



The Child Health Network for the Greater Toronto Area



2007/08 Annual Report



CHILD HEALTH NETWORK
for the Greater Toronto Area

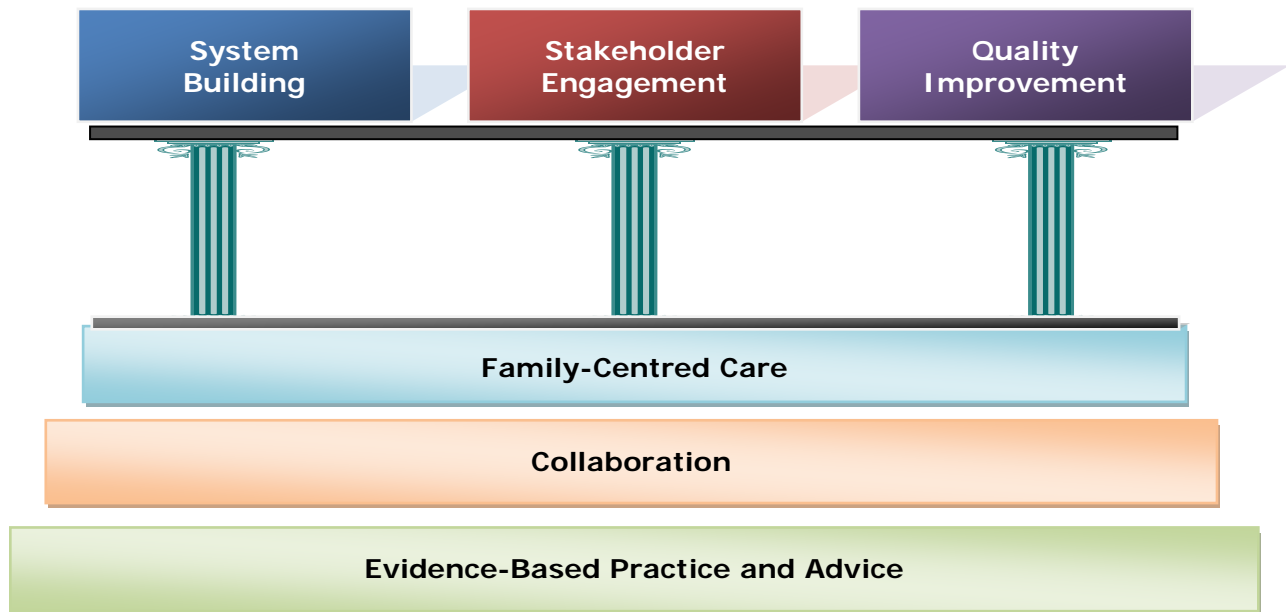


Working Together for Children's Health

Thank you to the members of the CHN who submitted photographs
for use in this year's Annual Report.

The drawing on the front cover was done by Courtney Bodnariuk, Age 13
and submitted by The Hospital for Sick Children

*Three Strategic Pillars & Core Values
Guiding the Work of the Network*



Strategic Pillars	Goals
SYSTEM BUILDING	1: Align with and influence Ontario's health transformation agenda.
	2: Influence implementation of an integrated system.
STAKEHOLDER ENGAGEMENT	3: Enhance opportunities for collaboration and participation.
QUALITY IMPROVEMENT	4: Improve knowledge transfer and evidence based practice across the Network.
	5: Strengthen measurement and evaluation of system performance.

CHN 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.

CHN 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.



Uniqueness of the CHN

1. The CHN is the largest Network in Canada representing the interests of both maternal/newborn and paediatric care providers.
2. Approximately 50% of all births in Ontario, and 20% of all births in Canada occur in the GTA.
3. Almost 50% of paediatric hospital care in the province is delivered by GTA hospitals.
4. The GTA region includes over 400 paediatric inpatient beds located on 18 sites.
5. 20% of the CCAC caseload in the GTA is focused on paediatric clients. Each day approx 2,700 children on the daily active caseload receive in-home care through CCACs. This volume of care is equivalent to that provided by a large community hospital.

MESSAGE FROM THE CHAIR & EXECUTIVE DIRECTOR

Dear Members and Friends:

The Child Health Network for the Greater Toronto Area (CHN) is pleased to present its 2007/08 Annual Report highlighting the recent accomplishments of the Network.

During this past year, partnership and advocacy with the Ontario Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs), the Ontario Perinatal Surveillance System (OPSS), the Provincial Council for Children's Health (PCCH), and the Canadian Institute for Health Information (CIHI) have helped the CHN advance its strategic goals. Some of the highlights emerging from our work include:

- Renewal of the CHN Board to include involvement of medical leadership and improve accountability to our membership.
- Exploration of opportunities to broaden our membership to incorporate the full catchment areas of the five LHINs.
- Further development of partnerships with LHINs to enhance their understanding of the work and value of the Network.
- Continued enhancement of the standardized perinatal, neonatal and paediatric databases (e.g., Niday Perinatal Database, Paediatric Indicators Project).
- Exploration of common home and community care indicators for the child and youth population.
- Initiation of a number of quality improvement initiatives to strengthen and improve patient care and service delivery.

As the health system moves forward with LHIN planning, the CHN will continue to work with its partners to be proactive in helping to transform the maternal/child health system by building on the momentum of change that is occurring within the system.

Throughout this change process, our dedication to CHN's core values of patient and family centered care, collaboration, and evidence-based practice and advice will ensure our commitment to building a sustainable and responsive maternal/newborn and child healthcare system.



A handwritten signature in cursive script that reads "Sheila Jarvis".

Sheila Jarvis, Chair, Board of Directors



A handwritten signature in cursive script that reads "Alison Quigley".

Alison Quigley, Executive Director

CHN BOARD OF DIRECTORS

REPRESENTATION	MEMBER	TITLE/ORGANIZATION
Tertiary Care Centres	Sheila Jarvis (Chair)	President & CEO, Bloorview Kids Rehab
	Seonag Macrae	Executive Vice President, Clinical Programs and Services, SickKids
	Barry McLellan	President & CEO, Sunnybrook Health Sciences Centre
Regional Children's Health Centres/ Advanced Level II NICUs	Bonnie Adamson	President & CEO, North York General Hospital
Regional Children's Health Centre's / Level II NICUs	Carolyn Baker	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	Cathy Szabo	Executive Director, Central 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)



STRATEGIC PILLAR I: SYSTEM BUILDING

Strategic Directions:

- 1. To align with and influence Ontario's health transformation agenda.**
 - 2. To influence implementation of an integrated system.**
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ADVOCACY EFFORTS

PROVINCIAL FOCAL POINT FOR MATERNAL/CHILD HEALTH

The CHN applauds the decision by the Ontario Ministry of Health and Long-Term Care (MOHLTC) to create a focal point for maternal/newborn and paediatric care through the appointment of a Provincial Lead, Maternal-Child-Youth Health Strategy (Health System Strategy Division).

This decision was initiated in response to ongoing advocacy efforts by the CHN and other organizations and in recognition of the following environmental pressures:

- The release of numerous reports in recent years highlighting current and emerging pressures related to maternal/newborn and child health.
- The absence of an overarching framework within which to review and prioritize recommendations arising from reports.
- The lack of reliable and valid perinatal and paediatric data to support planning and decision-making and monitor performance and outcomes.
- The lack of strategic alignment to optimize ongoing investments being made to a patchwork of maternal/child health services with no systematic process for monitoring outcomes.
- Barriers arising from structural, policy and cultural barriers that prohibit coordination and communication within the Ministry of Health and Long-Term Care and across ministries.
- Ongoing need for additional resources to support concerns arising from continued growth and capacity issues within the maternal/child health sector.

Priorities being addressed as part of the provincial maternal/child initiative will build on work initiated and advanced by the CHN over the past several years.

PCCH: PROVINCIAL PRIORITIES FOR MATERNAL/CHILD HEALTH	
IMMEDIATE PRIORITIES	MEDIUM/LONG - TERM PRIORITIES
<ul style="list-style-type: none"> • Increase capacity in Level II and Level III NICUs • Establish a comprehensive maternal-child-youth data convergence strategy • Improve access to specialized paediatric care • Improve access to primary paediatric providers, especially for newborns 	<ul style="list-style-type: none"> • Improve co-ordination of care for children and youth with special health care needs, specifically: <ul style="list-style-type: none"> • Children who are medically fragile / technology dependent • Children who have complex obesity • Children with significant mental illnesses and complicating psychosocial factors • Address issues for children with complex needs as they transition to adult services • Develop a comprehensive obstetric and paediatric Health Human Resources (HHR) plan

CritiCall NICU Work Group

In June 2007, the Provincial Council for Children’s Health (PCCH) submitted the results of a review on the provincial capacity of Level III Neonatal Intensive Care Units (NICUs). The review was undertaken in response to a request by the Ministry of Health and Long-Term Care (MOHLTC) for clarification regarding the recommended expansion of the NICU units in Hamilton and Toronto and the potential of increasing the risk of infection in those units. To help respond to these concerns, the MOHLTC announced the establishment of a NICU Infection Control Work Group to address these issues. Chaired by Dr Michael Dunn, Sunnybrook Health Sciences Centre, the focus of the Work Group was to determine a methodology to capture and track infections and facilitate organizational adoption of the methodologies. Membership of the Work Group included several members of the CHN.

CritiCall NICU Work Group: Recommendations
<ol style="list-style-type: none"> 1. That CritiCall make the recommended revisions to the NICU screens beginning June 10, 2008. 2. That monthly, quarterly and annual reports containing data regarding reasons for “restricted” and “closed” status. 3. That details of all infection control issues be compiled and shared with the Provincial Maternal-Newborn Advisory Committee. 4. That each neonatal unit enter data into the CritiCall Perinatal Screens every 12 hours (at a minimum) and whenever there is a change in status. 5. That hospital CEOs, Epidemiologists and Infection Prevention & Control Practitioners be informed of the revised Perinatal CritiCall screens and become actively involved in ensuring that infectious outbreaks and responsible agents are correctly identified and entered.

Emergency Department Visits by Children

This past year, the Canadian Institute for Health Information (CIHI) released the results of its analysis examining children's visits to emergency departments. The CHN worked with CIHI to develop the survey that formed the basis for data collection and review. The report – *Children and Emergency Departments in Ontario* – provides policy makers and hospital planners with new information to consider when exploring options for primary care and emergency services for children at the local level.

In follow up to the findings arising from the review, the CHN has agreed to partner with CIHI to undertake a more in-depth analysis of the data. This work will include analysis of hospital specific information with a focus on identifying opportunities for hospitals to address issues related to triage of children.

ENGAGING LHINS

The CHN is continuing to meet with the five (5) Local Health Integration Networks (LHINs) within its membership catchment area to:

- Explore opportunities to work together to strengthen planning, coordination and integration of services for the maternal/newborn and paediatric population within and across LHINs.
- Address issues arising from duplication and overlap of activities and, in particular, to enhance coordination of planning efforts within and across LHINs.
- Facilitate better sharing of data, information and expertise.
- Improve collaboration and linkages among key stakeholders.
- Ensure future planning efforts build on key findings/conclusions arising from previous reports and activities undertaken by the CHN and other planning groups.

Milestones achieved in advancing the LHIN/CHN partnership have included:

- A series of meetings with LHIN staff to increase understanding the current organization of maternal/ and paediatric health care services across the GTA and the province and other regions.

The primary goal of the CHN is to assist LHINs by providing them with data and information arising from:

- Current databases and data management initiatives (e.g., the Niday perinatal database system; Paediatric Indicator Project).
- Previous planning efforts (e.g., IRC-review undertaken by the CHN in response to a request by the MOHLTC).
- Existing policy guidelines/documents (e.g., MOHLTC endorsed scope of service definitions for levels of maternal/newborn and paediatric care).
- Human resource initiatives (e.g., human resource planning, recruitment, collaborative models of care emerging across the GTA).

- Confirmation of “Endorsements of Support” by the Central East LHIN, Central West LHIN, and Central LHIN supporting the CHN’s proposal to invite hospitals within their regions (whom are not currently members of the CHN) to join the Network.
- Inclusion of a LHIN analysis in the annual *CHN Niday Statistical Report* and the *CHN Paediatric Indicators Project Report*.
- Participation in LHIN-based planning teams for maternal/newborn and paediatric services.
- Provision of data, information and expert advice to support development of clinical service plans, disseminate best practices and test new innovations to improve quality and access to care.
- Facilitating cross-LHIN planning among the five LHINs with a focus on educating target audiences about what these linkages can offer in terms of improved health outcomes for mothers, newborns and children.

CAPACITY BUILDING: SHARING OUR LEARNINGS

Addressing NICU Capacity

Over the past several years, the CHN has repeatedly raised the importance of addressing concerns arising from high occupancy rates at tertiary (Level III) maternal/newborn centres. Growing demands and pressures being placed on these facilities are restricting their ability to manage care requirements and placing increasing pressure on the system. Throughout the past year, the CHN was frequently called upon to facilitate the transfer of babies to more appropriate levels of care to allow for accommodation of acutely ill newborns at tertiary facilities.

The issue of capacity and appropriateness of care will be addressed through the work of the *Provincial Maternal-Newborn Advisory Committee* – a Committee reporting through the Provincial Council for Children’s Health (PCCH). The role of the Advisory Committee is to recommend strategies to achieve a more coordinated system of maternal/newborn services with a focus on:

- Equitable access to timely, high quality, evidence-based, family-centered care at the appropriate level for all pregnant women and newborns in Ontario
- Equitable access to specialized services such as transportation, screening for Retinopathy of Prematurity (ROP), and maternal fetal fibronectin testing
- Leading practices for nosocomial infection prevention and control in the obstetrical and NICU environments
- Improved data and information systems to inform practice and policy and promote greater accountability

The CHN has addressed all of these issues to varying degrees over the past several years. This work is providing the foundation for much of the initial work being undertaken by the Advisory Committee. To

facilitate the sharing and transfer of this information several members of the CHN are represented on the Advisory Committee and its subcommittees.

Showcasing Our Success

This past year, the CHN hosted visiting delegations from Melbourne (Australia), Manchester (United Kingdom), Korea, and Northern Ontario. These meetings provided an opportunity for the CHN to showcase some of its work and support other jurisdictions exploring the merits of establishing networks. Many of the CHN members participated in these visits, hosted tours of their hospitals and provided opportunities for visitors to interact with clinical and academic leaders across the Network.

SYSTEM BUILDING: FUTURE PRIORITIES

- Collaborate with provincial and regional paediatric and perinatal networks to align initiatives
- Continue to advocate for regional changes to address issues within the maternal, newborn and paediatric health system
- Shift planning for maternal/newborn/paediatrics populations from a Cluster to LHIN context and align with LHIN Integrated Health Service Plan priorities
- Focus on building relationships and soliciting broader stakeholder engagement with new partners (e.g., Ministry of Children and Youth Services, Public Health Units, Community Health Centres)



STRATEGIC PILLAR 2: STAKEHOLDER ENGAGEMENT

Strategic Direction:

3. To enhance opportunities for collaboration and participation.

GOVERNANCE REVIEW & MEMBERSHIP

This year, the CHN Board of Directors undertook a governance review. The review resulted in a number of changes to the composition and membership of the Board and a series of recommendations for strengthening accountability to the membership.

CHN Governance Renewal: Points of Consensus

- *The CHN is a collaborative comprised of members from hospitals and CCACs in the Greater Toronto Area. The CHN is not an incorporated entity with powers granted to it under formal legislation or regulation.*
- *The CHN Board should remain small and be comprised of members with the appropriate experience, knowledge, and skills needed to govern the activities of the Network.*
- *The CHN needs to remain flexible given the current period of uncertainty in the healthcare environment. These uncertainties pose challenges for the CHN and other planning bodies.*
- *Future changes to the CHN Board need to consider how the composition and membership of the Board should change to strengthen the Network's working relationship with LHINs and incorporate the views and perspectives of 'new' voices around the table.*

Caring for Mothers & Children During a Pandemic

Members of the CHN continued their efforts to coordinate pandemic planning activities to help ensure an effective region-wide response to pandemic influenza. The involvement of the CHN in pandemic planning is closely linked to the leadership role being played by The Hospital for Sick Children and the Provincial Paediatric Pandemic Planning Committee (P4) in leading planning efforts with respect to the following areas: medical management (clinical guidelines); paediatric capacity; obstetrical capacity.

An assessment of the current progress and effectiveness of planning efforts was reviewed at a *CHN Pandemic Planning Learning Day* held on May 15, 2008. The Learning Day engaged more than 60 CHN members in a facilitated table top exercise as the basis for assessing the current state of preparedness in responding to a pandemic with a system-level response.

The discussion confirmed that a great deal of progress has been achieved with respect to obstetrical and paediatric pandemic planning across the region. A number of challenges and gaps requiring further discussion were identified and will form the basis for future work to be undertaken by the Network. The results of the Planning Day were featured in "The Pandemic Planner" a newsletter issued by the Ontario Emergency Management Unit.

PANDEMIC PLANNING: OUTSTANDING GAPS & CHALLENGES	
Centralized Decision-Making	<ul style="list-style-type: none"> ▪ Development and application of ethical guidelines and a framework to support decision making ▪ Clarity regarding communications responsibilities and leads
Standardized Approach to Guidelines	<ul style="list-style-type: none"> ▪ Consistent and systematic coordination of guidelines ▪ Awareness of tools in place to support decision making (i.e., discharge criteria for paediatrics) ▪ Transportation/transfer protocols (managing internal/external transfers) ▪ EMS protocols and plans ▪ Policies for cohorting of patients (organizational vs. LHIN-wide)
Clinical Guidelines	<ul style="list-style-type: none"> ▪ Admission criteria/ age cut off for transfers to ICU ▪ Application of SOFA criteria to paediatric patients ▪ Confirmation of delivery of care model ▪ Decisions re when to start prophylaxis
Ethical Guidelines	<ul style="list-style-type: none"> ▪ Decision making framework needed to support resource allocation (need this for transparency, fairness, access) ▪ Accountability for practice and practice decisions ▪ Approval of research protocols within organizations, across the region and at the provincial level
Human Resources	<ul style="list-style-type: none"> ▪ Physician/ staff redeployment ▪ Human resources plans ▪ Protocols re: staff working in multiple locations
Other Issues	<ul style="list-style-type: none"> ▪ Communication to diverse communities ▪ Preferential treatment ▪ Child care and other staff supports ▪ Midwifery ▪ Involvement of other groups in future planning discussions including: physicians, EMS, public health, universities, CAS, etc. ▪ Security – protecting resources; protecting limited access; locking cupboards ▪ Awareness of municipal police services plan re: support to hospitals

PERINATAL BEREAVEMENT

The CHN partnered with Perinatal Bereavement Services of Ontario to offer the RTS (Resolve through Sharing) Perinatal Bereavement Training Program in the Fall of 2007. This program enables health professionals working with families that have suffered a perinatal loss (miscarriage, stillbirth or neonatal death) to support them in their grief. The program will be repeated in November 2008.

PATIENT AND FAMILY-CENTERED CARE

Since 2002, the CHN has been working with its members to advance the practice of patient and family-centered care (FCC). A central part of the strategy was the development of a set of common standards

by which members could measure their progress in adopting FCC practices within their organizations. Although the standards were approved by the members, there has been varying degree of adherence to the standards across the Network. In order to address the variations, the CHN invited Beverley Johnson, CEO of the Institute for Family-Centered Care to present “Leadership in Family-Centered Care” at the 2007 CHN Annual General Meeting. The presentation challenged leaders within the Network to incorporate the principles and practices of FCC across their organizations and aligning the philosophy and practices of FCC with quality improvement initiatives. The CHN has established a small sub-committee to further develop the practice of FCC within the network and link it more closely to the quality improvement agenda.



STAKEHOLDER ENGAGEMENT: FUTURE PRIORITIES

- Implement directions arising from CHN governance & accountability renewal process
- Strengthen and support CHN member engagement
- Strengthen relationships between LHINs and the CHN
- Provide ongoing leadership in supporting obstetrical and paediatric pandemic planning
- Enhance patient and family-centered care

STRATEGIC PILLAR 3: QUALITY IMPROVEMENT

Strategic Directions:

4. *To improve knowledge transfer and evidence-based practice across the Network.*
 5. *To strengthen measurement and evaluation of system performance.*
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NIDAY PERINATAL DATABASE: FIFTH ANNUAL STATISTICAL REPORT

The *Niday Perinatal Database: Fifth Annual Statistical Report (2007/08)* was officially released at the CHN's Annual General Meeting in October 2008. The report presents the data for the fifth year post-implementation of the *Niday database*.

The Niday database is being used as the foundation for development of the Ontario Perinatal Surveillance System (OPSS).

Highlights of the Niday Perinatal Database: Fifth Annual Statistical Report, 2007/08

Capacity - There were 70,163 births at CHN member hospitals in the GTA, an increase of more than 4,200 births over 5 years.

Access - Hospitals in the Toronto Central LHIN provided services to 8,000 (42%) women who do not live in that LHIN.

Increasing preterm birth rate – 5,777 infants were born prematurely to women living in the GTA LHINs (an increase of 230 infants from 2006/07).

Continued reliance on obstetricians - Obstetricians continue to provide antenatal care to 85% of women and attend over 90% of births.

Intervention rates - Induction rates in the GTA rose from 19.0% in 2003/04 to 22.0% in 2005/06. Between 2005/06 and 2007/08, a more modest increase of 0.9% was observed.

Appropriate location of birth – The number of infants less than 32 weeks gestation being born outside of Level III hospitals rose from 31.2% in 2006/07 to 35.2% in 2007/08 (the largest increase in the past five years).

PAEDIATRIC INDICATORS PROJECT (PIP)

The *CHN 1st Annual 2007 Benchmarking Report: Paediatric Indicators Report* was officially released in March 2008. The report was developed through a partnership with PCCH as part of their annual Benchmarking initiative. This partnership enabled PCCH to include data from all CHN hospitals in their Report and for the CHN to report on data elements similar to and complimentary to the Paediatric Academic Health Sciences Centre (PAHSC).

The report provides data based on a standard set of indicators for the paediatric population across the GTA. Analysis in the report was designed to help CHN member organizations identify potential opportunities to improve clinical and operational efficiency and quality and utilization management processes.

The partnership with PCCH has helped the CHN to compare paediatric activity with peer hospitals and PAHAScs. Recommendations included in the report were also developed in conjunction with the PCCH. This enables community and PAHSC hospitals to work together to address issues related to paediatric hospital care.

**Highlights from the 2007 Benchmarking Report:
Paediatric Indicators Project**

- CHN hospitals contributed over 45% of all paediatric inpatient activity in the province (almost 54,000 cases).
- Paediatric volumes in some CHN hospitals are higher than at some Paediatric Academic Health Science Centres in the province.
- Over 20,000 neonatal cases are cared for in CHN hospitals – much in Level II hospitals (over 15,000 cases) (4800 cases at level III NICUs).
- Patient transfer activity in CHN hospitals demonstrates that a ‘system of care’ exists and that the concept of ‘appropriate care closer to home when possible’ is supported.
- Non-tertiary hospitals have a strong role in managing acutely ill and complex neonatal and paediatric patients and at times provide tertiary and quaternary care to these patients.
- The ‘regional maternal/newborn and paediatric health care system’ is still evolving and requires continued attention and commitment to improve.
- Both similarities and differences in clinical practices are evident between the CHN hospitals.
- There are differences in admission rates for asthma, diabetes and urinary tract infections amongst CHN hospitals.

ADVANCING REGION-WIDE QUALITY IMPROVEMENT

The CHN is engaged in a series of projects focused on bringing about region-wide quality improvement in patient care [see insert]. These initiatives have helped demonstrate the utility of the Niday and PIP databases including their potential applications in improving quality of patient care, bringing about system improvements, and realizing greater system efficiencies.

Currently, the CHN is advancing a series of projects focused on bringing about region-wide quality improvement in patient care.



This past year, significant progress was made in two of these projects:

Understanding Rates & Trends related to Caesarean Section: This review is helping members of the Network better understand caesarean section rates at the individual organization and system level through interpretation of the data using the internationally recognized ‘Robson classification’ tool. The results of the data analysis will help develop local monitoring of caesarean section rates and indications as well as strategies for bringing about quality improvements in care and service provision.

Defining the Barriers to High Risk Maternal Transfer in a Regionalized System for Perinatal Care (the <32 Week Project): *What are the primary barriers preventing the transfer of women giving birth <32 weeks gestation to a tertiary facility? What solutions can be generated based on the knowledge of the existing barriers to reduce the number of deliveries of infants <32 weeks gestation in non-tertiary centres?* These are the questions being addressed as part of a retrospective chart review focused on gaining a better understanding of the specific issues related to “appropriateness of care” for infants born at less than 32 weeks gestation. The project is being led by Dr. Hilary Whyte, a neonatologist and medical director of the Acute Care Transport Services team at The Hospital for Sick Children on behalf of the Network.

Investigation into the reasons why births are not occurring at the appropriate sites offers the Network an opportunity to embark on a quality improvement plan to enhance the quality of care and improve

outcomes for high-risk newborns. Although more data is required to complete the study, preliminary findings indicate that:

- ✓ The majority of premature births are occurring at Level II hospitals
- ✓ The majority of the time hospitals are not attempting to transfer mothers prior to the birth of their premature babies
- ✓ The number one reason for not attempting to transfer is “lack of time” (with the exception of infants 30-32 weeks gestation in Level II and II+ where hospitals are electing not to transfer mothers for the births)

HIGHLIGHTS OF THE <32 WEEK PROJECT		
CURRENT REALITY	STUDY DESCRIPTION	FUTURE DIRECTIONS
<ul style="list-style-type: none"> ▪ Approx. 34% babies <32 weeks gestation are born outside a tertiary facility every year; number progressively increasing ▪ “Outborn” babies have higher mortality and major morbidity rates than “inborns” (i.e., born at tertiary centers) 	<ul style="list-style-type: none"> ▪ Retrospective chart review ▪ All births < 32 weeks GA, from 2003-2007 ▪ CHN hospitals (Level I, II, and II+) ▪ Identify reasons why maternal transfer to a Level III facility did not occur 	<ul style="list-style-type: none"> ▪ Review data from baby’s charts to evaluate their outcomes and link outcome to circumstances surrounding birth ▪ Compare mortality/major morbidity of infants born in Level III vs. I/II/II+-transferred vs. I/II/II+-kept ▪ Cost/Benefit Analysis of making Level II/II+ into Level III facility vs. expanding facilities at Mount Sinai or Sunnybrook

ACoRN INSTRUCTORS COURSE

The Canadian Paediatric Society has recently released an education program entitled Acute Care of the at-Risk Newborn, otherwise known as the ACoRN Program. In June 2007, the CHN offered the first in a series of sessions to implement this program and enable upgrading of nurses delivering care to babies within the NICUs of the Network hospitals. This program will ensure high-quality, evidence-based care to all newborns experiencing problems around the time of birth. This past year the CHN initiated an instructor’s course in partnership with the ACoRN National Society. The training of local instructors will give hospitals more independence and capacity in implementing ACoRN within their organizations contributing to higher consistency and quality of care to newborns within the NICUs of CHN hospitals.

CONTRIBUTING TO EVIDENCE-BASED DECISION-MAKING: PAEDIATRIC HOME & COMMUNITY CARE INDICATORS

On January 15, 2008, the CHN hosted a *Planning Group* involving staff of the CHN and the five GTA CCACs. The purpose of the meeting was to update each other on issues pertaining to maternal/newborn and paediatric populations, discuss the current profile and challenges related to this caseload and explore opportunities for an enhanced partnership.

Based on the discussion there was consensus that the CHN and CCACS can work collaboratively to fill important gaps in two key areas:

1. Advance a better understanding of the paediatric home and community care caseload, and
2. Reach agreement on common paediatric home and community care indicators and benchmarks to inform data collection and support future planning and decision making processes.

The relative lack of data and information related to home and community care as it relates to children was viewed as an opportunity for the CHN and CCACs to work together to enhance collection of standardized data based on agreement concerning key indicators and benchmarks for this population. As a starting point for advancing work in this area, the CHN has been exploring opportunities for partnering with other organizations interested in advancing similar goals. Efforts will focus on influencing current initiatives, finding potential partnership opportunities, and creating forums for discussion and exchanges of ideas.

QUALITY IMPROVEMENT: FUTURE PRIORITIES
<ul style="list-style-type: none">▪ Refine and nurture the Niday database▪ Refine and nurture the PIP database▪ Continue to lead in the creation / expansion of a regional paediatric benchmarking initiative▪ Commit to outcomes evaluation initiatives to assess impact of CHN projects▪ Focus less on development of standards and more on knowledge transfer▪ Continued promotion/adoption of leading clinical standards and education programs▪ Prioritize best practice standards, evaluate uptake and monitor implementation

CHN MEMBERS – 2007/08

LHIN	CHN Members
Central East	<ul style="list-style-type: none"> • Lakeridge Health Corporation • Rouge Valley Health System • The Scarborough Hospital • Central East CCAC
Central	<ul style="list-style-type: none"> • Markham Stouffville Hospital • North York General Hospital • Southlake Regional Health Centre • York Central Hospital • Central CCAC
Central West	<ul style="list-style-type: none"> • William Osler Health Centre • Central West CCAC
Mississauga-Halton	<ul style="list-style-type: none"> • Halton Healthcare Services • The Credit Valley Hospital • Trillium Health Centre • Mississauga-Halton CCAC
Toronto Central	<ul style="list-style-type: none"> • Bloorview Kids Rehab • Mount Sinai Hospital • SickKids • St. Joseph's Health Centre • St. Michael's Hospital • Sunnybrook Health Sciences Centre • Toronto East General Hospital • Toronto Central CCAC



FINANCIAL SUMMARY 2007/08

For fiscal year ending March 31, 2008

REVENUE

Member contributions	\$549,015
MoHLTC contributions	\$60,000
Special events and other	\$116,480

TOTAL REVENUE	\$725,495
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EXPENSES

Staffing and benefits	\$543,767
Other expenses	\$104,442

TOTAL EXPENSES	\$648,209
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Excess (deficiency) of revenue over expenses for the year	77,286
Carry forward from previous fiscal year	\$212,370

OPERATING RESERVE	\$289,656
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Accounting services are provided by Ernst & Young.

(Ratified at CHN Board of Directors meeting on October 9, 2008)

