

There is something unique and extraordinary about working with children. Perhaps it's their dependence on us for the fundamentals of care when they are in our charge. Maybe it's their innocence and their faith in us to help them be the best that they can be. And then there's their courageous strength and resilience. For these reasons and more, providers of children's healthcare have a focused determination and passion for their work.

In order to succeed in our efforts, we learn early on the importance of *collaboration*: labouring as partners as members of versatile teams. These values are nurtured in our work environments and they tend to foster innovative alliances that enhance systems of care. One of the advantages of our sector's relatively small size is that there are greater opportunities to learn from each other and to collaborate across traditional boundaries. The results of these activities are clear: early uptake and knowledge transfer that benefits the health of children and youth.

Collaboration and active learning are major thematic threads woven throughout this third issue in our Child Health in Canada series. In the following 15 essays, you will encounter fresh perspectives on *health system performance* as it pertains to planning, delivering and evaluating care for children and youth.

Measuring Performance

From 2002-2005, the Evidence-Based Practice for Improving Quality (EPIQ) trial resulted in "significant improvement in patient outcomes" in neonatal intensive care units across Canada. EPIQ has been described at length elsewhere. For this article, Catherine Cronin and her fellow researchers instead explain what they learned from surveying and interviewing EPIQ team members and physician leaders about change drivers and obstacles associated with the project.

Largely, this is a story about knowledge transfer and the social and organizational processes involved in adopting, implementing and assimilating new approaches to process – matters that resurface throughout this special issue. Cronin et al. learned that leadership and staff enthusiasm were insufficient drivers for overcoming barriers such as the lack of dedicated quality improvement expertise and financial resources; as well, few physicians had any significant understanding of quality improvement methods or concept of how to be quality improvement leaders. Based on their review, the researchers conclude that improving quality outcomes requires healthcare leaders and managers to take a strategic approach, one that, in particular, supports physicians' pivotal role in the quality matrix.

Our second article discusses a project by British Columbia's Office of the Provincial Officer of Health to identify indicators that are useful for defining and tracking child health and well-being in the province. The further, larger aim of this effort is to develop a durable measurement system that will inform health policy, programs and services. Eric Young and his co-authors'

main point is less about results and more about methodology. On this front, I am sure many of us will sympathize with the difficulties the team encountered when weighing scientific evidence. There is a lot to learn here from how the team dealt with such common problems as finding and defining evidence, as well as the frequent paucity of data.

The final Measuring Performance piece addresses developments at my organization, The Hospital for Sick Children (SickKids). My colleagues Aaron Smith, Jeff Mainland and Irene Blais document the evolution of SickKids' Office of Strategy Management in 2006 and the implementation of an organization-wide strategy management system. With regard to the latter, I hope many readers will find useful the discussion of the SickKids Scorecard, a tool that assists performance management by supporting our ability to "translate" strategy into action. As I reflect on both this article and my involvement in the process, I return to the critical role internal engagement, education and results reporting play in fostering organization-wide uptake.

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Access to Care

The fact that our next section contains the most articles (six) reminds us that improving access to care is one of the most demanding areas of health system performance. Not unlike the contribution by Smith et al., the first article in this section continues to draw our attention to performance indicators. As part of the Canadian Paediatric Surgical Wait Times Project, Tamas Fixler and his co-authors analyzed capacity and demand in nine hospitals in five provinces. Project members found a "modest" and "ongoing" gap in pediatric surgical capacity; the good news is that changes such as additional elective operating room time, improved efficiency and adjustments to intensive care unit capacity can help to align capacity with demand. I know hospital administrators and government policy-makers will be interested not only in Fixler et al.'s findings, but also in possibly adapting their careful methodology.

The next essay takes us back to the theme of our second Child Health in Canada issue: the need to improve the mental health system. Rather provocatively – and, to my mind, convincingly – Karen Minden and Samantha Yamada argue that addressing wait times and system integration is "premature." To truly "fix" mental health care for adolescents, we need to know "what we are treating" and "what works." Like many other pieces in this issue, measurement and evaluation stand out in this paper as the sine qua non of effective change, a somewhat counterintuitive but persuasive contention.

While Minden and Yamada take us back to issue two, M. Judith Lynam and her co-authors return us to the very first issue of Child Health in Canada, which focused on the social determinants of health. Lynam et al. report on the Responsive, Intersectoral-Interdisciplinary, Child-Community, Health, Education and Research (RICHER) "social pediatrics" initiative. Underlining the importance we have encountered elsewhere of intersectoral and interdisciplinary collaborative efforts, the RICHER approach has been proven to foster access to primary healthcare for disadvantaged families. One of the points that leapt out at me was the initiative's ability to empower parents to grow their own knowledge about their children's health and how to navigate the health system. Surely these should be goals for nearly every child-and-youth health project.

At the Royal Victoria Hospital in Barrie, Ontario, the Paediatric Asthma Clinic (PAC) has been critical to tackling a thorny access-to-care problem that affects hospitals across the country. By leveraging the power of inter-professional care, Karen Fleming and her co-authors report, the PAC significantly lowered rates of emergency department visits and hospital admissions for paediatric asthma patients. The critical enable is the important role patient and family education has played in generating these results and, as the authors say, "in reducing the burden of asthma in our community" as well as related health-care expenditures. Education of another kind – this time, of staff – emerges as central in the piece by Karima Karmali and three of her colleagues who discuss efforts at SickKids to improve health equity through cultural competence programming. As the authors note, Eurocentric systems and services often fail to address the needs of increasingly diverse patient populations. Launched in 2009, the New Immigrant Support Network has helped to make cultural competence "an integral element in the provision of family-centred care" at SickKids' organizational, clinical and structural levels.

The final piece in this section returns us to collaboration. At the Holland Bloorview Kids Rehabilitation Hospital, Toyota's Lean methodology was adopted to revise the organization's service delivery models. Rachel Deans and her co-authors shine a light on the team-based approach to improvement this initiative involved, the concerted measurement activities undertaken and (as we have seen in other articles) the essential involvement of leadership – both management and clinical. When wait times decrease as a result of such efforts, you cannot fail to be impressed. As the authors note, however, the next critical labour will be to ensure the sustainability of the many efforts that led to this accomplishment.

Complex Care

It is one thing to collaborate within an organization, but that ambition perches at quite another level of magnitude when several come together in a strategic partnership. The inter-

organization team and resultant Integrated Complex Care Model (ICCM) described by Eyal Cohen et al. was established among three Toronto organizations to provide integrated care for children with medical complexity (CMC). Two major components of the model were alignment with policy priorities and integration at the point of care. It will be fascinating to witness the evolution of this highly promising model, and I will be particularly interested to learn how the goal of developing "more creative strategies to engage CMC and their families" will be accomplished and the extent to which those strategies will further enhance care.

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Transitions

One of the most frustrating obstacles in the children's health sector is our frequent inability to ensure older adolescents experience a seamless transition into the adult healthcare system. This is the difficult terrain into which Khush Amaria and her co-authors stride in their paper, wherein they argue that "transition should be a process that begins in childhood and ends sometime in adulthood." I admire this long-term sense of preparation and development, and I believe the authors' identification of specific solutions (e.g., again, greater education) and tools will, if adopted, greatly improve individuals' sense of well-being and even their health outcomes. Once again, though, success will depend on extensive and open collaboration, this time between adult and child-health service providers and organizations.

Adding evidence to support that point, the second article in this section addresses improvements recently made to transitioning neurosurgery patients from SickKids to Holland Bloorview for off-site rehabilitation. To date, the Kids in Transition program, Cindy Bruce-Barrett and her co-authors show, has "exceeded expectations" by, for instance, reducing the number of medically unnecessary days and the referral-processing time. As the authors point out, strategic leadership and a "highly functioning" improvement team were critical to effecting those dramatic improvements.

Systems Change

Pamela Fuselli and Amy Wanounou begin their contribution to the Systems Change section by stating the startling fact that "unintentional injury" kills more Canadians between ages 1 and 14 than any other cause. Unfortunately, injury prevention in this country is woefully lacking. However, we can, Fuselli and Wanounou assert, develop a "comprehensive and holistic

what works? why?



approach" to this "invisible epidemic" by, in part, learning from the experiences of other jurisdictions (e.g., Sweden). Taking a similar big-picture perspective on health system performance, Charlotte Moore and Marilyn Booth open a window onto Ontario's implementation of fetal fibronectin (fFN) technology, which tells whether a woman is unlikely to deliver within two weeks of presenting preterm-labour symptoms. This program's success demonstrates it is possible to make changes to complex health systems that result in improved care and cost-effectiveness through strategy-driven multi-party collaboration. I hope the authors are correct that this example of beneficial change can inform and inspire other system-level changes.

In Edmonton, Shawn Reynolds and two colleagues report on a project that is smaller and more local than the previous two, but that captures incisively many of the foundational themes found throughout this special issue. In their article, the authors discuss an innovative program that trained teams of parents and multi-disciplinary professional care providers to address more effectively problem behaviours among children with autism. The results of this experiment were positive in terms of behavioural gains and increased levels of parents' satisfaction and perceived competence.

There is a common thread between this article and the RICHER project described earlier: the importance of giving mothers, fathers and other informal care givers the knowledge they need to take a direct hand in their children's care. Widening the scope, there is an overarching lesson that, while often time-consuming and rarely straightforward, empowerment – of parents, staff, physicians, administrators and others – through education and collaboration really can make all the difference in our quest to build healthier lives, families, communities and entire health systems. HQ

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