



Proceedings of the Child Health Expert Roundtable

Hosted by the Canadian Medical Association

From Plan to Action

October 6, 2008
Ottawa, Ontario

Facilitation and Reporting by:
Sheffe Consulting Inc.



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Table of Contents

Section 1 – Introduction	1
Section 2 - Background	1
Section 3 –Program	2
Section 5 – Conclusions and Next Steps	3
Figure 1.1 – October 6/08 Child Health Roundtable Action Plan for Consideration	4
Appendix A – Participant List	
Appendix B – Program Agenda	
Appendix C – June 6 th Proceedings	
Appendix D – Evaluation Report	

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Disclaimer: This report was prepared as an account of the events and activities presented by the collective participants of the October 6th, 2008 Child Health Roundtable. The views and recommendations expressed herein do not necessarily state or reflect those of the CMA or any other participating agency.

Section 1 – Introduction

The following report details the results of the October 6, 2008 Child Health Expert Roundtable titled “From Plan to Action”. Hosted by the Canadian Medical Association (CMA), the objectives for this session were presented as follows:

- Facilitate capacity for networking and collaboration amongst Canadian child health stakeholders
- Build consensus on priority recommendations targeting Canadian governments to address child health...the early years
- Develop strategic and task-oriented actions for recommendations with identified champions
- Identify key messaging for a presentation to the Senate Sub-Committee on Population Health

This report documents the results of the From Plan to Action Session and will guide the stakeholders to identify advocacy priorities for child health.

Section 2 - Background

In 2006, National Health Goals – specifically child health during the early years (children under the age of 5) was recognized as a CMA Board priority. Since that time, the CMA has worked in collaboration with child health leaders on initiatives such as the *Child and Health Initiative*, resulting in the development and launch of the Child and Youth Health Charterⁱ and the Child and Youth Health Challenge.

In May, 2008, the CMA, in collaboration with the Canadian Paediatric Society (CPS) and the College of Family Physicians of Canada (CFPC) presented to the Senate Sub-committee on Population Health recommendations to move forward on child health with a focus on the early years. To support and inform these and future recommendations to the Senate Sub-committee, the CMA hosted two Child Health Expert Consultations in June & October 2008. The CMA and its partners have been invited to present to the Senate Committee again in early 2009, and will bring forward the action plans developed from the October Expert Roundtable.

Section 3 –Program

Unlike the June Expert Consultation that was attended primarily by national health organization representatives, the October session included participants from both national and community health organizations (Appendix A – participant list).

The program (Appendix B – Agenda), facilitated by Sheffe Consulting Inc., featured presentations from Senator Wilbert J. Keon, Senate Committee on Population Health; Dr. Margaret Clarke,

University of Calgary; Dr. Robin Williams, Council for Early Childhood Development (CECD); and Sherry W. Thompson, Sherry Thompson Consulting. These presentations provided Canadian and international evidence to support a focus on the early years and examples of programs implemented to move from theory into action.

This second roundtable was designed with this same goal in mind: to move child health recommendations towards actions. Dr. Ruth Collins-Nakai, Past President of the CMA, presented five themed recommendations which were derived from four sources:

- Proceedings of the June 6th Expert Consultation (Appendix C – June 6 proceedings);
- World Health Organization Commission on the Social Determinants of Health Final Report – Chapter 5 – Equity from the Startⁱⁱ;
- Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology – Maternal Health and Early Childhood Development in Cubaⁱⁱⁱ; and
- Early Years Study 2^{iv}

Participants were asked to break into five groups (one for each proposed recommendation) based on their interest. Each group was tasked with refining the proposed recommendation and identifying actions and champions which support their respective recommendation. Each action plan was presented to the plenary group who then provided additional comments, revisions or suggested champions. The participants also proposed a sixth recommendation which focuses specifically on the role that CMA can play. Figure 1.1 captures the results of the action planning.

During the plenary discussion, participants identified nine overarching principles that must be considered in developing actions related to child health:

1. Program/initiative/policy must be **culturally based**;
2. Program/initiative/policy must adhere to values of **equality**;
3. All children are **respected and valued**;
4. **Quality standards** (training, infrastructure, housing, etc.) must be developed and met;
5. **Maternal health and wellbeing** is a crucial aspect to early child health and wellbeing;
6. **Best practices and best conditions** must be sought, modeled and implemented;
7. **Holistic definition of health is used in program/initiative development**: defined by the World Health Organization as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”;
8. **Evaluation and accountability** tools are implemented and made part of program design; and
9. **Ensure target audiences contribute input** when developing programs and resources.

Section 5 – Conclusions and Next Steps

Following the roundtable discussions, Senator Wilbert J. Keon offered his thoughts on the session. Senator Keon remarked on the fascinating research presented on brain development and the work of both the CECD and South Australia. He expressed satisfaction over the proposed whole of government approach to ECD and full spectrum of population health, pointing to the evident need for integration between health and education plus all other variables with an affect on individual health. Senator Keon was also supportive of the recommendation that the CMA takes a policy

leadership role in ECD. Senator Keon assured the experts that the Senate would reinforce the need to invest in ECD and that it is the responsibility of the Prime Minister and Ministers, plus leaders across the country, to weigh in on this important issue. Finally, Senator Keon thanked the experts for confirming his belief that ECD is the platform from which population health should be delivered.

This report will be used by the CMA to inform their presentation to the Senate Committee on Population Health in 2009. In addition, the CMA will refer to this report for child health advocacy and programming initiatives related to CMA national health goals.

The CMA has distributed this report to all roundtable participants and invites them and all child health advocates to use the information provided in this report to further the Child and Youth Health Challenge and adopt actions that will enhance the health of all children in Canada. Our collective challenge is to champion what role we should play to generate action on child health. How do we get child health moved to the front of the agenda federally, provincially, territorially, locally — even within our own groups?

Figure 1.1 – October 6/08 Child Health Roundtable Action Plan for Consideration

Recommendation	Action Items	Recommended Champions
<p>1. Develop a Pan-Canadian infrastructure and mechanism to:</p> <ul style="list-style-type: none"> • Lead and coordinate child health and wellbeing; • Participate in global child health initiatives; • Implement and evaluate models at the federal, provincial, territorial, Aboriginal and community levels which support cross-sectoral structures, mechanisms, and professional training. 	<p>1.1 – Whole of Government Approach Ensure a whole of government approach to the infrastructure with federal leadership advocating a Pan-Canadian approach</p> <p>1.2 – Multi-ministry Cabinet Committee Create a multi-ministry cabinet committee with ECD as priority (federal, provincial, territorial levels)</p> <p>1.3 – Joint Advocacy Apply cross-sectoral joint advocacy coordinated by government (including business)</p> <p>1.4 – Child and Youth Commissioner or Secretary of State position Introduce a Child and Youth Commissioner or similar-type position (i.e. Secretary of State) to transcend government barriers</p> <ul style="list-style-type: none"> • Include First Nations Children into Commissioner mandate <p>1.5 – Child and Youth Health Advisories Create Child and Youth Health Advisories at provincial/territorial level</p> <p>1.6 – Annual Parliamentary Report Influence parliament (i.e. via presentations to Senate etc.)</p> <p>1.7 –Economic Imperative to Invest Provide an economic imperative for investing in maternal health and ECD</p> <p>1.8 – Community-based Clinics Establish community-based clinics/centres that:</p> <ul style="list-style-type: none"> • Provide one-stop shopping for parents • Include age specific clinics within • Leverage and strengthen physician-patient/family relationships • Connect with primary schools and other community structures as well as professions and shared care models (primary, secondary and tertiary care) 	<ul style="list-style-type: none"> • Federal, provincial, territorial, aboriginal and municipal governments • Auditor General and provincial auditors • Canadian Federation of Municipalities (CFM) • Statistics Canada • Canadian Institute for Health Information (CIHI) • Health Council of Canada

	<p>1.9 – Changes to Training of Health Professionals Advocate for changes to training of health professionals:</p> <ul style="list-style-type: none"> • Multidisciplinary • Community-based (out of the hospitals) • Holistic focus on child and youth health and wellbeing • New (flexible) funding and remuneration models (e.g., fee code for 18-month visit, salaried physicians) • Continuing professional and leadership development <p>1.10 – Cross-sectoral Evaluation Ensure cross-sectoral evaluation with a nationwide Early Developmental Index (EDI)</p> <ul style="list-style-type: none"> • Produce an Annual Report to increase accountability • Ensure shared accountability for outcomes (from government, to physicians to parents) 	
<p>2. Challenge physicians and other health care professionals, schools, educators, early childhood professionals and governments to build integrated, universally accessible, centre-based population health based programs as a first tier of development attached to schools where possible</p> <ul style="list-style-type: none"> • Increase competencies of parents • support the physical, social, emotional, language and cognitive development of the child 	<p>2.1 – Investment in Centres of Excellence Provide Federal government investment into a network of Centres of Excellence for Child Development with a new mandate to engage provinces and territories</p> <ul style="list-style-type: none"> • Public Health Agency of Canada (PHAC) and National Collaborating Centre on Child Health <p>2.2 – Pan-Canadian Basis for Common Measures Implement common measures on a Pan-Canadian basis (e.g., breastfeeding rates, 18 month assessment and EDI at 5 years)</p> <ul style="list-style-type: none"> • Introduce Pan-Canadian standards for measures and program component delivery <p>2.3 – Cross-ministry Structure Establish a cross-ministry structure to lead child health and wellbeing improvements and to deliver the program (include Finance)</p> <ul style="list-style-type: none"> • Break down the silos between education, early childhood and health more broadly with top-down leadership <p>2.4 – Early Child Development and Parenting Centres Establish and fund integrated Early Child Development and Parenting Centres</p> <ul style="list-style-type: none"> • Include a special focus on improving outcomes for Aboriginal children 	<ul style="list-style-type: none"> • Canadian Childcare Federation • Teachers Federations • Principles Federation • Public Health Agency of Canada (PHAC) • Network of Family Councils • Canadian Association of School Health (CASH) • Canadian Association of Family Resource Programs (FRP Canada) • Special Link – Social Workers • Ontario Association of Social Workers (OASW) • Colleges and Universities (physicians, teachers, early childhood educators, speech pathologists, psychologists, social workers)

	<ul style="list-style-type: none"> • Include medical care and a cross-departmental funding mechanism • Establish beacon sites with schools as the hub in each province to change one community at a time • Build community multidisciplinary teams including local physicians linked to specialist services • Create seamless transition between early and later health care • Have the centre attached to a school to improve its sustainability and establish a beginning to the first tier of education as a continuum 	<ul style="list-style-type: none"> • Council on Early Child Development
<p>3. Protect women of reproductive age and children against harmful effects of all toxins in the environment including toxic stress by expanding reporting, education, services and intervention programs and policies.</p>	<p>3.1 – Collaborative Education Program Implement a collaborative educative program that includes all health professions (see list of champions below)</p> <p>3.2 – Improve Data Surveillance (Canadian Perinatal Surveillance System (CPSS) regulations plus toxic focus)</p> <p>3.3 – Assessment Tools Develop assessment tools to identify gaps and issues</p> <p>3.4 – Intervention Programs Create intervention programs that</p> <ul style="list-style-type: none"> • Are based on best practices (national and international) with appropriate supports • Target communities in need • Focus on community development (urban, rural, Aboriginal, Inuit) 	<ul style="list-style-type: none"> • Canadian Paediatric Society (CPS) • Society of Obstetricians and Gynaecologists of Canada (SOGC) • College of Family Physicians of Canada (CFPC) • Canadian Association of Midwives (CAM) • Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) • Public Health Agency of Canada (PHAC) • Mental Health Commission of Canada (MHCC) • SRP • FNIHB • CPA • CAN • CPHA • CAMIAH • CAPD thru CDA • Aboriginal Organizations including: <ul style="list-style-type: none"> • AFN • ITK • MNC

		<ul style="list-style-type: none"> ● CAP ● NWAC ● IPAC ● ANAC ● NIICHR ● NEAHR ● NAHO ● NCCAH ● IAPH
<p>4. Dedicate more funding toward research methods, practices, implementation and application that are:</p> <ul style="list-style-type: none"> ● focused on healthy early child development (mental, physical and emotional) ● culturally competent and culturally based (Note: Aboriginal peoples are distinct from and unique to immigrant and new populations) ● responsive to community needs and center on community and policy maker engagement with both the methods and use of results ● built on/supporting efforts already underway to create, compile and exchange evidence/knowledge 	<p>4.1 – Promote System Changes</p> <ul style="list-style-type: none"> ● Modify funding mechanisms within and in addition to CIHR to help perpetuate, encourage and facilitate ECD research (e.g., ability of researchers to engage with communities, intervention research, methods, funding timelines) ● Improve data collection, sharing and access <p>4.2 – Assess Data Gaps and Research Barriers Assess gaps in data and research barriers from the perspective of all stakeholders (researchers, policy makers, practitioners and community/parents)</p> <ul style="list-style-type: none"> ● Identify disparities of Aboriginal and other disadvantaged children ● Promote two-way dialogue to ensure cultural competence of results that resonates with all stakeholders ● Identify missing data <p>4.3 – Build a research continuum of evidence</p> <ul style="list-style-type: none"> ● Acknowledge and build on knowledge and knowledge exchange/mobilization efforts (national and international) on various topics related to child health <ul style="list-style-type: none"> ○ Data, methods, evidence compilation, intervention research ○ Enlist communities’ input on how to apply research methods ○ Limit replication of proven science ● Link existing research and surveillance data sets with the EDI and locate the information in a national clearinghouse for improved accessibility <p>4.4 – Pan-Canadian Evaluations Conduct meaningful Pan-Canadian evaluations that are useful to research, community and able to inform policy</p>	<ul style="list-style-type: none"> ● Council for Early Childhood Development (CECD) ● Canadian Institutes of Health Research (CIHR) ● Maternal, Infant, Child & Youth Research Network (MICYRN) ● Manitoba Centre for Health Policy (MCHP) ● Active Healthy Kids Canada (AHKC) ● Canadian Institute of Child Health (CIH) ● Population Health Intervention Research of Canada (PHIRC) ● Public Health Agency of Canada (PHAC) ● PHAC National Collaborating Centres ● Baby Friendly Initiative ● Network Environments for Aboriginal Health Research (NEAHR) Centres ● Canadian Institute for Health Information (CIHI) ● Health Council of Canada ● International initiatives (UK)

<p>5. Invest in programs, tax and compensation benefits that address determinants of overall health including mental, dental, access and equality related to maternal and children’s health.</p>	<p>5.1 – Equity for children - based on need Equality must be non-negotiable: meaning every child gets equal benefit out of the public purse (NB – Aboriginal children) based on need</p> <ul style="list-style-type: none"> • Recognize the statement that “every child have a good start” is not a partisan or ideological issue • Requires leadership at highest levels of government which will happen when Canadians are lobbied to tell government that every child matters. Government responds to change it doesn’t initiate it <p>5.2 – Have Prime Minister lead ECD effort</p> <p>5.3 – Cross-departmental Group Create cross-departmental group (Ministers, Deputy Ministers and Treasury) to plan and implement ECD strategy</p> <p>5.4 – Maternal Health Invest in maternal health in parallel to ECD</p> <p>5.5 – Tax Credit</p> <ul style="list-style-type: none"> • Introduce tax credit for mothers and extended family caregivers (pre & postnatal) • Introduce a tax credit or free provision of dental and vision care for children <p>5.6 – Inclusion in Healthcare Expand current essential health services for children to include a more comprehensive basket of services comprising of mental and physical health (i.e. medical, dental and vision)</p> <p>5.7 – Parenting Courses Tax credit or refund for completing/passing parenting courses</p> <ul style="list-style-type: none"> • prenatally • to age 2 years • to age 5 years • to age 17 years <p>5.8 – Childcare Provide quality, universal, accessible and affordable childcare for all parents who choose to use it</p>	<ul style="list-style-type: none"> • Aboriginal children and youth organizations • Centres of Excellence • Institute for Research on Public Policy (IRPP) • Canadian public – get every person involved in actively shaping public policy
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<p>6. The CMA recognize the central role of physicians in supporting and advocating for healthy child development and commit to establish an infrastructure within CMA to provide physicians with the knowledge, skills, and tools to support collaborative engagement in the community planning, service delivery and evaluation related to Early Child Development.</p>	<p>6.1 – Be a Champion of ECD (voice behind the intent)</p> <p>6.2 – Embed ECD themes into medical training</p> <p>6.3 – Host Discussions Move Pan-Canadian dialogue beyond the FPT by hosting discussions as an outside body and carrying agreements forward with government involvement</p> <p>6.4 – Info POEMS Conduct a series of info POEMS focused on ECD (Patient Oriented Evidence that Matters)</p> <p>6.5 – CMAJ Focus Focus a CMA journal on ECD (Lancet was used as an example)</p> <p>6.6 – Baby Friendly Initiatives Use Baby Friendly initiatives to reach target audience of families</p> <p>6.7 – Physician Involvement Look for practical opportunities to get each physician involved</p>	<ul style="list-style-type: none"> • CMA and its stakeholders
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ⁱ Canadian Medical Association, Canadian Paediatric Association, College of Family Physicians of Canada. *Child and Youth Health: Our Challenge/La santé de nos enfants et de nos jeunes : le vrai défi*. October 2007. <http://www.ourchildren.ca/index.htm>

ⁱⁱ World Health Organization, *Commission on the Social Determinants of Health Final Report – Chapter 5 – Equity from the Start*. 2007. (http://www.who.int/social_determinants/final_report/en/)

ⁱⁱⁱ Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology, *Maternal Health and Early Childhood Development in Cuba*. February 2008. (<http://www.parl.gc.ca/39/2/parlbus/commbus/senate/com-e/soci-e/rep-e/rep08feb08-e.pdf>)

^{iv} Hon. Margaret Norrie McCain, J. Fraser Mustard, Dr. Stuart Shanker, *Early Years Study 2 – Putting Science into Action*. March 2007 <http://wwwFOUNDERS.net/fn/news.nsf/24157c30539cee20852566360044448c/5e0d29958d2d7d04852572ab005ad6a6!OpenDocument>