with community care providers
- ✓ Address human and physical resource constraints impacting on stability within the system
- ✓ Build on successful models of inter-professional collaborative care in the maternal/child health care system (e.g., transport teams, neonatal teams)
- ✓ Initiate innovative solutions for recruitment of physician and other health human resources

STARTING A NEW CHAPTER

The CHN was one of the first health networks established in Ontario in the 1990s to bring people and organizations together to find solutions to growing problems with the quality, access and efficiency of health care services.¹

As this document is written, it appears that Ontario is about to open a new chapter in the history of a regional approach to maternal, child and youth health.

The newly formed Provincial Council for Maternal and Child Health (PCMCH) has brought clinical, administrative and policy leaders together to provide strategic direction, advise the government and drive the implementation of provincial priorities in this field. The PCMCH has created a task force to recommend a new network model for maternal, child and youth health that will set out the structure, roles, governance and funding for regional networks, define their relationship with their LHINs and with the PCMCH, and include a strategy for achieving province-wide coverage by networks.

Figure 2:

Changing Landscape Impacting the CHN in 2010

- ✓ Development/ maturation of provincial structures (e.g., PCMCH, BORN Ontario)
- ✓ Development/ maturation and variation of LHIN planning related to maternal/child populations
- ✓ Disconnects between hospital and LHIN planning, inter-LHIN planning, and regional level planning
- ✓ Ongoing uncertainties about regional maternal/child health planning including clarity around roles and scopes of services, as well as appropriate funding and accountability

In anticipation of a new model for networks for maternal, child and youth health, the CHN Board of Directors examined various options for the Network's activities pending this imminent change. Given the commitment to fiscal responsibility, the Board decided to wind down CHN's operations effective September 30, 2010.

This decision was influenced significantly by the changing landscape in the health care sector [see Figure 2]. Staff and committee chairs formulated plans to ensure that key initiatives underway were primed for transition to a new network model.

¹ Other examples are the Cardiac Care Network, the GTA Rehab Network, the Trillium Gift of Life Network, other regional child health networks. Regional maternal/child networks included: Southwestern Ontario Maternal Newborn Child & Youth Network (LHINs 1&2); Central West Obstetrical & Neonatal Nurses and Child & Youth Health Partnership (LHINs 3&4); Child & Youth Health Partnership (LHINs 3&4); Child Health Network for the Greater Toronto Area (LHINs 5,6,7,8 & part of 9); Perinatal Partnership Program for Eastern and Southeastern Ontario (LHINs 10&11); Child & Youth Health Network of Eastern Ontario (LHIN 11); and, Northern Perinatal & Paediatric Network (LHINs 13&14)

THE BEGINNING

Established in 1998, the CHN emerged from directions issued by the Ontario Health Services Restructuring Commission. During its 12 years of operation, the driving goal remained unchanged: to create a more connected and integrated system of health care delivery for maternal, newborn and paediatric services within the Greater Toronto Area (GTA). Efforts to develop a regional system of care focused on ensuring that patients received care at the most appropriate location depending on their needs and that providers were continually supported with the tools and linkages to deliver the best care possible. [See Figure 3.]

Sponsored and driven by its members, the CHN espoused and implemented a regional approach to care. The regional approach was based on defined levels of care, supported by a clear scope of services for each level, and the designation of levels of care to hospitals within the GTA in accordance with a policy statement developed by the Ministry of Health and Long-Term Care (MOHLTC).²

Figure 3: CHN Vision & Mission

Vision: A sustainable and responsive maternal, newborn and child healthcare system achieved through better integration and interaction between hospitals, community care access centres, and other partners.

Mission: To provide leadership in strengthening the regional maternal, newborn and child healthcare system by facilitating partnerships across the care continuum and supporting changes in care delivery through quality improvement and knowledge transfer.

At its inception, the CHN was comprised of 20 acute care hospitals (operating on 24 sites) – including three providing tertiary care – as well as one children’s tertiary rehabilitation and complex continuing care hospital, and nine Community Care Access Centres. (When the Network closed, there were 18 acute care hospital members and Community Care Access Centres in the GTA had regrouped from nine to five). This membership composition brought together an array of health service providers including nursing and allied health care professionals, physician specialists and sub-specialists, chiefs of paediatrics and chiefs of obstetrics, hospital CEOs, program directors and managers, and researchers and educators. Member organizations signed an annual agreement defining their roles and accountabilities including governing mechanisms, payment of membership fees, conflict resolution

² These designations and levels of care/ scope of service descriptions were released in February 2000 in a policy statement that included four levels of care for maternal /newborn care (levels 1, 2, 2+, 3) and three levels of care for paediatric care (acute care community hospital/short stay unit; regional children’s health centres; tertiary care centres)

procedures, and authorization to share with each other their hospital-level data in effort to improve quality of care.

The CHN operated in Canada's largest and most diverse metropolitan area.³ More than 69,000 babies are born each year in the GTA, representing approximately 51 per cent of the province's total births.⁴ Over half of the children living in Ontario reside within the GTA.⁵

³ The GTA population represents 41% of the province's total.

⁴ BORN Ontario, 2009-10 reported 69,707 hospital births in the 24 original CHN member hospitals in the GTA

⁵ Government of Ontario, Ontario Population projections Update 2009-2036, 2009
<http://www.fin.gov.on.ca/en/economy/demographics/projections/projections2009-2036.pdf>

A LASTING LEGACY

The CHN set a high standard for cultural change among its members, encouraging them to rethink what was done and where, and to consider how stronger collaboration and linkages among them could better match patient needs with services. An immediate impact of establishing the CHN was a visible energizing and mobilizing of individuals and organizations around this collaborative and strategic vision. The Network became a vehicle for initiating and supporting change at the clinical, organizational and system levels. Some of the enduring legacies achieved by the Network are described in the following sections.

A CULTURE OF WORKING AS ONE

The Network advanced the perspective that partnerships are essential to plan effectively for needs on a regional basis and to inspire the various providers to think and act like parts of a true system. Over the years, the CHN galvanized individuals and organizations to engage in dialogue, think about new ways to deliver care, adopt new practices of care, and collaborate on shared data initiatives to support and improve planning and decision-making. Throughout the CHN's existence, an appreciation steadily grew of the mutual value of collaboration, coupled with respect for the value of individual roles and their contribution to the system as a whole.

Involvement in the CHN encouraged member organizations to assess their potential contribution to a regional system of care. Organizations took the opportunity to champion their roles, develop programs to support them, and embrace the concept of serving as a Network resource. For example, Credit Valley Hospital (Mississauga) and the Rouge Valley Health System (Scarborough) made substantial investments to become satellite paediatric oncology centres affiliated with SickKids. Southlake Regional Health Centre (Newmarket) developed a regional child and adolescent mental health centre. Holland Bloorview Rehabilitation Hospital and SickKids set up an integrated child development program. These and other initiatives were undertaken in response to the continuing focus among the CHN members to integrate and rationalize services as the basis for more effective programs with staff resources serving more clients in a more timely manner.

FORGING STRONGER RELATIONSHIPS

The CHN provided forums to strengthen relationships between health care providers by creating opportunities for collegiality, sharing and support. The Network made an important contribution to developing peer networks among professionals, increasing information sharing, and improving communications between individual organizations. As a result, hesitancy has been replaced by a genuine willingness to consult with colleagues, problem-solve together and jointly take action on various initiatives.

For example, significant capital investments were made by a number of hospitals across the GTA to develop new or expanded birthing, neonatal intensive care and paediatric units. With the Network in place, these investments were not made in isolation but fit into a regional approach to care. CHN's standards and guidelines supported these capital renewal initiatives and encouraged member organizations to develop plans to enhance these programs, allocate more resources including staff, and focus more attention on building collaborative arrangements with other facilities to achieve integrated services.

ADVANCING THE ADVOCACY AGENDA

The CHN provided a platform for dedicated champions to highlight maternal, newborn, child and youth health programs within their organizations and across the region. Even at the end of the CHN's mandate, the members continued to invest much time and energy in advocating for changes to improve care delivery and respond to resource challenges. Some of the key issues concerned:

- ✓ lack of coordinated maternal/child health planning across LHINs
- ✓ increased complexity of patient caseload in hospital, the community and the school system (e.g., increasing incidence of pre-term births, multiple births, low birth weight infants)
- ✓ service gaps and the need for greater collaboration in key program areas (e.g., neonatal follow-up, eating disorders, child development).

LEVELS OF CARE AS A FOUNDATION FOR SYSTEM-BUILDING

In 2001, the CHN developed and released two documents describing the clinical scope of maternal, newborn and paediatric services associated with the designated levels of care that were assigned to hospitals by MOHLTC. This work was done at the ministry's request. The documents described the scope of practice related to specific levels of care defined in a February 2000 MOHLTC policy statement.⁶ The guidelines contained in these documents had a strong influence on CHN members planning reconfiguration or expansion of services (within and across organizations) as well as staff recruitment and capital building projects.

FOCUS ON PATIENT- & FAMILY-CENTRED CARE

The CHN created a framework for advancing patient and family-centred care, including a core definition and 17 standards. Entitled *Integrating Family-Centred Care into Health Care Practice: Towards a Common Framework of Understanding*, the framework encouraged members to take a closer look at their current policies, programs, and practices and set priorities within their organizations to embrace the values and principles of patient- and family-centred care in their day-to-day activities.

While developed for maternal, newborn and paediatric services, the standards are relevant throughout health care as a whole and many hospitals are now embracing patient and family-centered care across their entire

Figure 4: Definition of Family-Centred Care

Family-centred care is a philosophy and an approach to health care that shapes the provision of care, programs, policies and facility design. It reflects values and attitudes more than protocol.

Family-centred practitioners recognize the vital role that families play as members of the health care team. They acknowledge that emotional, social, cultural, and developmental support are integral components of health care. With this approach they:

- ✓ Empower children, youth and families and foster independence.
- ✓ Support children and families in decision-making and care giving.
- ✓ Build on individual and family strengths and respects their choices.
- ✓ Involve children and families in all aspects of planning, delivery and evaluation of health care services.

Members of the Network embrace the philosophy of family-centered care – both at the network and organizational levels – in recognition of the central role played by families in ensuring the health and well-being of family

⁶ The framework announced by the Ministry mandated expansion of the CHN beyond newborn and children to include maternal services, directed participation of the Community Care Access Centres, and confirmed the fundamental components of a regionalized system of services organized by the designations of levels of care to be provided by individual hospitals. The CHN members were directed to work together to clarify the definition of the Scopes of Services for the designated levels of care prescribed by the ministry.

organizations [See Figure 4.] The framework has been profiled nationally as a best practice initiative.

BETTER DATA TO DRIVE DECISION-MAKING

PROVINCIAL PERINATAL SURVEILLANCE SYSTEM

The CHN took the lead to develop and write the proposal to establish a Provincial Perinatal/Infant Surveillance System, now known as BORN Ontario. This role emerged as a result of growing interest among regional and provincial partners to align various perinatal data holdings on the web-based Niday Perinatal Database platform and utilize this infrastructure as the foundation for a province-wide data system.

Historically, comprehensive perinatal data for the province of Ontario was not available because of the limited quantity and questionable quality of previous data sources. In 2002, the CHN adopted the Niday Perinatal Database as the basis for developing a central repository for standardized perinatal data collected across the GTA.⁷ Implementation of the database at all 24 hospital sites involved in obstetrical care in the GTA was a major accomplishment that contributed significantly to the eventual adoption of the common database across the province. The CHN took pride in its leadership role in the creation of BORN Ontario, a valuable resource that benefits maternal and newborn health care province-wide.

PAEDIATRIC INDICATORS PROJECT

The success of the Niday database stimulated interest in having a similar database for paediatrics, leading the CHN to launch the Paediatric Indicators Project (PIP) in 2007. Aligned with provincial and national initiatives, the project focused on reporting on standard indicators to monitor the paediatric health care system for the purpose of quality improvement and access management across the care continuum.

The PIP benchmarking project furthered the adoption of a consistent approach for collecting, analyzing, monitoring and reporting on paediatric indicators. Similar to Niday, the PIP initiative informed planning and policy development and helped identify continuous quality improvement opportunities in terms of both clinical outcomes and operational efficiencies.

⁷ The Niday Perinatal database became the platform for development of the Ontario Perinatal Surveillance System which served as the foundation for what is now known as BORN Ontario.

The project also marked the first time that community hospitals and non-paediatric academic health sciences centres became involved in measuring and comparing their paediatric activity data. Their participation reflected an effort to better inform stakeholders about the breadth of paediatric care delivered in hospitals.

DATA HIGHLIGHTS OPPORTUNITIES

Over the past several years, the CHN has put these information resources to effective use by reviewing data to identify regional trends and opportunities for quality improvement, professional education and program development or reconfiguration. For example, the CHN undertook a research study on the growing trend for newborns less than 32 weeks gestation to be delivered outside of tertiary facilities, with a view to developing a better understanding of the barriers to appropriate patient transfers. Another study – the Birthing Review Project – analyzed data on cesarean section and induction rates across the GTA as a platform to inform continuous quality improvement strategies. The CHN also completed an in-depth review of data about the care of children in emergency departments and began work on strategies to address some of the issues raised.

PROMOTING HIGH STANDARDS BY SHARING BEST PRACTICES

The CHN has raised awareness that each member is expected to meet consistent, high quality-service standards as embodied in best treatment practices. This expectation has raised the bar for the performance of individual organizations. CHN's work to facilitate adoption of common guidelines has helped define what the bar will be. It is expected that peer comparisons will continue to highlight areas for improvement so that targeted efforts can be made to achieve high quality-service standards in every organization. Debate over new approaches to care, exchange of opinion on the appropriateness of care at different levels, and commitment to evidence-based practice reinforced the members' determination to embrace a Network-wide interest in sharing best practices.

The CHN devoted significant time and resources to the development of clinical practice standards and education programs to promote their adoption within all organizations. A series of clinical guidelines were prepared in specific areas to promote equity and consistency in the delivery of care across the regionalized system [Figure 5]. The CHN also sponsored education workshops to support the regionalized model of care and provide members with an opportunity to learn about and share best practices [See Figure 6].

Figure 5: CHN Best Practice Guidelines

MATERNAL/NEWBORN	NEONATAL	PAEDIATRIC
Augmentation of labour	Breastfeeding the high risk infant	Blood product administration
Breastfeeding guidelines	Developmental care	Competencies for emergency nurses working with children
Family-centered care	Discharge of the healthy newborn	Conscious sedation
Fetal fibronectin testing	Family-centered care	Diabetes
Management of maternal Group B Strep Sepsis (GBS)	Management of newborns with Group B Strep Sepsis	Emergency medical directives
Management of mothers with mental health problems	Management of the infant with seizures	Enteral tube feeding
Perinatal substance abuse	Neonatal hypoglycemia	Family-centered care
	Neonatal infection control	Management of abdominal pain
	Neonatal pain management	Management of central lines
	risk	Management of children with seizures
		Management of the child with urinary tract infection
		Narcotic administration
		Pain management
		Sickle cell disease

Figure 6: CHN Shared Education Workshops

MATERNAL/NEWBORN	PAEDIATRIC
<p>Acute Care of High Risk Newborns (ACoRN)</p> <p>Multiple births</p> <p>Neonatal resuscitation guideline roll-out</p> <p>Perinatal bereavement</p> <p>Substance abuse in pregnancy</p>	<p>Care of children with special health care needs in the community</p> <p>Caring for the chronically ill child</p> <p>Evidence based practice in child health</p> <p>Paediatric ECG monitoring</p> <p>Paediatric emergencies</p> <p>Paediatric emergency triage (dissemination and roll-out of the paediatric CTAS⁸)</p> <p>Paediatric palliative care</p> <p>Pain management in children</p>
<p>Family-centred care</p> <p>Patient safety</p> <p>Transfer protocols</p>	

⁸ CTAS: Canadian Triage and Acuity Scale.

QUANTIFYING THE RELATIONSHIP BETWEEN PROGRAM SIZE AND EFFICIENCY

What is the minimum patient volume needed to make a program efficient and effective? At the request of MOHLTC, the CHN created a model for the economic size of maternal/newborn and paediatric programs for use as a planning tool. The model was based on a concept of efficiency and quality that would minimize the cost per unit of service by:

- ✓ minimizing overstaffing;
- ✓ minimizing the number of staffed beds;
- ✓ providing safe, high quality care; and
- ✓ accommodating fluctuations in admissions/patient census.⁹

Applying the model of economic program size, the minimum sizes for quality and efficiency of key elements of maternal/newborn and paediatric programs were identified [Figure 7].

Figure 7: Models of economic size (quality and efficiency)

Maternal/ Newborn	<p>Minimum size for quality and efficiency of maternal/newborn programs:</p> <ul style="list-style-type: none"> - 2000 - 3300 births/ year <p>Minimum size for efficiency and quality of Level II nursery:</p> <ul style="list-style-type: none"> - 20 bassinets
Paediatrics	<p>Minimum size for quality and efficiency:</p> <ul style="list-style-type: none"> - Average daily census of 14 – 18 patients - 20 - 26 beds @ 70% occupancy - dedicated paediatric nursing staff

⁹ The model was developed with support by the Hay Group. It is important to note that the model was developed strictly as a planning tool and was not meant to denote a preferred model for delivery of efficient/ economic patient care. Other models for delivery of patient care may be equally effective and efficient.

SUPPORTING CHANGE & INNOVATION IN CARE DELIVERY

Working with its members, the CHN responded to requests by LHINs to advance innovations in practice through the development of a number of proposals. A key initiative focused on introducing paediatric emergency nurses into emergency departments in the Central LHIN. The aim was to improve care for children in the Emergency Departments while increasing capacity and sustainability within the health care system.

COMMUNICATING DURING A CRISIS

The CHN developed a protocol to define responsibilities and provide guidelines for the successful and professional management of incidents affecting its members and their employees, patients and families and the public during crisis situations. The protocol was developed in response to the CHN's experience and involvement with the SARS outbreak (2003), provincial pandemic planning and preparedness, and planning for the June 2010 G20 conference.

Development of the Quick Emergency Response Protocol (QERP) clarified the formal structure and process that would enable CHN members to function effectively as a regional team during an emergency or crisis situation. For example, it identified specific clinical issues that would benefit from resolution based on systems solutions, and confirmed the official linkages and communication protocols to be used to ensure members received timely information and had access to advice and support on emerging and unexpected issues.

PROMOTING GREATER STABILITY IN PAEDIATRIC COVERAGE

Meeting longstanding concerns with respect to stability in physician coverage for paediatric and newborn care was a recurrent issue confronting the CHN. Interest in this issue prompted the Network to explore development of an Alternate Payment Plan (APP), working with paediatricians in the Central East LHIN. This work led to a physician human resources strategy that included planning for on-call coverage and hospital work supported by a comprehensive compensation package that would eliminate the need for stipends. Significant progress was made in advancing these discussions with staff at MOHLTC.

MEASURING PERFORMANCE AT A SYSTEMS LEVEL

Does a regionalized system of care make a difference in the quality, accessibility and affordability of services for mothers, newborns, children and youth in the GTA? Does it help people access the right services in the right place at the right time? Does it improve continuity of care? To begin to answer such questions, the CHN created an evaluation framework in 2000 with specific indicators to track the Network's performance. The framework was based on seven core criteria [see Figure 8].

Figure 8: A Framework for Evaluating Performance at a Systems Level – 7 Criteria

1. Accessibility (timely access)
2. Accountability (to CHN's members and MOHLTC)
3. Affordability
4. Appropriate care (quality)
5. Effectiveness (outcomes)
6. Integrated and coordinated care
7. Satisfaction (patients/clients, families, providers)

The results of the initial evaluation confirmed that a regional model of care was in fact emerging and members felt that links were being created. In particular, the initial evaluation revealed:

- ✓ Strong support among members for working together to adopt consistent, high quality service standards
- ✓ A desire among individual member organizations to assess their role in maternal/ child health and their potential contribution to a regional system of care
- ✓ An interest in collaborating more closely to develop education initiatives and strengthen other relationships for collegiality, sharing and support.

Overall, the findings in general pointed to a need for better data and indicated what factors should be measured to understand areas of concern. Filling the longstanding data gap in the maternal/child sector within the health system became a top priority. This agenda led to the data initiatives described earlier in this report and ultimately became the platform on which all CHN priorities (including quality improvement initiatives) were built.

LESSONS LEARNED

The experience of the past 12 years has taught CHN and its members much about what it takes to make a regional network a success. Here are a few of the lessons learned, for the benefit of those working in networks now or in the future.

VOLUNTARY MEMBERSHIP AND INVOLVEMENT CAN TAKE YOU A LONG WAY.

The CHN members took their involvement and role as agents of change seriously. CEOs, physicians, program directors and managers and other health care providers from the hospital and community sector (with widely differing backgrounds and experience) worked hard to affect change. As a direct result of these efforts, many previously competing acute care hospitals within the region now collaborate closely to further the adoption of evidence-based practices of care, develop systems approaches to support patient transfer/retro-transfer, and offer education sessions to improve and standardize the skill base of staff across the Network. Examples can also be found of program consolidation and the creation of satellite clinics to extend the reach of specialized services into other parts of the region. These steps have given patients better access to higher quality, more cost-effective services.

While participation in and financial support for the Network's activities remained entirely voluntary, understanding of the mutual value of collaboration grew among providers and organizations. This reality leads to the conclusion that the most effective lever of change for voluntary networks is a focus on best practices, performance measurement and quality improvement.

INVOLVEMENT OF PHYSICIANS IS INVALUABLE TO BRING ABOUT CHANGE.

The CHN encouraged active physician participation in the building of the regional maternal, newborn, child and youth health system. The appointment of a medical advisor/ lead for the Network and the leadership of physicians on the CHN's core Task Forces (Maternal /Newborn Services and Paediatric Services), as well as the eventual participation of these leaders as voting members of the CHN Board of Directors, were invaluable in both communicating the need for change and creating support for change. Physician recruitment focused on meeting 'regional needs' also emerged as a concept embraced by a number of Chiefs of Obstetrics and Paediatrics at regional centres.

THE COMMUNITY CARE SECTOR MATTERS.

Access to coordinated ambulatory/outpatient services, as well as the ability to provide consistent levels of home care, public health and other community support services, has a profound impact on the potential for transformation of the system. These activities form an important part of a complete continuum of care and must be integrated with the development of inpatient programs and services in both regional centres and community hospitals.

RESOLVING FUNDING ISSUES REQUIRES ONGOING ADVOCACY.

Generally, maternal, newborn, child and youth health programs are funded through global hospital budgets. The redistribution of patient caseloads and higher acuity of caseloads created expectations that funding would flow in support of these changes. However, securing appropriate funding for hospitals to equip and staff patient care units in these fields, and providing staff with additional training to expand their knowledge and expertise, was a constant challenge. Throughout its mandate, the CHN continued to advocate funding changes. As part of these efforts, the CHN developed costing models that defined appropriate staffing and equipment needed to support regional centres and regional programming. Costing models were later developed for neonatal intensive care units, paediatric inpatient care and paediatric same day surgery.

The CHN also called for a dedicated funding envelope, stressing that it should include adequate remuneration for physicians (obstetricians, paediatricians and others) to provide in-hospital and on-call care for inpatients and outpatients. As well, funding mechanisms should be designed to promote outpatient/ ambulatory care to avoid hospitalizations (i.e., observation and short stay care in hospitals should be properly funded).

REGIONAL AND PROVINCIAL DEMANDS MUST BE CAREFULLY BALANCED.

Networks must constantly strive to strike a balance between responding to competing demands from members and achieving consensus among them, while at the same time trying not to get too far ahead of the provincial agenda. To succeed, the CHN had to work steadily to obtain and reinforce the commitment of its own members, while securing the necessary support of provincial and LHIN leaders through alignment with broader strategies.

CHANGING ROLES IN A CHANGING HEALTH CARE SYSTEM

Like other networks designed to enhance integration of health service delivery across regions or province-wide, the CHN was established through relationship-building among providers. In Ontario, the network concept was in many respects the first attempt to bring about integration of services prior to the establishment of provincially mandated LHINs.

The creation of LHINs on March 1, 2006 marked a period of dramatic change for Ontario's health care system. LHINs took on responsibility for planning, funding and integration of local health services provided by hospitals, community care access centres, community health centres and the home care, long-term care, mental health and addiction sectors. As part of this transformation, MOHLTC assumed the role of steward of the health care system, shifting its focus to strategic decision-making, setting direction and creating an environment where local decisions (at the LHIN and provider level) can be made to best serve communities.

The advent of LHINs heightened the importance and relevance of regional planning, particularly with respect to clinical services and optimal use of human and other resources. However, as noted above, the emergence of LHINs created some confusion over the role of the CHN (and other regional or provincial networks). LHINs also introduced a new layer of planning complexity, resulting in significant variation in plans and priorities within networks that encompassed multiple LHINs. These changes had an impact on the ability of the CHN to carry out its work and influence the planning agenda.

When the CHN closed, the relationship between the CHN (and health networks in general) and the LHINs remained uncertain. At the core of resolving this uncertainty is the need to address the fundamental reality that most regional networks do not align with LHIN regional boundaries and therefore have relationships with more than one LHIN. At the same time, province-wide networks – such as those for cardiac care and organ donation – and the relatively new Provincial Council for Maternal and Child Health (PCMCH), also have relationships with multiple LHINs.

The CHN is well aware that if its work is to be effective, it must be aligned with the directions of the PCMCH. It is encouraging that efforts are underway to resolve these issues. Specifically, as noted earlier, the PCMCH has formed a task force to recommend a new network model for maternal, child and youth health that will include, among other components, the optimal relationship between regional networks, their LHINs, and the PCMCH. A report with recommendations (including a clear articulation about the relationships between PCMCH, the LHINs, and regional networks) is expected to be completed by the 2010.

A FINAL WORD

A regional system of delivery of health services for mothers, newborns, children and youth is a consistent vision endorsed by key groups across Canada (and other jurisdictions) for more than four decades. The members of the Child Health Network for the Greater Toronto Area translated that vision into action.

Those who participated in the work of the CHN recognized and valued the fact that the Network marked a significant crossroads in the history of Ontario's maternal and child health system. The CHN helped health care providers consider the importance of planning beyond their walls and weigh the contribution that each of them make to the broader system of care. The Network demonstrated that together members had the critical mass and vision required to bring about significant change that would have been difficult for any single organization to achieve on its own.

The CHN endorsed and celebrated the establishment of new provincial entities, BORN Ontario and the PCMCH. These bodies were seen as welcome and encouraging signs that the government was committed to the maternal and child health agenda and providing a focal point for implementing change, improving quality, and carrying on some of the legacies of the Network.

At the time of its closing, the CHN's work plan (2010/11) was structured around the following core, value-added activities:

- ✓ Providing data and information to support planning and decision-making at the organizational and regional level
- ✓ Responding to immediate and longer-term opportunities to improve care delivery within the region
- ✓ Providing ready access to knowledge transfer opportunities and convening expert forums (where necessary) to improve planning and care delivery
- ✓ Initiating and/or participating in LHIN planning to advocate for and support maternal/child integration opportunities.

As a new network model emerges, it will be essential to consider the type of structural relationships needed to support provincial planning bodies (such as PCMCH and BORN Ontario) and well as the LHINs. In this context, the functions that could and should be performed by regional maternal, newborn, child and youth health networks must be carefully assessed. It may well be advisable to continue the above core activities of the CHN in some form.

Though the CHN has ceased activity, its members remain committed to the goal of strengthening the regional system for maternal, newborn, child and youth health by facilitating partnerships across the care continuum and supporting changes in care delivery through quality improvement. A key challenge for providers and organizations that were part of the Network is to determine how they can most effectively use their collective experience and knowledge to advance maternal, newborn and paediatric activity in the new world of regional and provincial policy.

If the experience of the CHN is any indication, then voluntary networks can be the solution for breaking down the geographical and cultural barriers that impede integrated health care delivery. Networks may, in fact, be better positioned to achieve system goals that put patients and families first with far less resistance – and in the process create linkages that last.

**CHN Board of Directors
(as of September 2010)**

REPRESENTATION	MEMBER	TITLE / ORGANIZATION
Tertiary Care Centres	Sheila Jarvis	President & CEO, Holland Bloorview Kids Rehab
	Marilyn Monk	Vice President, Clinical Programs, SickKids
	Dr. Barry McLellan	President & CEO, Sunnybrook Health Sciences Centre
Regional Children's Health Centres / Advanced Level II NICUs	Bonnie Adamson (Chair)	President & CEO, North York General Hospital
Regional Children's Health Centres / Level II NICUs	Carolyn Baker (Vice Chair)	President & CEO, St. Joseph's Health Centre
Short Stay Paediatric Units / Level II NICUs	Janet Beed	President & CEO, Markham Stouffville Hospital
Community Care Access Centre	Don Ford	CEO, Central East Community Care Access Centre
Physician Leads	Dr. Glenn Berall	Chief of Paediatrics, North York General Hospital Chair, Paediatric Services Task Force, CHN
	Dr. Mathias Gysler	Chief of Staff, The Credit Valley Hospital Chair, Maternal/Newborn Services Task Force, CHN
	Dr. Jonathan Tolkin	Community Paediatrician Chair, Coordinating Committee, CHN

CHN Secretariat Staff:

- Alison Quigley - Executive Director
- Rhonda Remedios - Executive Assistant
- Moya Johnson - Clinical Admin, Lead, Paediatric Services Task Force
- Beverley Nickoloff - Policy Admin, Lead, Maternal/Newborn Services Task Force
- Barbara Chapman - Senior Project Manager,
- Tammy Budhwa - Senior Health Planner,
- Vivian Holmberg - Senior Health Planner

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