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Social Pediatrics Initiative

Enacting a 'RICHER' Model

Responsive
Intersectoral & Interdisciplinary
Child
Health
Education &
Research

February 2010

*A Report to the British Columbia Medical Services Foundation
and Canadian Nurses Foundation*





An Intersectoral Partnership Initiative



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- Health Authorities:
 - Vancouver Coastal Health Authority (VCHA)
 - Provincial Health Services Authority (PHSA)
 - BC Children's, Sunny Hill & BC Women's



‘Social Pediatrics’: An Innovative Model of Health Services Delivery for BC Children & Families on the Social, Cultural and Material Margins: A Pilot Study

A Report to the British Columbia Medical Services Foundation
(BCMSF) and
Canadian Nurses Foundation (CNF)

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Collaborators and Acknowledgements

In preparing this report we would be remiss if we did not acknowledge the range and nature of support that has been made available to support this research and this practice initiative. First our **community partners** must be recognized for their clear commitment to building community capacity and in particular for working tirelessly to ensure that children in Vancouver's Strathcona neighbourhood do have a brighter future. Without their support, families would not have found us. The community partners have fully engaged with us and have offered space and their time. But more importantly, they have helped us to illustrate that by working differently - by working in partnership with what we have - we can extend resources (human, material, and social) and, make the initiative stronger and more effective.

We also must acknowledge the BC **Children's and Women's Hospital and Health Centre** support for the practice initiative from its outset and as it has developed. Dr. Robert Armstrong (Head of the Department of Pediatrics), Heather Mass and subsequently Dr. Becky Palmer (Vice Presidents of Nursing) receive special mention for their willingness to explore new practice approaches in order to ensure that some of our most vulnerable children do have access to needed primary and specialized services. The support illustrates their commitment to fostering best practices in children's health.

Vancouver Coastal Health's community and mental programmes have worked diligently with Social Pediatrics Initiative (SPI) nurse practitioners to support children. Val Munroe, in her role as Operations Director for Vancouver Community Programmes, has provided leadership within nursing and community programmes. With the support of Dr. John Carsley, Chief Medical Health Officer of Vancouver Coastal Health, she has facilitated the institutional and agency linkages needed in an initiative of this complexity.

Also from the outset **Child Health BC** (Dr. Robert Peterson) saw the potential of this idea for not only the Vancouver community but other communities in BC. They have assisted us in sharing the research and practice insights with colleagues throughout the province.

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Finally, we must thank the families, and the children who have taught us to look beyond adversity and have shown us their strengths and resourcefulness.

Executive Summary

“Health-care systems contribute most to improving health and health equity where the institutions and services are organized around the principle of universal coverage... and where the system as a whole is organized around Primary Health Care (including both the PHC model of locally organized action across the social determinants of health, and the primary level of entry to care with upward referral)” (Commission on Social Determinants of Health, WHO Report, 2008: p. 95).

The CSDH World Health Organization’s report (2008) on health equity underscores the need for access to the full range of health services in order to reduce child health inequities.

However, despite technological advances and the advent of new treatments for the spectrum of diseases that affect children’s health over the last few decades, children who are vulnerable because of their material and social circumstances remain the most likely to suffer the consequences of delayed development and poor health. Lack of access to appropriate health care further compounds children’s vulnerabilities and has been identified as an ongoing challenge for children ‘at risk’ in both urban and rural settings. Lack of access compromises continuity of care and interferes with timely referrals for assessment and treatment.

In Vancouver’s inner city there is limited primary health care coverage. This research reports on an *alternative approach to care delivery* for children who are vulnerable as a consequence of their social and material circumstances.

In an effort to provide primary health care that is accessible and responsive to the needs of children and their families in a culturally and socially complex community a new model of service delivery is being implemented in the Strathcona neighbourhood of Vancouver’s Downtown Eastside (DTES). This service delivery initiative for ‘at risk’ children and their families has evolved out of more than a year of discussions and consultations with community groups and service providers. It takes direction from ‘social pediatrics’ and is being tailored to meet the needs of the DTES community.

This report summarizes the insights from the pilot study of this practice initiative and illustrates ways it has been tailored to foster access and deliver responsive primary health care to children at risk.

The initiative incorporates a number of forms of innovation. It is a partnership between community-based organizations and two health authorities. The initiative is an ‘engaged outreach’ model of a specialized tertiary centre. It introduces the Nurse Practitioner role as the point of entry to the health care system, but the practice is enacted in community-based

settings, in partnership with community-based clinicians in public health and primary care physicians. It links families 'in' and establishes 'links across' sectors to ensure children have timely access to primary care and specialized pediatric services. The community-based partnership provides an avenue for supporting children and families in receiving health care, as well as support to address the social

determinants of health. The initiative has developed new systems of practice to foster community engagement, to mobilize supports for families and to ensure timely access to primary and specialized care for children at risk.



Background

Despite technological advances and the advent of new treatments for the spectrum of diseases that affect children's health over the last few decades, children who are vulnerable because of their material and social circumstances remain the most likely to suffer the consequences of delayed development and poor health.

In BC, population studies have assisted in the identification of communities of children who are at risk for developmental delay (Kershaw, *et al.*, 2005). We have also recognized local and international research on the benefits of early intervention programmes for fostering child health and development (Baker, *et al.*, 1999; Bronfenbrenner, 1986; Irwin, *et al.*, 2007; Kemmis and McTaggart, 2000; Kershaw, *et al.*, 2007; Kitzman, *et al.*, 1997, 2000; Lerner, 1991; Margolis, *et al.*, 2001; Olds, *et al.*, 1997, 2004; Pelto, *et al.*, 1999; Werner, 1997) and are taking steps towards putting in place developmentally appropriate resources for preschool children throughout BC.

Nonetheless, many children of all ages, and their families, continue to face enormous barriers to accessing health care services in their communities. Lack of access to appropriate health care further compounds children's vulnerabilities and has been identified as an ongoing challenge for children 'at risk' in both urban and rural settings (Health Officers of BC, 2007). Lack of access also compromises continuity of care and interferes with timely referrals for assessment and treatment (Martin-Misener and Valaitis, 2009; Romanow, 2002; Starfield, 1998). Unfortunately, there are a number of communities in BC, with limited Primary Health

Care (PHC) coverage (Watson, *et al.*, 2005). And, despite the introduction of PHC clinics, many children of all ages, and their families, face enormous barriers to accessing health care services. Vancouver's inner city is a case in point. It is one of the poorest neighbourhoods in the country (Statistics Canada, 2005) with a mortality rate that is 3 times the provincial average and although there are a number of specialty community-based programmes for the adult population, the health resources for children are limited.

Population studies throughout the world have established links between social and material deprivation and poor health over the life course (Marmot and Wilkinson, 2006; Raphael, 2007; Wilkinson, 1996). Disadvantaged children are more likely to have developmental delays, poor peer relations, poor school performance and engage in criminal activity (Anda, *et al.*, 2009; Commission on Social Determinants of Health, 2008; James, 1995; Julien, 2004; Power, *et al.*, 1991; Rutter, 1975). Provincial mapping, of child development, has identified a number of neighbourhoods in BC with 1:5 to 1:10 children identified as delayed in nine or more domains (Kershaw, *et al.*, 2005). In the inner city 67.2% of the kindergarten children are delayed in communication and general knowledge skills (Kershaw, *et al.*, 2005) and face a number of challenges including substandard housing and ongoing health problems, behavioral and learning problems, and Fetal Alcohol Spectrum Disorders (FASD). As well, 35% of these children live in single parent headed households and 44% are reported to speak English as a second language (Kershaw, *et al.*, 2005). One in five of these children have parents who are immigrants or refugees, or parents who are Aboriginal (Kershaw, *et al.*, 2005). These child

health profiles suggest that many children in this neighbourhood have needs for both primary and specialty health care services.

“When people within communities are marginalized, their abilities to access the benefits of healthy ‘environments for social care’ are curtailed. Populations who are ‘socially excluded’ or on the ‘social and material margins’ are less likely to derive the health benefits of population level interventions” (Marmot and Wilkinson, 2006).

In addition to being poor, the children we are concerned with face a number of challenges which include being stigmatized or marginalized because of exposure to substance use or family violence and/or being in families with caregivers who need support for their own health issues. Such issues create barriers that must be recognized in the ways care is provided. As well, children in new immigrant families must overcome cultural and practical barriers to participation in the community (such as language fluency) while children in First Nations families must cope with the legacy of policies and practices that have eroded the capacities for family and community support of children. It is well documented that such children are at greatest risk for not having their own health and developmental needs met. The health impact is *cumulative over the life course*. Therefore children who are socially excluded and who are living with prolonged and persistent social and material disadvantage, are more likely to have poor health (Anda, *et al.*, 2009; Kitzman, *et al.*, 1997, 2000; Margolis, *et al.*, 2001; Olds, *et al.*, 1997; Power, *et al.*, 2002;

Spencer, *et al.*, 2005; Werner, 1989; Wilkinson, 1996).

Research has shown that issues of access in this community are not limited to the lack of availability of services. As Browne (2005) has noted in her research with adult Aboriginal populations, people’s decisions about where to go for health care are not simply a matter of ‘choice’. They are shaped by a number of factors including how patients anticipate that they will be treated in community clinics or physician offices; the assumptions and judgements that patients think will be levelled toward them when they seek care; patients’ worries that their health concerns will be dismissed because of these assumptions (Tang and Browne, 2008). These findings have implications for how primary care services (PHC) can be designed to be more responsive to the complexities of access, particularly for patients experiencing racialization and impoverishment.

Hay and colleagues’ (2006) research on health care in the Canadian context echoes Browne’s observations and notes that populations in both urban and rural communities with high rates of material and social disadvantage are less likely to have accessible and appropriate health care services. In addition to a lack of providers they indicated that such practice contexts required different models of service delivery and new approaches to health professional education in order to provide care that is responsive to the health needs of the population. It is timely, therefore, that we explore *alternative approaches to care delivery* for children who are vulnerable as a consequence of their social and material circumstances. One such alternative is a social pediatrics approach (Julien, 2004, 2006; Lynam, *et al.*, 2008; Manciaux, *et al.*, 1978).

The Social Pediatrics Initiative: In October 2007, a new model of service delivery was introduced in Vancouver's inner city, in an effort to provide primary health care that is accessible and responsive to the needs of children and their families in a culturally and socially complex community. This interdisciplinary, intersectoral service delivery initiative for 'at risk' children and their families evolved out of more than a year of discussions and consultations with community groups and service providers that sought to make visible the challenges practitioners and families face in accessing both PHC and specialty services. The **Initiative** takes direction from 'social and community pediatrics' and is being tailored to meet the needs of this particular inner city neighbourhood. This pilot study, funded by BCMSF and CNF, sought to study the model as it was implemented.

In what follows we provide an introduction to the theoretical premises of 'social pediatrics' as it was initially conceptualized. This is followed by a description of the research aims, methods and an analysis of the key study findings.

Conceptualizing Social Pediatrics

Our initial conceptualization of social pediatrics as enacted in the social pediatrics initiative (SPI) is informed by a range of literature, some of which has an explicit focus on social pediatrics. This conception was extended by examining conditions associated with fostering resilience and wellbeing among children at risk. Our social pediatrics initiative is being enacted in a community context and encompasses practices across the spectrum of service delivery from health promotion to specialty interventions. Our conceptualization is also informed by

literature that draws attention to the role of the formal and informal sectors of the health care system as supports or resources for health.

Social pediatrics is an approach that has been developed over three decades by pediatrician Gilles Julien in Montreal. It is designed to complement existing tertiary and primary services and provide care to those children who are most vulnerable; with particular concern for those "groups of children who are experiencing extreme difficulty on the physical, social and psychological levels as well as families experiencing an alarming level of stress" (Julien, 2004, p.91). The Vancouver inner city initiative incorporates elements of social and community pediatric approaches to service delivery for 'at risk' children and families (Julien, 2004; Kitzman, *et al.*, 1997, 2000; Manciaux, *et al.*, 1978; Margolis, *et al.*, 2001; Olds, *et al.*, 1997).

A central premise that underpins this approach is the ***recognition of the importance of enduring socially supportive relationships as a condition that mitigates risk*** for vulnerable children (Julien, 2004; Werner, 1989, 1992, 1997) and a belief in the competence of children, parents and families. This model attempts to divert children from dangerous trajectories through sustained involvement with the child and family in collaboration with existing services. It is not simply a place of care but rather a model for establishing relationships with children and their families to achieve the goals of care.

One cornerstone of success hinges on access and continuities of care throughout childhood. It is a community-based approach that foregrounds the importance of creating enduring supportive relationships while also working in partnership with other community-based organizations to remedy services that are

fragmented and do not accommodate natural transitions between early childhood, school age and youth.

Creating the team and enacting the approach:

The research team for this initiative reflects the types of partnerships formed to enact the practice initiative. At the outset of the practice initiative, relationships were established with the Network of East Vancouver Community Organizations and member organizations Ray Cam Community Co-operative and Vancouver Native Health. Over the course of the two years of the pilot study additional clinical resources were allocated to the initiative – The initial clinical team included one full time Nurse Practitioner (Scott) and a part time pediatrician with responsibilities for clinical and education-training (Loock). As Scott developed relationships with community-based organizations, day cares and schools, as well as with the VCH public health nurses working with children and families in the neighbourhood, the referral base for clinical services expanded rapidly. On this basis additional clinical support was provided in year two (Nurse Practitioner Nawrocki) with the additional support and holiday coverage of a third (Nurse Practitioner Canessa).

As well, after 18 months there was an evident need for additional pediatric specialty support for children in this neighbourhood. The need for additional supports was manifested in part by the presence of Nurse Practitioners who were making primary care accessible to children and their families. At this point in the initiative 380 children and families (none of whom had a consistent primary care provider) and many of whom had complex health conditions, were enrolled in the practice. The clinicians' analysis of the patient profile revealed a need for

referral and consultation for a range of pediatric specialists. In November 2009, Loock with the support of Vancouver Coastal Health, BC Children's of the Provincial Health Services Authority PHSA and community physicians, successfully spearheaded an application –to MSP- AFP (Alternative funding plan) for specialist services for children in Child Health Area 2 – which includes the inner city neighbourhood in which SPI is being enacted.

As this overview illustrates, this practice initiative began with a conception of practice for children living on the social and material margins. The practitioners who enact the model were also actively engaged in forming partnerships and mobilizing the resources needed to respond to the health needs of children in this neighbourhood. As such, in addition to the practitioners' commitment, the institutional and community support for the initiative were key considerations in its implementation and evolution.

Research Goals & Objectives

The **goals** of this pilot study were to provide:

- (1) knowledge about a new model of PHC delivery to the pediatric population, especially those at high risk, that is complementary to existing community health services
 - (2) knowledge of ways to foster intersectoral engagement in the design and delivery of an innovative model of practice
 - (3) knowledge to inform clinical practice education and
 - (4) identify indicators of accessibility, responsiveness and effectiveness of the model of practice.
-

Knowledge was sought that could be drawn upon to inform the further development of this particular practice context and provide insights that could potentially be taken up in other communities and by other regional health authorities with concerns about health care access for children, youth and their families.

Theoretical and methodological insights from this pilot study will be drawn upon in the development of a more comprehensive study of this model of service delivery and its impact on children's health care.

The **objectives** of this pilot study were to identify:

- (1) the *processes of care delivery* that characterize the 'social pediatrics' approach (as compared to traditional 'biomedical' care) to service delivery
- (2) the organizational and infrastructure supports and resources needed to enact this intersectoral practice model
- (3) indicators that can be tracked over time to demonstrate the impact of this approach to practice on access, responsiveness and child health outcomes.

As explained in the background of the report, the initiative is meant to be responsive to the health needs of children and families and to be undertaken in partnership with existing community-based resources. For these reasons and because we were explicating a model of practice as it evolved, we employed inductive methods.

Methodology

In keeping with the tenets of the partnership model of practice, this two year study used a participatory case study design informed by

critical theoretical perspectives. Critical theoretical perspectives guide the researcher to engage with the complexities of social organizations and social relations. They seek to illustrate how different forms of power operate, how such practices are sustained and how individuals understand and make sense of them (Lynam, *et al.*, 2008, in press). In enacting a study informed by these premises, the structure and design seeks to foster participation and to recognize and value different perspectives and forms of knowledge as processes are explicated.

In order to ensure that a range of perspectives on the issues of interest are captured over the course of the study, we proposed to form a community advisory committee. Our community partners wanted ongoing engagement with the initiative and an advisory committee, in their view, did not afford sufficient opportunities for engagement. As such this initial intention evolved to a partnership. Products of the study that reflect this engagement include, among other things, a Partnership Framework (see Appendix 1) and a Guiding Principles document (see Appendix 2).

Methods

The study received ethical approval from UBC and Vancouver Coastal Health's ethical review boards. The data gathering and analysis methods employed to address the study are consistent with critical and participatory inquiry. We sought to understand the issues of health care access from a range of perspectives. We therefore developed a **sampling strategy** that helped us to gain access to a range of viewpoints. A **community facilitator** was hired to facilitate recruitment from a range of community stakeholders. This person was

identified by the community partners. A number of different strategies for gathering data were employed in order to gather detailed insight on peoples' experiences of accessing health care in this neighbourhood. In what follows we summarize the target groups and nature of data gathered from them (see also Table 1).

We undertook: **individual and small group** interviews with community key informants (*people working as volunteers or staff in programmes for children in the community eg, child care providers; support workers etc.*); with parents who reflected the social and ethnocultural diversity of the neighbourhood (*eg. Immigrant parents, Aboriginal parents, poor parents etc.*); and with health professionals (*public health nurses, community physicians, mental health workers etc.*) working with children and families in the neighbourhood; clinicians involved in providing SPI services participated in individual or **reflective interviews**. **Field notes** tracking the evolving organizational structures and processes were also recorded by the lead investigator. In addition to gathering these forms of interview data to meet the third study objective, a systematic search of the literature was undertaken and this along with analysis of the data identified appropriate indicators to track.

Table 1 –Interview Data Sets

| Modes of data Collection | Type of Participants | Number of Interviews | Number of Participants |
|---------------------------------|---------------------------------------|-----------------------------|-------------------------------|
| Small group Interviews | Community Key Informants | 2 | 9 |
| | Health Professionals | 2 | 10 |
| | Parents (with limited English skills) | 3 | 16 |
| Individual Interviews | Health Professionals | 3 | 3 |
| | Key Informants | 1 | 1 |
| Reflective Interviews | Practitioners | 17 | 2 |
| Totals | | 28 interviews | 41 participants |

Key Findings

This report provides a brief overview of the insights from the study. More detailed accounts of research insights are presented in Lynam, *et al.* (in press). As well, over the course of the two years of the pilot study, the research team members engaged in dialogue with other

researchers, clinicians and those engaged in different aspects of service delivery. These forums assisted us to apprehend others' understandings of community priorities, barriers to access and challenges of service delivery. This information also enabled us to align our work with emerging insights on social and biological influences on inequities in children's health and programmatic, or organizational responses to them. Appendix 3 provides a listing of publications and invited presentations made by members of the research team. In keeping with BCMSF guidelines no funding was used for conference participation.

In what follows we share key findings in relation to the three study objectives.

Objective 1: Explicate the processes of care delivery that characterize the 'social pediatrics' approach

In studying the initiative, and peoples' perspectives on it, we have realized that it is important to explicate the philosophy that embodies SPI practice and the concepts that are salient to the ways it has been enacted.

SPI is enacting a philosophy that is committed to supporting children facing multiple forms of disadvantage. The philosophy includes a ***commitment to equity*** that recognizes children facing multiple forms of disadvantage require additional supports, resources, or interventions in order to achieve similar developmental and health outcomes to the broader population.

Our research identified structural and social barriers to access. To overcome these barriers the clinical team enacted an '***engaged outreach***' approach that provides primary

health care to children and, where necessary, ***links children with*** necessary specialized assessments and treatments. The approach is enacted in partnership community organizations who had established trusting relationships with families. Specifically our organizational partners, voice an explicit commitment to providing support to children and their families, to building the capacity of individual families, and the community, to support optimal child development. ***They are positioned to facilitate access to resources to address the social determinants of health.*** In these ways the full SPI 'team' is a resource for individual children and families as well as a resource for the community.

For children and families in this study the concepts of ***linking 'in' and linking 'across'*** health services sectors were key aspects of approaches that effectively fostered access. Strategies for ***linking 'in'*** usually involved other trusted community members from both the formal and informal sectors (*eg. day care providers; early childhood educators, teachers; public health nurses*) recognizing a child's health need and facilitating contact with the Nurse Practitioners. Linking 'in' was also facilitated by having the NPs provide their services in settings where children and families gathered and settings families' perceived as 'safe'.

Safety is a key consideration in this neighbourhood where children and families frequently encounter or observe people living in the street and adults engaged in a range of behaviours associated with 'street crime'. Many parents and children have experiences of abuse and/or of being in care, and as such do not always view health, or other professionals, as allies. Such experiences also interfere with access and as such, clinicians needed to be

visible in the community and work together with those with whom parents and families had built trusting relationships. In particular, study participants repeatedly underscored the importance of professionals **not engaging in ‘pre-judging’** the families.

The clinical team developed a systematic approach to assessment that recognized the importance of child development and developmental delay as well as the impact of the social determinants of health on the child and family health profiles. The assessment framework also takes into account community level data that note the prevalence of conditions associated with poverty, alcohol and substance use, mental illness family disruption etc. so that the clinicians are able to identify the nature of supports needed by the child and family and so that we can ensure that the initiative is working to foster access for those children at greatest risk.

The clinical response included what would be viewed as ‘traditional’ health care treatments. As well, where appropriate, the clinicians facilitated **‘linking across’** service delivery sectors by initiating referrals for specialist assessments and treatments, linking in with community-based resources that would complement such referrals or treatments and, where needed, mobilizing community resources to address the social determinants of health such as: fostering access to food; clothing; housing; income supplements or child care etc.

Objective 2: Identify the organizational and infrastructure supports and resources needed to enact this intersectoral practice model

In addition to working in partnership with the clinicians to mobilize additional supports for families, **community organizations provided clinical and office space** and facilitated their linking with other community-based organizations in the neighbourhood. The host institution (BC Children’s) paid the clinical salaries and, within the organization, provided administrative supports (eg. clerical, booking, record keeping, and mobile diagnostic equipment, telephone and computer tools) and a professional development network (eg. all clinicians are part of a professional teams within the organization).

The clinicians also built communication and collegial links with other neighbourhood clinical groups (eg. Health care teams at Vancouver Native Health; North Health Unit; dental groups, etc.) and with those who provided services in other formal sectors (eg. Community mental health, MCFD, education).

In addition to the community-based working relationships, relationships with those in decision making roles (at VCH and at PHSA-Children’s and Women’s) were engaged in dialogue to explore ways to foster access.

As well, as the initiative evolved and children and families began accessing it, additional primary care (NP) resources were added. As noted above, a successful application was made to introduce additional pediatric specialist services to the neighbourhood – particularly in areas of high need (eg. mental health, child development and general pediatrics).

Partnership in this initiative has come to mean ‘value added’. As a child’s situation is assessed, the value of what each person or sector brings to the table is considered and taken into account as plans are made. Partnership is

enacted in a ‘formalized’ structure. As the **partnership model** (Appendix 1) illustrates, a series of ‘tables’ have been created, that create avenues for participation and engagement. The concept of partnership extended beyond the ways the clinicians worked with individual families. It also extended to the ways resources were pooled and made available to support the initiative *and* the ways the clinicians worked to support the development of community capacity. The tables also provide means for the initiative to create forums of ‘accountability’ where actions, priorities or decisions can be explained, or put into context. Emerging or identified needs or priorities can be put on the ‘table’ so strategies for addressing them can be explored.

The ‘tables’ also provide avenues for introducing new clinicians, students, community resource people to the model, to help them understand the challenges faced by children and families in the inner city and to help them appreciate the importance of communities as partners.

Objective 3: Indicators that demonstrate the impact of this approach on access, responsiveness and child health outcomes

In this study we were interested in identifying both **child focused** and **community focused** indicators for a number of purposes. These purposes included a desire to: ensure that we would be able to demonstrate that the initiative was fostering access for the target population of children; ensure that the range and nature of conditions that influence access could be described and a rationale for the types of services or approaches needed to respond to this population of children’s health needs could be provided and; we also wanted to ensure that

we would be able to demonstrate the impact of the initiative on children’s health or development.

To this end, we have identified a series of indicators related to: the child’s health condition, the child’s development; social determinants of health and exposure to adverse childhood experiences (ACEs) as they are manifest in particular families, and the range and nature of services with which families are engaged.

This information is being incorporated into an interdisciplinary electronic patient record that will allow clinicians to track the progress of individual children while also allowing them to generate profiles of the density and complexity of need, the responsiveness of the initiative to children’s health and developmental needs.

Impact

This is one of BC Children’s (BCCH) first experiences with a community-based PHC model. At the outset of the research we proposed that lessons learned would be drawn upon in forming institutional partnerships in other health regions to explore the feasibility of introducing or adapting the model to address health needs of at risk children in other communities and regions.

Dissemination & Exploration: Through different **forms of engagement** directly related to the research and our discussions of the insights derived from it, we have fostered a working relationship between formal health service sectors, while also fostering engagement between the formal sector and community-based resources.

To date we have **published** one paper in an international journal (Lynam, Loock, Scott and

Khan, 2008) and have a second in press (Lynam, Looock, Scott, Wong, Munroe and Palmer). We also have outlines for a number of additional papers including: the partnership framework, the role of the Nurse Practitioner in primary health care delivery and approaches to educating the next generation of health care providers.

We have been fortunate to have been ***invited to present this work*** at a number of neighbourhood, local, provincial, national and international workshops and conferences. (In keeping with conditions of the BCMSF funding – presentations have been funded by sponsoring organizations or individuals' own grants).

As proposed in the initial application, we plan to ***host a community workshop*** to share the insights from the study and to engage our community partners in showcasing the ways they have benefited from, and contributed to, the evolution and development of the initiative.

In the past few months we have been invited to ***engage in dialogue with a number of BC communities*** to explore the feasibility of implementing the Social Pediatrics Model for children and families at risk.

Capacity development: The grant has also contributed to capacity development in a number of ways. The engagement with the community has created a number of resources (notably the partnership model and guiding principles document) that are now being used to guide their engagement on initiatives with other groups and service sectors. Through our publications and presentations, ***the social capital of the community*** and its value to the children and families has been highlighted. The research team has worked collaboratively with the community partners and shared research

resources– publications, literature etc. with the community partners as they have developed their own plans and programmes to support children and families in the inner city.

Although it was not the central focus of the research – because the primary care providers in this initiative are Nurse Practitioners – we have learned a great deal about the ***potential for the NP role*** within the social organization of BCs health services.

As well, the documentation of the nature and extent of need, the challenges families face in gaining access to primary and specialized health services, and the consequences for children enabled us to make a strong case for additional specialist supports for children in this neighbourhood. As such, the initial services will soon be complemented by outreach specialist services through the 'SPOCK' funding.

The BCMSF grant supported the hiring of undergraduate and graduate student research assistants and, in this way, has contributed to the development of ***research capacity related to community-based research approaches***.

Future Research: This pilot study enabled us to develop an expanded research grant for the Canadian Institutes of Health Research. In early 2009 we were awarded a ***CIHR: Partnerships for Health Services Innovation Grant***. This funding will allow us to: 1) further refine the conceptualization of the model as services and partnerships develop and diversify; 2) measure parents' perspectives of Primary Health Care access and responsiveness and 3) appraise the impact of SPI on 'at risk' children's health, development and health care access by tracking community and child focused indicators identified as salient in this pilot study.

Summary

Vancouver's inner city has a disproportionate number of children who are at risk because of their social and material circumstances. Recent developmental mapping of children at kindergarten entry age level indicate that 66% of children in this inner city neighbourhood are not developmentally ready for kindergarten. Development is both an indicator of health and a social determinant of health. Despite community-based screening programmes, many of these children are not identified as needing additional health interventions or developmental supports because they are 'outside' of formal systems care. This situation is further compounded by the lack of primary health care resources for children and their families, in this neighbourhood. For these reasons a new model of 'engaged outreach' has been implemented in this inner city neighbourhood. We had an opportunity to study the initiative from its outset through BCMSF research funding. The research that is reported here sought to gain multiple perspectives on an emerging approach that has come to be known within the community as 'SPI' the social pediatrics initiative. In this report we have provided an overview of the methods employed in the research and provided an overview of the key concepts that characterize the approach and the organizational practices and processes that have been developed to support its implementation.

The initiative incorporates several forms of innovation: it is a partnership between two health authorities and a group of community-based organizations; it introduces the Nurse Practitioner role as the point of entry to the health care system, but the practice is enacted in partnership with community-based clinicians in public health, primary care physicians. It links families 'in' and establishes 'links across' sectors to ensure children have timely access to primary care and specialized pediatric services. The community-based partnership provides an avenue for supporting children and families to receive health care as well as supports to address the social determinants of health.

The interdisciplinary research team continues to work together to build upon the clinical and research insights from this study as they engage in dialogue with other practice groups concerned to foster the health of children at risk in other regions of BC and Canada.

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Appendix 1- Partnership Framework

A MODEL FOR INNER-CITY HEALTH CARE*

*Developed in partnership with the Social Pediatrics Initiative March 2009

Rights based – health care is a right of everyone living in our community

Responsive to the needs of the community

Respectful of the life experiences of community members

Reciprocal – professionals and community members learn from each other

Relationship based – valuing the ongoing relationships with children, families, and members of the community

Core Principles

1. We recognize that 'health care' is broader than the treatment of disease. We will deliver service in a way that respects the whole person, their family and their community.
2. We provide services in accessible and non-threatening environments that are respectful of, and responsive to, the cultural, social, and economic condition of citizens in the inner city.
3. We value continuity of care for everyone, and particularly for children.
4. Health care professionals work in partnership with community organizations to identify health care needs and to mobilize resources to address them.
5. The vision is for a sustainable, intersectoral model of health services delivery in partnership with community-based organizations.

The Program

The Inner-City encompasses the neighbourhoods of Strathcona, the Downtown Eastside, Grandview Woodlands, Mount Pleasant, and Hastings-Sunrise and those children and families who receive services in these neighbourhoods. A considerable proportion of children are coping with conditions known to increase risks of illness and delays in development (e.g. poverty, family instability, social exclusion).

Families with children in this neighbourhood have limited access to primary health care services, and subsequent referrals to diagnostic and specialty assessments and

treatments. Lack of access to such health care services delays treatment of children's health conditions, which compounds the negative impacts throughout their lives.

In the social pediatrics model, children are the point of entry to health care services and care is provided using a social justice/family centered approach. Priority health care needs include:

1. child-focused specialties including pediatrics, mental health, and other health related disciplines.
2. primary health care services for children/youth and their families.
3. pre and post natal care, together with other specialties addressing the needs of mothers.
4. coordinated care that includes the family in the coordination of services.
5. child focused interventions and supports including resources that foster healthy development and coping, including art and music therapies, sports and recreation opportunities.
6. family focused interventions that maintain and preserve the family unit and foster effective, positive, supportive relationships within the family structure.

The Role of the Community

Community organizations are the primary vehicle for community participation in the program. Community organizations have residents on their Boards of Directors. These organizations have a commitment to inner-city communities and are well-positioned to hear directly from residents.

Community-based organizations will facilitate the work of health care professionals who subscribe to the Core Principles services. This may include providing space for meetings, health assessments, examinations or therapies.

Community organizations will work for continuous improvement in programs and services through their participation in the Network of East Vancouver Community Organizations (NEVCO).

Partners

The Partners are committed to the core principles. While many organizations support these principles and have played an important role in service and program development organizations now playing an active role include:

1. The Provincial Health Services Authority - Children's & Women's Hospital

There is an initial allocation of 2 nurse practitioners and specialty physicians. Applications for additional resources and professional services to support the practice initiative will be initiated by the practice team with the support of the research and community partners as opportunities arise within different forums of health care funding. (e.g. application for additional child focused specialty physicians). The health care professionals also work in close collaboration with the Vancouver Coastal Health Authority, and schools in the Inner-City.

2. Network of East Vancouver Community Organizations

NEVCO is an open and inclusive organization of community organizations. Member organizations participate in decision-making through the Board of Directors and through NEVCO's Health Table. Primary community agencies involved in social pediatrics include: the Ray-Cam Co-operative Community Association, Strathcona Community Centre, Vancouver Native Health Society, Sheway and the YWCA Crabtree Corner.

3. University of British Columbia

The Researchers hold faculty appointments at the UBC School of Nursing and Faculty of Medicine as well as other researchers affiliated with UBC and the partnering health care organizations. The research team is committed to a ***participatory research model*** that will explain and describe the social pediatrics approach. The research is funded independently through appropriate health research funding.

Operational Framework

Dialogue and decision making happens at a number of 'Tables':

- The Program Table
- The Research and Evaluation Table
- The Clinical Service Table
- The Partnership Table

Key partners will have representatives who participate at various tables depending on the level and area of involvement of each partner. These tables will be dynamic to reflect the environment.

1. The Program Table:

Purpose: To discuss issues of concern, barriers, successes, and more "operational" issues related to overall delivery of the services and their impact on the community including organizations and families.

Participants: Service providers from health, community and other key partners. Other 'stakeholders' from both the Community and from Health Care organizations are invited to participate in dialogue on emerging issues and/or to engage in dialogue to identify strategies for resolving or address.

For further information, contact Dr. Chris Looock at cloock@cw.bc.ca or Lorine Scott at lscott@cw.bc.ca.

2. The Clinical Service Table:

Purpose: To provide for case conferencing and for connection amongst service providers who share common interests in providing services to identified children and families. To develop a coordinated plan of care to address specific child/family needs given the resources available.

Participants: Point of care service providers including health care, social services, education, community organizations/service providers. Meetings may include the family.

For further information, contact Vivian Nawrocki at vnawrocki2@cw.bc.ca or Lorine Scott at lscott@cw.bc.ca.

3. The Partnership Table:

Purpose: To facilitate dialogue among Key Partners and community organizations in order to promote the program and to improve its capacity to serve the community's health care needs.

Participants: The NEVCO Board of Directors is comprised of representatives from East Vancouver organizations and from all sectors of human, health and education services. The Table meets at the regular monthly Board meeting and may include any of the key partners and community members.

For further information, contact Fern Jeffries at fernjeffries@novuscom.net, or Sabine Tanasiuk at sabine.tanasiuk@vancouver.ca.

4. The Research and Evaluation Table

Purpose: The purpose of this table is to guide and support the purposes of the research which are:

- to learn about community-based client-centred models of health care delivery in an inner-city environment;
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- to assess the effectiveness of this program in fostering access to primary, and specialty health care services for children and their families,
- to share the lessons learned with other inner-city communities in the province and the country.

Participants: The researchers, service professionals and community partners meet regularly.

For further information, contact Dr. Judith Lynam at

Judith.Lynam@nursing.ubc.ca or Dr. Chris Loock at cloock@cw.bc.ca.



Appendix 2 - Guiding Principles Document

TRUST* RESPECT* * CONFIDENTIALITY* * *

The Social Pediatrics Initiative operates within a framework of principles of Trust, Respect and Confidentiality.

These principles apply to relationships between the people who deliver health, social and educational services and between those workers and members of the community, including people who work for community agencies and community partners. This applies to the clinical purposes of the Social Pediatrics Initiative as well as to the research purposes.

In order to further both the research and clinical aims, there will be various meetings, workshops and interviews. Participants are expected to adhere to these principles before, during and after meetings, workshops or interviews.

*** *Trust*** – includes an understanding that behaviours are motivated by service to children and families, not for self aggrandizement or benefit.

**** *Respect*** – includes valuing the gifts that each person brings to the collective effort of the Social Pediatrics Initiative or the community at large. Any concerns about what has been said around the table will be resolved at the table and not taken to other venues for discussion or resolution unless done so with the agreement of all parties involved.

***** *Confidentiality*** – means that information about individual families or children that is shared in the meeting will be used solely for furthering clinical or therapeutic procedures to which the family has consented. Issues or initiatives that are discussed at the table will not be shared with others unless done so with the express agreement of all parties involved.

Appendix 3- Sample Clinic Schedule

Sample Clinic Schedule – January 2009

| | | |
|------------------|---|--|
| Monday | 11:00am – 1:30pm | Strathcona Community Centre Clinic Drop-in's welcome |
| | 11:00am – 1:30pm | Ray-Cam Community Centre Clinic Booked appointments: Call 604-875-2345 ext 5104 Drop-in's welcome |
| Tuesday | 8:30am – 12:00pm | Phil Bouvier Child Care Center Clinic |
| | 9:30am – 12:00pm | Ray-Cam Community Centre Clinic Drop-in's welcome |
| Wednesday | 9:30 am – 11:30 am 2 nd & 4 th Wednesday's | Woman's Health Clinic (NHU) Booked appointments Only! Call 604-875-2345 ext 5104 |
| | 12:30pm – 4:30pm | Grandview Elementary Clinic |
| | 1:30pm – 4:30pm | Ray-Cam Community Centre Clinic/or Community Outreach Visits Booked appointments Only! |

| | | |
|-----------------|--------------------|--|
| Thursday | 8:30 am – 12:30pm | Phil Bouvier Family Place Clinic |
| | 9:30 am – 12:30pm | Ray-Cam Community Centre Clinic Drop-in's welcome |
| | 12:30 pm – 4:30 pm | Seymour Elementary Clinic |
| | 1:00 pm – 4:30 pm | Ray-Cam Community Centre Clinic/or Community Outreach Visits Booked appointments Only! |
| Friday | | No clinics |

North Health Unit: 1651 Commercial Drive (2nd Floor - # 200)

Grandview Elementary School: 2055 Woodland Drive (1st Floor Medical Room)

Phil Bouvier Family Centre: 717 Princess Street (1st Floor – Social Peds Room)

Ray-Cam Community Centre: 920 E. Hastings (2nd Floor – Room 304)

Seymour Elementary School: 1130 Keefer Street (Medical Room Beside the Office)

Strathcona Community Centre: Keefer Street (2nd Floor – Teen Lounge)

Appendix 4 – Presentations and Publications

Publications

M Judith Lynam, Christine Loock, Lorine Scott and Koushambhi Basu Khan (2008) Culture, health, and inequalities: New paradigms, new practice imperatives. Journal of Research in Nursing, 13: 138 <http://jrn.sagepub.com/cgi/content/abstract/13/2/138>.

M Judith Lynam, Christine Loock, Lorine Scott, Sabrina M Wong, Valerie Munroe, Becky Palmer (in press) Social paediatrics: Creating organisational processes and practices to foster health care access for children 'at risk'. Journal of Research in Nursing.

Invited Presentations

Lynam, M.J., Loock, C., Scott, L. "Child health in the community". Connecting the Dots: Bringing our Children Home, 5th Annual Conference for Aboriginal Families and Service Providers. Croatian Cultural Centre, Vancouver, October 20, 2008.

Loock, C. "Equity, Rights and Children's Health: Defining Social Pediatrics in Canada" CSPAN (Canadian Social Pediatrics Advocacy Network). Canadian Pediatric Society Meeting, Victoria, June, 2008.

Scott, L. "Building a New Bridge to Health Care for Hard to Reach Families in Vancouver British Columbia". C&W Social Pediatrics Initiative. 5th International Council of Nurses (ICN): International Nurse Practitioner/Advance Practice Nursing Network. Toronto, Ontario, Canada ; September 17-20, 2008.

UBC Celebrate Research: "The Social Pediatrics Initiative (SPI): A community partnership approach to children's health" Presenters:
 Researchers and Clinicians: Lynam, M.J., Loock, C., Scott, L. Wong, S.
 Community Partners: Tanasiuk, S., Jeffries, F., Brown, C.
 Research Assistants: H. Vandenberg, E. Worden
 School of Nursing Community Workshop, Presentations of 4 community-based projects including SPI. Phil Bouvier Child Care Centre, Strathcona, Vancouver March, 2009.

Lynam, M.J.

"Culture, Health and Inequities: Nurses Tackle the Thorny Issues"

"It's Not Idle Chatter: Making Sense of Theories of Family Nursing"

A series of Plenary Presentations at: 'Growing Together 2009':

Australian Association of Maternal, Child and Family Health Nurses 3rd Biennial Conference Adelaide, Australia, April, 2009.

Lynam, M.J. Nursing Practice Innovations: Taking the lead in responding to the needs of At Risk Children. Presentation to the Southgate Institute Adelaide, Australia, Wednesday April 1, 2009.

Lynam, M.J. In Dialogue: Exploring Best Practice Approaches to Foster Childrens' Health. Development Inservice for Maternal Child Nurses, Adelaide, Australia, April 1, 2009.

Child Health BC (Best Practices) Workshop: Introducing the Social Pediatrics Initiative. One day workshop with presentations from Community, Clinicians and Researchers. Coast Plaza Hotel, Vancouver. September 25th, 2009

Loock, C., Lynam, M.J., Scott, L. Child Health BC, Executive Committee: Summary and Recommendations of the Social Pediatrics Best Practices Workshop. The Wosk Centre for Dialogue. October 2, 2009.

Loock, C. SPI – SPOCK - Social Pediatrics for vulnerable children. Frontline Health – Vulnerable Populations - Medicine Series. UBC Faculty of Medicine, October 22nd, 2009.

Lynam, M.J., Loock, C. "The Social Pediatrics Initiative: Fostering health care access for children at risk" Presentation at the Human Early Learning Partnership Regional Workshop Series. The State of Children's Development in British Columbia, Vancouver-Coastal Region, Vancouver, Italian Cultural Centre, November 4th, 2009

Loock, C., Yu, G., Scott, L., Lynam, M.J., Dharamasi, S. Pediatric Grand Rounds, BC Children's Hospital. "Celebrating the 20th Anniversary of the UN Convention of the Rights of the Child: The future is here, it's just not equally distributed". Friday November 23, 2009.
