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Youth Population Health Assessment Roundtable Report: Recommendations for Moving Forward

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Executive Summary

Interventions aimed at reducing tobacco use, increasing physical activity and encouraging healthy eating for youth are important as exposure to risk conditions in the early years increases risk in adulthood. Chronic diseases affect quality of life and place a significant burden on the Canadian healthcare system. Programs and policies aimed at helping Ontario youth lead healthy lives is a priority. Initiatives such as Youth Excel as well as a number of national, provincial and local surveys have been important in generating evidence in youth health on which programs and policies aimed at improving youth health can be based.

Youth Excel is funded by the Canadian Partnership Against Cancer (CPAC) as part of an initiative called CLASP: Coalitions Linking Action and Science for Prevention. Youth Excel aims to establish and advance priorities for moving evidence to action, accelerating the development of knowledge exchange capabilities among partner provinces and strengthening the collaboration among research, policy and practice and youth leaders.

On February 16 and 17, 2011 stakeholders were convened in Toronto to take part in the *Ontario Youth Population Health Assessment Roundtable* to explore feasible ways to work together to conduct youth population health assessment and to explore the value of collaboration. This 2-day workshop built on an earlier event held on April 15, 2010 entitled, *Youth Health Roundtable: Priorities for Ontario* which identified the need for developing a coordinated youth health assessment system as a key priority.

Participants of the February 2011 event represented a mix of both self-identified data users and self-identified data collectors from the policy, practice and research spheres. Participants shared their perspective on the data needs of those working in policy, practice and research and information about current local, provincial, national and international surveys underway in youth health. Key gaps that were identified at the meeting included the lack of a provincial risk factor surveillance system for youth health as well as the lack of local data in youth health.

This report provides recommendations for moving the youth population health assessment agenda forward. Recommendations include creating partnerships among those working in policy, practice and research and further developing a learning system approach to youth population health assessments which focuses on the need for local data. The use of local data that can be rolled up regionally and provincially will greatly assist those who use the data as well as those that collect the data to enable youth to live healthier lives in Ontario.

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Introduction:

Youth in Ontario face a risk of developing chronic disease as a result of tobacco use, inadequate physical activity and poor nutrition. Chronic diseases such as diabetes, hypertension and cancer affect quality of life and places burden on a healthcare system that is already strained. Chronic diseases can be avoided through changes that include avoiding tobacco use, engaging in regular physical activity and eating healthily. Interventions aimed at these factors are important as exposure to risk conditions in the adolescent years increases risk in adulthood. Programs, policies and environments aimed at helping Ontario youth lead healthy lives is a priority.

Though surveys such as the Youth Smoking Survey and the Ontario Student Drug Use and Health Survey collect important data on youth health (tobacco use, physical activity and healthy eating), Ontario does not currently have a coordinated youth population health assessment system. The regular collection of indicators on youth health will help Ontario develop evidence-informed strategies and interventions aimed at improving the health of Ontario's youths.

The following is a brief summary of the *Ontario Youth Health Situational Assessment* (Church, Gubbels, Russell, Wong, & Manske, 2011) which provides Ontario specific information on tobacco use, physical activity and healthy eating amongst youth.

Tobacco Use Amongst Youth

According to the Youth Smoking Survey (YSS), youth smoking rates in Ontario have halved between 1994 and 2004. However, youth smoking rates have since become stagnant. In the 2008-2009 cycle of YSS, the Ontario smoking rate for grades 6-9 was 1.4% and 11.9% for grades 10-12. Other tobacco products such as cigars, cigarillos, little cigars, pipe tobacco, and smokeless tobacco (i.e. chewing tobacco) have become increasingly popular with youth. In Ontario, 10% of youth in grades 9-12 who have never tried cigarettes have tried alternate forms of tobacco; although youth are not yet using these forms of tobacco at the same rate as cigarettes, data from the 2008-2009 YSS suggests a large number of youth are trying and using cigarillos and flavoured tobacco products as an alternative to cigarettes, and at rates that warrant increased monitoring and action. In particular, the use of cigarillo and flavoured tobacco products is high: 28% of Ontario youth in grades 9-12 reported trying cigarillos (36% in Canada), and 21% reported trying flavoured tobacco products (28% in Canada) (University of Waterloo, 2010).

Alarmingly, YSS data also found that cigarillo smokers do not consider themselves to be 'smokers,' a crucial matter for prevention and cessation programs (Propel Centre for Population Health Impact, 2010).

Ontario has made significant progress with its *Smoke Free Ontario Strategy* and announced in April 2011 an additional investment of \$5 million which includes new smoking cessation programming initiatives, and the development of youth-led strategies focused on smoking prevention. Additionally, the

Supporting Smoke-Free Ontario by Reducing Contraband Tobacco Act was passed in June 2011 to protect youth from accessing cheap, illegal tobacco. The new legislation includes stronger controls over all types of raw leaf tobacco grown in or imported into Ontario, new fine levels for possessing illegal tobacco, and new illegal tobacco seizure authority for police officers. Recent regulatory amendments to the Smoke-free Ontario Act (July 1, 2010) have helped to further reduce youth access to low cost tobacco products that are appealing to youth by prohibiting the sale of flavoured cigarillos, and setting minimum cigarillo package size requirements. These are positive steps which build positive momentum on reducing youth smoking rates. Regular community monitoring of youth smoking rates and assessments of tobacco prevention programs is needed in order to continue to build on the gains that have been achieved in reducing tobacco consumption among youth.

Physical Activity Levels Amongst Youth

The majority of youth in Ontario do not meet the minimum requirement for daily physical activity. The Public Health Agency of Canada recommends that children and youth accumulate a minimum of 60 minutes of moderate to vigorous physical activity 7 days per week. In Ontario just 7% of youth accumulate at least 60 minutes of moderate to vigorous physical activity 6 days per week (Church, Gubbels, Russell, Wong, & Manske, 2011). Older youth are particularly at risk for not meeting minimum daily physical activity levels and as such are at a higher risk of developing chronic disease. This has important ramifications for youth as they transition into adulthood as physical activity patterns established during childhood are important in laying the foundation for physical activity habits in adulthood. Physical activity is an integral component of health and wellness in youth and potential benefits of physical activity include chronic disease reduction, obesity reduction and enhanced cognitive function and academic performance among many others (Bates, 2006).

The Ontario Ministry of Education has implemented a *Daily Physical Activity in Elementary Schools, Grade 1-8*, Policy. The policy stipulates that school boards ensure that all elementary students, including students with special needs, have a minimum of twenty minutes of sustained moderate to vigorous physical activity each school day during instructional time (Ministry of Education, 2005). The existence of such a policy is integral to ensure that youth engage in physical activity, however regular and consistent monitoring and evaluation of youth physical activity levels and policies is needed to gain a clear picture of physical activity levels among youth in Ontario. Multisectoral collaboration between government, non-government organizations, schools, health professionals, and community groups is needed to ensure effective action.

Healthy Eating Amongst Youth

Currently, Ontario youth do not consume the recommended number of servings of foods from the major food groups of Canada's Food Guide (Public Health Agency of Canada, 2011). This poor nutrition is coupled with increasing rates of overweight and obesity among children and youth in Canada. Critical factors leading to these undesirable outcomes are the marketing of foods and beverages high in fat,

sugar and/or sodium as well as increased portion sizes and food availability. Various social determinants such as income and education also influence the ability to make healthy food choices. Youth from households where no member has more than a high school diploma are more likely to be overweight or obese than youth from households with more advanced levels of education as are youth from low-income families and aboriginal youth (Public Health Agency of Canada, 2011). Unfortunately, these same social determinants impose challenges in accessing nutritious foods (e.g., in northern, rural and remote communities) (Public Health Agency of Canada, 2011).

In order to increase healthy eating and reduce the prevalence of overweight and obesity in youth, it is important to adopt a multisectoral approach to build social and physical environments for youth to engage in physical activity and provide healthy eating options. Increasing the availability of nutritious foods and decreasing the availability of foods and beverages high in fat, sugar and/or sodium to youth is a critical factor in curbing rising rates of overweight and obesity.

Ontario schools are increasingly moving towards being 'junk food free' and are offering healthier alternatives in the school environment. The Ontario *School Food and Beverage Policy* ensures that food and beverages sold on school premises meet nutritional standards as set out by the policy (Ministry of Education, 2010). The province of Ontario has increased its funding and support toward youth nutrition. This investment is needed towards establishing, monitoring, and evaluating programs and policies designed to promote healthy eating among youth.

Overview of Youth Excel CLASP

Youth Excel is funded by the Canadian Partnership Against Cancer (CPAC) as part of an initiative called CLASP: Coalitions Linking Action and Science for Prevention. The goal of CLASP is to integrate cancer prevention with the prevention of other chronic diseases; to integrate science, policy and practice to optimize prevention efforts; and to catalyze cross-provincial / territorial partnerships to improve individual and population health. CLASP is a 2.5 year investment that spans from October 2009 to March 2012.

Youth Excel CLASP is comprised of provincial teams in each of the seven participating provinces (NL, PE, NB, ON, MB, AB, BC) and links researchers, policy and program leaders. The pan-Canadian Joint Consortium for School Health (JCSH) is also involved with Youth Excel CLASP and serves to link Federal / Provincial / Territorial education and health ministries. The Propel Centre for Population Health Impact, a partnership between the Canadian Cancer Society and the University of Waterloo with a pan-Canadian mandate to build knowledge exchange capacity, serves as secretariat for the *Youth Excel* CLASP.

Youth Excel CLASP envisions in ten years that all Federal, Provincial, and Territorial jurisdictions in Canada will have capacity to enable leaders in policy, practice, research and evaluation, and youth themselves, to use the best available evidence to inform action, and to learn from their actions – all to continuously improve policies and programs that reduce the incidence of tobacco use, poor nutritional

habits, and inactivity among youth aged 10-18 years. Two goals will help to achieve this vision:

1. To strengthen provincial level knowledge exchange capacity that includes four components a) community monitoring systems to support planning and evaluation of policies and programs for children and youth, b) the ability to use distillations of relevant evidence about the type of intervention most likely to work, c) means for moving evidence into action, and d) means to generate evidence from action (capacity development goal).
2. To reduce risk and incidence of chronic diseases among youth through the use of population interventions (policies and programs within and beyond the health sector) that address underlying social, economic, and environmental conditions that give rise to risk behaviours and diseases (impact goal).

Youth Excel in Ontario

First Roundtable: Youth Health Roundtable: Priorities for Ontario

On April 15, 2010, *Youth Excel Ontario CLASP* held a one-day workshop in Toronto, entitled “*Youth Health Roundtable: Priorities for Ontario*”. The workshop was coordinated and hosted by the Propel Centre for Population Health Impact at the University of Waterloo, Public Health Ontario, the Ontario Ministry of Health Promotion and Cancer Care Ontario. The purpose of the Roundtable was to articulate Ontario priorities for youth health (physical activity, tobacco and healthy eating) to inform the May 2010 National Roundtable on Comprehensive School Health (CSH).

According to the *Youth Health Roundtable: Priorities for Ontario Roundtable Report*, the top priorities that emerged from the Roundtable included (in rank order):

1. Develop coordinated youth health assessment system for tobacco use, physical activity and healthy eating among youth
2. Develop core indicators with respect to local and provincial surveillance system
3. Conduct situational assessment of youth health in Ontario: programs, policies, data sources, surveillance and trends
4. Develop a sustainable system for collection of data on key areas of youth health at individual and school-community levels that is integrated with local and provincial use (i.e., information is fed back into the system)

Second Roundtable: Ontario Youth Population Health Assessment Roundtable

As a follow up to Ontario’s April 2010 Roundtable, stakeholders were convened on February 16 and 17, 2011 in Toronto to take part in the *Ontario Youth Population Health Assessment Roundtable*. This roundtable meeting focused on the top four priorities outlined above from the April 2010 workshop– to develop a coordinated youth population health assessment system for tobacco use, physical activity and healthy eating.

The Roundtable was coordinated and hosted by Public Health Ontario and the Propel Centre for

Population Health Impact with in-kind planning support from the Ministry of Health Promotion and Sport, the Ministry of Education, the Ontario Physical and Health Education Association and Toronto Public Health. The overall goal of the meeting was to explore feasible ways to work together to conduct youth population health assessment and to explore the value of collaboration. The overall objectives of the meeting were:

1. To convene data collectors and data users to examine how to advance youth population health assessment
2. To present work that is currently underway in youth population health assessment
3. To understand the context data users are working in, including the policy and practice environments (Ontario Public Health Standards and youth engagement strategy (Ministry of Health Promotion and Sport); healthy schools framework, curriculum, and joint consortium on school health (Ministry of Education), vulnerable populations (Ministry of Child and Youth Services)
4. To explore the concept of a core indicators and measures (CIM)¹ approach to standardizing measures and obtain feedback on the proposed CIM of Youth Tobacco Control

The intended meeting outcomes included:

- A common understanding of data that are currently being collected and why (i.e., what questions data collectors are trying to answer with their surveys)
- Main elements of a practice and policy-relevant system of data collection for youth tobacco, healthy eating, and physical activity assessment in Ontario, including the role of core indicators and measures within such a system
- Recommendations to ensure broad input to development of a policy-and practice-relevant youth population health assessment system
- Collective agreement on expectations of each other in moving towards a common assessment system

Prior to the Roundtable, a survey (see Appendix A) was distributed to participants with questions specific to data users and data collectors. Data collectors were asked to identify data collection projects currently underway in youth health. Data users were asked to describe their role(s) in health promotion and what particular information is needed to facilitate evidence-informed decisions about physical activity, healthy eating and tobacco use among youth. In preparation for the meeting, both data users and collectors were asked to identify barriers and solutions with regards to moving forward on youth population health assessment in Ontario.

Participants of the event represented a mix of both self-identified data users (55%) and self-identified data collectors (45%) from the policy, practice and research spheres. With the help of a facilitator who

¹ Previously referred to as Minimal Data Set (MDS). MDS was renamed to Core Indicators and Measures (CIM) of Youth Tobacco Control based on feedback from participants at a meeting (entitled Improving Community Monitoring for Youth Tobacco Use: Action Planning for MDS) held on June 8 & 9, Toronto, Ontario.

employed a break-out group format comprising of small learning circles, both data users and collectors shared their perspective on the data needs of policy, practice and researchers and information about current local, provincial, national and international surveys underway in youth health. Additionally, participants discussed barriers and solutions to a youth population health assessment system. A transcription of the discussion points from this session can be found in the Technical Report (see Appendix B).

Key themes that emerged from the participant surveys as well as the various discussions held at the two-day Roundtable included:

1. Expressed need for local data: The lack of local data hampers the ability of those working in youth population health assessment at the local level to address their needs.
2. No provincial youth population health assessment: Ontario does not currently have an ongoing provincial system looking at risk factors for youth health.
3. Need for the development of Core Indicators and Measures: A set of common core indicators and measures has merit and may be beneficial to addressing issues of survey fatigue within schools.
4. Limited access to students in schools: Schools often decline participation in school surveys (and thus access to students) because of:
 - a. Survey fatigue (too many survey requests); and
 - b. Perceived lack of benefit to participate (needs to be linked to academic achievement).
 - c. Need for data linkage on tobacco use, physical activity and healthy eating to student achievement.
 - d. Lack of engagement prior to survey implementation. The education sector needs to be engaged in survey development and analysis as surveys often reflect only a health perspective. Integrating a health and education outcome perspective in surveys may increase access to students and increase the perceived benefit by schools of participating in surveys.
5. Funding obstacles: Sustainable, ongoing funding is a challenge to those working in youth population health assessment.
6. Lack of youth engagement: Youth are not involved in the survey development phase (e.g. instrument development or reliability and validity testing). The engagement of youth with the results of surveys is also integral to obtain buy-in.

In addition to learning circles and group discussions, a number of presentations were made at the Roundtable event. Dr. Jane Griffith, Epidemiologist and Team Leader of the Epidemiology Unit at CancerCare Manitoba, was invited to speak at the Roundtable regarding the Manitoba Youth Health Survey. Dr. Griffith provided a brief overview of the development and administration of the Youth Health Survey. Dr. Griffith explained that in Manitoba, a community health assessment is conducted every 5 years and the data collected are used for planning purposes. Regional Health Authorities (RHAs) expressed that provincial and national data were not meeting the needs of health planners at the local level and thus, emerged the *Manitoba Youth Health Survey*. Questions were derived from the SHAPES survey . During their first implementation data were collected from 55,000 students in grades 6 through

12 on tobacco use, alcohol use, physical activity and diet (among other indicators). After data collection was completed and the data were analyzed, each participating school received an individualized report with their school-specific data. Following the first round of data collection, the RHAs met with several agencies and formalized themselves as Partners in Planning for Healthy Living.

Partners in Planning for Healthy Living (PPHL) are a group of 22 partners (which include RHAs, government ministries and non-governmental organizations) who work together to build a chronic disease risk factor surveillance system that is integrated with community planning and best practices. PPHL support the development of knowledge and capacity within communities. One of the key principles of PPHL is a focus on practice-based evidence. Evidence is derived at the local level through local data collected. Local data serves to add context through local knowledge and action.

PPHL partners work together to develop organizational, community and regional capacity and use evidence in planning programs. PPHL partners are working together to build an integrated knowledge system through activities related to surveillance, knowledge exchange, program and policy development, implementation and evaluation, and strategic and investigator driven research. Dr. Griffith noted that some of the critical factors that led to the success of the Youth Health Survey and the PPHL were the creation of partnerships, multi-level leadership and the integration of local data into planning cycles at RHAs.

Michelle Brownrigg, Director of Physical Activity and Equity at the University of Toronto Faculty of Physical Education and Health, presented on the Active Healthy Kids Report Card. The Report Card is in its sixth year of production and provides insight into how Canada is faring in terms of providing physical activity opportunities for children. The Report Card is an evidence informed communications and advocacy tool designed to increase awareness of physical activity in Canada and its development points to the challenges of secondary analysis of different surveys and comparability across Canada. The Report Card has been useful in increasing awareness among the public and has spurred the creation of a network of provincial and territorial partners.

Jennifer Cowie-Bonne, Director of Partnerships & Public Affairs at Ophea, presented on the Ontario Report Card Supplement to the Active Healthy Kids Report Card. The Ontario Report Card Supplement is in its first year of production and is intended to be disseminated to the provincial government, provincial stakeholders and regional stakeholders. Both presentations highlighted that the Active Healthy Kids Report Card and the Ontario Supplement can be tools to motivate action, guide strategic direction and increase public awareness of the importance of physical activity for youth.

What is the Issue in Ontario?

Lack of local data in youth health hinders contextualization and poses a problem for program planning, policy development and evaluation. Local public health units are tasked with ameliorating health indicators by identifying at risk groups, developing strategies to address health problems and evaluating the effectiveness of those programs. However, a lack of local data poses a significant problem in making

program planning decisions as local data are needed to meet needs of specific at risk populations. The availability of local data can lead to the development of education and prevention strategies that are grounded in a local context and further address health burdens that are specific to local populations.

Local public health units can play a major role in preventing youth in taking up tobacco use, increasing physical activity and encouraging healthier food choices through the creation of programs that are locally relevant. Ontario is home to geographically and culturally disparate populations and regions and therefore a uniform approach to youth health may not be successful at reducing tobacco use, increasing physical activity and encouraging healthier eating practices. The availability of local data is instrumental in providing a clear picture of youth health indicators by region and developing relevant interventions aimed at addressing issues within a local context.

While urban and rural youth do share some commonalities with regard to risk factors, there are some significant differences in contexts that hinder a unified approach to youth health. For example, the availability of fresh produce in some remote regions in Ontario is an issue that populations in urban settings do not necessarily face. The varying contexts in which youth find themselves in Ontario should be a key consideration when developing programs and/or policies to address youth health.

The Ontario Public Health Standards (OPHS) requires that population health assessment, surveillance, research and program evaluation generate evidence which improves public health programs and services by building a public health knowledge base. Additionally, the Chronic Disease Prevention Standard requires reducing the burden of preventable chronic diseases of public health importance (Ministry of Health Promotion and Sport, 2010). Since Ontario youth do face risk for developing chronic disease as a result of tobacco use, inadequate physical activity and poor nutrition, having local data for youth population health assessment will assist meeting the requirements established for fundamental public health programs and services as set out in the OPHS (Ministry of Health and Long-Term Care, 2008).

Youth Population Health Assessment System

Based on the various discussions held as well as Dr. Jane Griffith's presentation on Manitoba's Youth Health Survey, participants of the Roundtable event collectively discussed elements of a framework viewed to be critical for a successful youth population health assessment. Discussions regarding the barriers as well as solutions to overcome barriers with respect to each element of the Youth Population Health Assessment System (see Figure 1) were discussed on day 2 of the Roundtable event.

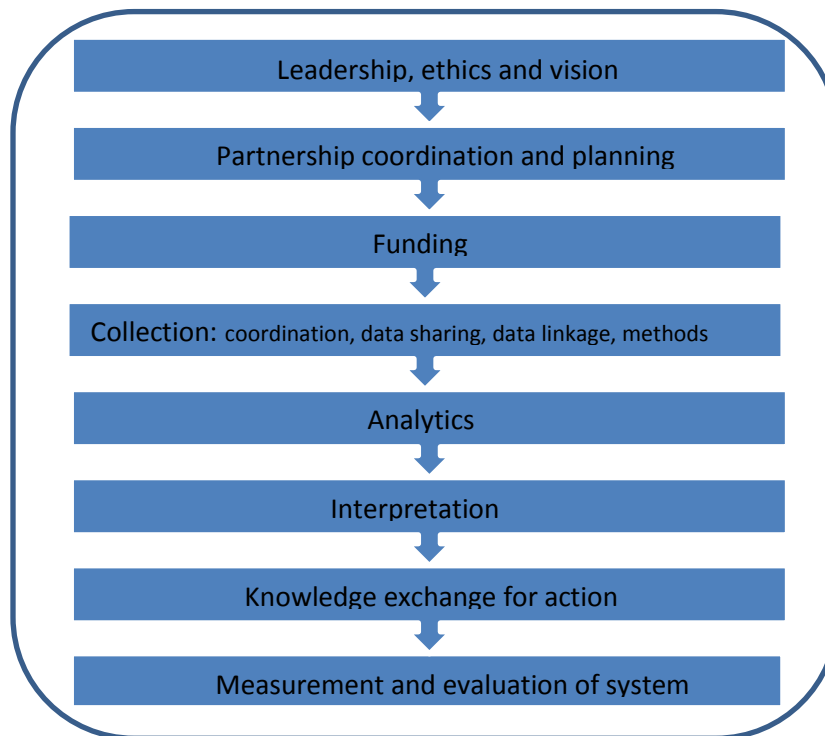


Figure 1: Youth Population Health Assessment

The text below describes each element of the youth population health assessment enumerated in Figure 1 (further descriptions of core concepts outlined below are found in Appendix C).

Leadership, Ethics and Vision

Participants felt that a key barrier with regard to leadership and vision included conflicting priorities among research, policy and practice. Scientific rigour is important to researchers, whereas those working in policy need accountability measures to enable results based planning. End users on the other hand, seek measures that are easy to understand and that have been validated. Thus, it is evident that those working in research, policy and practice are collecting and/or using data to suit different needs. A suggested solution to overcome this barrier is to hold a visioning meeting with key stakeholders to specify priorities around youth health and clarify the unique roles and contributions of the various players involved.

Partnership Coordination and Planning

Participants identified several barriers related to partnership, coordination and planning including a lack of clarity and focus among partners working in youth health and varying levels of capacity and resources. Proposed solutions to overcome these barriers include developing an open communication strategy and focusing on strengths of organizations that can lead and/or support a youth population health assessment system.

Funding

Lack of sustained funding and the purpose of existing funding being limited to data collection and not necessarily to support a learning-for-action system were identified as key barriers. Having a clear understanding of the approach to building a youth population health assessment learning-for-action system was suggested as a solution to this barrier.

Collection

The diversity of populations (e.g. ethnocultural, remote versus urban, et cetera) and difficulty accessing students (due to the large number of school boards in Ontario, “over-researching” of the population) were identified as barriers to collection by Roundtable participants. Solutions to overcome this barrier included developing a clear vision and leadership for youth health, collecting broader data at multiple levels and involving schools boards and other key partners in the design of surveys to ensure content is built to reflect diversity and suited to educators’ (school boards, schools) needs.

Analytics

The lack of coordination and common approaches to data analysis of local and provincial surveys were identified as a barrier. Increasing the capacity for analysis as well as reaching consensus on what is achievable in the data analysis phase were identified as potential solutions.

Interpretation

Participants of the Roundtable generally felt that the “sense making phase” or interpretation of data is an area that needs more attention and resources. Identifying best practices in data interpretation and frequent consultation and dialogue between epidemiologists, program staff and the community to help interpret findings were proposed as potential solutions to these barriers.

Knowledge Exchange for Action

The diversity of contexts within Ontario as well as identifying who is responsible for knowledge exchange activities (as knowledge brokers tend not be stand-alone position) were identified as key barriers to knowledge exchange for action. Identifying primary and secondary audiences, building relationships with stakeholders, identifying appropriate communication channels and developing products targeted to the various audiences were proposed as potential solutions to this barrier.

Recommendations for Action

A number of recommendations for action were proposed and discussed at the February 2011 Roundtable. While the list below is not exhaustive, it represents what many participants identified as

key to moving a youth population health assessment system forward.

Visioning

Visioning was identified as an important activity to undertake following the Roundtable as a method for long-range planning and setting realistic plans to move the youth population health assessment framework forward. Participants of the Roundtable identified a visioning day as key to develop a coordinated approach to youth population health assessment in Ontario. This recommendation also ties into the need for establishing a supportive mechanism where partners are convened to create a multi-sectoral, collaborative approach to youth population health assessment.

Building on Emerging and Existing Structures to Advance Youth Population Health Assessment

One of the key messages of Dr. Griffith's presentation was that we cannot wait for "everything" to be in place before we move forward. We need to identify partners that are currently interested and begin to move forward. Over time, others will begin to see the value of what we are trying to create/achieve and others will come on board eventually.

Building on emerging and existing structures to advance youth population health assessment resonated with a number of the participants. Discussions focused on the current Ontario government budget deficit and the reality that large investments from government may not be realistic at this time. Building a youth population health assessment system on emerging and existing structures requires identifying strengths in the current "system" (i.e., capacity that is already in place), requires commitment and expertise by parties who are in a stage of readiness to act, and recognizes the need for continuous evaluation and documentation of lessons learned along the way.

Partners in Planning for Health Living (PPHL) in Manitoba have been successful in using in-kind supports (along with limited one-time infusion of funds through their Regional Health Authorities (RHAs)) to help support the spectrum of population health assessment activities in their province from data collection, data analysis, interpretation, reporting, dissemination and action. PPHL has built up their partnership incrementally and can be a viable model for Ontario. PPHL relies on practice based evidence and has built capacity incrementally at organizational, community and regional levels to create a coordinated population health assessment system that addresses needs at the local and provincial levels. The success of the Youth Health Survey in Manitoba was a result of the creation of partnerships, multi-level leadership and the integration of local data into planning cycles of RHAs, while leveraging existing resources and partnerships.

Clarification of Roles and Responsibilities

Participants felt that in order to move a coordinated youth population health assessment forward, roles and responsibilities will need to be clarified. This speaks to the leadership and coordination elements that were proposed for a youth population health assessment framework as the leadership roles will

need to be teased out and clarified (i.e. intellectual leadership, public servant leadership, et cetera) in order to create a coordinated system with strong research and analytical supports. The clarification of roles and responsibilities will minimize duplication by increasing communication and collaboration among policy, practice and research, help with the visioning process and decision making as well as focus accountability. Additionally, the clarification of roles and responsibilities will serve to create synergies among multiple partners and stakeholders and provide an opportunity to create a coordinated youth population health assessment system where various partners are working towards a common vision.

Core Indicators and Measures (CIM) for Youth

Core Indicators and Measures (CIM) for Youth capture the information critical for policy and program decisions on a particular topic. The intent is that these core indicators and measures are used consistently, potentially alongside jurisdiction- and study-specific indicators and measures. CIM for Youth will result in consistent measures that are comparable by focusing on the number of indicators and measures to those that are most critical for assessment. CIM for Youth can be integrated for youth population health assessment by collecting data at the local level at regular intervals to inform end users and build capacity in youth health. Participants of the Roundtable event identified CIM for Youth as a potentially useful tool that can provide local public health units with a snapshot of their local situation that can be compared over time and by geography.

Using CIM for Youth may reduce the number of surveys filled out by schools thereby potentially alleviating survey fatigue and reduced response rates among schools. The CIM for Youth can also further collaboration among data collectors as groups can work together to develop common measures for particular indicators and may further share the results.

Next steps

Follow-up Visioning Meeting

The idea of holding a follow-up meeting(s) to conduct a more in-depth visioning exercise to further develop a framework for an Ontario-specific youth population health assessment learning system was put forth and supported by stakeholders. This meeting should include a small group of key leaders selected on the basis of organizational affiliation. Public Health Ontario, in collaboration with the Propel Centre for Population Health will work together to organize and host this meeting.

Rather than reinventing the wheel, the information gathered at this Roundtable on data needs, barriers and solutions will form the basis for discussion at this visioning follow-up meeting. A longer term supportive mechanism, such as the Healthy Schools Working Table, could play a role to advance the framework for a coordinated youth population health assessment system.

Notes of Commitment

Participants of the February 2011 Roundtable were asked to identify actions they would undertake to move the youth health agenda forward. Notes of commitment were made by each participant and included networking with key contacts, informing organization leaders around potential partnerships, informing policy makers about the need for a coordinated youth population health assessment system, and helping to develop research infrastructure that will contribute to a 'learning' system (for a complete list of the notes of commitment, please refer to Appendix B: Technical Report).

Conclusion

This report aims to provide a synthesis of discussions held at the February 2011 Ontario Youth Health Assessment Roundtable and provides options for moving the youth health agenda in Ontario forward. To reiterate, key points raised during the two-day workshop include: 1) the lack of and need for local data on youth health in Ontario; and 2) the lack and need for a provincial learning-for-action surveillance and monitoring system that can support policy, practice and research leaders in making informed decisions for youth health in Ontario. Public Health Ontario and the Propel Centre for Population Health Impact will organize and coordinate a meeting with stakeholders to vision and potentially clarify roles and mandates and develop a framework for youth population health assessment for the province.

The Technical Report (attached here as Appendix B), which provides a summary of the flipchart documentation as well as key discussion points made at the February 2011 Roundtable, was prepared and distributed on March 21, 2011 by Public Health Ontario to all Roundtable participants as well as other stakeholders and is available on the Youth Excel CLASP website (<http://www.propel.uwaterloo.ca/youthexcel/index.cfm?section=19&page=301>).

Appendix A: Roundtable Survey

Template for Participants

**Towards a Coordinated System for Evidence-Informed Decision Making
Ontario Youth Population Health Assessment**

Please complete this template prior to the meeting on February 16th. Once completed, please make two copies: one to submit at the start of the day on the 16th and a second to keep with you to present during the 2-day roundtable event.

Please identify yourself as a data collector, a data user, or both by completing the corresponding questions below.

Questions for Data Users:

1. Describe your role in youth health promotion. Include in your description: a) issue area(s) you are involved in, b) whether your work informs policy development primarily, development/implementation of interventions primarily, or involves analysis and interpretation of data for both purposes, and c) level you work at (local, provincial, national).

2. What are particular things you want to know, that assessment data could provide, that would help you make more evidence-informed decisions about physical activity, healthy eating, tobacco use among youth? What are the problems you are trying to solve? This question is about specific pieces of knowledge you need. It could be related to statistics about prevalence of risk behaviours, trends over time, comparative evaluation of specific interventions, best practices, interactions, etc. For example *“I want to know if there is any change in youth smoking after the new health warnings are*

released”.

3. Think about the current system of data collection and use of those data to drive program and policy. Give an example of something that is well-coordinated, and an example of something that is poorly coordinated in the current system. For example *“Currently, there is good coordination between data collected provincially and my local needs. Currently, there is little coordination between various youth-oriented surveys increasing demand on schools.”*

4. What barriers do you see towards moving forward on a coordinated youth population health

assessment in Ontario? For example *“investments in data already collected leave little room for*

adaptation".

5. What ideas do you have for overcoming these barriers? Include in your answer your thoughts on how we can ensure broad input into development of a policy- and practice-relevant system of data collection and use. For example *"a minimal data set may make it feasible for at least some data to be collected in common"*.

Questions for Data Collectors:

1. Describe data collection projects you are involved in. Include level you work at (local / provincial) & issue areas.

2. Thinking of the data collection project(s) you are involved in, what are some specific measures in those projects that can be used to make evidence-informed decisions about physical activity, healthy eating, tobacco use among youth? Give examples of specific items and how they can inform

program and policy development. What problems are you trying to solve?

3. Think about the current system of data collection and use of that data to drive program and policy. Give an example of something that is well-coordinated, and an example of something that is poorly coordinated in the current system. For example *"Currently, there is good coordination between data collected provincially and my local needs. Currently, there is little coordination between various youth-oriented surveys increasing demand on schools."*

4. What barriers do you see towards moving forward on a coordinated youth population health assessment in Ontario? For example *"Changing how we ask about tobacco use will affect continuity*

of data and our ability to look at trends".

5. What ideas do you have for overcoming these barriers? Include in your answer your thoughts on how we can ensure broad input into development of a policy- and practice-relevant system of data collection and use. For example *"Create opportunities for data providers to network in ways that*

help them do their own work more efficiently".

Appendix B: Ontario Youth Health Assessment: Technical Report

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What Data Users Need to Make Evidence-Informed Decisions

Attendees were divided into two groups with members representing data users and data collectors participating in each group. Data users were asked to identify what information they require to make evidence-informed decisions. The lists below represent answers provided by data users that have been organized into categories depending on the data element identified (i.e. risk factor, methods, program/policy data, et cetera).

Risk factors

- Consistent and accurate prevalence measures related to contraband tobacco use
- Exposure to 2nd hand smoke at home, work, play including physical environmental exposure and social cultural environment (e.g. modelling)
- Prevalence of other tobacco use (e.g. chew/spit)
- Cessation - youth need for cessation
- Childhood obesity and determinants including physical and social environment, what's accurate and relevant and available consistently across Canada
- Consumption of convenience foods
- Data quality for physical activity
- Prevalence of sedentary behaviour (e.g. screen time)
- Contextual information on behaviours (e.g. physical activity)
- Documentation on processes (type, duration, intensity, etc.) and their effectiveness on outcomes
- Issue of measuring diet in youth and the environment in which they eat
- Existing chronic diseases (e.g. asthma, diabetes, anaphylaxis, other)- association of risk factors to school attendance, participation in physical activity, relation to nutrition/healthy eating. To use findings to ensure appropriate information related to these chronic diseases that are prevalent among youth is incorporated into policy/procedure
- Prevalence of chronic conditions among youth (e.g. diabetes, asthma) which is important influence on physical activity
- Built environment (BE) characteristics (e.g. access to public transport, state of repair of housing complexes)
- Smoking/drinking prevalence within various settings
- Research that assesses how built environment affects smoking /drinking prevalence
- Information about youth subcultures and identity formation to better understand why they're doing what they're doing (e.g. drinking, Manitoba findings)
- Prevalence of risk behaviours within communities that are smaller than geographic public health units (e.g. Jane-Finch)
- Knowledge, attitudes, behaviours
- Psychographic profile of youth

- Engagement of youth - impact of level of engagement on health behaviours and other risk factors
- Risk factors by socio demographic characteristics
- What pre-determinants (factors before age 9) influence youth (10-19) behaviours (e.g. “life trajectory approach”)
- Mental health, depression, bullying
- Other issues –alcohol, sexuality
- Determinants of health
- Identify other at-risk populations
- School connectedness/engagement
- Inequities and roll up
- Parents education, parents born in Canada, youth employment
- Access to programs that influence 3 risk behaviours and factors that influence access, impact of programs on behaviours
- Trends over time on key factors

Methods

- Information on validity, reliability and real world meaning/utility of various indicators
- Adequate sample size to permit stratification (e.g. behaviours by age group)
- Ensure data are analyzed with consistent cut points-clear definitions of the indicators e.g. new child and youth physical activity guide just changed-how many minutes are required
- Regular data collection is important
- Information on who is missing from data collection
- Sampling - representativeness
- Consent for student participation (active versus passive)
- Ensuring representative data by:
 - Showing leadership for what we are doing and advocating for passive consent (Early Development Index (EDI) is an example of passive consent that could be followed)
 - Framing issue of passive consent-if we don't have the information we can't help them
- Provincial level information (as done in Manitoba) i.e. in a report
- Resources re: objective measures vs. self-report

Program/policy data

- How is Ontario's new elementary school health and physical activity curriculum policy being implemented, and what is the impact on behavioural outcomes
- What is policy environment that shapes opportunities for healthy behaviours - surveillance, research
- How effective are the policies, separately and/or in combination
- Sufficient data for provincial-level analysis on non-traditional risk factors for obesity (e.g. policy

environment)

- Impact of smoke free policies on tobacco use
- Effectiveness of program and policy implementation data - baseline data or regular data collection to analyze trends
- Teacher qualifications implementing programs, policies (e.g. PE specialist teaching PE)
- Prevalence and trends in risk behaviour at local, regional, provincial level to inform program and policy in youth health

Data linkages

- Collect both school level data and individual (student) level data
 - Link the above to each other (and if possible include community level data on policy)
 - Include some type of feed-back loop (student data needs to go back to school boards)
- Information on implementation of policies (e.g. daily physical activity) and link to individual data
- Link demographic information (ethnicity, income, immigration status, etc.) and link to behaviours –single parent status
- Linking behaviour data to student achievement (EQAO)
- Data on food and beverage policy linking to student achievement
- Evidence that links self-report to objective measure of physical activity
- Links to student achievement and success
- School and community data on policy and link to individual data
- Connecting local, regional, provincial data

Local data

- Public health at municipal level
- Data available at the local level
- Habits and behaviours at the local level (public health unit and school level)
- Utilization of public health services

School needs

- Need to meet school needs
- Need to provide school with results/reports
- Data for French speaking population
- Francophone reports/school reports
- Curriculum implementation and factors influencing it
- Develop a standard approach for all school boards

Other

- Low frequencies of indicators can identify students
- Existing initiatives - how can they be made better?

- Need to ensure that data collected has a purpose and relevance attached to it since at times multiple data is collected on a topic but not all of it is used/ applied. Also need to consider that data may have a purpose/ relevance to collect however none of the stakeholders (e.g., public health) may be able to influence it as an indicator
- Effective interventions – better access to better/best practice information, and more of that information
- How to engage youth effectively in the research and evaluation process (e.g. re: Pan Am games)

What Data Collectors Collect and Why

The tables below reflect points made in verbal presentations about various surveys and data collection initiatives. It is not a comprehensive listing and reflects the verbal input of participants. As such, information may not be comprehensive or completely accurate.

Name	Health Behaviour in School-aged Children (HBSC)
Frequency	Every 4 years, 1989-1990 first year
Coverage	-International, national: Israel, US, Europe, Canada (6 provinces, 3 territories) -Ontario n=3,600, international n=26,000 -Grades 6-10, grades 6-8 versus grades 9-10
Languages	English, French, Inuktitut
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - School, mental health, injury, bullying, etc. - Geographic image of area around schools-conditions on sidewalks : 0.5, 1.0, 1.5 and 5 km around school (fast food outlets) <p>Methods:</p> <ul style="list-style-type: none"> - 60 minutes student survey-paper and pencil survey - Administrator survey - Stratified sample to get representative sample (start with school boards then schools) - 5 levels of consent: Queen's consent, Public Health Agency of Canada (PHAC), school board, school, parental and student <p>Other information:</p> <ul style="list-style-type: none"> - Usable postal codes for 63% of students - 50% of survey questions determined by WHO, 10 % by Health Canada, 40% by provinces/researchers - Provincial samples this past round - PHAC own data and Joint Consortium for School Health (JCSH) provide feedback on report format - Can compare provinces/territories to national average - Data sharing agreement-provincial government getting data set from PHAC - Researchers can get access to past surveys - Government can pay for data analysis
Website	http://www.hbsc.org/index.html
Contact	John Freeman, freemanj@queensu.ca

Name	Toronto School-Based Student Health Survey
Frequency	1 st time, hope every 5 years, data collection planned for April 2012
Coverage	Grade 7-12, sample
Languages	English and French
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Health status of Toronto students - Demographic data (age, gender, ethnicity, socioeconomic status, language, immigration and settlement, length of time in Canada, family affluence, living situation, postal code, sexual orientation) - Protective factors (self-rated health, resiliency, self-esteem, self-efficacy, school connectedness, family connectedness, school attendance, parental regulation and monitoring) - Tobacco use - Healthy weights - Physical activity and fitness - Alcohol use, drug use - Dietary behaviours, food skills and food security - Mental health - Sexual behaviours - Exposure to violence - Injury prevention and safe environments - Oral health - Health care access - Social connectivity - Hygiene and infection control - Environment - Health (open ended-general concerns about health, sleep) - Sun health <p>Methods/Other information: NA</p>
Contact	Caroline Murphy, cmurphy2@toronto.ca

Name	Tobacco Informatics Monitoring System (TIMS)
Frequency	Ongoing
Coverage	Health regions (Saskatchewan, Ontario), others provincial level
Languages	English
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Uses CTUMS, CCHS, CAMH monitor & OSDUHS - Tool of estimates based on already collected data - 140 indicators with above surveys - Tabulations/analyzed data (sex, age, occupation, income) - Takes 10-15 seconds to get results - Includes point estimates and confidence intervals
Website	http://tims.otru.org
Contact	Shawn O'Connor, shawn_oconnor@camh.net

Chronic disease Informatics Monitoring System (CDIMS) data portal, sister site to TIMS	
	<ul style="list-style-type: none"> - Expected availability TBA - Will house results from available data - Provincial, national , sub-provincial
Contact: Shawn O'Connor, shawn_oconnor@camh.net	

Name	Waterloo Eating Behaviours Questionnaire (WEBQ)
Frequency	Irregular, linked to research studies
Coverage	Investigator initiated
Languages	English
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Used by researchers to investigate (e.g. Porcupine, B.C., pregnant women Alberta, Windsor, Region of Waterloo) food record-1, 3 days <p>Methods:</p> <ul style="list-style-type: none"> - 24 hour diet recall - Includes photographs of foods - Where food purchased and consumed <p>Other information:</p> <ul style="list-style-type: none"> - Schools can get results back right away - Used to evaluate effects of various policies on food intake - Individuals get their own identifier to permit tracking for various projects - May be done for a targeted population or for a sample that is representative of a population
Website	www.uwfbq.ca , Login: Demo and Password: Demo123
Contact	Rhona Hanning, rhanning@uwaterloo.ca

Name	Dataset, "Ecological Dataset"
Frequency	Built environment (BE) annual, Canadian Community Health Survey (CCHS) annual
Coverage	Provincial, BE going back 20 years, nationally representative BE data
Languages	English
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Built environment mapped with GIS - Explore municipal variability in health behaviours, e.g. cancer screening (outcomes could be explored with ICES) - Indicator of fast food retailer and their density - Percentage of area that is park space - Walkability of neighbourhood, risk of neighbourhood - Census subdivision <p>Other Information:</p> <ul style="list-style-type: none"> - Mapped linked to latest CCHS - Accessible for research purposes - free - Not publically accessible
Contact	Scott Leatherdale, scott.leatherdale@cancercare.on.ca

Name	Youth Risk Behaviour Survey (YRBS) (modelled after CDC survey, with a few exceptions) - in Eastern Ontario Health Unit
Frequency	Every 3 years started in 2000, 2003, 2007, 2010
Coverage	-Grades 7-12, all schools -70 schools, all grades, 2 classes per grade, per school
Languages	English and French
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Nutrition, body image, physical activity, tobacco, marijuana, other drugs, alcohol, injury prevention, sexual health (grade 7-8, only in public school), no physical measures - Utilization of health unit services and knowledge and satisfaction of services - Demographics, parent's education, parent's country of birth - New questions on depression, suicide for this cycle <p>Methods:</p> <ul style="list-style-type: none"> - 20-25 minutes, survey administered in classroom as self-completed written survey - Passive consent – changed this year, need active consent, 50% response rate <p>Other information:</p> <ul style="list-style-type: none"> - Problem with consent is not refusal but kids don't take consent home or forget to bring it back - If student is of age can provide consent themselves - Report for community in both languages - School summary report based on what health unit thinks is important (local issues) - Other organizational reports/presentations
Website	http://www.eohu.ca/home/index_e.php
Contact	Gamil Shahein, gshahein@eohu.ca

Name	School Health Environment Survey (SHES)
Frequency	2007-08
Coverage	400+ Ontario schools → elementary and secondary school
Languages	English and French
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Physical activity, healthy eating and tobacco control organized by 4 pillars of the Foundations for Healthy School Framework (e.g. teaching and learning, physical environment, social environment, community partnerships) - Indicators and measures for 4 pillars and discerned by initiation/action/maintenance <p>Methods:</p> <ul style="list-style-type: none"> - Sampled by health unit (HU) - HU recruitment of schools <p>Other information:</p> <ul style="list-style-type: none"> - Current version is the Healthy School Planner: free online tool to facilitate very small re-survey, planning and evaluation, undergoing revision and utilization - Provincial report and HU level report , each school that participated
Website	www.healthyschoolplanner.ca & www.shapes.uwaterloo.ca
Contact	Steve Manske, manske@uwaterloo.ca

Name	Built Environment and Active Transport (BEAT)
Frequency	First time, multi-year project
Coverage	-1,000 households (Toronto: 4 types of neighbourhoods differentiated by socioeconomic status and street layout) -18 schools, grades 5-6
Languages	English, Chinese, Vietnamese, Tibetan, Roma
Indicators	Content: <ul style="list-style-type: none"> - Physical activity-how active are elementary kids - Relationships between environment and transport decisions Methods: <ul style="list-style-type: none"> - Cross sectional study - Kids wear accelerometers for a week and complete survey - Parents complete a travel diary - Principals complete administrators survey-HSB Other information: <ul style="list-style-type: none"> - Finished in April 2011 - Environment around house more important than school environment - Funded by Heart and Stroke Foundation of Canada (HSFC) and CIHR - Develop school plans for active transport - Research driven - Used by MetroLinks - OAHPP can support though knowledge brokering
Contact	Guy Faulkner, guy.faulkner@utoronto.ca

Name	Ontario Student Drug Use and Health Survey (OSDUHS)
Frequency	Every 2 years since 1977
Coverage	-Provincial level with regional representation-GTA, North, East, West, South-West -n=9,000-10,000, grades 7-12 -6 public health units bought extra sample (York grades 9-12, others grades 7-12)
Languages	English
Indicators	Content: <ul style="list-style-type: none"> - Drug use, sedentary behaviour, physical activity, physical education, tobacco, diet, socio- demographic - Focus on behaviours, social connectedness, resiliency, support, empowerment Methods: <ul style="list-style-type: none"> - Paper survey-30 minutes, self-report - Health unit's can add questions and augment samples Other information: <ul style="list-style-type: none"> - Housed at CAMH - Trend information available - Questions reviewed every cycle-screen time update, responsive-adding new drugs, slang terms - Funded by MOHLTC
Contact	Angela Boak, angela_boak@camh.net

Name	The Peel School Health Survey
Frequency	2004, 2011
Coverage	-n=12,000 students, -Grades 7-12, -23 secondary schools, 37 elementary schools
Languages	English
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - 2004-paper survey- height, weight, 2011-adding dental and physical fitness - Dental only grade 10-12 - Physical fitness grade 9-10 leger test, sit reach, grip strength, sit-ups - Two versions: one grades 7-8 and one high school-can't ask about sexual health for grade 7-8 - Physical activity, healthy eating, mental health and bullying, injury, sun safety, alcohol, drug use, tobacco, sexual health <p>Methods:</p> <ul style="list-style-type: none"> - 1 hour including dental, height and weight - Physical assessment takes 10 minutes per student to complete - Trained fitness assessors do fitness assessment - Nurses go into school to collect data - Analysis by grades but not by school, school board can request analysis/reports - Cluster analysis planned for 2011 but not done in 2004 - Use adapted census categories for ethnicity - Active consent, use telephone consent on day of survey <p>Other information:</p> <ul style="list-style-type: none"> - 2004 report available online but not comparable to current survey - Work closely with school boards, use CAMH survey to decide on questions, Peel Public Health makes final decision - Coordinate with CAMH so schools not approached twice - Used mostly by Peel Health
Contact	Sheila Datta, sheila.datta@peelregion.ca

Name	Youth Smoking Survey (YSS)
Frequency	Every 2 years since 2002
Coverage	-National, provincial representative, except territories, no on reserve, students -n=54,000 (nationally), n=12,000 (Ontario)
Languages	English and French, invitation letters sent in multiple languages
Indicators	<p>Content:</p> <ul style="list-style-type: none"> - Contraband (use, purchase), alternate forms of tobacco (e.g. cigarillos, chewing tobacco), tobacco prevalence - Knowledge, attitudes, behaviour - Smoking, behaviour (categories: non-susceptible, susceptible, daily, former, experimental) - Exposure in home, cars, 2nd hand smoke - Determinants of tobacco-sources, social, peer, family - Alcohol, marijuana, other drug use - 2010: physical activity - participation in school, sport, screen time, sedentary behaviour, healthy eating - Ethnicity - School connectedness - School policies, school performance, time spent reading, truancy - School level program and policy data (Healthy School Planner of SHAPES) with formal data linkage to student data <p>Methods:</p> <ul style="list-style-type: none"> - Paper and pencil survey - Weighted-sample - YSS uses SHAPES tools/infrastructure to collect data - Collect data from all kids in school with consent - Use mix of active and passive consent-adapted in different provinces (e.g. New Brunswick uses phone broadcast system) <p>Other information:</p> <ul style="list-style-type: none"> - Funded by Health Canada, - Provides action steps for school, schools get feedback report back in 5-6 weeks - 3 reports: executive summary and long report for teachers, report for parents and provincial report for ministries - Health units can buy extra sample size - Data access-policy and student level, publically available through application on website (for researchers, public health units) - 85%-87% participation rates in schools, 38% active consent in Ontario - Partnered with provinces to add data –PEI, New Brunswick - In Ontario add sample for some health units (2 this round 2010-11) - School administrator-healthy school planner tobacco module - Match data with GIS information -1km radius from school
Website	www.yss.uwaterloo.ca
Contact	Steve Manske, manske@uwaterloo.ca

Data Collection Surveys Underway

Name	COMPASS Study
Frequency	Every year for 4 years
Coverage	-Will start in Ontario -Sample n=115 high schools -Grade 9 cohort
Languages	English
Indicators	Content: <ul style="list-style-type: none"> - Student level – lifestyle - School level – policies Methods: <ul style="list-style-type: none"> - Quasi experimental design - Consent process has information regarding intention to transition to Ontario Health Study Other information: <ul style="list-style-type: none"> - Schools get annual report that interprets results and provides best practice - Allows opportunity for school to see student changes follow implementation of policy changes
Contact	Scott Leatherdale, scott.leatherdale@cancercare.on.ca

The following provide less complete information that individuals may wish to pursue:

Registered Dietitians of Canada Eattrack website
<ul style="list-style-type: none"> ○ work in progress, not publically available) ○ Health Canada gets information on food contents through FoodTracker ○ This is faster than 5 year Canadian Nutrient File
Commissioned public opinion polls
<ul style="list-style-type: none"> ○ Example data: Ophea, Ontario CDP Alliance doing poll in anticipation of provincial election ○ Example agencies to conduct poll: ISPOS-Reid, Environics ○ Example topics: Smoking in public housing, Smoke-free movies
Geographic Information Systems
<ul style="list-style-type: none"> ○ Example usage: Hamilton Public Health had tobacco inspections overlaid on Census data

What's Well-Coordinated Currently, and What's Poorly Coordinated – Group Discussion

Following the small group discussions, attendees were reconvened and asked to identify elements that are well coordinated and poorly coordinated in youth health. The below table captures points raised by attendees.

Well-coordinated	Poorly coordinated
<ul style="list-style-type: none"> - Module selection for Canadian Community Health Survey (CCHS) - CCHS has multiple products (from indicators themselves to reports) <ul style="list-style-type: none"> - ability to roll up from local to provincial level 	<ul style="list-style-type: none"> - Module selection for CCHS - Who is participating in decision making and opportunities/choices/decisions all may be influenced by personality, political agenda and not necessarily just scientific considerations - Unequal power of participants-there may not be a solution but more time for decision making process could help
<ul style="list-style-type: none"> - Association of Public Health Epidemiologists of Ontario (APHEO) <ul style="list-style-type: none"> - core indicators-documents information about indicators on public website 	<ul style="list-style-type: none"> -Lack of provincial risk factor surveillance system <ul style="list-style-type: none"> - who collects what? - who's funding what? - who's analysing what? - who's coordinating what?
<ul style="list-style-type: none"> - Education Quality and Accountability Office (EQAO) – student achievement 	<ul style="list-style-type: none"> - Particular audiences define their own indicators their own way, and are not necessarily talking to each other
<ul style="list-style-type: none"> - Tobacco surveillance at University of Waterloo including lots of reports 	<ul style="list-style-type: none"> - Usability of results when working with youth
<ul style="list-style-type: none"> - Knowledge exchange activities (e.g. PHAC, Association of Public Health Epidemiologists in Ontario (APHEO), OAHPP) 	<ul style="list-style-type: none"> - Current formats for dissemination do not use electronic/social media
<ul style="list-style-type: none"> - Ontario Chronic Disease Prevention Alliance (OCDPA) 30 NGOs are coordinated (e.g. advocacy) - Coordination within spheres 	<ul style="list-style-type: none"> - Coordination across/among spheres
<ul style="list-style-type: none"> - School-based surveys are well coordinated BUT 	<ul style="list-style-type: none"> - Schools are bombarded. This will get worse if focus remains mostly on schools. With many surveys conducted from different stakeholder groups, it's not a coordinated approach as to when each survey will be done in schools; each survey group works independent of each other – can result in board expressing survey fatigue.
	<ul style="list-style-type: none"> - Bringing researchers and practitioners together to consider all aspects, from development of interventions to evaluation (knowledge exchange among researchers)
	<ul style="list-style-type: none"> - Lack central leadership with a vision and goal for future

Well-coordinated	Poorly coordinated
	<ul style="list-style-type: none"> - Informed consent-how it's developed - Ethics review processes to access students - Research must do ethics approvals but Ministry doesn't need to AND principals can decline and say no
	<ul style="list-style-type: none"> - Reaching vulnerable populations at provincial level (e.g. street youth, detention, Aboriginal populations)

DAY 2, FEBRUARY 17, 2011

Below is a summary of the key points raised in discussions held on Day 1.

What Data Users Need to Know	Current Data Available –Illustrative not Comprehensive
<p>1. Information related to various content issues</p> <ul style="list-style-type: none"> - Physical activity - Healthy eating - Tobacco use - Connectedness - Engagement - Mental health/depression - Bullying - Determinants - Demographics - Policy - Alcohol - Sexuality - Chronic disease identification 	<ul style="list-style-type: none"> - YSS measures tobacco, physical activity, obesity, sedentary living, healthy eating (Steve Manske) - TIMS – tool of already collected information on 140 indicators related to tobacco, including CTUMS (annual), CCHS (annual), CAMH monitor (annual), OSDUHS (every 2 years) (Shawn O’Connor) - Waterloo Eating Behaviours Questionnaire (access is via investigator initiated studies) – immediate results to individuals, schools (Rhona Hanning) - Health Behaviour in School-aged Children (HBSC) (John Freeman) - Ontario Student Drug Use and Health Survey (OSDUHS) (Angela Boak) - Eastern ON Youth Risk Behaviour Survey (Gamil Shahein)
<p>2. Information appropriate to various levels</p> <ul style="list-style-type: none"> - School - Grade - Local (neighbourhood) - Regional/municipal - Provincial - National - Compare to other provinces, internationally 	<ul style="list-style-type: none"> - YSS for national, provincial results Grade 6-12. Health units can buy extra sample size for local results (Steve Manske) - Health Behaviour in School-aged Children (HBSC) (John Freeman) - Toronto Student Health Survey will collect height and weight as well as many self-reported indicators and can do analysis by SES, age, gender, ethnicity, immigration, postal code, sexual orientation (Caroline Murphy) - Peel School Health Survey includes pa, healthy eating, tobacco dental, height, weight (Sheila Datta) - Youth Risk Behaviour Survey in Eastern Ontario for nutrition, body image, injury prevention, alcohol, sexual health, tobacco, marijuana, other drugs (Gamil Shahein) - SHAPES in Ottawa, Hamilton, Thunder Bay to inform their own planning (Steve Manske) - Healthy School Planner – free online tool to facilitate school-level planning and evaluation related to physical activity, healthy eating, tobacco (Steve Manske) - School Health Environment Survey (SHES) (Steve Manske) - Built Environment and Active Transport (BEAT) (Guy Faulkner)

What Data Users Need to Know	Current Data Available –Illustrative not Comprehensive continued
<p>3. Linking</p> <ul style="list-style-type: none"> - Linking self-report to objective measures of physical activity - Link changes in trends to policy changes - Link behaviours to student academic achievement (e.g. EQAO) - Link to opinion survey data, ICES, clinical data, GIS mapping data, for depth understanding 	<ul style="list-style-type: none"> - COMPASS (coming in Sept 2011 in 115 high schools) to link behavioural data to GIS mapping of built environments (e.g. impact of walkability of communities on physical activity) – will also interpret results and provide feedback along with best practice recommendations (Scott Leatherdale) - Built Environment and Active Transport (Toronto)-4 types of neighbourhoods by SES and street layout to look at impacts on pa (1000 households, wear accelerometers to measure physical activity)(Guy Faulkner)
<p>4. Trends</p> <ul style="list-style-type: none"> - Trends over time in behaviours - Trends over time on key factors related to behaviours 	<ul style="list-style-type: none"> - YSS - CTUMS - CCHS - SHAPES
<p>5. Data quality and methods</p> <ul style="list-style-type: none"> - Module development and formal testing of validity and reliability 	
<p>6. Info on Individual Determinants</p> <ul style="list-style-type: none"> - Knowledge, attitudes, opinions - Engagement 	<ul style="list-style-type: none"> - YSS captures knowledge, attitudes and behaviours related to physical activity, obesity, sedentary living, healthy eating, tobacco
<p>7. Info on environmental determinants e.g. how policy environments shape healthy behaviours</p>	<ul style="list-style-type: none"> - Healthy School Planner
<p>8. Information that addresses current issues and new knowledge</p> <ul style="list-style-type: none"> - Changing indicators in response to new or changing issues - New indicators based on research 	
<p>9. Sufficient power for local/subgroup analysis</p>	<ul style="list-style-type: none"> - SHAPES collects data from whole school
<p>10. Ready access</p> <ul style="list-style-type: none"> - to data - to summarized information - to best practice information 	<ul style="list-style-type: none"> - TIMS – tool of already collected information on 140 indicators related to tobacco, including -CTUMS (annual), CCHS (annual), CAMH monitor (annual), OSDUS (every 2 years)

System Elements for Youth Risk Factor Surveillance

The below elements were identified as key for a successful youth risk factor surveillance system.

1. Leadership, ethics and vision
2. Partnership coordination and planning
3. Funding
4. Collection
 - a. Coordination
 - b. Data sharing
 - c. Data linkage
 - d. Methods
5. Analytics
6. Interpretation
7. Knowledge exchange for action
8. Measurement and evaluation of system

Barriers to Coordination and Strategies to Overcome Them

Participants were asked to form 2 learning circles and identify barriers and solutions to overcome barriers around the 8 elements for a youth risk factor surveillance system (on the previous page). The tables below represent an amalgamation of points raised by both groups.

LEADERSHIP AND VISION	
Barrier	Solution
<ul style="list-style-type: none"> - Conflicting priorities across groups (researchers, policy, practice, NGOs, government, etc.) 	<ul style="list-style-type: none"> - Visioning activity with key stakeholders and government, be explicit about priorities - “Enlightened self-interest” role clarification (where we agree and disagree)
<ul style="list-style-type: none"> - Lack of mandated system (for surveillance) <ul style="list-style-type: none"> - overlaps, lack of clarity (driven by evaluation and accountability needs) 	<ul style="list-style-type: none"> - Premier understands other priorities (not just education) - Advocacy in a coordinated way
<ul style="list-style-type: none"> - Research leadership in government or NGOs (barriers in policy, difference between research and advocacy, research should stay in scientific community) 	<ul style="list-style-type: none"> - Research based in science community or arm’s - length agencies
<ul style="list-style-type: none"> - Who? What organization? 	<ul style="list-style-type: none"> - List organizations who attended meeting - Use continuous quality improvement to guide next steps→planning committee - Manitoba: Executive of people - 1 CEO who talked amongst other UPs/CEOs in other agencies, identify the 1 starter person
<ul style="list-style-type: none"> - Need to work collaboratively; sector/culture barrier - Shared leadership : ‘leading leaders’ 	<ul style="list-style-type: none"> - HBSC-Advocacy from PHAC (1 person) - Rotating leadership?
<ul style="list-style-type: none"> - Competing priorities; e.g. professional goals 	<ul style="list-style-type: none"> - Have vision and ethical framework
<ul style="list-style-type: none"> - Tension between research and surveillance 	<ul style="list-style-type: none"> - Have common vision and engage in planning process→ partnerships
<ul style="list-style-type: none"> - Lack of senior support for collaborative efforts in public health (and beyond) 	<ul style="list-style-type: none"> - Planning committee discuss role of public health- 36 public health units (looking at standards) - May not involve all health units to begin with - Asking to add core (minimal) indicators - Compensatory sample (i.e., adding a sample from non-participating health units’ regions and weighting all samples appropriately to get a provincially representative sample)
<ul style="list-style-type: none"> - Meeting needs of multiple stakeholders (local data to support needs for program-provincial/national data not relevant) 	<ul style="list-style-type: none"> - MDS-supplement ‘buy’/additional sample
<ul style="list-style-type: none"> - Legislation: people don’t know what the current legislation will allow them to do (e.g. PHIPA-does not require ethics) 	<ul style="list-style-type: none"> -Conference that includes the legislation of current requirements – APHEO’s 2011 conference

PARTNERSHIP, COORDINATION AND PLANNING	
Barrier	Solution
- Lack of clarity and focus among partners	- Open communication strategy/system - Ground rules for communication
- Varying levels of capacity/resources/flexibility	- Play to strengths-bring what you have to offer - Accept different levels - Be creative
- No interest in sharing and being consistent (benefits not obvious)	- Work with those who have interest and dedication - Be aware of elements of research teams - Increase incentive and benefits
- No hubs for youth health in communities	- Use “Best Start” example (tie with funding) - Bring public health, mental health, youth (etc.) together to create community level network
- Lack of youth involved	- Look at successes - Explore solutions
- “Forcing partnerships” may lead to inaction	- Work with those who are interested
- Lack of comfort going forward “as is”	- Define partnerships better
- Different agendas put forth by different stakeholders	- MOHs (some reps) present from health units (e.g., from smaller health units and those who’ve done school surveys before)
- Not having all relevant partners at the table (ID based on organization’s mandate and individual passion)	- Partner meeting - Identify who should be there
- Fixed cycle of surveys (e.g. HBSC every 4 years) - Mandate: broad based, different from others → national, international comparison data	- Put surveys on in different years - Align better - Recognize cost in doing things differently (beyond in-kinds) - Special funding for the coordination and planning process
- Partnership with education and public health needs to be better coordinated → include Ministry of Education in committee to increase facilitate buy-in at Toronto schools - Research ethics application (2009 application for 2012/13 implementation)	- Capitalize off the Tobacco Network structure (heavily resourced with staff and funding) - Alter/expand on this network - Different roles and responsibilities, establish principals for partnerships - Terms of Reference, consensus building process
- List of partners: - Association –Directors of Education, MOHs, Teacher’s Federation - Ministry of Education has a working table with list of who should be at the table	- Bring system to the Healthy Schools working table

FUNDING	
Barrier	Solution
- Sustained funds	- Understand what needs to be built and the approach, incremental vs. big
- Purpose of funds limited to collection (not learning system)	- Need to think about dissemination and implications
- Depending on government funding - Overdependence on funds	- Expand partners to perhaps private sector - Look to people, resources and in-kind support
- Coming from many/varied sources (leads to different expectations and decreases coordination)	- Have a common vision - Have parties at the same table
- Organizations want the recognition for their resources being used and their 'own' report	- Broader groups, "Community Report Cards" - Learn from existing collective surveillance projects (e.g. Ontario Health Study)
- Accountability (varied examples of funding, information, publication)	
- Absolute dollars - to collect, analyze, translate, disseminate - relative priorities/competing priorities - competition for funding - Researchers not rewarded for doing policy-based research (University culture)	- Funding is better coordinated between research and practice - link funding cycles - mapping who has grants and identifying - map researchers with public health interventions that 'help' - OAHPP for linking - RRFSS Model-buy additional sample/questions
- Health units have hard time 'accepting funds' - must collaborate with a university - grant applications - purchasing bylaws - RFP for certain partners not allowed - need to register to see RFP on Merx - hard to match practitioners and researchers - Strategy shared drive funding (not the opposite) - Timeline to do competitive procurement (troublesome and long)	- Partnership with academic institutions - Sole source RFP - integrate into planning process

COLLECTION (“Coordination, data housing and sharing, data linking, methodology.”)	
Barrier	Solution
<ul style="list-style-type: none"> - Size and geography of Ontario (variation of population), number of school boards 	<ul style="list-style-type: none"> - Clear vision, goal, leadership - Consider all factors when deciding on tools and methods - Mixed approaches-engagement of those at the ground level - Increase understanding and comfort with mixed methods, increase basic research
<ul style="list-style-type: none"> - Need for various levels of data - Need good methods and design due to variability (i.e. rural, urban) 	<ul style="list-style-type: none"> - Involve experts in the design - Collect broader data at multiple levels
<ul style="list-style-type: none"> - Education/LHINS/ health units have various boundaries 	<ul style="list-style-type: none"> - GIS and postal codes help
<ul style="list-style-type: none"> - Not reaching some students/youth (e.g. First Nations) 	<ul style="list-style-type: none"> - Partnering with those who are engaging - Use varied methodologies
<ul style="list-style-type: none"> - Linking: Privacy and ownership of data 	<ul style="list-style-type: none"> - Look to those institutions that have solutions (e.g. ICES, University of Waterloo) - CDC centralized system need to address ethics etc.
<ul style="list-style-type: none"> - Public and consumer apathy regarding surveys 	<ul style="list-style-type: none"> - Provide (info) data back to population - Promote, explain to ‘consumers’ the value (e.g. Ontario Health Survey) - ‘Incentivize’ participation - Understand your segmented audiences
<ul style="list-style-type: none"> - Standardization versus flexibility (‘tension’) 	<ul style="list-style-type: none"> - Minimal data set (i.e., core indicators and measures), understand surveys have flexible/optional component-users select components which are optional
<ul style="list-style-type: none"> - Organizations protective of data/restrict access to data 	<ul style="list-style-type: none"> - Partnership set up to facilitate sharing - Mechanisms in the system to facilitate sharing - Respect what groups don’t want shared when possible
<ul style="list-style-type: none"> - Getting buy-in from school board (as gatekeepers) and other key partners 	<ul style="list-style-type: none"> - Involve them in the beginning - They get something (what they may need) out of it - Ensure content is built around their issue (e.g. connection between learning outcomes and health)
<ul style="list-style-type: none"> - What we want not defined 	<ul style="list-style-type: none"> - This allows for methods to be determined
<ul style="list-style-type: none"> - Various capacity in measurement 	<ul style="list-style-type: none"> - Share tools and built capacity

COLLECTION	
Barrier	Solution
<ul style="list-style-type: none"> - Staffing capacity of health units (need to determine who is going to do it) 	<ul style="list-style-type: none"> - Planning done well in advance - Nurses involved in helping out (contract out or utilize own – can other health professionals also help (e.g., registered dietitians)?) - Look at best practice modules already in existence - Source out the data collection
<ul style="list-style-type: none"> - Data ownership 	<ul style="list-style-type: none"> - Planning/coordination committee to ‘decide’ <ul style="list-style-type: none"> - multiple owners? - transparency - all can have access
<ul style="list-style-type: none"> - Myths: <ul style="list-style-type: none"> - “More data are better.” - “ If you can make a chart of the data, it’s good data.” 	<ul style="list-style-type: none"> - Trust that in order to ‘agree’ we need to be strategic
<ul style="list-style-type: none"> - Timelines to make decisions <ul style="list-style-type: none"> - data collection strategy 	<ul style="list-style-type: none"> - MDS? (may not be solution) - Thoughtful expert advice and trust
<ul style="list-style-type: none"> - Data intellectual property and rights at the University (sign off)-need to publish data but can’t ‘own’ data 	<ul style="list-style-type: none"> - Requirement for academics to seek publication in peer review journal-part of the contract <ul style="list-style-type: none"> - allow provision for comments - submission to journal
<ul style="list-style-type: none"> - Methods of measurement shared not contradict to educational philosophy 	<ul style="list-style-type: none"> - Ensure linkage with policy
<ul style="list-style-type: none"> - Lack of knowledge of collectors about their subjects (e.g. “jump on a scale”) 	<ul style="list-style-type: none"> - Youth practitioners at the table to help inform data collection
<ul style="list-style-type: none"> - Being able to keep consistency over time for continuity <ul style="list-style-type: none"> - keep trend data - health unit lack in-house expertise re: better rigour (e.g. sampling) 	<ul style="list-style-type: none"> - Co-practice to draw from

ANALYTICS (“Making tools available to others.”)	
Barrier	Solution
- Little coordination of analytics (analysis and approaches)	- Come to agreement on what we’re comfortable with
- Analysis expected from a survey to surpass what was done in collection	- ‘Forward thinking’ to analysis in development - Recognize limitations help people understand this - Familiarize people with the basics of surveillance and sampling - Increase capacity for analysis
- Context changes	- Ensure interpretation captures these changes
- Different ability/capacity for analysis	- Provide/share resources, tools, training, etc.
- No structure for central connection for those doing public health analytics	- Increase structure and supports for public health and others who need to do analytics - CARRFS developing a collective approach
- Competing demands of epidemiologists	- Hire more epidemiologists
- Centralized versus local, how can centralized meet local needs? (e.g. OAHPP, CCO, OTRU, all doing analyses of CCHS)	- Have both central and local analysis
- Common indicators and definitions; lots of time to achieve this, always changing	- Recognition from bosses to realize common indicators take time - come to meetings; keep talking to each other - get bosses to talk to each other (planning team)
- Who is the leader? (e.g. OTRU has money)	- Identify a leader; talk to those who are at this meeting - role clarity
- Different software programs	- IT/share syntax on a website - shared macros - BORN surveillance system-Niday database → explore this model - Standards for reporting

INTERPRETATION (“Information to knowledge.”)	
Barrier	Solution
<ul style="list-style-type: none"> - “We don’t do this so well” 	<ul style="list-style-type: none"> - Set up an approach like the “need to know” groups in Manitoba <ul style="list-style-type: none"> - different levels of organizations coming together: community, health/rec etc.
<ul style="list-style-type: none"> - Volume of data processes (skim over, low funding, no time) 	<ul style="list-style-type: none"> - Recognize different realities for different contexts - Make analysis easier to increase time for interpretation
<ul style="list-style-type: none"> - Responsibility for interpretation <ul style="list-style-type: none"> - deciding who has this?-each organization and who needs to know? 	<ul style="list-style-type: none"> - Identify best practices in data interpretation (e.g. give advance copies to epidemiologists for input) - Engagement with community - Access to data (secondary re-analysis available) - Community of practice to build community between groups - Resource system and expertise - Quality assurance processes (technical standards and expectations)
<ul style="list-style-type: none"> - Different definitions 	<ul style="list-style-type: none"> - Make explicit via technical reports and data guides
<ul style="list-style-type: none"> - Knowledge and expertise of end user and understanding how it will be used 	<ul style="list-style-type: none"> - Epidemiology 101 course-recommended for all Public Health staff to take
<ul style="list-style-type: none"> - Understand who the audience is (e.g. public health vs. public?) - Expertise in content area - Interpretation of results may be difficult-external factors 	<ul style="list-style-type: none"> - Consultation, more dialogue, with epidemiologists and program staff at all phases - Collaboration on report analytic staff with staff partnership
<ul style="list-style-type: none"> - Language (e.g. melanoma vs. skin cancer) needs to be appropriate for end user - Comfort of researchers to use less technical terms - Limited time 	<ul style="list-style-type: none"> - Prompting collectors to think about interpretation of data - Sharing ‘more successful’ documents <ul style="list-style-type: none"> - lexicon/dictionary: “range means...” - glossary of plain language for methods (e.g. Editor John Last’s Dictionary of Epidemiology) - utilizing program staff to help with translation and interpretation of data.
<ul style="list-style-type: none"> - Report from this meeting a barrier? - Research and public health intensive-no school representation <ul style="list-style-type: none"> - making comparison with whom? and what are the permissions required 	<ul style="list-style-type: none"> - Context taking into consideration when writing proceedings

KNOWLEDGE EXCHANGE (KE) FOR ACTION (“Two way exchange of knowledge by those who gather and those who implement policy and programs.”)	
Barrier	Solution
<ul style="list-style-type: none"> - Identifying who is responsible for KE, what is the expectation (beyond initial purpose)?, high demand, high variability (varied and languages) 	<ul style="list-style-type: none"> - Identify primary and secondary audiences in advance - Who ‘could’ use the data be considered - Cyclical process for responding to other audiences/stakeholders
<ul style="list-style-type: none"> - Continuity of players (funding mandates) 	<ul style="list-style-type: none"> - Training and technical assistance to address this, use KE brokers and Ontario’s resource centres
<ul style="list-style-type: none"> - Not ‘knowing’ the community using the knowledge 	<ul style="list-style-type: none"> - Use experts who already have good links - Not one time thing, go back and forth many times - Build relationships
<ul style="list-style-type: none"> - Lack of planning for dissemination (researchers) 	<ul style="list-style-type: none"> - Check assumptions on users
<ul style="list-style-type: none"> - Uptake of research findings (don’t believe it) 	<ul style="list-style-type: none"> - Creating a culture that values evidence and integration evidence into planning
<ul style="list-style-type: none"> - Trust and respect between partners 	<ul style="list-style-type: none"> - Organizations use existing best practice resources
<ul style="list-style-type: none"> - Time and money-knowledge broker - Reward from academic career advancement perspective 	<ul style="list-style-type: none"> - Finding innovative solutions for KE activities; out of the box ideas
<ul style="list-style-type: none"> - Need for follow up to KE activities - Usability/utility of the formats of reports 	<ul style="list-style-type: none"> - More research? - Go to where people are talking - ID who is the key person - shared roles?
<ul style="list-style-type: none"> - Huge amount of knowledge and information available to access the piece you need at the right time 	<ul style="list-style-type: none"> - Endorsement and affirmation of the right contacts
<ul style="list-style-type: none"> - Getting results into the hands of the right people 	<ul style="list-style-type: none"> - Communication plan and engagement plan from outset
<ul style="list-style-type: none"> - KE plans: turning it to action 	<ul style="list-style-type: none"> - Involve youth in the action
<ul style="list-style-type: none"> - What is effective KE? - What does it look like for epidemiologists, public health units, academia? 	<ul style="list-style-type: none"> - Role of knowledge brokers?

Bicycle Rack

A “bicycle rack” of comments was maintained to capture thoughts and issues that are important but not directly relevant to the specific outcomes of this meeting.

1. Indicators analysis-getting input from users on key indicators, feeding back information from various sources.
2. Linking dataset to pre age 9 and post age 19 for longer-term tracking.
3. Self-report data and need for monitoring versus physical measures for studies.
4. Issues for coordination as schools being bombarded.
5. Injury and its prevention is important:
 - Education Quality Accountability Office (EQAO)
 - Grades 3, 6, 9/10
 - Publically accessible results for every school in Ontario annually
 - Includes demographic data
 - Most school boards make results available
6. Shawn O’Connor will prepare invitation to participants to identify indicators that he can incorporate into his preparations.
7. What are opportunities to do formal data linkage (e.g. at ICES) of survey data to clinical administrative datasets. Whom could we talk to at ICES to explore these ideas/methods?
8. What pre-determinants (factors before age 9) influence youth (10-19) behaviours, e.g. “life trajectory approach.” Consider/discuss with Ontario Health Study how to do this.
9. Value of different approaches to physical activity measurement (e.g. accelerometer for studies and self-report for trend analysis over time).

Moving the Vision of a Coordinated System Forward: Crystallizing What Needs to Happen - Recommendations

1. Propel and OAHPP should synthesize the discussion from these two days in a draft framework for youth risk factor assessment and action:
 - Include the elements identified in this meeting as important for such a system, including leadership, ethics and vision; partnership coordination and planning; funding; collection (coordination, data sharing, data linkage, methods); analytics; interpretation; knowledge exchange for action; and measurement and evaluation of system
 - Develop a graphic depiction of this framework akin to the Manitoba “snowman”
 - Seek targeted input from key stakeholders as part of this development process
2. Propel and OAHPP should plan follow up meetings and process to conduct a more in-depth visioning exercise for a framework of this system. This meeting should include a small group of key leaders selected on the basis of organizational affiliation as well as personal passion for this initiative.
3. OAHPP should plan and host a larger follow-up meeting to discuss the draft framework. Seek multiple perspectives to include in this meeting, including those represented at the meeting reported here and more.
4. A longer-term ‘table’ should be identified to advance this framework and its attendant actions, with staff support (perhaps the Healthy Schools Working Table).
5. OAHPP should prepare documentation of the February 16 and 17, 2011 meetings, including this technical report that transcribes the flip chart documentation and discussion points with minor edits. OAHPP should prepare a second short, synthesized report for broader distribution.
6. The information generated in these meetings on data needs, barriers and solutions should be validated with a broader group of stakeholders before the next meeting.
7. Participants of the February 16 and 17, 2011 meeting should communicate with their own organizations about the outcomes of this meeting and next steps they can take to move this agenda forward.

Personal Commitment to Move Youth Health Agenda Forward

Attendees were asked to identify how they would be moving the youth health agenda forward following the Roundtable. Below are commitments identified by attendees:

- Inform policy makers at my organization about the need for this initiative
- Report back to my supervisor and our staff members charged with a risk factor report, so we can discuss incorporation of Propel Youth indicator definitions
- I will discuss and share this with the Ontario Healthy Schools Coalition
- I will discuss this day, its objectives and content with my colleagues and senior management and foster buy in for participation in next steps
- Ask/think about linkage with ORBSS recommendations
- Talk to colleagues and supervisors about the concept of a coordinated province-wide survey on school/youth health
- Receive feedback from colleagues about best practice related to reaching school boards to reach students
- Connect with people I met regarding co-operative inquiry, learn more and try to apply in my work
- I will speak to the Ontario Chronic Disease Prevention Alliance about this meeting at their next meeting
- Discuss with team
- Discuss with colleagues
- Inform organization leaders of potential for partnership and collaboration
- Talk to colleagues at CAMH regarding OSDHUS and this meeting
- I will ensure the report is drafted and convene another meeting
- I commit to sharing the info from this meeting with my director and colleagues
- To develop research infrastructure that will contribute to this “learning” system

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Appendix C: Glossary of Terms

Analytics – A detailed examination of data collected to identify patterns and trends.

Collection – A systematic collection of data that creates a body of evidence from which to base public health decisions with regard to youth population health assessment.

- a. Coordination – the organization of different bodies (this may involve data collectors, organizations, stakeholders) to enable working together effectively.
- b. Data sharing – that practice of making data available to others. This enables transparency and openness.
- c. Data linkage – connecting or associating data sets to shed light on interrelated factors.
- d. Methods – systematic procedure to collect data (i.e., surveys, interviews, et cetera).

Funding – Providing resources (human, financial and other means) to carry out a project (this may involve data collection, program planning and evaluation activities).

Interpretation – The process by which information (i.e. data) is transformed into knowledge (definition generated during Roundtable).

Knowledge exchange for action – Two way exchange of knowledge by those who gather information and those who implement programs and policies (definition generated during Roundtable).

Leadership, ethics and vision – Identifying shared priorities through long-range planning among partnerships that align interests to move forward on a coordinated youth population health assessment and further ensuring that informed consent, confidentiality and scientific integrity are maintained throughout the process (Last, 2007).

Measurement and evaluation of system – Systematic and objective assessment of the design, implementation, effectiveness, and impact of interventions with the purpose of using findings to improve program outcomes.

Minimal data set (Core Indicators and Measures) – Captures minimal amounts of data on a particular topic and further limits the number of indicators and measures to those that are most critical for assessment. The MDS is intended to be used as a set of standardized questions related to specific indicators.

Partnership, coordination and planning – The organization of various stakeholders/groups into partnerships that define roles and responsibilities for moving a coordinated youth population health assessment agenda forward.

Youth – Persons between and including ages 10-19 years (Church, Gubbels, Russell Wong & Manske, 2011).

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