



**Interprofessional Workshop Series
Implementing Best Practices
Social Pediatrics Part I:
An Innovative Approach to
Fostering Health in the
Community**

*September 25, 2009
Vancouver, BC*

Followed by:

**Social Pediatrics Part II:
Innovative Partnership as
Investments: Improving Outcomes
for Vulnerable Children & Families**

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Contents

CONTENTS	2
EXECUTIVE SUMMARY	1
KEY CHALLENGES TO DEVELOPING THE INITIATIVE.....	1
KEY SUCCESS FACTORS OF THE SOCIAL PEDIATRICS INITIATIVE	1
ACKNOWLEDGEMENTS	2
INTRODUCTION	3
ABOUT THE SOCIAL PEDIATRICS INITIATIVE	3
ABOUT CHILD HEALTH BC	3
WORKSHOP PURPOSE AND OBJECTIVES	3
HIGHLIGHTS FROM OPENING SPEAKERS	5
RELEVANCE OF SOCIAL PEDIATRICS: THE STATE OF CHILDREN DEVELOPMENT IN BC.....	5
FAMILY PERSPECTIVE: STACEY’S STORY.....	5
PANEL PRESENTATION ON THE SOCIAL PEDIATRICS INITIATIVE	7
BACKGROUND TO THE PROGRAM: HISTORICAL OVERVIEW OF SOCIAL PEDIATRICS IN BC AND CANADA.....	7
DESCRIPTION OF SOCIAL PEDIATRICS INITIATIVE	7
DESIGN OF THE SOCIAL PEDIATRICS INITIATIVE	8
PARTNERSHIP MODEL: THE SOCIAL PEDIATRICS INITIATIVE AND RAYCAM	8
MOVING FORWARD	9
FOLLOW-UP WORKSHOP: INNOVATIVE PARTNERSHIP AS INVESTMENTS: IMPROVING OUTCOMES FOR VULNERABLE CHILDREN & FAMILIES	10
EXECUTIVE SUMMARY	10
SETTING THE STAGE.....	10
PLENARY PANEL: SHARING LESSONS LEARNED IN WORKING WITH PARTNERS TO REACH VULNERABLE POPULATIONS ...	10
VIDEO CLIP: CHILDREN’S VOICES	12
INSIGHTS ON THE RICHER INITIATIVE.....	12
WHY ARE RELATIONSHIPS IMPORTANT?	13
MUSIC BOX CHILDREN’S CHARITY – INVESTING IN CHILDREN’S DEVELOPMENT.....	13
WHY PLACE BASED PARTNERSHIPS, ENGAGEMENT & ACCOUNTABILITY?	13
PANEL: OUR MANDATE, OUR VISION, OUR CHALLENGES	14
REFLECTIONS FOR MOVING FORWARD	15
SUMMARY OF WORKSHOP LESSONS FOR MOVING FORWARD	16

Executive Summary

Child Health BC hosted the first in a series of interprofessional best practice workshops on the theme of Social Pediatrics at the Coast Vancouver Hotel on September 25, 2009. The second workshop took place on January 17, 2011. A summary of the second workshop begins on page 10 of this report. The event introduced over thirty five clinicians, practice leads and community representatives to the **Social Pediatrics Initiative**. The Social Pediatrics Initiative is a neighborhood health care service that targets vulnerable children/families in the Vancouver Downtown Eastside.

Workshop speakers presented evidence and actual accounts of the barriers experienced by children and families living in communities where there is a disproportionate share of socially and economically determined inequalities in health. A panel of presenters described how the Social

Social Pediatrics Initiative

- Listening to community
- Building relationships
- Reducing inequalities
- Fostering access

Pediatrics Initiative, established in partnership with community organizations and government services and with Family Nurse Practitioners providing services to assist vulnerable children and families in one inner city BC community. The model blends the traditional biomedical approach to health care with the Social Justice approach and employs the guiding principles of engagement, partnership and equity to listen to the needs of children/families, build strong community relationships, foster access to health care and other essential services, and reduce inequalities.

Key Challenges to Developing the Initiative

- The majority of community services (including healthcare) in communities with socially and economically determined inequalities are designed for the needs of

the adult population

- Community organizations in neighbourhoods that would benefit from such an initiative are inadequate and extremely overburdened
- Time to earn trust of community organizations

Key Success Factors of the Social Pediatrics Initiative

- Earning trust of community groups with respect to safety and sustainability (permanence) of the Initiative within the community
- Relationships with community groups and residents – recognizing them as major assets and embraces them as integral players in addressing local challenges
- Listening to the community – recognizing them as equal contributors in the design, development and implementation of the Initiative
- Commitment of Initiative, including community partners, to the principle: “do no harm”.

During the group discussion segment of the workshop, delegates met in small groups to explore cases and share experiences as well as thoughts on how the Social Pediatrics Initiative approach might be used in other communities to build resilience and create opportunities for access to care. Summarizing the knowledge shared during the workshop, participants noted the following:

- Initiative pursues an **interdisciplinary and inter-sectoral health care approach**.
- Initiative is designed to improve **access, responsiveness and continuities of care** within target communities.
- **Partnerships, engagement and accountability** are critical to the success of such a community partnership initiative.

Acknowledgements

Child Health BC extends appreciation and thanks to the workshop organizing committee, presenters, and participants from the five health authorities, the Provincial Health Services Authority (PHSA), University of British Columbia (UBC), government ministries, and community groups for their support and contribution to the success of the workshop.

Introduction

Child Health BC hosted the first in a series of interprofessional best practice workshops on the theme of Social Pediatrics at the Coast Vancouver Hotel on September 25, 2009. The event introduced over thirty five clinicians, practice leads and community representatives to the Social Pediatrics Initiative.

About the Social Pediatrics Initiative

The Division of General Pediatrics is the largest Division within the Department of Pediatrics, six Hospital-Based Pediatricians and 30 community Based Pediatricians, and plays a key role in partnering with smaller communities throughout BC. The Division has worked closely with the Province of British Columbia to establish a pilot program in Social Pediatrics, focusing on the underserved population in the Vancouver Downtown Eastside. The Social Pediatrics Initiative is a neighborhood health care service that targets vulnerable children/families in this community.

About Child Health BC

Child Health BC, an initiative of BC Children's Hospital, is a network of the province's five geographic health authorities, the Provincial Health Services Authority, the Ministry of Health Services, the Ministry of Children and Family Development, the Ministry of Healthy Living and Sport, the Ministry of Education, health professionals and care facilities dedicated to excellence in the care of infants, children and youth in BC.

Child Health BC's vision is the best health for infants, children and youth in BC. The mission is to build an integrated and accessible system of care for the purpose of improved health status and health outcomes for BC's infants, children and youth. The mandate is to bring together partners from the health authorities, the Ministry of Health, the Ministry of Children and Family Development, and other provincial agencies and services to optimize the health of

children and youth and to improve access to high quality clinical health services.

Child Health BC is working to ensure children receive the right service at the right time, in the right place and by the right provider. Through cooperative partnerships; regional subspecialty programs; education and dissemination; research; monitoring quality and performance; and developing standards, protocols and guidelines, Child Health BC is creating an integrated, standardized and accessible system of care available to all children in BC.

Workshop Purpose and Objectives

The purpose of the workshop was to introduce interdisciplinary health providers to the Social Pediatrics Initiative, a community partnership model of care. The workshops objectives included:

1. To describe the experience of one community in extending and enriching health care access and the capacity of interdisciplinary health providers to respond to the social determinants of health.
 - a. To introduce a community partnership model of health care that has been designed to foster access and continuities of care for socially vulnerable children/youth and their families.
 - b. To present the preliminary research insights on access and responsiveness of the Social Pediatrics Initiative that is being undertaken in a community with a disproportionate share of socially and economically determined inequalities in health.
 - c. To describe the approaches taken by the Family Nurse Practitioners in the Social Pediatrics Initiative to build relationships with children, families, schools, health care providers (e.g. family physicians, pediatricians, and public health) and community based

organizations in order to link children with needed resources.

2. To explore the potential for, and challenges of introducing a social pediatrics approach in other communities in BC by analyzing the elements of this inner-city project that may be at play in other communities that wish to achieve similar goals.

Highlights from Opening Speakers

During the first segment of the workshop, participants explored challenges faced by families living in communities where there is a high level of vulnerability among children.

Relevance of Social Pediatrics: **The State of Children Development in BC**

Lead: Joan Schroeder, Community Development Manager, Human Early Learning Partnership (HELP)

Ms. Schroeder provided recent socio-economic data which indicate that:

- BC has the highest number of children living below the poverty line and this has been the trend for the past five years.
- Over one quarter or 29% of children entering kindergarten are vulnerable in at least one aspect of their development and the Vancouver school district has the highest percentage of vulnerability among children in the province.
- The most vulnerable children are from the middle class because most children reside in this social group. This implies that a universal system of health care driven by the concept of equity might be more effective in responding to needs.
- The Strathcona and Comox Valley communities have the highest rates of vulnerability in the province and poor socio economic status is linked to vulnerability in these and many other neighbourhoods across BC. The socio economic factor is not always easy to predict as there are other communities that have been able to build resilience in spite of these challenges. These communities could hold answers to strengthening resilience in other neighbourhoods and require more in-depth study.

Additional factors contributing to vulnerability among children include rising obesity rates, and advances in technology that have reduced the amount of time parents spend with children.

According to Ms. Schroeder, reducing vulnerability will require public investment together with community innovation. Three fundamental concepts recommended for building resilience and reducing vulnerability are:

- a. The quality of community governance and collaboration
- b. Access to quality resources and programs
- c. Social capital and community cohesion

Family Perspective: **Stacey's Story**

Lead: Stacey Bonenfant, Family Representative

Ms. Bonenfant, a resident of one inner city community talked about her challenges as a single parent and highlighted some of the barriers she encounters in her efforts to access appropriate supports for her family.

Ms. Bonenfant's oldest son has been diagnosed with behavioural disorders and requires special services and care. In her presentation, Stacey cited inadequate day care spaces and high day care costs, inadequate government funding and competing government priorities, long wait times, working full time while raising a family and difficulty accessing the right therapies/treatments for her son as some of her main barriers in accessing community services.

Ms. Bonenfant was able overcome some of these barriers with the assistance of staff from The Social Pediatrics Initiative who were instrumental in facilitating connections to necessary assessment and treatment services. The family also received some government funding which will be used to finance special therapies and care. Stacey expressed appreciation for the support from the Social Pediatrics Initiative and made positive comments about the approach and professionalism of staff that made her feel comfortable with using the services.

Overview of Social Pediatrics: Recognizing and responding to the challenges of health services delivery for children and vulnerable families, and an introduction to Social Pediatrics model (RICHER)

Lead: Dr. Judith Lynam, MD, FRCPC, FCCMG, Professor, Advisor & MSN Program Coordinator, University of British Columbia

during childhood to improve chances for healthy growth and maturity. Dr. Lynam, placed emphasis on the fact that interventions must be timely and effective in working with both children and parents.

To further highlight the challenges faced by vulnerable children and families, Dr. Judith Lynam presented findings from studies on inequality in vulnerable communities and its impact on child health. According to the evidence, inequalities are largely socially determined and are magnified when people live on the social margins, do not have access to education or health care and are excluded from full participation in society. Groups that are most likely to be at risk in BC are immigrants, refugees, aboriginals, women, and persons suffering from mental disabilities or addiction.

Dr. Lynam explained that the groups identified above are not inherently vulnerable. Vulnerability is a manifestation of how various factors in society work together to privilege some groups and overlook others. She noted that these factors could be disrupted to give children better opportunities for success. To build more cohesive and resilient communities, families must feel engaged and provided with appropriate opportunities to build capacity. Vulnerable families should be positioned to derive needed benefits and reduce barriers therefore, programs that strengthen community based resources and make them accessible to children and families are critical.

In children, inequalities are cumulative over the life course. The EDI¹ (which measures child early development), shows that children who are delayed in their development have subsequent problems therefore, it is important to invest in children early or at some point

¹ EDI- Early Development Instrument

Panel Presentation on the Social Pediatrics Initiative

Leads: Dr. Christine Loock, MD, FRCPC, Associate Professor, Developmental Pediatrics, UBC, Pediatrician, Sunny Hill Health Centre for Children
Lorine Scott, Family Nurse Practitioner, Social Pediatrics Initiative
Carole Brown, Coordinator, Ray Cam Center
Fern Jeffries, Private Consultant and Specialist in Community and Organizational Development

Four speakers shared with participants the background and design of the Social Pediatrics Initiative (including how it functions as a community partnership) as well as barriers and key success factors to be considered if pursuing this approach in other communities in BC.

Background to the Program: Historical overview of Social Pediatrics in BC and Canada

Dr. Christine Loock outlined the development of the Social Pediatrics Initiative. She said the Initiative grew out of a concern for the social and economic situation of families living in Vancouver's inner city. The communities that make up this area include the Downtown Eastside, Strathcona, Grandview and Woodlands, Mount Pleasant and Hastings Sunrise neighborhoods. These are some of the poorest communities in Canada and health care and other community services are inadequate and extremely over burdened. Most of the community services in this area (including healthcare) are designed for the needs of the adult population and as a consequence, children and families lack access to appropriate care.

Description of Social Pediatrics Initiative

The Social Pediatrics Initiative is a neighborhood health care service that targets vulnerable children/families. It is a member of the Network of East Vancouver Community Organizations (NEVCO) which is a coalition and advocacy group made up of 60 community based organizations that work together to support community action. The Social Pediatrics Initiative operates on the guiding principles of partnerships, equity and engagement and seeks to change the traditional health care model where families were responsible for coordinating and finding services on their own

to one where families receive assistance to manage/coordinate these activities. The Initiative also recognizes the social roots of inequities in ways that relationships are constituted and in the nature of resources developed and provided in order to respond to the needs of children and families (Julien, 2006). In brief, the Social Pediatrics Initiative combines the traditional bio-medical approach to healthcare with the social justice approach. This allows for greater collaboration and cooperation among persons from varying disciplines and groups.

According to Ms. Lorine Scott, Family Nurse Practitioner, one key objective of the Initiative is to construct a continuum of care that links primary health care for children and families through specialty care through the community² that families create around themselves. The main challenges for the Social Pediatrics Initiative which are to:

1. Help the one in four children in this community that are developmentally vulnerable.
2. Prevent the sidelining of children from reaching their full potential in society.
3. Eliminate marginalization of children as this makes them at higher risk for illnesses.
4. Make appropriate and adequate care accessible to children and families.
5. Respect the rights of the child for a healthy and prosperous society.

²Community is defined as the supports that families identify as their community in raising children.

Design of the Social Pediatrics Initiative

Ms. Scott said the Initiative places the point of health care access in the communities that children congregate, e.g. day care centers, schools, community center, family's home, etc. Neighborhood schools are a primary point of access for the Social Pediatrics Initiative and community clinics are run from these and other locations. The Social Pediatrics Initiative also extends its services to any organization that offers services to children within the community. According to Ms. Scott, this strategy helps to increase access while reducing the barriers that families experience e.g. feeling unsafe, not feeling accepted, geographical location of services, etc.

As part of the Initiative's services, Family Nurse Practitioners pay special attention to the child's developmental trajectory through:

- Routine developmental surveillance of children
- Case management and coordination of care with other providers
- Preliminary detailed assessment of children
- Direct linkages with specialized health care services

The Social Pediatrics Initiative also acts as health resource for children in community programs and actively participates at all community partnership tables and community public health.

Between 2006 and 2009, the Social Pediatrics Initiative received 350 patients 80% of which were children under twelve. The other 20% were women and older children/youth. There is no organized referral structure for patients and children may be referred to the Initiative in any way.

Partnership Model: The Social Pediatrics Initiative and Raycam

One community organization that works in close collaboration with the Social Pediatrics Initiative is the Ray-Cam Centre. This is a community resident run facility built in 1976

from the collective vision, commitment and energy of parents who desired a safe place for children. The center's key principle in engaging with the community is to "**do no harm**". Ray-Cam promotes and supports programs and activities that help to advance the power and ability of residents, engage and involve local groups in solving their own problems, and improve the overall well being of the community and its residents.

Importance of Listening to the Community

The success of the Social Pediatrics Initiative in East Vancouver neighborhoods can be credited to the respect of the above principle and relationships with community groups and residents. The Social Pediatrics Initiative sees the local organizations as major assets and embraces them as integral players in addressing local challenges. These groups became equal contributors in the design, development and implementation of the Social Pediatrics Initiative strategies/services. This approach has resulted in the development of a program responds to real situations and needs. Ms. Jeffries noted that the Community Health Care Model, a partnership between the Social Pediatrics Initiative and the Network of East Vancouver Community Organizations, aims to be characterized as: Responsive, Respectful, Reciprocal, Relationship Based and Rights Based.

One important outcome of the Social Pediatrics Initiative's relationship with the community has been the opening of access to pediatric specialists that children and parents in the inner city were not able to access to in the past. External organizations and agencies seeking to start projects or programs within in the community were encouraged to commit to the local knowledge, community building practices, and political strength of local partners and also recognize the collective wisdom and assets they bring to discussions, programs and strategies.

Moving Forward

During the group discussion segment of the workshop, delegates met in small groups to explore cases and share experiences as well as thoughts on how the Social Pediatrics Initiative approach might be used in other communities to build resilience and create opportunities for access to care. Summarizing the knowledge shared during the workshop, participants noted the following:

- Initiative pursues an **interdisciplinary and inter-sectoral health care approach**.
- Initiative is designed to improve **access, responsiveness and continuities of care** within target communities.
- **Partnerships, engagement and accountability** are critical to the success of such a community partnership initiative.

Reflecting on the workshop, participants noted the importance of the Social Pediatrics Initiative, and similar models, in progress towards the following long-term goals:

1. **A universal approach to health care informed by equity** - This should help to provide a means for addressing and responding to the uniqueness of social context, health and developmental profiles.
2. **Improved models of service delivery to cover continuum of care from community to specialist services** - This involves providing avenues for community and family engagement and accountability, creation of partnerships that capitalize on community capacity to support child/family, interdisciplinary collaboration to take advantage of particular expertise of different members of clinical practice and the creation of best practices to respond to local challenges.
3. **Closing the gaps between research, policy and practice and encourage services that address inequalities in health care access for vulnerable children and families.**

In the shorter term, participants also made the following specific recommendations:

1. Develop a template to map and evaluate levels of intervention and engagement delivered by the Social Pediatrics Initiative.
2. Work with Child Health BC to host other workshops to increase inter-sectoral and inter-regional collaboration and knowledge.

Follow-Up Workshop: Innovative Partnership as Investments: Improving Outcomes for Vulnerable Children & Families

Executive Summary

The second workshop of a two-part series on Social Pediatrics was hosted by Child Health BC, in partnership with the RICHER Social Pediatrics Initiative, and BC Children's Hospital. The one day event took place at the Coast Coal Harbour Hotel, Vancouver, BC on Monday January 17, 2011. In attendance were health care professionals and community partners from communities across the province.

Highlights:

Dr. Maureen O'Donnell, Executive Director, Child Health BC, welcomed participants to the workshop that continued the sharing of best practices from the first Social Pediatrics Workshop in September 2009.

Setting the Stage

Shared by: Christine Loock, MD, FRCPC, Associate Professor Developmental Pediatrics, UBC, Pediatrician, Sunny Hill Centre for Children

Dr. Loock shared the lessons she had learned from an important mentor, Dr. Geoff Robinson, including the importance of getting to know government decision-making, remaining active in practice, and being patient about the pace of change. Dr. Loock set the stage for the workshop by reviewing the workshop objectives, and establishing the 'case for change' for a focus on children and, especially, early identification of and intervention for vulnerable children. Dr. Loock emphasized that social pediatrics is an "engaged" form of practice.

Social Pediatrics an approach that seeks to recognize the social roots of inequalities in the ways relationships are constituted and in the nature of resources developed and provided in order to respond to the needs of children and families.

- Julien, 2006

Describing the RICHER initiative, Dr. Loock emphasized the importance of the commitment to the 5 R's (Responsive, Respectful, Reciprocal, Relationship Based and Rights Based), the "kitchen table" meetings for maintaining strong community partnerships, and measuring impact.

Plenary Panel: Sharing Lessons Learned in Working with Partners to Reach Vulnerable Populations

During the first segment of the workshop, four speakers shared lessons they had learned in extending the reach of health care services and collaborating with other sectors to reach vulnerable populations.

Key Lesson 1: There are strong humanitarian and economic arguments for investing in early childhood development.

Shared by: Dave Park, Economist Emeritus of the Vancouver Board of Trade and Research Associate, Justice Institute of BC

Mr. Park shared findings from the *Economic aspects of the Development of Criminality among Children and Youth* (Sept 2010), a report from the Justice Institute of BC in partnership with the Vancouver Board of Trade. Mr. Park summarized the strong humanitarian and economic reasons for investing in early childhood development. For example, the national cost of youth not graduating from high school is estimated to result in tangible and intangible losses of \$43 million. In BC, it costs \$20,000 per year for each youth under community supervision and \$215,000 for each in custody. Many early childhood interventions

are more effective, than later interventions, in avoiding many of these costs to society.

Key Lesson 2: Inter-sectoral partnerships may result in a higher impact model than a single-sector investment.

Shared by: Larry Gold, MSW, MS, President of BC Children's Hospital and Sunny Hill Health Centre for Children

Mr. Gold shared his previous experience at the Connecticut Children's Medical Center, one of 5 partner organizations in the Southside Institutions Neighbourhood Alliance. The experience demonstrated the high impact that resulted from bringing together partners from multiple sectors (e.g. health care, education, media) on a disadvantaged neighbourhood. Together, the partners pooled \$5 million and leveraged these, with the support of the business community, to address the following five aspects in disadvantaged Hartford neighbourhoods:

- **Education** - through the creation of the learning corridor.
- **Health care** - through clinics in the learning corridor.
- **Safety** - through lighting and neighbourhood policing.
- **Employment** - through partners committing to give first choice of new jobs to neighbourhood residents.
- **Housing** - through low-cost, low-interest mortgages on 180 units.

Key Lesson 3: Channels for reaching vulnerable populations may emerge in unexpected ways.

Shared by: Michele Fryer, RN, MHSA, Director, Acute Pediatric and Perinatal Programs, Vancouver Island Health Authority (VIHA).

Ms. Fryer described some of the characteristics of VIHA's population including above average proportions of children in care, in abuse situations, and on income assistance from lone parent households. Ms. Fryer shared key elements of VIHA's strategic direction and the initiatives underway towards VIHA's objectives, such as: the Nanaimo Pediatric Ambulatory Care Unit (a partnership with CHBC), discharge

planning for aboriginal children with complex care needs, and NPs practicing with midwives in Campbell River. In the Cowichan Valley, a group of obstetric family practice physicians has been established with support from the Ministry of Health, providing the community with access to prenatal care. A number of grassroots community health networks have emerged in the VIHA area. The groups have open memberships that include educational, law enforcement, service clubs, faith based organizations and municipal parks and recreation to enhance the health and wellbeing of community residents. While some of these groups were initially formed because of concerns about changes to VIHA's services, the purpose of the groups have evolved. The aim of the Cowichan Valley Community Health Network, for example, is to work together to develop an effective and sustainable community and health system. The doors of many of these groups are open for VIHA to join them in improving access to health care.

Key Lesson 4: It is necessary to help organizational leaders make the connections between social determinants and health inequities.

Shared by: Patty Daly, MD, FRCPC, Chief Medical Health Officer & VP, Public Health for Vancouver Coastal Health Authority

Dr. Daly noted that managing health inequities are of great interest to decision-makers because it offers a pathway for managing health care within our given resources. Dr. Daly demonstrated a few examples, including:

- Hospitalization rates, substance abuse, COPD, injuries and differences between low and high socio economic status groups (data from the Urban Public Health Network in partnership with Canadian Institute for Health Information).
- Parallels between maps of Life Expectancy and Early Developmental Index, indicating striking differences between neighbourhoods, even those that are adjacent.

Helping decision-makers see the connections between social determinants and health

inequities has improved traction of initiatives to reach vulnerable populations. Dr. Daly pointed out that the prominence of “reducing health inequities” on Vancouver Coastal’s strategic plan is a significant accomplishment since a significant proportion of regional health authority resources are allocated to acute care. The adoption of this focus is evident in several Vancouver Coastal initiatives – including those focused on food security, ‘healthy built environments’, daycare licensure, and health literacy. Dr. Daly suggested that a reframing of child poverty into a prosperity agenda may help bring the provincial government and business partners on board.

Video Clip: Children’s Voices

Children and youth use verse to describe the connection between early childhood development and outcomes and mobilize viewers to action.

Insights on the RICHER Initiative

Introduction by: Carol Brown, Manager, Ray-Cam Community Centre

RICHER is a community outreach model of practice that began providing health care services for children at risk in Vancouver’s inner city. This initiative provides primary care and increased access to specialist care for children and families with complex health and developmental needs.

Representing one of the community partners in the RICHER initiative, Ms. Brown shared her perspective on the critical success factors:

- The RICHER initiative, and the partnerships supporting it, was developed with a commitment to the 5 R’s.
- The community (and representatives of) did not get sidelined as the RICHER initiative developed; rather, their input and participation in developing solutions continue to be welcomed.

Evaluation findings from: Dr. Judith Lynam, UBC Professor and Lead Investigator for the SPI Initiative.

From the perspective of a partner joining the community, Dr. Lynam noted that ‘good’

partners for social pediatrics initiatives are ones that had an explicit commitment to capacity building and engaging with the neighbourhood and had mechanisms of accountability to their neighbourhood constituents. Dr. Lynam reviewed a significant body of research underpinning this investment in cohesion. This theoretical legacy behind the RICHER project has established:

- Health inequities can be materially but also socially determined.
- The importance of relationships as sources of support, connection and affirmation for overcoming health inequities.

The RICHER initiative is focused on understanding and dismantling social and structural barriers to access to health care. Participatory research was undertaken to answer the evaluation question: Does SPI foster access to PHC for ‘at risk’ children & families? Dr. Lynam reviewed the findings:

- **RICHER serves children and families that literature identifies as vulnerable:** those from households that have one or many of the following disadvantages: low income, lone parent, new immigrant households.
- **RICHER serves children with developmental delays.** Survey results indicate that children have physical, language and emotional challenges.
- **RICHER overcomes access barriers**, both by providing timely (most on the same day), place-based access but most notably through the clinician’s interpersonal style that:
 - Is compassionate and respectful (as verified in survey results).
 - Knows the family and their situation.
 - Involves the parents in decision-making.
 - Empowers families towards better health outcomes.

Dr. Lynam noted that the innovation of RICHER comes from the admission that expertise comes in many forms, including the knowledge of key people that can link the family into

neighbourhood activities, food and clothing with a limited budget.

The philosophy of respect for the person and willingness to work with child and family to develop capacity is carried through in all aspects of the practice.

- Dr. Judith Lynam, RICHER Research Lead

Why are relationships important?

Shared by: Lorine Scott, MN, NP (F), Family Nurse Practitioner, Social Pediatrics Initiative, BC Children's Hospital

Ms. Scott provided concrete examples of how the clinical relationships within RICHER:

- Are **place-based** - services are delivered within a humble space in a familiar neighbourhood.
- **Approach from family's lived experience** - NPs recognize and build upon parent/family resilience and work to overcome distrust of the system.
- **Consider the social determinants of health** - NPs carry out child development surveillance at every single encounter.
- **Build capacity** - NPs work with clients to build a social circle of supports within their community.

Ms. Scott shared stories of two different mothers and their children to demonstrate how primary care is the catalyst that intersects all of the agencies required. In the first example, the mother had notable social capital but her housing situation and undiagnosed personal health issues were standing in the way of her families' wellness. In the second example, the mother had a limited support community. The prologue to these stories demonstrated how the RICHER model has made a difference through:

- Identification and management of undiagnosed health conditions.
- Family access to appropriate service and by doing so, a decrease in root causes of ill health (e.g. unsafe housing, nutrition, etc.).
- Empowerment of parents.

Music Box Children's Charity – Investing in Children's Development

Shared by: Shazeen Suleman, MSC, 3rd year medical student at UBC

Ms. Suleman introduced the Music-Box Children's Charity. The charity is a channel for 2nd year medical students to fulfill Community-Service Learning requirements. The intent of this experience is to build an understanding of and interest in giving back to the communities they work in. At the foundation of Music Box is the assertion that music should be a right, rather than a privilege, because it is such an integral part of early development. The Music Box's Allegro! Project engages 2nd year medical students to reach 3-5 year olds through music lessons and simultaneously assess developmental milestones. Music Box instructors also attend the Social Pediatrics Community Roundtable. Music Box is a unique approach that marries arts education, health care, and health advocacy with youth leadership. Music Box currently operates in Vancouver and Toronto with 65 volunteers and is opening other Canadian chapters.

Why Place Based Partnerships, Engagement & Accountability?

In this segment of the workshop, clinicians and community partners involved in RICHER share successful approaches for connecting with and reaching out to vulnerable populations.

An Illustration of Partnerships

Shared by: Ashley Roberts MD, FRCPC, Pediatric Infectious Disease Specialist, St Paul's Hospital and Lorine Scott

Dr. Roberts and Ms. Scott shared Norman's story. Norman's mother had a history of substance abuse and Norman was born with abstinence syndrome. At 8 weeks he was discharged from BC Children's but was not followed up through the BC Women's Oaktree clinic (which provides specialized HIV care for infected women, pregnant women, partners, children and youth, and support services for affected families.

After being in the care of his maternal grandmother on an Aboriginal reserve, Norman has recently been reunited with his birth mother. Norman's mother is now clean and managing her HIV status. When Norman first came into the clinic with his birth mother, his HIV status was unknown and the family was in crisis because of his behavioural issues. Because of RICHER NPs' strong relationships with sub-specialists, they were able to arrange and complete a full developmental assessment of Norman within a week. As well, they arranged emergency respite and a new housing situation over the Thanksgiving weekend, mobilizing partners to help this family. This is the RICHER difference – "timely, efficient, coordinated, place-based service IN the community, response to needs of patient and family."

The clinicians credit much of their success to community partners and also to each individual's commitment to a non-judgmental way of relating to the client. The program structure also gives sub-specialists the freedom to walk a family across the street to the lab. Norman's family is an example of one that will need follow-up to ensure that connections within the family's identified social circle are maintained.

Engagement

Shared by: Vivian Nawrocki MN NP (F), Family Nurse Practitioner, Social Pediatrics Initiative, BC Children's Hospital

Ms. Nawrocki described her learning curve to understand service gaps in the community. As well she described successful approaches for collaborating with and consulting youth about the service issues in their community. She also described the relationships that have been critical to capacity-building within the community.

Accountability

Shared by: Kate Hodgson, Executive Director of the Network of Inner City Community Services Society, Vancouver, BC

In the Downtown Eastside, there has been a wariness of many organizations, researchers and professionals that have come into the community to study, take information and leave without giving back to the community. Therefore, it is essential that RICHER is a long-term commitment. Ms. Hodgson noted that the weekly Community Table (aka "Kitchen Table") is a crucial mechanism for the relationships between tiers of medical service (e.g. primary care, sub-specialty), community centres and service partners, and residents. After meeting regularly over a few years and hammering out community issues together, there is a strong working relationship between participants at the RICHER Community Table. Members demonstrate commitment to the principles of trust, confidentiality and respect at the Community Table. Without the Community Table in place, Ms. Hodgson shared that she has seen other organizations not have the connection with the community and abort their outreach to these vulnerable populations.

Panel: Our Mandate, Our Vision, Our Challenges

In the last segment of the workshop, three participants shared what they have learned about establishing the infrastructure for social pediatrics within BC and invited questions from all participants.

Led by: Jeremy Berland BSW MSW, Deputy Representative; Associate Deputy of Monitoring, Research, Evaluation, & Audit, Office of the Representative for Children and Youth

Mr. Berland shared his Office's measurement system, partnership with the Provincial Health Office, including indicators on the health, learning, safety, family economic well-being, family/peer/community connections, and behavior of BC's children and youth. Through these indicators, the Office learned that there has been an:

- A decrease in suicide rate.
- A decrease in teen pregnancy.
- An increase in graduation and youth voluntarism.

- Ongoing risks for Aboriginal children and youth and patterns of disadvantage for those in the North, Interior, & North Vancouver Island.

Mr. Berland identified the following success factors, encouraging the audience to:

- **Invest in relationships** that must be intentional. Start with common ground. Create trust.
- **Put yourselves in the client's shoes.** To improve health literacy and empower clients from vulnerable populations, think: 'What would I want?' if this was my own child.
- **Practice the 'Good referral' process** - contact the organization and help the client to get there.
- **Log referrals** since this can be a valuable starting point for discussions on areas for improvement with partners.

Led by: Patty Keith, RN, RM, PhD Director of Planning, Maternal/Child, Vancouver Coastal Health

The Pediatric Child & Youth Council is a table of partners with an aim to develop relationships and build capacity among partners across the continuum of care to reach the vulnerable populations of children, youth and women. This Council has been established as a communication network. It has strong relationships with other councils focused on a specific care focus, such as primary care, prevention and acute care. The Pediatric Child & Youth Council is uniquely population focused and includes Executive Sponsors from diverse areas of care and organizations (including Child Health BC and BC Children's Hospital). As a member of the Council, Vancouver Coastal's Department of Community Engagement also plays an important role in increasing the Council's understanding of and connection to community partners and clients.

Led by: Barb Fitzsimmons, RN, MSN, EDA, VP Patient Care Services, BCCH & Sunny Hill Health Centre for Children

Ms. Fitzsimmons described that RICHER has been a learning opportunity for PHSA to better engage partners (such as Vancouver Coastal) at the outset. A participant from Vancouver Coastal responded with thanks that RICHER was the right thing to do. Ms. Fryer noted that VIHA would welcome the opportunity to try this model.

Reflections for Moving Forward

Reflections from: Marie Clare Zak, Director of Social Policy, Community Services, City of Vancouver

The City of Vancouver is unique because it has a social planning role. For example, the City of Vancouver has a \$4 million grants program for social issues, capital for child care and early childhood development tables. Ms. Zak reflected that there is increasing acceptance within the City of Vancouver of the being active in advocacy. She noted that she was struck by:

- The importance of senior-level support for such initiatives.
- The return on investment in coordination and collaboration with partners.
- The importance of connectedness for RICHER sponsors, practitioners and clients.

The workshop inspired the following lines of inquiry:

- What would the RICHER model look like in other neighbourhoods in the City of Vancouver?
- How could organizations in the Downtown Eastside (e.g. City of Vancouver, SFU, Vancouver Community College and Vancouver Coastal) come together to address neighbourhoods needs (especially those of children and youth) in a model like the one used in Hartford, Connecticut?

Reflections from: Dave Park, Economist Emeritus of the Vancouver Board of Trade and Research Associate, Justice Institute of BC

A true measure of a Nation's standing is how well it attends to its children – their health and safety, their material security, their education and socialization, and their sense of being loved, valued, and included in the families and societies into which they are born.
- UNICEF, Innocenti Research Center, 2007

Mr. Park re-emphasized the importance of early childhood development. He noted that his perception of the RICHER initiative is that it is an economical approach that leverages the resources of partners. As Ms. Scott had described:

- The RICHER model is not expensive.
 - It requires funding for NP positions.
 - The provincial Medical Services Plan has provided sessional funds for physician specialists.
 - Community partners provide space and facilitate the necessary relationships.
- These modest investments “allow us to reach out to families that cost us the most”.

Mr. Park added that with the help of a program like RICHER, children could be diverted from a life of crime and end up with a much more prosperous life. Mr. Park noted that the workshop had reinforced the value of partnerships in addressing early childhood development for vulnerable populations.

Reflections from: Christine Loock, MD, FRCPC, Associate Professor Developmental Pediatrics, UBC, Pediatrician, Sunny Hill Centre for Children

Dr. Loock remarked that, although it may not have existed a decade ago, decision-makers now have the evidence for social pediatrics. There is, however, still a gap between what we know and what we are doing. Dr. Loock called participants to action with the following key points:

- Social issues are societal concern. They are everybody’s issues (as also noted by Mr. Berland). It is not a problem we can ask to the government to fix.
- Social pediatrics is an investment (not a cost) with long-term pay-offs.

Summary of Workshop Lessons for Moving Forward

Organizations wishing to implement a model like RICHER are encouraged to:

- Consider reframing risk factors (e.g. poverty) into a prosperity agenda.

- Clearly connect the dots between risk factors and outcomes of health inequities for decision-makers.
- Invest in relationships across the four tiers of health care service, as well as early childhood education, developmental disabilities services, mental health, family and social supports, child advocacy and legal services, research, education and interdisciplinary collaboration.
- Consider the “value add” of intersectoral partnerships to address interconnected risk factors.
- Reinforce these relationships and ongoing communication through community “kitchen tables” and an explicit commitment to the 5 R’s.

Professionals engaged in social pediatrics are encouraged to:

- Recognize and value of resilience and skills of families.
- Practice the “good referral” process: sending off the referral, contacting other organizations with the client and/or ensuring the client can access the referred services.

In response to the workshop, many participants voiced the hope to see the RICHER model implemented across BC, customized to BC’s unique communities.