INCLUSION HEALTH

Clinical case discussion series

Session 1: Role of family doctors in COVID recovery and caring for underserved populations

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McGill University, October 2021

No conflicts of interest to declare

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Monthly topics

Session 1 – Oct 15, 2021 – Helping patients overcome collateral harms of the pandemic (Dr Andermann)

Session 2 – Nov 12, 2021 – Language barriers when caring for immigrants and refugees (Dr Leblanc)

Session 3 – Dec 10, 2021 – Social history taking and social prescribing (Dr Andermann)

Session 4 – Jan 7, 2022 – Families with disabilities, rare conditions and special needs (Dr Leblanc)

Session 5 – Feb 4, 2022 – Family violence and promoting healthy family functioning (Dr Andermann)

Session 6 – Mar 4, 2022 – Adolescent health, gender and sexual orientation (Dr Leblanc)

Session 7 – Apr 1, 2022 – Poverty, unemployment, food insecurity & housing precarity (Dr Andermann)

Session 8 – Apr 29, 2022 – Cultural safety and caring for Indigenous patients (Dr Leblanc)

Session 9 – May 27, 2022 – From global health threats to local action (Dr Andermann & Dr Leblanc)

https://www.cfpc.ca/CFPC/media/Resources/Medical-Education/CanMEDS-Family-Medicine-2017-ENG.pdf
https://www.cfpc.ca/CFPC/media/Resources/Education/Residency-Training-Profile-ENG.pdf

CPA 9. Provide medical care that challenges systemic racism and supports health equity with/for Indigenous peoples and other racialized or underserved patient communities

a. Provide culturally and psychologically safe care experiences for patients and families
b. Provide trauma-informed care experiences for patients and families
c. Provide care that is sensitive to the health impact of racism and other social determinants
d. Attend to language barriers and work with or facilitate access to interpreter services as required
e. Attend to personal and professional development to gain knowledge, cultural humility, and self-awareness and to challenge systemic racism

CPA 27. Work with individual patients to secure their social and health care needs

a. Take a personal history and assess the social determinants of health as integral parts of care planning
b. Develop a care plan with the patient that addresses the social determinants of health
c. Provide patients with the information they need to be their own advocates and to direct their own health care decisions
d. Provide troubleshooting and health systems navigation help and articulate the patient's needs to others when necessary
e. Work with the patient, their family, and other care providers to secure access to care and other appropriate health and social resources

Learning objectives for this afternoon

By the end of this session you will be able to:

- Understand the concept of COVID-19 as a "syndemic"
- Explain the collateral impacts of the pandemic on patient outcomes
- Identify approaches for caring for underserved and marginalized populations

Schedule for this afternoon

- Part 1 – brief introduction
- Part 2 – presentation invited speaker
- Part 3 – discussion clinical cases
- Part 4 – take home messages

Is COVID a pandemic, a syndemic or both?

PANDEMIC

- “an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people”

Last J. *A Dictionary of Epidemiology*, 4th ed. Oxford: Oxford University Press, 2001.

SYNDEMIC

- “the concentration and deleterious interaction of two or more diseases or other health conditions in a population, especially as a consequence of social inequity and the unjust exercise of power”

Singer M. *Introduction to Syndemics*. San Francisco, CA: Jossey-Bass, 2009.

Social determinants contribute to outbreaks

It is increasingly recognized that "poverty, overcrowding, population displacement, weak health systems, inadequate access to safe water and sanitation and the health status of specific populations are all contributing factors to epidemics and emerging disease outbreaks" (13). Those who live in degraded physical and social environments are at greater risk of contracting, propagating and even dying from communicable diseases (14).

Andermann A. Outbreaks in the age of syndemics: New insights for improving Indigenous health. *Can Commun Dis Rep* 2017;43(6):125-32. https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/publicat/ccdr-rmtc/17vol43/dr-rm43-6/assets/pdf/17vol43_6-ar-02-eng.pdf

EARLY INDICATIONS OF SYNDEMIC

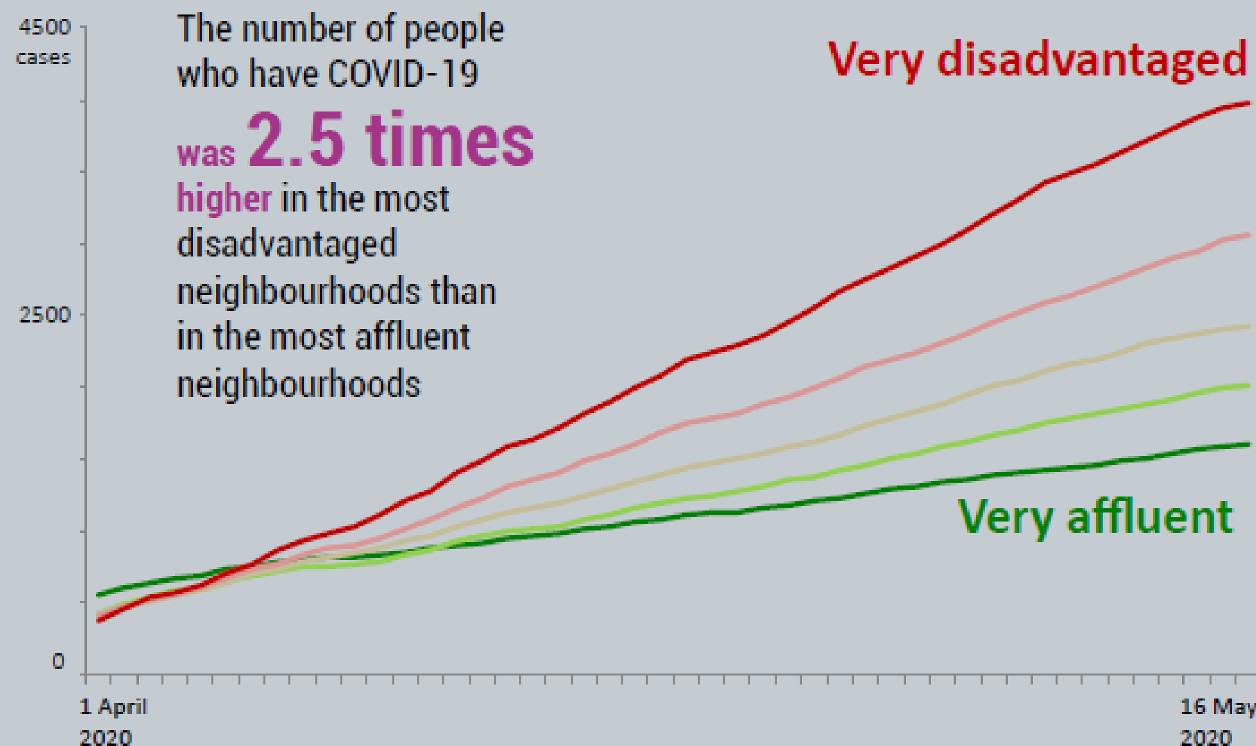
Update on the health of Montrealers during the pandemic

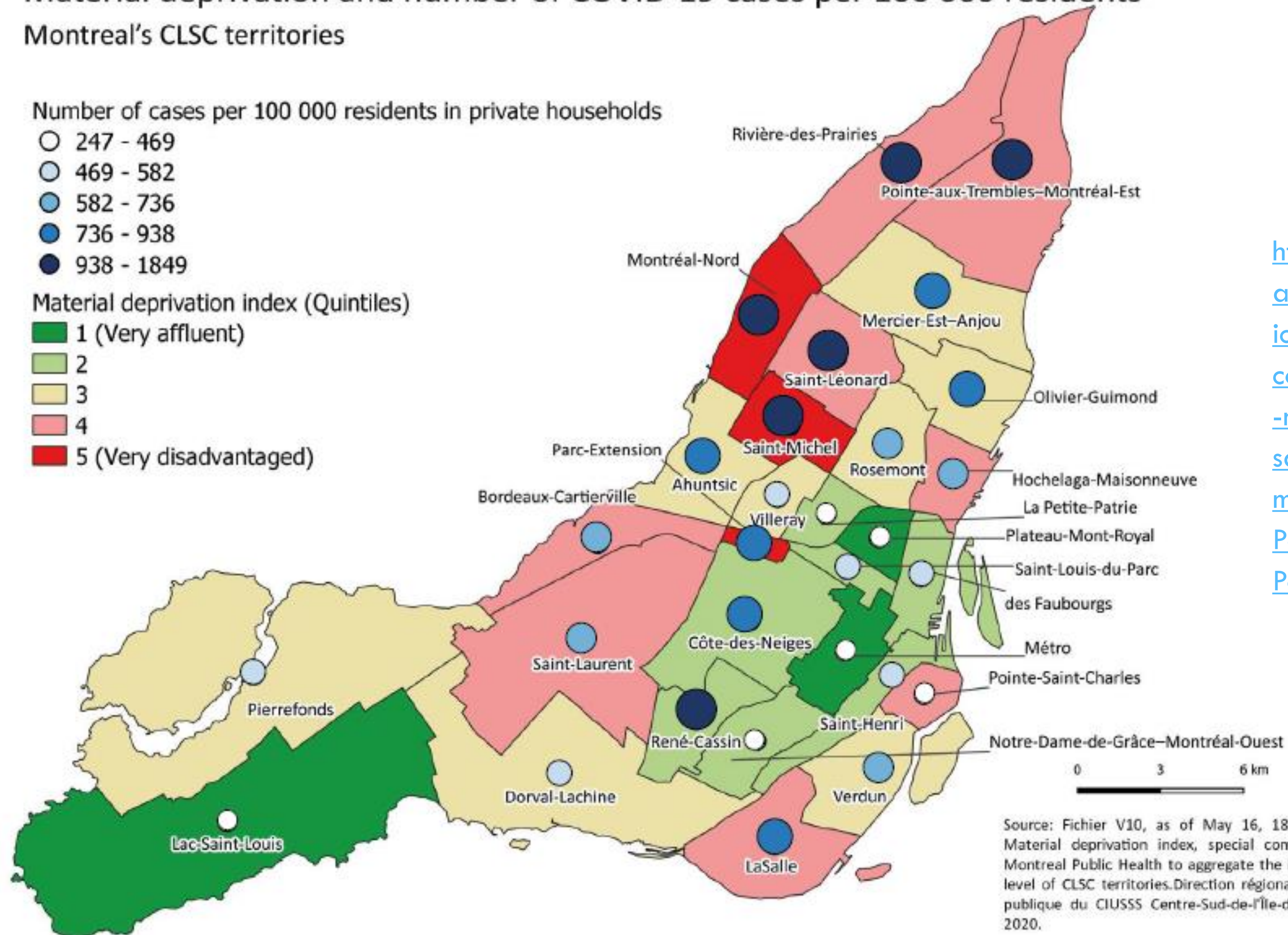
UNEQUAL TOLL OF THE PANDEMIC

COVID-19 is hitting harder in the most disadvantaged neighbourhoods on the island of Montréal

The sectors have been divided into 5 equal groups, based on level of material deprivation: Very disadvantaged Disadvantaged Average Affluent Very affluent

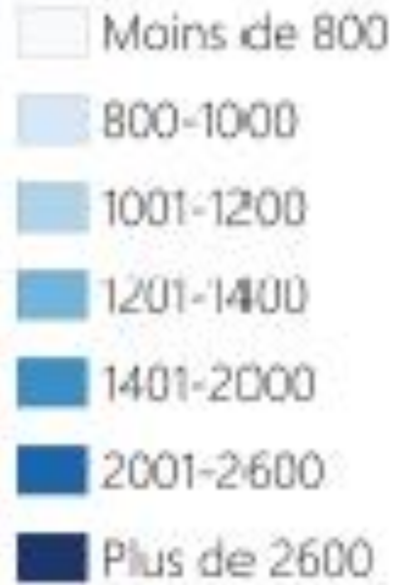
As of May 16th, there were **2.5 times more people with COVID-19** in Montréal's most disadvantaged neighbourhoods than in the most affluent ones. The gap has been constantly growing since the beginning of the pandemic. This finding is drawn from data related to the number of cases in the community and not in closed settings such as CHSLDs, and can be used to put forward possible avenues for action to improve the situation in those neighbourhoods.





Data as of May 2020

https://santemontreal.qc.ca/fileadmin/fichiers/Campagnes/coronavirus/situation-montreal/point-sante/inegalites-montreal/Inegaux-Pandemie-Population-EN.pdf



Riviere des Prairies

Montreal North

St Michel

Parc extension

Cote des Neiges

Data as of
Nov 17, 2020

https://santemontreal.qc.ca/fileadmin/fichiers/Campagnes/coronavirus/situation-montreal/COVID19-Situation-Montreal-Arrondissements-VillesLiees.pdf

WHY THESE DIFFERENCES?

Conditions associated with material deprivation puts the most disadvantaged individuals at greater risk of being in contact with COVID-19. These conditions often result from social inequalities that existed long before the pandemic struck. For example, in the most disadvantaged neighbourhoods,

there is a higher number of essential workers (attendants, clerks, cashiers, taxi drivers, etc.) who have jobs where contact with other people is unavoidable

there is a higher number of dwellings that are crowded or located in densely populated buildings, which can increase the risks of virus transmission

there are unfavourable living conditions, which increases the risks of chronic diseases and lowers the capacity of fighting the virus

there is little access to outdoor spaces where recreational or sport activities can be practised at a safe distance.

Figure 2. Cumulative number of confirmed cases of COVID-19 for each quintile of ethnic concentration: Ontario, January 15, 2020 to May 14, 2020 (n=16,169 cases)

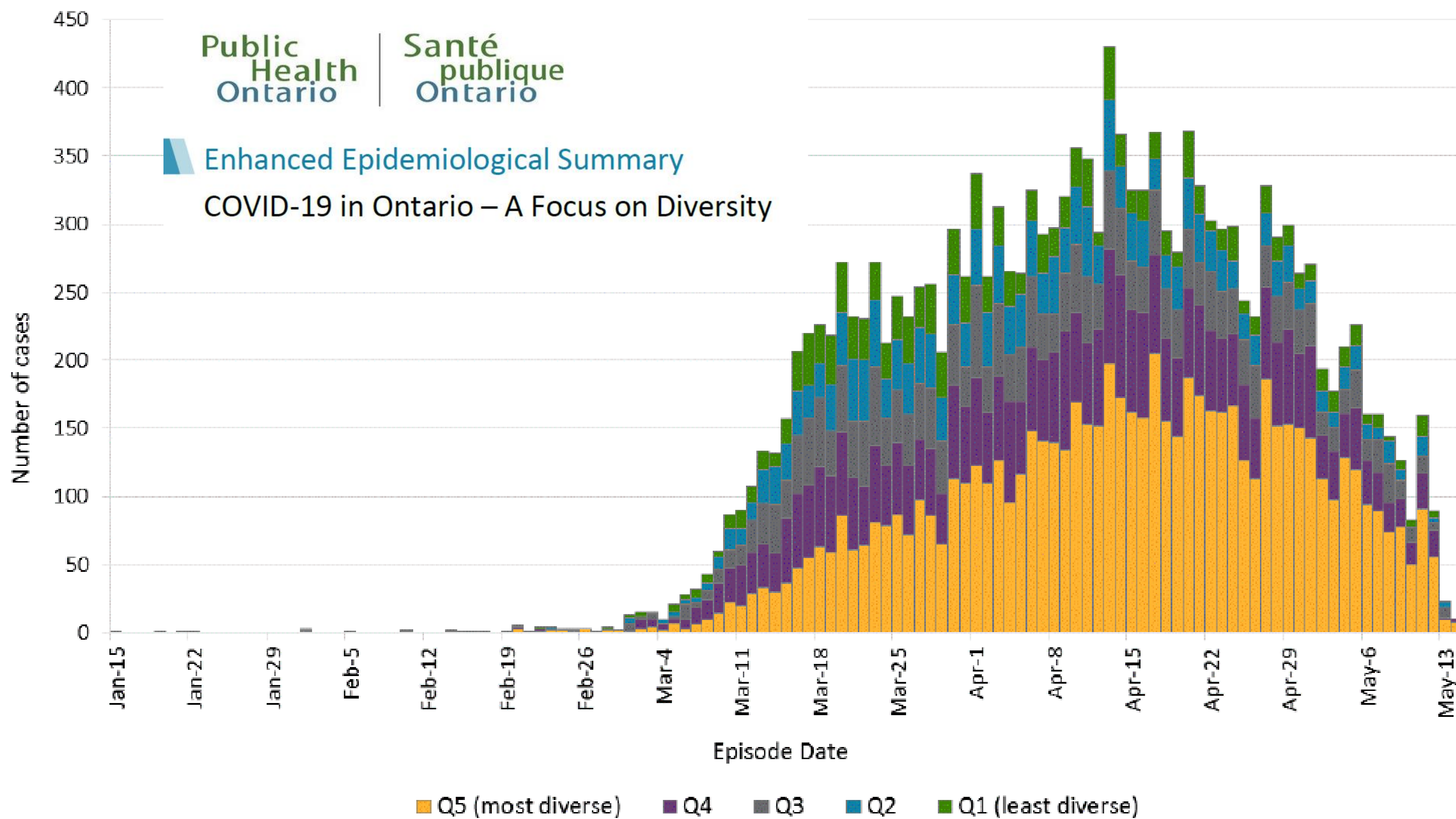


Table 2. Age-adjusted mortality rate and number of deaths among confirmed cases of COVID-19 for each quintile of ethnic concentration: Ontario, January 15, 2020 to May 14, 2020

Quintiles of ethnic concentration	Number of cases	Number of reported deaths	Case fatality rate	Age-adjusted mortality rate
Q1 (Least diverse)	1,409	116	8.2%	3.3
Q2	1,851	126	6.8%	4.0
Q3	2,308	121	5.2%	4.3
Q4	3,444	124	3.6%	4.5
Q5 (Most diverse)	7,157	235	3.3%	7.6

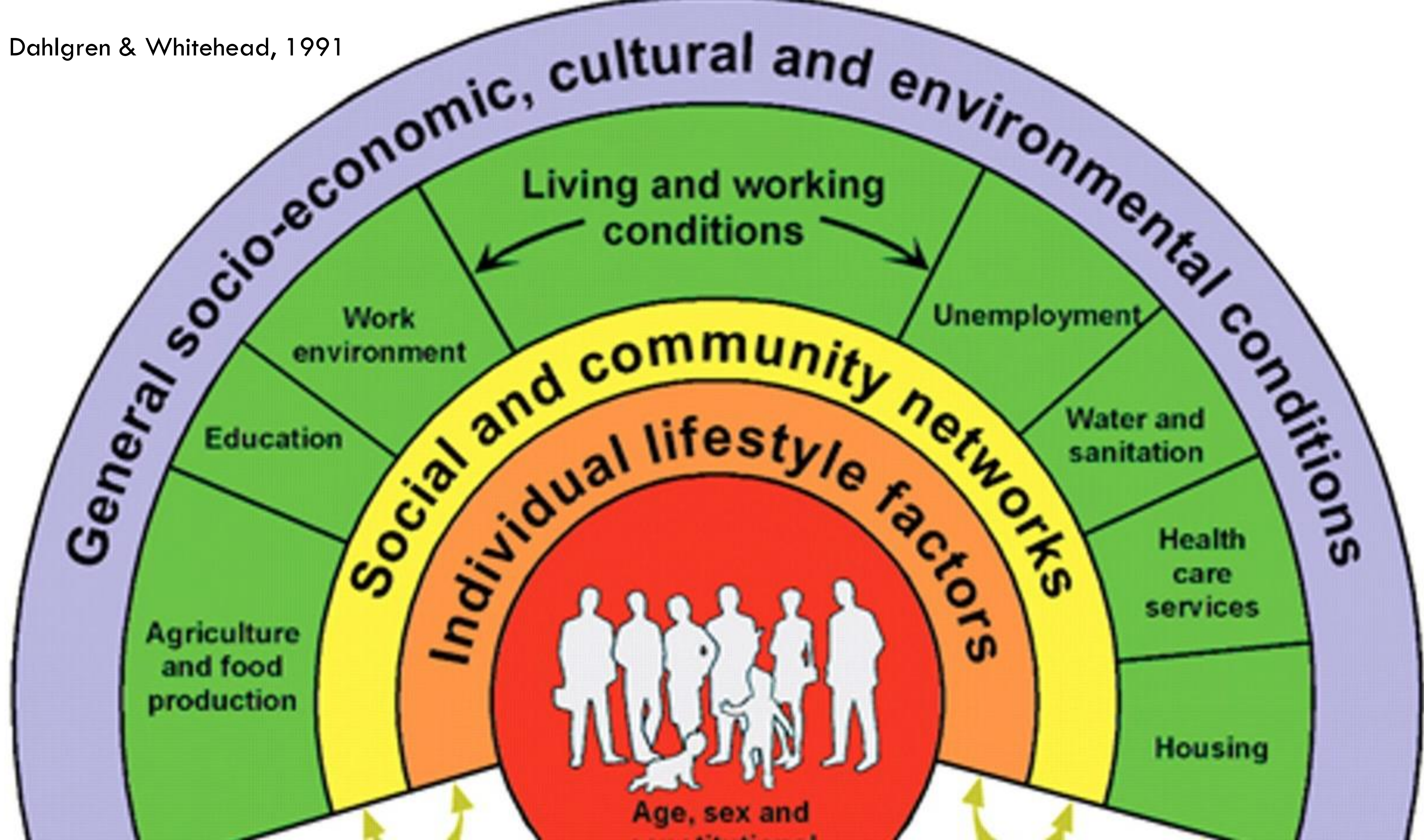
Includes all COVID-19 cases reported as 'Fatal'.
Rates per 100,000 population (bar heights) are adjusted for the size and age structure of the population.
Cases that reside in long-term care settings are not included in this analysis.
Data Source: integrated Public Health Information System (iPHIS) database, Coronavirus Rapid Entry System (CORES) database, The COVID-19 Ottawa Database (The COD), ON-Marg 2016.

Population of the Ethnic Concentration Quintiles

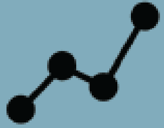
Population characteristic	Quintile 1 (least diverse)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (most diverse)
Population	2,075,031	2,209,550	2,393,497	2,838,290	3,874,794
Proportion of the population	15.4%	16.4%	17.8%	21.1%	28.8%
Non-White, non-Indigenous	2.5%	5.7%	12.9%	28.9%	67.6%
Black	0.6%	1.2%	2.3%	4.7%	10.5%
East and Southeast Asian	0.9%	2.1%	4.7%	10.3%	22.3%
Latino	0.2%	0.5%	1.1%	2.1%	2.5%
Middle Eastern	0.2%	0.5%	1.3%	3.2%	6.0%
South Asian	0.4%	1.1%	2.6%	6.5%	22.7%

Recent immigrant (<5 years)	0.2%	0.5%	1.3%	3.2%	8.8%
Cannot speak English or French	0.3%	0.6%	1.2%	2.4%	5.6%
Seniors (age 65+)	25.2%	20.5%	17.1%	14.2%	11.8%
Low income	12.0%	10.8%	11.2%	13.2%	20.7%
Without high school diploma	20.0%	17.9%	16.3%	15.7%	17.9%
Lone-parent families	28.2%	27.7%	27.5%	27.9%	28.9%
Dwellings that are apartment buildings	12.1%	14.1%	18.5%	24.0%	34.6%
Average number of persons per dwelling	2.3 persons	2.5 persons	2.6 persons	2.7 persons	3.1 persons

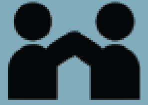
Dahlgren & Whitehead, 1991



RECOMMENDATIONS :



COLLECT DATA ON COVID'S SOCIAL DETERMINANTS

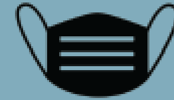


FACILITATE COMMUNITY COLLABORATION AND CONSULTATION

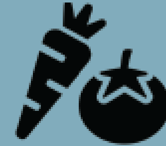
IMPROVE ACCESS TO HEALTH INFORMATION AND GUIDELINES THROUGH A MULTILINGUAL COMMUNICATION

PROMOTE ACCESS TO HEALTH AND PSYCHOSOCIAL SERVICES

PROVIDE UNIVERSAL ACCESS TO FINANCIAL SUPPORT MEASURES



ENSURE THAT COVID-RELATED WORKPLACE HEALTH AND SAFETY MEASURES ARE RESPECTED



GUARANTEE FOOD SECURITY

PREVENT EVICTIONS LINKED TO THE PANDEMIC

PROMOTE FAMILY WELL-BEING

STRENGTHEN INTERCOMMUNITY RELA-TIONS AND ACT AGAINST RACISM

https://sherpa-recherche.com/wp-content/uploads/summary_impact_covid.pdf

Registering with a Family Doctor

On this page:

Register to find a family doctor

Updating a Registration on the Québec Family Doctor Finder

Reporting a Change in Your Health Situation

Finding a Family Doctor Yourself

Registering with a Family Doctor

Related

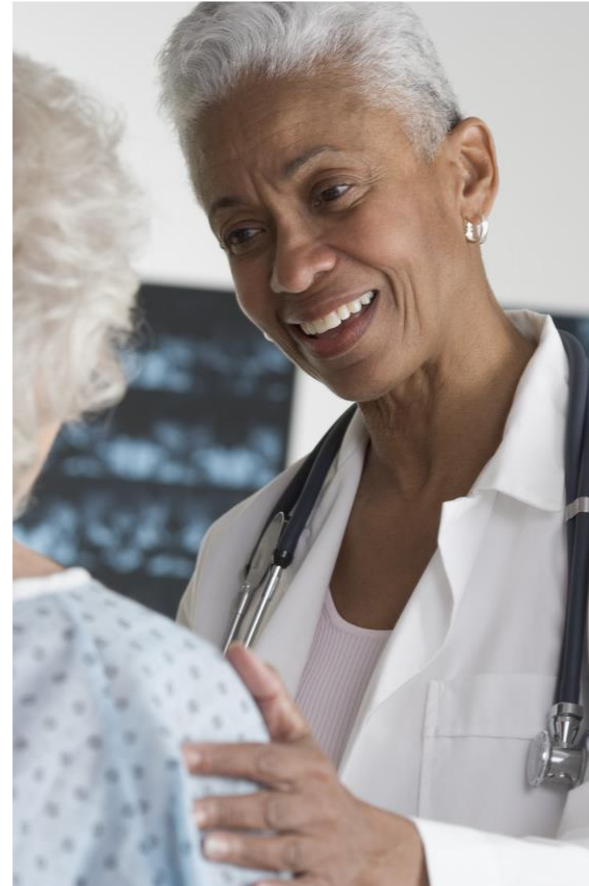
Family medicine group (FMG), University family medicine group (U-FMG) and super clinic

Finding a Resource Offering Medical Consultation On The Same or Next Day

- https://www.quebec.ca/en/health/finding-a-resource/registering-with-a-family-doctor

What health workers can do at the patient level

- Use trauma-informed care
- Take a social history
- Learn about the local referral resources
- Help patients access benefits / entitlements
- Advocate for your patient’s needs
- Create a shared management plan

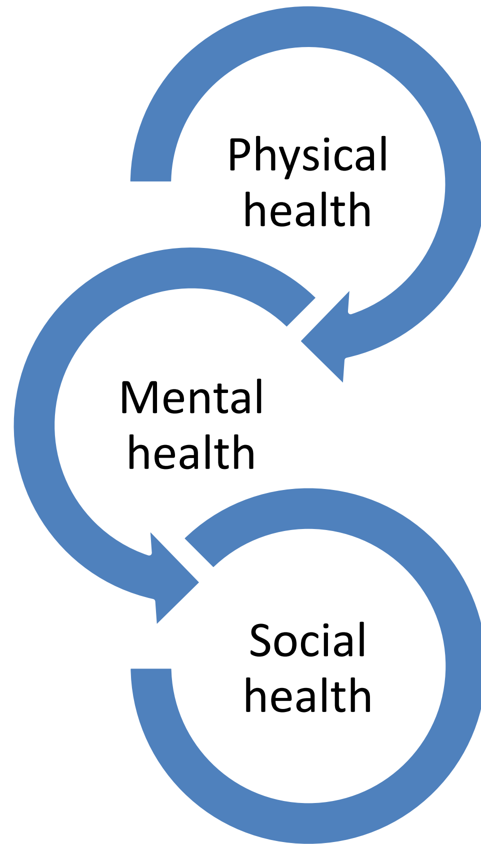


Practice trauma-informed care

Table 2. Principles of trauma-informed care

PRINCIPLE	APPLYING THE PRINCIPLE
Trauma awareness and acknowledgment	• Be aware of the prevalence and effect of trauma on substance use, and physical and mental health, and ensure that all staff members understand how trauma affects life's experiences • Recognize the effect of violence and abuse on a patient's development and coping strategies • Recognize the pervasiveness and long-term effects of violence and abuse
Safety and trustworthiness	• Help patients feel they are in a safe place • Recognize the need for physical and emotional safety • Avoid interventions that might trigger or retraumatize a patient • Design services that maximize access and participation by trauma survivors (including flexibility in scheduling) • Consider cultural competence with respect to a person's context (eg, financial instability) and life experiences
Choice, control, and collaboration	• Include patients in decisions affecting treatment • Develop a collaborative relationship • Involve service users when designing and evaluating services
Strengths-based and skills-building care	• Support a patient's empowerment • Highlight a patient's strengths and resilience rather than focusing on symptoms and pathology
Cultural, historical, and gender issues	• Incorporate processes that are sensitive to a patient's culture, ethnicity, and personal and social identity, as well as to his or her experience with trauma associated with group marginalization

Whole person care



e.g. Diabetes, high blood pressure, etc.

e.g. Anxiety, depression, addictions, etc.

e.g. Housing precarity, poverty, violence, etc.

Employment Interventions in Health Settings: A Systematic Review and Synthesis

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ABSTRACT

PURPOSE Employment is a key social determinant of health. People who are unemployed typically have worse health than those employed. Illness and disability can result in unemployment and be a barrier to regaining employment. We combined a systematic review and knowledge synthesis to identify both studies of employment interventions in health care settings and common characteristics of successful interventions.

METHODS We searched the peer-reviewed literature (1995-2017), and titles and abstracts were screened for inclusion and exclusion criteria by 2 independent reviewers. We extracted data on the study setting, participants, intervention, methods, and findings. We also conducted a narrative synthesis and iteratively developed a conceptual model to inform future primary care interventions.

RESULTS Of 6,729 unique citations, 88 articles met our criteria. Most articles (89%) focused on people with mental illness. The majority of articles (74%) tested interventions that succeeded in helping participants gain employment. We identified 5 key features of successful interventions: (1) a multidisciplinary team that communicates regularly and collaborates, (2) a comprehensive package of services, (3) one-on-one and tailored components, (4) a holistic view of health and social needs, and (5) prospective engagement with employers.

CONCLUSIONS Our findings can inform new interventions that focus on employment as a social determinant of health. Although hiring a dedicated employment specialist may not be feasible for most primary care organizations, pathways using existing resources with links to external agencies can be created. As precarious work becomes more common, helping patients engage in safe and productive employment could improve health, access to health care, and well-being.

Example: Almost 100,000 people live in the community of Cote des Neiges

- 58.1% of the population are new immigrants (16,500 people) and non-permanent residents (5,500 people), which is almost double the percentage for the rest of Montreal
- There is 4.4% of the population (over 4,000 people) that understands neither English nor French
- Pre-COVID, over 6,000 people living in Cote des Neiges were unemployed. The unemployment rate in Cote des Neiges is 12.2% compared to 9.2% in the rest of Montreal
- 31.2% of families have only one parent living in the home and managing the household (most often a single mother) which constitutes a total of almost 5,000 single-parent families
- 42.3% of the population over the age of 65 years live alone, comprising over 5,000 people

Logistical supports

- Newly arrived immigrants may not speak up if unsafe work conditions fear of losing job
- Persons who are non-status asylum seekers / precarious status may fear coming forward
- Persons who speak neither English nor French may not understand preventive recommendations
- Multigenerational living situations means older relatives placed at risk
- People living in small, overcrowded apartments makes it difficult to isolate from their families
- Those experiencing food insecurity unable to isolate if can only afford a couple days of food
- Persons who are single parents or caregivers for dependents may have difficulty isolating

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ADVOCACY

Using your expertise and influence to advance the health and care of patients, communities and populations

IS YOUR PATIENT PARTICULARLY VULNERABLE? Y N

IS YOUR PATIENT UNLIKELY TO NAVIGATE THE "SYSTEM" EFFECTIVELY? Y N

ARE THERE DETERMINANTS THAT NEED SUPPORT FOR THE HEALTH OF YOUR PATIENT/COMMUNITY TO IMPROVE? Y N

WILL THE SOLUTION NEED THE HELP OF A THIRD PARTY? Y N

IS THERE A LARGE POWER DIFFERENTIAL BETWEEN YOUR PATIENTS/COMMUNITY AND THE CONTROLLERS OF THEIR DETERMINANTS OF HEALTH? Y N

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS... YOU MAY NEED TO ADVOCATE

ADVOCACY MAY LOOK LIKE

CALLING A CONSULTANT, PARAMEDICAL STAFF OR LABORATORY
PERSONALLY ENGAGING AN INSTITUTION'S ADMINISTRATION
GETTING INVOLVED WITH AN IMPLICATED COMMUNITY GROUP
CONTACTING OR LOBBYING THE APPROPRIATE GOVERNMENT BODY
MOBILIZING THE MEDIA
PERFORMING RESEARCH DIRECTLY RELATED TO THE ISSUE...

HEALTH NEEDS REFLEXION, CONCERN AND ADVOCACY...

INCOME AND SOCIAL STATUS CULTURE GENDER SOCIAL ENVIRONMENTS HEALTH AND SOCIAL SERVICES HEALTHY CHILD DEVELOPMENT PERSONNAL HEALTH PRATICES AND COPING SKILLS BIOLOGY AND GENETICS PHYSICAL ENVIRONMENTS EMPLOYMENT AND WORKING CONDITIONS EDUCATION SOCIAL SUPORT NETWORKS...

COMMUNITY ENGAGEMENT · HEALTH ADVOCATE · PUBLIC POLICY · MEDIA SUPPORT · RESEARCH

Collège québécois des médecins de famille · cape Canadian Association of Physicians for the Environment

Author: Dr. Jean Zigby

La pauvreté

Collège québécois des médecins de famille

Outil pour les médecins de famille du Québec[1]

"Il y a de plus en plus de preuves manifestes qu'une meilleure situation sociale et économique va de pair avec une meilleure santé. En réalité, ces deux éléments semblent être les déterminants les plus importants de la santé." Agence de la santé publique du Canada.[2]

DÉCEMBRE 2015

On a longtemps pensé que la santé d'une population découlait principalement de son système de soins de santé; on sait maintenant qu'il n'en est qu'un des nombreux déterminants. Tout comme la haute pression, l'hypercholestérolémie, le tabagisme et le diabète, la pauvreté diminue l'espérance de vie et est un facteur de risque important pour de nombreuses pathologies médicales.[4 & 5]

Les médecins s'informent régulièrement des antécédents familiaux et médicaux de leurs patients, mais leur statut socio-économique est une information tout aussi pertinente. Il faut dépister la pauvreté au même titre que l'on dépiste les autres facteurs de risque.[5]

Pauvreté et santé

Pas uniquement les habitudes de vie

Ce ne sont pas que les habitudes de vie moins favorables, comme le tabagisme, qui rendent les personnes pauvres plus malades. Les études démontrent que les habitudes de vie n'expliquent qu'une partie de l'écart. On pense que le fait de vivre un stress chronique et d'avoir le sentiment de n'avoir aucun contrôle sur sa vie explique au moins en partie cette augmentation de risque.[6 & 7]

Effet sur la santé selon un gradient social des plus riches aux plus pauvres

Il a aussi été démontré que la pauvreté affecte la santé par gradient social. En effet, les personnes les plus favorisées au niveau socio-économique (le quintile supérieur, les chefs de grandes entreprises, par exemple) sont en moyenne moins malades que les personnes du quatrième quintile, qui, elles, sont moins malades que celles du troisième et ainsi de suite.[12]

Plus malades dès l'enfance

Les personnes élevées dans la pauvreté sont plus malades que le reste de la population, et ce, dès leur enfance. D'abord, il y a davantage de naissances prématurées et de naissances de faible poids.[8] Les enfants pauvres souffrent davantage d'asthme, d'infections respiratoires, d'otites, de retards de croissance, de surpoids et de troubles de comportement.[9] Le manque de nourriture ou les logements insalubres ne sont pas les seuls à contribuer à ces problèmes. Les petits qui subissent la pauvreté ont des niveaux de cortisol plus élevés dans la salive[10], ce qui est lié au stress chronique et influence des fonctions cognitives.[11]

Difficulté à se sortir de la pauvreté chronique

Le meilleur moyen de prévenir la perpétuation de la pauvreté chronique est d'agir dès la petite enfance. La fréquentation des Centres de la petite enfance (CPE) a été démontrée efficace en ce sens.[13]

CLEAR COLLABORATION

THE CLEAR TOOLKIT

Training frontline health workers to ask about and act upon the social causes underlying poor health

The purpose of this toolkit is to empower and educate health workers on how to address the social causes of poor health.

When caring for patients, you will often see the same kinds of health issues appearing again and again within the community. Instead of providing a "quick fix," what more can be done to prevent these health problems in the first place?

Many health problems often have the same underlying causes related to daily living conditions and circumstances at home, including: poverty, hunger, isolation, abuse and discrimination.

Using the four-step process in this toolkit will help you to identify the underlying causes of the conditions you treat regularly. Together you and your colleagues can work to make your community a better and healthier place by starting to ask about and act upon the underlying social causes of poor health.

1 TREAT
2 ASK
3 REFER
4 ADVOCATE

STEP 1: TREAT

Of course, your primary role is to treat and care for patients. Nonetheless, while treating patients, there are some questions you can ask them. These will help you and your colleagues get a better idea of why we keep seeing the same conditions, and what we can do to reduce the likelihood of them happening again. Once you have asked the questions you can refer patients to the right places and people in your local community so that they can get the support they need.

You may think that some of the causes of illness are intimidating and difficult to deal with, but you do not have to solve all of these problems on your own. Using this toolkit will help you connect your patients with other resource-persons like yourself for added help and support.

REMEMBER TO:

- Be attentive and listen
- Be respectful and empathetic
- Be compassionate and understanding
- Build trust and security
- Be thoughtful of the wider context
- Be accessible and open
- Be aware of cultural heritage
- Be tolerant of what you may hear

1

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http://cqmf.qc.ca/wp-content/uploads/2016/04/CQMF-Outil-LaPauvrete_Final.pdf

https://www.mcgill.ca/clear/download

Caring for patients with lived experience of homelessness

Anne Andermann MD DPhil CCFP FRCPC Gary Bloch MD CCFP Ritika Goel MD MPH CCFP
Vanessa Brcic MD CCFP Ginetta Salvalaggio MD MSc CCFP(AM) FCFP
Shanell Twan Claire E. Kendall MD PhD CCFP
David Ponka MDCM CCFP(EM) FCFP MSc Kevin Pottie MD MClSc CCFP FCFP

Research

Web exclusive

Health workers who ask about social determinants of health are more likely to report helping patients

Mixed-methods study

Anila Naz MD MPH Ellen Rosenberg MD Neil Andersson MD PhD Ronald Labonté MA PhD Anne Andermann MD DPhil
On behalf of the CLEAR Collaboration

CMAJ

Taking action on the social determinants of health in clinical practice: a framework for health professionals

Anne Andermann MD DPhil; for the CLEAR Collaboration

https://www.mcgill.ca/clear/products

Public Health Reviews

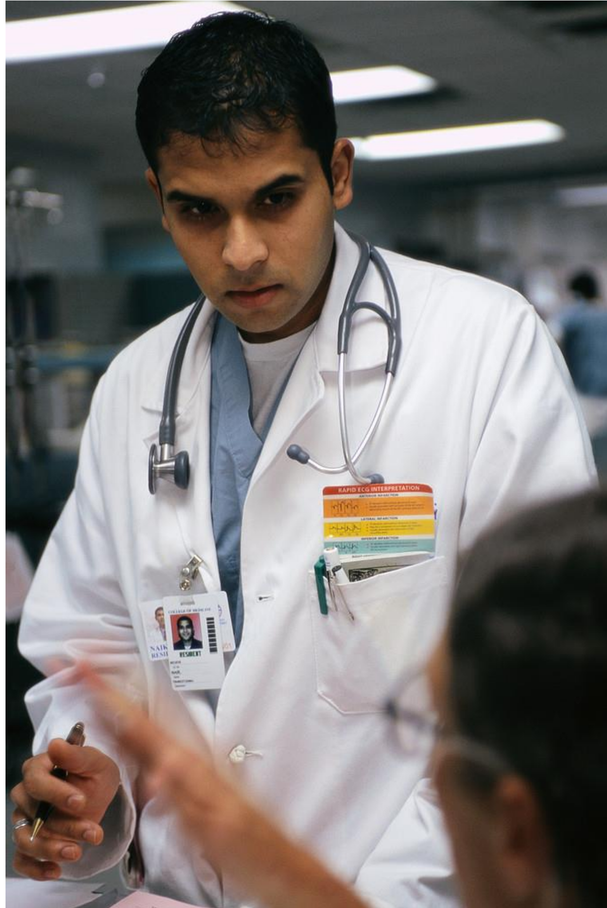
REVIEW

Open Access

Screening for social determinants of health in clinical care: moving from the margins to the mainstream

Anne Andermann[1,2]

What can be done at the organizational level



- Integrated services
- Culturally adapted
- Accessible to those most in need
- Outreach and patient navigation services
- Extra time available
  - Especially in initial encounter and for translator services

What you can be done at a population / government level

- Increase access to financial support and other benefits
- Increase logistical supports for underserved populations
- Translating materials into multiple languages
- Using community brokers and supports to explain updates
- Creating more supportive environments

Challenges and opportunities

Challenges

- Many persons who are marginalized and living in poverty remain uncounted
- No “one size fits all” solutions that work for all situations – e.g. newly arrived immigrants, persons with disabilities, gender inequity, etc.
- Limited evidence base
- Many diverse players and various jurisdictional responsibilities

Opportunities

- Pandemic “shine a light” on inequities
- Political will to “build back better” to support COVID recovery
- Opportunity to create structural changes that can lead to more supportive social environments across the life course (e.g. formalizing work of informal caregivers, equitable pay scaled, access to low cost quality child care, etc.)

United Nations | Department of Economic and Social Affairs

POLICY BRIEF NO 65

Responses to the COVID-19 catastrophe could turn the tide on inequality

Even as all of humanity confronts COVID-19, it is becoming increasingly clear that pre-existing inequalities along various dimensions are differentiating its impact. At the same time, inequalities within and across countries also stand to widen because of the crisis. Such outcomes are not inevitable: past experience shows that sufficiently bold measures that put people at the centre of crisis response and recovery can lead to better, more equitable and resilient outcomes for all.

Summary
This brief identifies inequalities around the COVID-19 pandemic in exposure, vulnerabilities and coping capacity. It suggests that crisis responses in four areas could turn the tide on inequality. These include expanding systems for the universal provision of quality social services; identifying and empowering vulnerable groups; investing in jobs and livelihoods; and acting through the multilateral system to respond to disparities across countries.

LIVING AND WORKING CONDITIONS DETERMINE THE CHANCES OF INFECTION

https://olc.worldbank.org/system/files/PB-65.pdf

BRIEFING NOTE:

THE ECONOMIC IMPACTS OF COVID-19 AND GENDER INEQUALITY

Questions?

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