

University of Toronto Family Medicine Report

2020

Caring for Our Diverse Populations



Family & Community Medicine
UNIVERSITY OF TORONTO

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Message from the Interim Chair

On behalf of the department of Family and Community Medicine, it is my privilege as Interim Chair to present the 2020 University of Toronto Family Medicine Report: Caring for Our Diverse Populations.

In last year's report we provided a broad sweeping overview of family medicine. In this year's report we elected to drill down and feature many of the diverse populations that family doctors care for. The report highlights the exceptional work being done by University of Toronto family doctors with individuals, their families and diverse communities to optimize care for those with specific needs related to their backgrounds, experiences, health status, social circumstances and other aspects of their lives. It illustrates the remarkable range of clinical services provided by family doctors and the teams they work with, the highly personalized care they provide, and the benefits associated with team-based interprofessional care. The complementary benefits associated with co-managing patients with other family doctors who have acquired expertise in specialized areas of practice are also evident.

UTOPIAN, the University of Toronto Practice-based Research Network, provided an important source of data used in the construction of this report and offered a window into the health and diseases of people in the Toronto region permitting an analysis of the needs of the populations served.

This report will be of interest to those who wish to understand the varied nature and broad scope of clinical services provided by family doctors in Toronto and environs, and the benefits accrued to our diverse communities by the involvement of caring, person-centred primary care providers and teams. The patient stories presented in the chapter provide the reader with a deeper understanding of how illness, disability, oppression and social conditions affect the lives of many.

Other points of focus are programs of support and education for health care providers to enable up-to-date evidence-based care for the broad practice needs and the educational initiatives for our learners in family medicine in areas such as Indigenous health, cultural safety, as well as management of patients suffering from the challenges of addictions, mental illness and adverse social determinants.

The intent of the four principles of family medicine is well illustrated in the report—providing skilled, culturally-safe comprehensive clinical care; embedding ourselves into communities and attending to their needs; serving as a resource to patients and populations through education, support and care coordination; and developing and maintaining strong relationships and partnerships with patients and families.

The COVID-19 pandemic has exposed and exacerbated inequities in health care. Anti-racist action to correct injustices is of paramount importance. This report defines the role of dedicated primary care providers in delivering care and conducting research to improve the lives of diverse populations as necessary ingredients toward achieving equitable care.

I hope you enjoy reading the report and I welcome your comments.

David Tannenbaum

Interim Chair

Department of Family and Community Medicine

Foreword

AUTHOR
Ross Upshur

In early January 2020, cases of a severe respiratory disease were reported from Wuhan, China. The disease soon had a name COVID-19 and the culprit was SARS-CoV-2 virus. Very quickly, an unprecedented global pandemic was underway, with all countries in the world affected. Several jurisdictions were particularly hard hit, with hospital services completely overwhelmed in the first phase of the pandemic. At the time of this writing (summer 2020), over 10,000,000 cases and over 500,000 deaths have been reported globally. Curve flattening and social distancing have entered the lexicon of daily conversation.

In Toronto, we prepared for the worst. The health system rapidly pivoted to cancel elective procedures, suspend ambulatory clinics and convert to virtual care. All of society participated. Businesses shut down, schools closed, universities moved to online learning. Fortunately, we were spared the type of unmanageable surges in demand for health services and tragically high mortality rates first seen in northern Italy and New York City.

Family doctors have been playing a significant role in the pandemic, finding innovative ways of ensuring continuity of care and support for patients virtually. At the forefront of the pandemic in our communities, many family doctors have been sought out as trusted voices in the media. Researchers also quickly turned to the reliable resources of the Department of Family and Community Medicine (DFCM), particularly our UTOPIAN database.

While the pandemic has stimulated the development of creative solutions, it has also exposed systemic issues in the delivery of health care. There were challenges in ensuring family doctors had adequate personal protective equipment (PPE). Questions were raised about the extent of the duty to care in the absence of PPE. Many family doctors were unable to provide care at the level of service required for their practice and feared that their patients were at increased risk. Because of poor integration and communication between family doctors and our public health system, some family doctors felt unable to contribute fully. Many experienced

financial difficulties. Mental health challenges have also increased in both patients and practitioners.

This report explores how family medicine serves a diverse spectrum of populations, including those that face significant barriers to accessing care and may be at increased risk for adverse health outcomes. Some of the increased risk is related to biological factors, some to structural causes and some to combinations of both. Studies have already shown a disproportionate impact of COVID-19 on older adults, particularly in long-term care settings and those with multi-morbidity or serious chronic illness. The impact of the social determinants of health have manifested as higher rates of disease in areas with lower income and higher proportions of racialized minorities falling ill.

The fragility of our health, social and economic systems has been exposed by the pandemic, and the next phase will play out in the community. Clearly, there is a much greater role for family medicine to play going forward, an opportunity for us to innovate, experiment and work towards better integration and appreciation of family medicine as the foundation of the health care system. Explicitly acknowledging the impact of the structural causes in the determinants of health and paying particular attention to protecting the most at risk people in our communities will be of paramount concern. Given the important role of surveillance and now well recognized importance of community health, the time for better integration and partnership of family medicine with public health has come. Home to one of the largest family medicine residency programs in the world and with an international reputation for facilitating ground-breaking research, DFCM is well positioned to lead the way.

Dr. Ross Upshur is a Professor at the University of Toronto Department of Family and Community Medicine, the Head of the Division of the Clinical Public Health at the Dalla Lana School of Public Health at the University of Toronto, the Associate Director Lunenfeld Tanenbaum Sinai Health and a family doctor at Bridgepoint.

Patient Foreword

As a patient partner, I often speak publicly about the importance of having the voice of people who have been marginalized in various forms at decision making tables to collaborate on solutions to ensure better services overall. In the case of family doctors, it is very important for us to build an understanding of how the social determinants of health or lack thereof can impact healthy living.

I feel family doctors have a lot of influence, and they too face barriers providing the health care they would like to see in the system. This is why working together to create change that promotes social justice is so important.

In my personal journey of fleeing domestic violence, I faced many barriers with the many systems I came across. It was exasperating trying to navigate through different policies that often held me in poverty. It wasn't until I found the right supports and learned to advocate for myself that I was able to move forward.

Including the voices of people with lived experience of homelessness, poverty, mental health, addictions, domestic violence, disability and newcomers is very empowering for those involved and informative for family doctors. It reduces the stigma and discrimination that often create oppressive practices within health care.

I have been included in a variety of ways such as research, data collection, sharing my story, speaking at conferences, joining committees and working on training material for medical students and I can see that family doctors are working to create a more equitable health care system.

Dawnmarie Harriott

Voices from the Street Coordinator



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CHAPTER 1

About This Report

AUTHORS:

Katherine Rouleau, Gary Bloch, Karen Tu, Sumeet Sodhi, Michael Kidd & David Tannenbaum

When people think of medicine, they often think of diagnosing and treating a person's physical or mental illness. However, there is overwhelming evidence that the context in which a person lives—where they live, their income, gender and sexual orientation, ethnic and racial background, and many other social and economic factors are often the primary determinants of an individual's health. It is this context that is often referred to as the social determinants of health. This understanding has been repeatedly reinforced by the powerful, historical events of 2020. Those from lower socio-economic groups, racialized, underhoused or other marginalized backgrounds are disproportionately impacted by the health and social impacts of the COVID-19 pandemic (CBC News, 2020). What's more, the powder keg caused by four centuries of race-based oppression in North America is once again exploding into a movement to end the disproportionate impact of racism on the health of Black and Indigenous peoples in the United States and Canada.

Family doctors have an important role to play in addressing the challenges and barriers in accessing and receiving care due to social marginalization or complexity and working towards the creation of a more equitable health care system. This year's University of Toronto Family Medicine Report builds upon last year's inaugural report (Tu et al., 2019) by taking a closer look into our diverse populations. The stories in this report show that while Canada's universal health care system is providing opportunities for Canadians to access medical care, there are still significant barriers for many to improve their physical, mental and emotional health. The front-line experiences represented in this report offer an understanding of how family medicine can address

the needs of those who are negatively impacted by social policies and structures that can lead to health inequities.

Family doctors rely on deep and often long-term relationships to gain unique insight into the lived realities of their patients and their communities. Through immersing ourselves in our patients' stories, we learn about their health needs and use our knowledge and training to address those priorities. Fortunately, many family doctors—and our patients—are speaking up about health inequities more loudly and forcefully than ever before. These voices are needed more than ever right now.

Using research to address the needs of specific populations

Through the establishment of the University of Toronto Practice-Based Research Network (UTOPIAN) at the University of Toronto Department of Family and Community Medicine (DFCM), doctors, researchers, educators and policy makers can now ask questions and conduct research that is directly relevant to family practice patients.

UTOPIAN is a network of over 1,700 family doctors working in clinics and hospitals across the Greater Toronto Area and beyond. UTOPIAN aims to conduct and support high-quality research to better serve the primary care community and our patients. This includes evaluation of our health care system, support for quality improvement activities, identification of potential study subjects for clinical research, patient and doctor recruitment and a range of clinical research activities including clinical trials.

UTOPIAN has developed a primary care electronic medical record (EMR) database, the UTOPIAN Data Safe Haven. Data extracted from the EMRs of participating doctors are de-identified, cleaned, coded and held in the secure UTOPIAN Data Safe Haven server. Significant work has been undertaken to ensure the extracted EMR data are transformed into research-ready data and that the highest standards of privacy are maintained.

By harnessing the potential of UTOPIAN, we can better understand who our health care system is caring for, who it needs to care for better, and what we can do to make our care better. Using UTOPIAN data and other sources, many of the populations that are addressed in this report are defined by specific medical conditions, social structures and policies, historical oppression, and the interplay between these factors. In many cases, research focusing on these groups has resulted in innovative solutions and targeted approaches, including education programs or specialized family medicine-based care clinics, such as those for refugees and newcomers, people living with HIV/AIDS, people who experience racism, people who use substances, people experiencing homelessness, and older adults with complex health conditions. An ongoing goal for UTOPIAN is to grow and improve upon our ability to better understand the needs of our diverse populations and measure the impact of interventions designed to improve care and mitigate the effect of inequities in health care.

Where the data is coming from

This report uses data drawn primarily from UTOPIAN. It includes data extracted up to March 31, 2019. Annual 2018 data in this report refers to the time period from April 1, 2018 to March 31, 2019. Included in the UTOPIAN electronic medical record data are over half a million patients that our UTOPIAN family doctors see in multiple different settings. In this report we describe and analyse the 396,892 patients that are enrolled with one of our 360 UTOPIAN physicians or have had at least two visits in the last three years. Details of our data cleaning and cohort identification processes along with methods to identify patients with specific chronic diseases or risk factors can be found in the technical appendix*.

**https://issuu.com/dfcm/docs/technical_appendix_final_27oct2020*

The role of family medicine

As one of the largest family medicine departments in the world that trains around 40 percent of Ontario's family doctors and 25 percent of Canada's family doctors, DFCM has the unique ability to prepare future family doctors to better address the needs of the diverse communities they serve. We do this by aspiring to be good role models, working within multi-disciplinary health teams and developing academic and training approaches that specifically target those needs.

We also aspire to address health issues by influencing the shape of social policy, through advocacy, research and community engagement. It is impossible to speak to socially created health risks without understanding the social drivers of those risks. For Indigenous peoples, for example, social policies maintain the legacy of colonialism; for people with disabilities, policies reinforce exclusion from the workplace; for people living without adequate income, policies keep income security program rates at a level that dramatically increases the health impacts of living in poverty. Family doctors bear witness to all these inequities and are well placed to advocate for change.

This report illustrates and gives specific examples of the role that DFCM plays at the forefront of efforts to reshape health care, and especially primary care, to address the most pressing needs and most powerful risks to health faced by the people and communities we serve. Our unique ability to collect and analyze front line experiences and health data reinforces our efforts to address major health issues from a truly holistic understanding of social, mental and physical health needs, and through innovative clinical care, education, advocacy and research.

This report is designed to showcase the incredible breadth of work of our family doctor colleagues across the Greater Toronto Area and beyond. They are leading family medicine toward a realization of its potential to care for our patients in a way that truly reflects the lived realities of the individuals, families, and communities we serve.

COVID-19, UTOPIAN and family medicine

This report was largely completed before the COVID-19 pandemic began in Canada. Therefore, it does not directly report on COVID-19. Although at the time of publication, we did not have the data to completely understand how COVID-19 has impacted the populations focused on in this report, many of us are working on the front lines of the pandemic, and have witnessed many of our patients being affected. Currently, UTOPIAN is being deployed for research studies and important data collection and analysis during the COVID-19 pandemic. This will help us determine the impacts of public health policy and emergency preparedness planning on the health and wellness of patients under our care, which we hope to report on in the future.

Dr. Katherine Rouleau is an Associate Professor and the Vice-Chair of Global Health and Social Accountability at the University of Toronto Department of Family and Community Medicine and a family doctor at St. Michael's Hospital.

Dr. Gary Bloch is an Associate Professor at the University of Toronto Department of Family and Community Medicine, an AMS Phoenix and Senior Wellesley Institute Fellow, the co-Chair of the St. Michael's Hospital Academic Family Health Team's Committee on Social Determinants of Health and a family doctor at St. Michael's Hospital.

Dr. Karen Tu is a Professor and the Associate Director of the UTOPIAN Data Safe Haven at the University of Toronto Department of Family and Community Medicine and the Institute for Health Policy, Management and Evaluation, a Research Scientist at North York General Hospital and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Dr. Sumeet Sodhi is an Associate Professor and Academic Lead for the Indigenous Health Partners Program at the University of Toronto Department of Family and Community Medicine and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Dr. Michael Kidd is the former Chair of the University of Toronto Department of Family and Community Medicine and the Director of the World Health Organization Collaborating Centre on Family Medicine and Primary Care and a family doctor.

Dr. David Tannenbaum is the Interim Chair and Associate Professor at the University of Toronto Department of Family and Community Medicine and a family doctor at Sinai Health System.

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CHAPTER 2

Snapshot of Our Patient Care Activities

AUTHORS:

Noah Crampton, Karen Tu, Noah Ivers & Onil Bhattacharyya

Family doctors are always seeking ways to improve the care of their patients. To better understand how family doctors can provide better care, it is critical that we first understand who our patients are and what care they receive. In fact, family doctors are engaged in an extensive amount and breadth of complex clinical work with patients. When data about this work is analyzed, remarkable snapshots can be gleaned about the types of patients treated by family doctors and the care they are receiving. Below we present real-world insights on the patients seen by family doctors who are part of the electronic medical record database component of the UTOPIAN network over the course of a year, and the corresponding clinical care received by these patients.

Patients of all ages are seen by their family doctor and, in general, slightly more female patients are seen than males (Table 1).

TABLE 1: PATIENTS OVERALL AND BY AGE AND SEX*

AGE	MALE		FEMALE		ALL PATIENTS	
	Number	Percentage	Number	Percentage	Number	Percentage
0–18 years	35,382	20	34,785	16	70,167	18
19–34 years	33,518	19	43,351	19	76,869	19
35–49 years	34,402	19	47,818	22	82,220	21
50–64 years	38,841	22	48,357	22	87,198	22
65+ years	34,505	20	45,933	21	80,438	20
Total	176,648	45	220,244	55	396,892	100

**Patients in UTOPIAN with at least two visits in the last three years or enrolled to a UTOPIAN physician*

When it comes to regular day-to-day clinical activity, family doctors tend to see more patients aged 65 years and older, and more of their female patients (Table 2).

TABLE 2: PATIENTS OVERALL AND BY AGE AND SEX WHO HAVE HAD AT LEAST ONE OUTPATIENT VISIT IN 2018*

AGE	MALE		FEMALE		ALL PATIENTS	
	Number	Percentage	Number	Percentage	Number	Percentage
0–18 years	20,538	58	21,282	61	41,820	60
19–34 years	15,272	46	27,447	63	42,719	56
35–49 years	19,098	56	32,754	68	51,852	63
50–64 years	26,712	69	36,475	75	63,187	72
65+ years	26,656	77	35,728	78	62,384	78
Total	108,276	61	153,686	70	261,962	66

**Based on 176,648 male patients and 220,244 female patients
Number of patients who have had at least one family doctor outpatient visit divided by the total number of patients in that age group*

If we look at which patients are regularly seen by family doctors, the likelihood of a prescription being written increases with age, with 91 percent of patients aged 65 years and older receiving a prescription within the last year. There is also a much higher likelihood of women aged 19–34 years receiving prescriptions compared to men of a similar age (Table 3).

TABLE 3: PATIENTS OVERALL AND BY AGE AND SEX WHO HAVE HAD AT LEAST ONE OUTPATIENT VISIT AND ONE OR MORE PRESCRIPTIONS IN 2018*

AGE	MALE		FEMALE		ALL PATIENTS	
	Number	Percentage	Number	Percentage	Number	Percentage
0–18 years	10,278	50	11,318	53	21,596	52
19–34 years	9,649	63	21,478	78	31,127	73
35–49 years	13,502	71	24,535	75	38,037	73
50–64 years	22,067	83	29,988	82	52,055	82
65+ years	24,410	92	32,575	91	56,985	91
Total	79,906	74	119,894	78	199,800	76

**Based on 108,276 male patients and 153,686 female patients that had a family doctor outpatient visit in 2018
Number of patients who have had at least one prescription in 2018 divided by the total number of patients who had at least one outpatient visit in 2018 in that age group*

Family doctors see patients of all socioeconomic backgrounds. UTOPIAN patients tend to live in neighborhoods with higher income and less material deprivation. Material deprivation is defined as “the inability for individuals and communities to access and attain basic material needs” (Matheson et al., 2018). However, there are pockets of low income and deprivation: 19 percent of patients live in the lowest income neighbourhoods and 16 percent live in the most deprived neighbourhoods (Table 4a and 4b).

TABLE 4A: PERCENTAGE OF PATIENTS LIVING IN NEIGHBOURHOODS WITH THE LOWEST TO HIGHEST INCOME LEVELS

Neighbourhood Income Level	Percentage of patients
Lowest income	19
Moderately low income	16
Mid-level income	17
Moderately high income	19
Highest income	26
Missing	3

**Based on 396,892 patients with valid postal codes that were successfully mapped to income quintiles (provided by Statistics Canada)
Quintiles represent one fifth (or 20%) of all people*

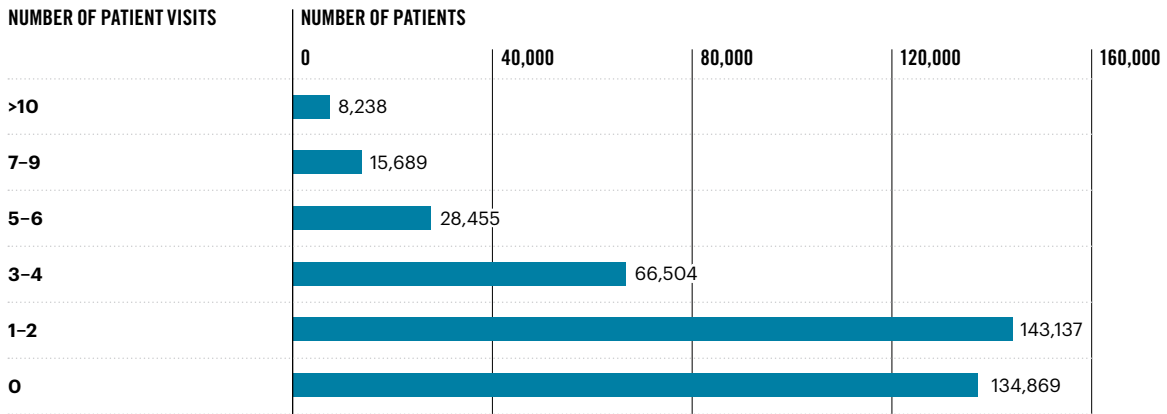
TABLE 4B: PERCENTAGE OF PATIENTS LIVING IN NEIGHBOURHOODS DEFINED BY PARTICULAR MATERIAL DEPRIVATION

Neighbourhood Deprivation	Percentage of patients
Most deprived	16
Deprived	16
Mid-level	19
Less deprived	22
Least deprived	24
Missing	3

**Based on 396,892 patients with valid postal codes that were successfully mapped to material deprivation quintiles (provided by the Canadian Institute for Health Information)
Quintiles represent one fifth (or 20%) of all people*

Nearly two thirds of UTOPIAN patients saw a UTOPIAN family doctor at least once in the last year. It is noteworthy that two percent of patients had ten or more visits with their family doctors (Figure 1).

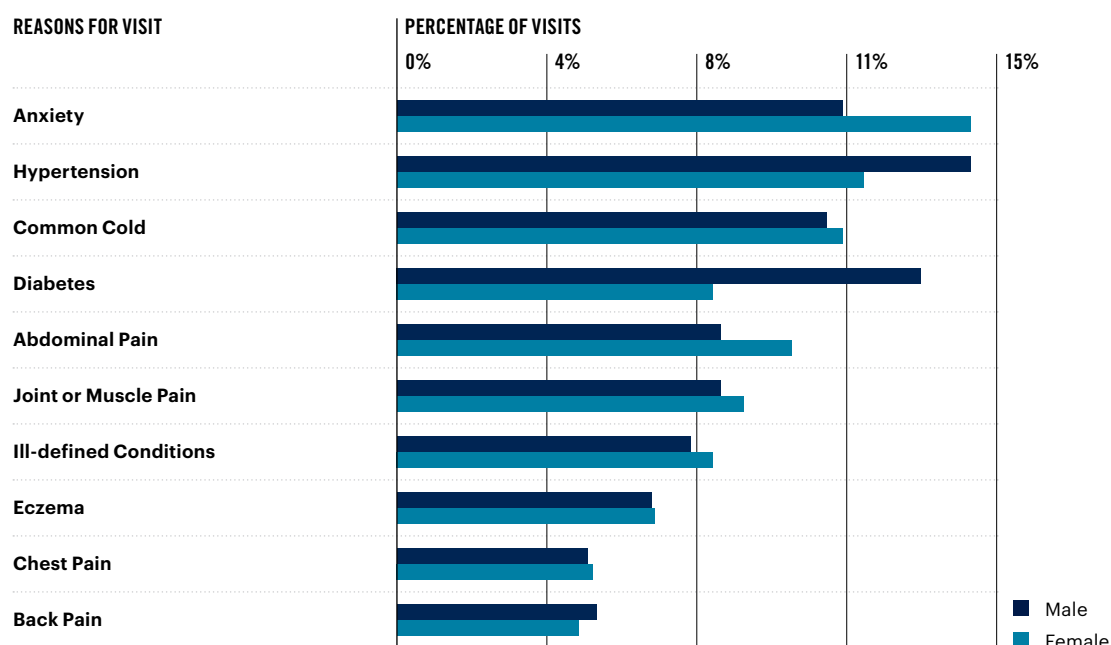
FIGURE 1: VOLUME OF VISITS BY PATIENTS TO UTOPIAN FAMILY DOCTORS IN 2018*



*Based on 396,892 patients

Family doctors see people for a wide variety of medical reasons. The most frequent reason for clinic visits to a family doctor, according to billing records, is anxiety. However, doctors also saw patients nearly as often for hypertension, the common cold and diabetes, clearly illustrating the broad scope of conditions they deal with on a daily basis (Figure 2). These numbers may under-estimate the conditions managed by family doctors, since most patients want to address multiple concerns per visit, but only one issue is tracked in billing records per visit.

FIGURE 2: TOP 10 REASONS FOR VISITS TO FAMILY DOCTORS BY SEX IN 2018*



*Based on 108,276 male patients and 153,686 female patients that had a visit in 2018

Family doctors engage in highly diverse clinical activities, and treat people across a broad range of conditions and level of complexity. The important insights revealed about patients and health care services in the UTOPIAN database provides a robust foundation of knowledge to more deeply explore the features of particular groups treated by family doctors, as explored throughout the rest of this report.

Dr. Noah Crampton is a New Investigator and Lecturer at the University of Toronto Department of Family and Community Medicine and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Dr. Karen Tu is a Professor and Associate Director of the UTOPIAN Data Safe Haven at the University of Toronto Department of Family and Community Medicine and the Institute for Health Policy, Management and Evaluation, a Research Scientist at North York General Hospital and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Dr. Noah Ivers is a Canada Research Chair in Implementation of Evidence-based Practice, Scientist at the Women's College Research Institute, Adjunct Scientist at ICES, an Associate Professor at the University of Toronto Department of Family and Community Medicine and a family doctor at Women's College Hospital Family Practice Health Centre.

Dr. Onil Bhattacharyya is the Frigon-Blau Chair in Family Medicine Research at Women's College Hospital, Senior Scientist at the Women's College Research Institute, an Associate Professor at the University of Toronto Department of Family and Community Medicine and the Institute for Health Policy, Management and Evaluation, and a family doctor at Women's College Hospital Family Practice Health Centre.

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CHAPTER 3

Caring for Children and Youth

AUTHORS:

Francesco Leanza, Laura Kinlin, Catherine Ji,
Sarah Carsley & Catherine Birken

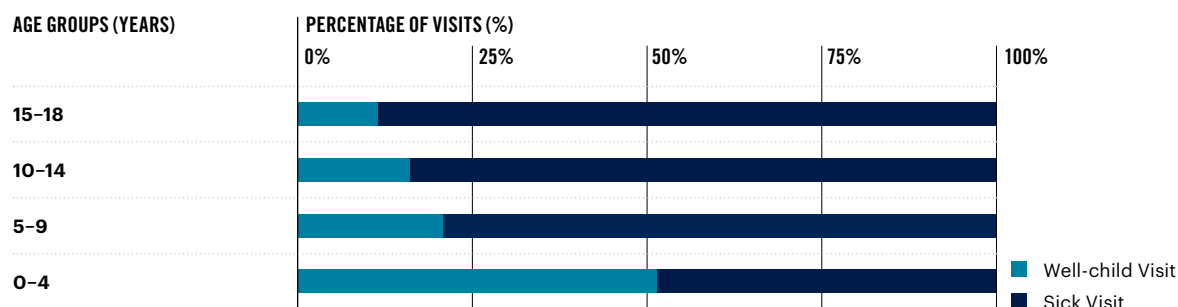
As medical providers for youth across Ontario, family doctors get to know many of their young patients and their families from infancy into adulthood. This relationship provides a unique opportunity to provide comprehensive, long-term continuous care that brings additional value to the patient-doctor relationship, families, communities and the health care system.

Family doctors providing care for children and youth in Ontario

When caring for children and teenagers, family doctors apply health promotion and disease prevention strategies that have the potential for significant, long-term impact on their patient's health. They address important aspects of paediatric care during 'well-child' visits (more commonly known as routine check-ups), including monitoring of growth, development, mental health and screening for at-risk youth. When concerns or needs are identified, family doctors can make referrals to specialists for further assessment and care. Family doctors can also counsel youth and their families and help them find relevant resources on topics like nutrition, mental health services, as well as parenting support.

Family doctors also assess children and youth when they are sick or there are specific health concerns. In children zero to four years old, 52 percent of visits were 'well-child' visits. The proportion of 'well-child' visits decreases to 21 percent of visits in children five to nine years old and continues to decrease as children become older (Figure 1). Family doctors may, therefore, have fewer opportunities for preventive health care at 'well-child' visits in school-aged children and teens, and should, as much as possible, use 'sick' visits to provide screening for at-risk youth, guidance, counselling, and preventive care.

FIGURE 1: PERCENTAGE OF 'WELL-CHILD' VISITS VERSUS 'SICK' VISITS FOR CHILDREN AND YOUTHS IN 2018, BY AGE GROUP*



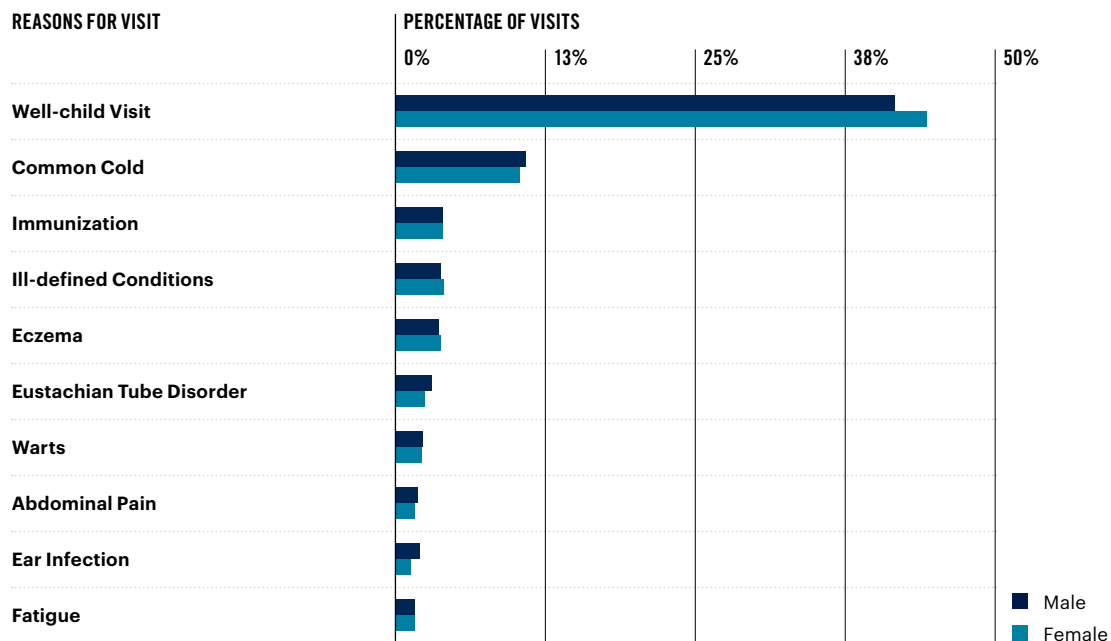
*Based on a total of 106,579 children and youth visits recorded in UTOPIAN in 2018

Common reasons children and youth see their family doctor

The most common reasons for children and youth to see their family doctor are shown in Figures 2 to 5. Based on UTOPIAN data, immunizations and the common cold are amongst the most frequent visit reasons for youth of all ages. Abdominal pain and skin conditions, such as eczema and warts, are common across all age groups.

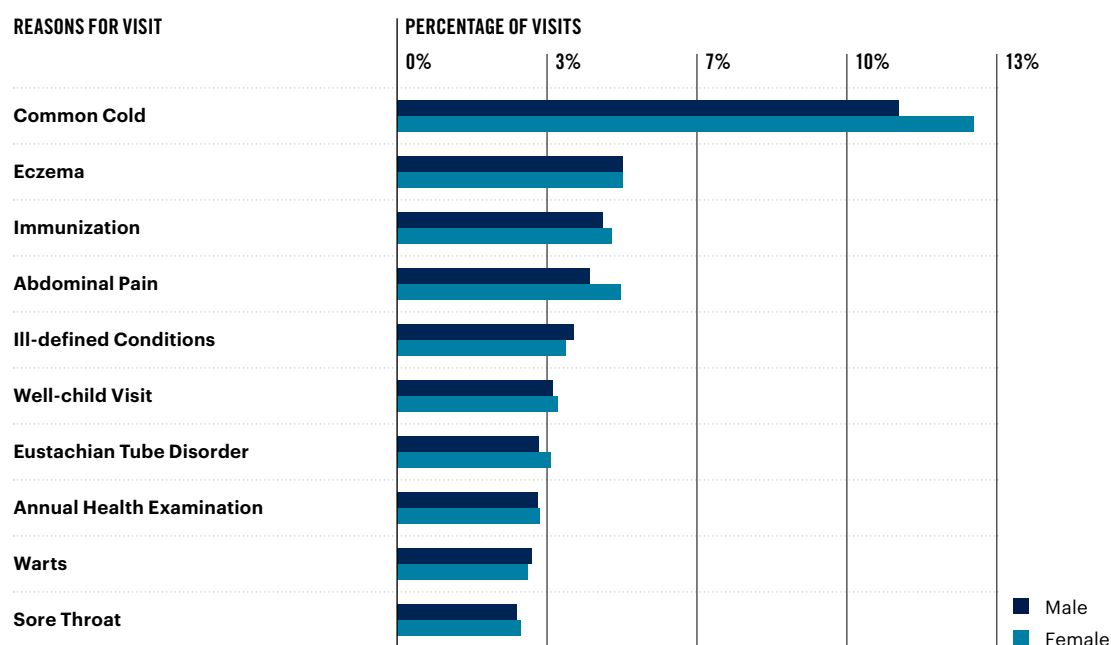
Overall, the data show that mental health-related concerns are a frequent reason older youth visit their family doctor, especially for female patients. Anxiety is the second most common reason 10 to 14 year olds visit their family doctor, and the number one reason in 15 to 18 years old. Depression is the ninth most common visit concern among patients aged 15 to 18.

FIGURE 2: TOP 10 REASONS FOR VISITS TO FAMILY DOCTORS IN 2018 BY SEX FOR PATIENTS AGE 0-4 YEARS*



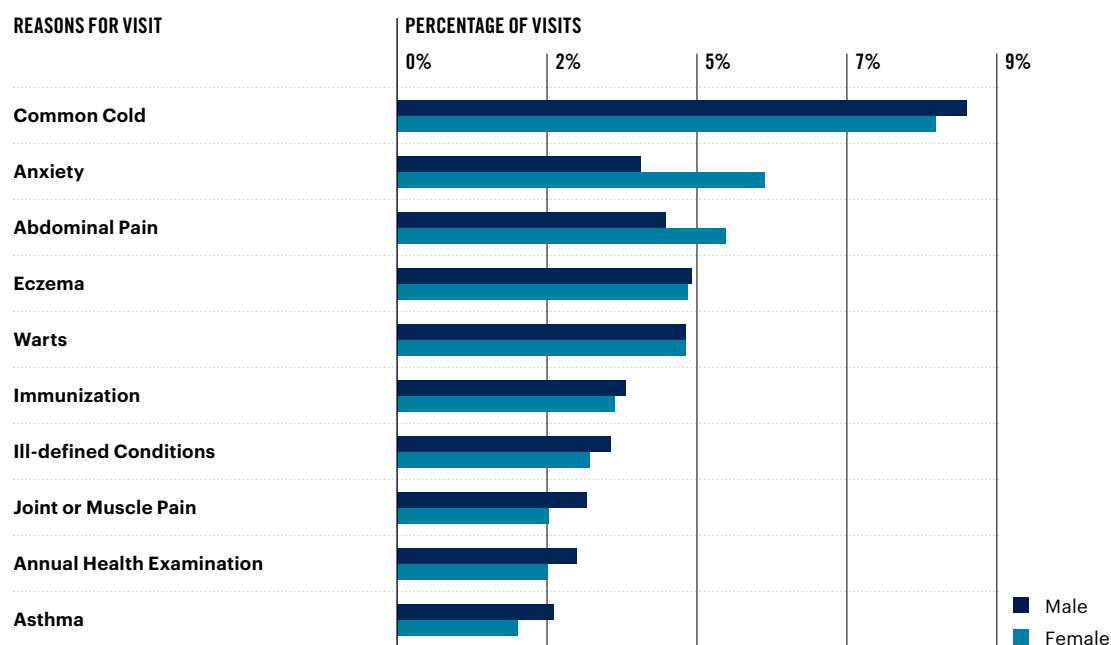
*Based on 26,099 visits by male patients and 23,714 visits by female patients age 0-4 years

FIGURE 3: TOP 10 REASONS FOR VISITS TO FAMILY DOCTORS IN 2018 BY SEX FOR PATIENTS AGE 5-9 YEARS*



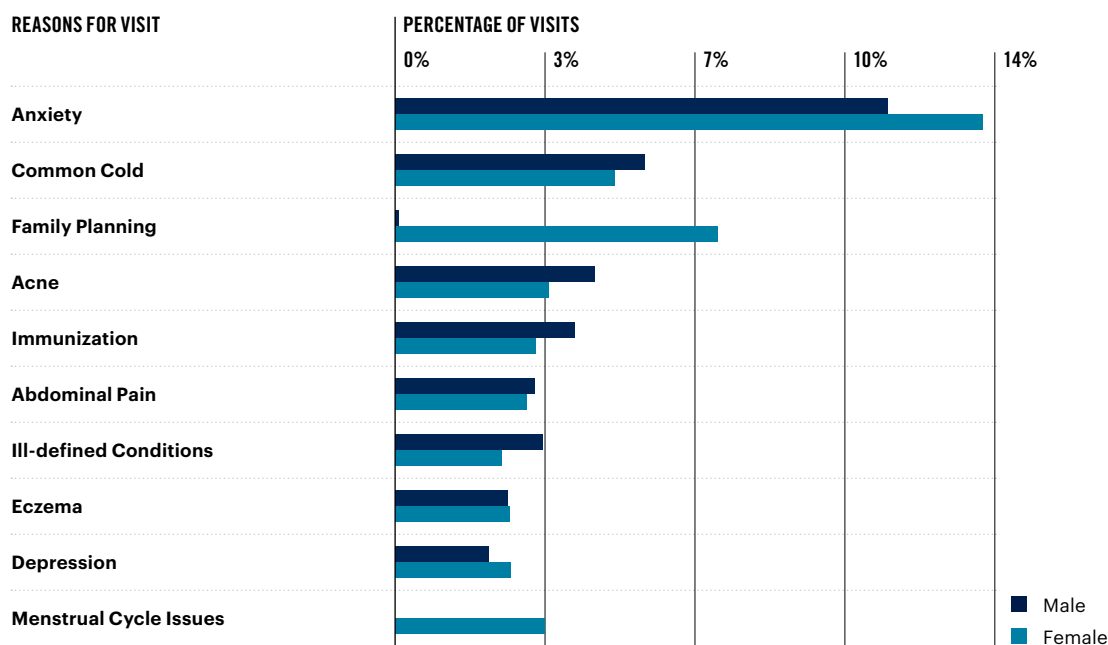
*Based on 9,951 male patients and 9,840 female patients age 5-9 years

FIGURE 4: TOP 10 REASONS FOR VISITS TO FAMILY DOCTORS IN 2018 BY SEX FOR PATIENTS AGED 10-14 YEARS*



*Based on 8,273 male patients and 9,009 female patients age 10-14 years

FIGURE 5: TOP 10 REASONS FOR VISITS TO FAMILY DOCTORS IN 2018 BY SEX FOR PATIENTS AGE 15-18 YEARS*



*Based on 7,542 male patients and 12,151 female patients age 15-18 years

Commonly prescribed medications in children and youth

Data from UTOPIAN show that for the 70,167 children and youth, there was a total of 60,274 prescriptions written, giving an average of 0.86 prescriptions per child or youth.

Amongst all children and youth who received a prescription, antibiotics and asthma medications were part of the ten most commonly prescribed medications across all age groups (Tables 1-4). Medications for attention-deficit hyperactivity disorder (ADHD) became more common after age 10 and were more often prescribed for male patients.

In the group of teenagers aged 15-18 years old who received a prescription, a total of 18 percent were prescribed medications for anxiety or depression (9 percent prescribed Escitalopram and 9 percent prescribed Fluoxetine). When examined by sex, 10 percent of female and 8 percent of male patients from this group were prescribed these two medications. Amongst the same age group, 23 percent of prescriptions to female patients were for oral contraceptive pills (Table 4).

TABLE 1: TOP TEN MEDICATIONS PRESCRIBED FOR PATIENTS AGE 0–4 YEARS IN 2018, BY SEX*

	Medication Name	Purpose	Female Patients	Male Patients
1	Amoxicillin	Antibiotic to treat bacterial infections	39%	40%
2	Salbutamol	Inhaled medication to treat asthma	13%	17%
3	Hydrocortisone	Topical steroid for skin inflammation and itching	9%	9%
4	Fluticasone	Inhaled medication to treat asthma	7%	10%
5	Betamethasone	Topical steroid for skin inflammation and itching	6%	7%
6	Azithromycin	Antibiotic to treat bacterial infections	6%	7%
7	Clotrimazole	Topical cream to treat fungal infections	6%	4%
8	Fusidic acid	Topical antibiotic to treat bacterial infections	5%	5%
9	Cefprozil	Antibiotic to treat bacterial infections	4%	5%
10	Epinephrine	EpiPen for severe allergic reactions	3%	4%

*Based on 3,550 male patients and 3,090 female patients age 0–4 years who received a prescription in 2018

Note patients may be prescribed more than one type of medication

TABLE 2: TOP TEN MEDICATIONS PRESCRIBED FOR PATIENTS AGED 5–9 YEARS IN 2018, BY SEX*

	Medication Name	Purpose	Female Patients	Male Patients
1	Amoxicillin	Antibiotic to treat bacterial infections	35%	29%
2	Salbutamol	Inhaled medication to treat asthma	15%	17%
3	Fluticasone	Inhaled medication to treat asthma	10%	11%
4	Betamethasone	Topical steroid for skin inflammation and itching	6%	7%
5	Azithromycin	Antibiotic to treat bacterial infections	6%	6%
6	Epinephrine	EpiPen for severe allergic reactions	4%	5%
7	Dexamethasone	Oral steroid to reduce inflammation	5%	4%
8	Fusidic acid	Topical antibiotic to treat bacterial infections	4%	4%
9	Hydrocortisone	Topical steroid for skin inflammation and itching	4%	4%
10	Cefalexin	Antibiotic to treat bacterial infections	4%	3%

*Based on 2,768 male patients and 2,623 female patients age 5–9 years who received a prescription in 2018

Note patients may be prescribed more than one type of medication

TABLE 3: TOP TEN MEDICATIONS PRESCRIBED FOR PATIENTS AGED 10–14 YEARS IN 2018, BY SEX*

	Medication Name	Purpose	Female Patients	Male Patients
1	Amoxicillin	Antibiotic to treat bacterial infections	17%	15%
2	Salbutamol	Inhaled medication to treat asthma	14%	16%
3	Fluticasone	Inhaled medication to treat asthma	7%	9%
4	Betamethasone	Topical steroid for skin inflammation and itching	7%	7%
5	Methylphenidate	Attention deficit hyperactivity disorder	3%	9%
6	Epinephrine	EpiPen for severe allergic reactions	5%	6%
7	Azithromycin	Antibiotic to treat bacterial infections	5%	5%
8	Mometasone	Nasal congestion caused by allergies	4%	5%
9	Dexamethasone	Oral steroid to reduce inflammation	5%	4%
10	Clindamycin	Antibiotic to treat bacterial infections	5%	2%

*Based on 2,552 male patients and 2,597 female patients age 10–14 years who received a prescription in 2018

TABLE 4: TOP TEN MEDICATIONS PRESCRIBED FOR PATIENTS AGED 15–18 YEARS IN 2018, BY SEX*

	Medication Name	Purpose	Female Patients	Male Patients
1	Levonorgestrel & Estrogen	Hormonal medication for birth control	23%	0%
2	Salbutamol	Inhaled medication to treat asthma	8%	11%
3	Clindamycin	Antibiotic to treat bacterial infections	8%	9%
4	Amoxicillin	Antibiotic to treat bacterial infections	6%	7%
5	Adapalene	Topical cream for acne	5%	7%
6	Betamethasone	Topical steroid for skin inflammation	5%	5%
7	Escitalopram	Oral medication for anxiety/depression	5%	4%
8	Fluoxetine	Oral medication for anxiety/depression	5%	4%
9	Methylphenidate	Attention deficit hyperactivity disorder	2%	7%
10	Naproxen	Anti-inflammatory for pain relief	5%	2%

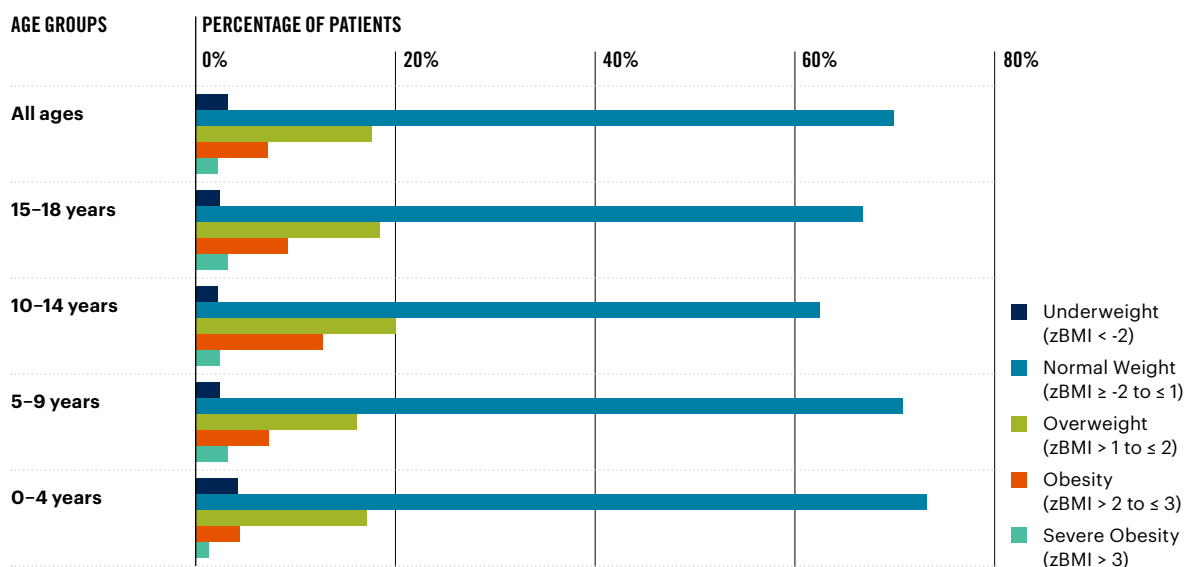
*Based on 2,418 male patients and 3,994 female patients age 15–19 years who received a prescription in 2018

Overweight and obesity in children and youth

Of the 23,628 children and youth for whom a standardized body mass index (zBMI) could be calculated based on weight and height measurements in 2018, more than a quarter (27 percent) were overweight or obese according to World Health Organization growth reference standards (de Onis, 2007; de Onis, 2009). The proportion of males who were overweight or obese was higher than the proportion of females who were overweight or obese across all age groups (Figures 6–8). This sex-based difference was largest for children between the ages of 10 and 14 years old and has been previously reported in middle childhood in Canada (Carsley et al., 2019; Rodd & Sharma, 2016).

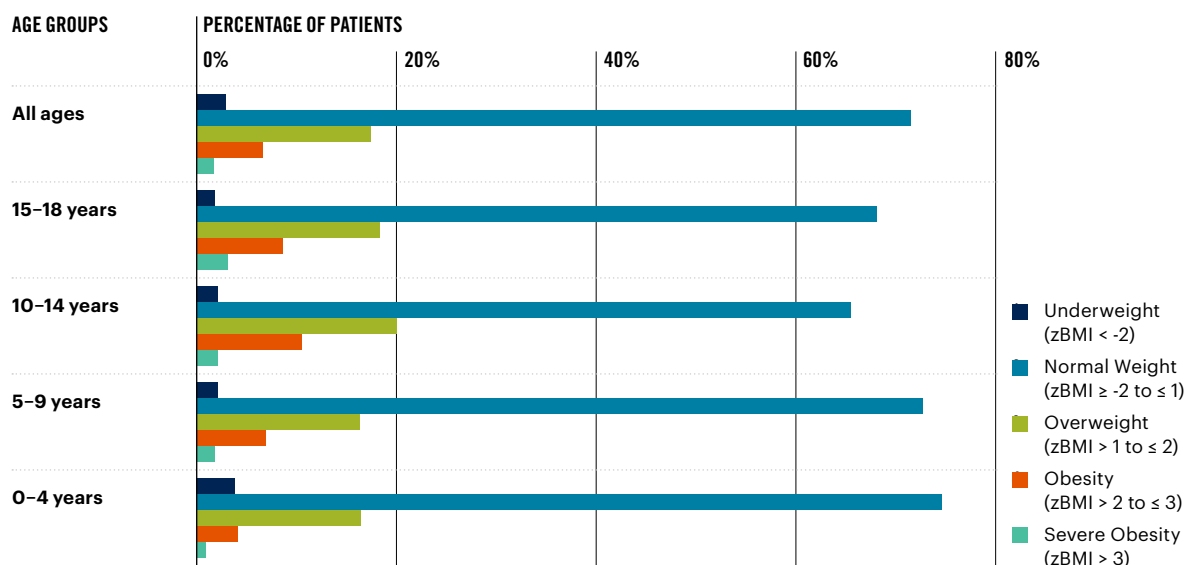
Overall, UTOPIAN data confirm that being overweight or obese continues to be a common health problem in children and youth. Given that many children and youth are being cared for by family doctors, opportunities for primary care-based prevention, screening and management of obesity by family doctors should be further explored.

FIGURE 6: STANDARDIZED BODY MASS INDEX (zBMI) FOR CHILDREN AND YOUTH BY AGE*



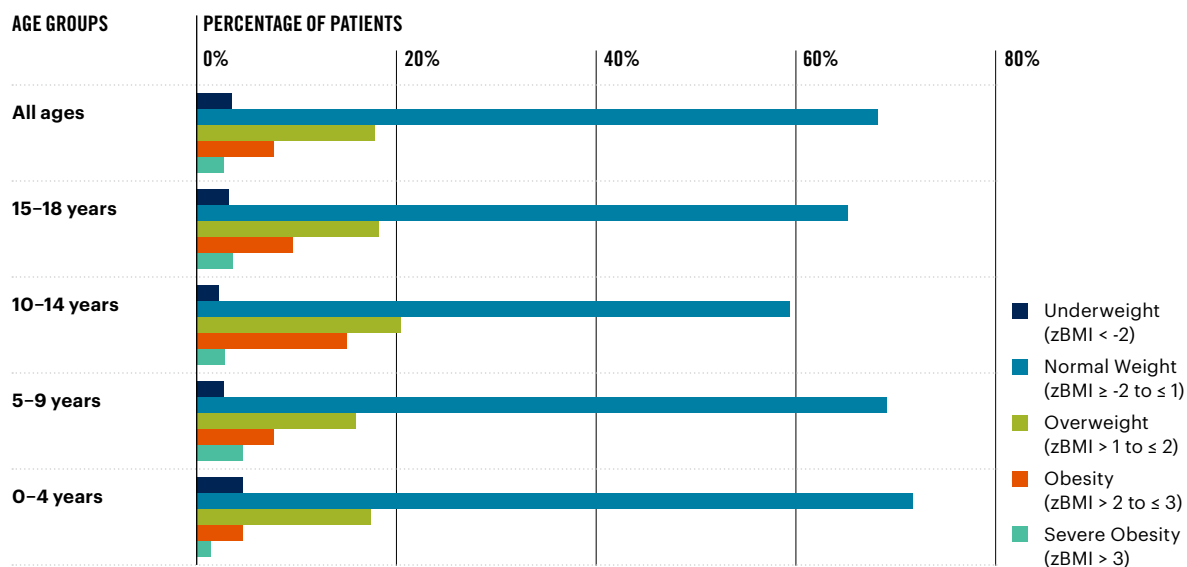
*Based on 22,660/70,167 = 32 percent of patients ages 0–18 years with zBMI recorded or calculated in 2018

FIGURE 7: STANDARDIZED BODY MASS INDEX (zBMI) FOR FEMALE CHILDREN AND YOUTH BY AGE*



*Based on 11,187/34,785 = 32 percent of female patients ages 0-18 years with zBMI recorded or calculated in 2018

FIGURE 8: STANDARDIZED BODY MASS INDEX (zBMI) FOR MALE CHILDREN AND YOUTH BY AGE*



*Based on 11,473/35,382 = 32 percent of male patients ages 0-18 years with zBMI recorded or calculated in 2018

Overall implications for the care of children and youth

UTOPIAN data help us better understand the health and needs of children and youth seeing their family doctor. These data show that family doctors are providing care for children and youth not only for preventive and acute care but also for behavioural and mental health-related concerns. The long-term relationships that family doctors have with their young patients foster trust and allow for early initiatives to promote health and wellness to Ontario's children and youth.

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Dr. Laura Kinlin is a general paediatrician and a post-doctoral research fellow at the Hospital for Sick Children.

Dr. Catherine Ji is a Lecturer at the University of Toronto Department of Family and Community Medicine and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Dr. Sarah Carsley, PhD, is the Applied Public Health Science Specialist in Healthy Growth and Development at Public Health Ontario and an Assistant Professor in Epidemiology at the University of Toronto.

Dr. Catherine Birken is a Professor in the Department of Paediatrics at the University of Toronto, a Senior Scientist at the SickKids Research Institute, and a general paediatrician at the Hospital for Sick Children.

Coordinating care for children with severe allergies



Thirteen-year-old Matthew has multiple food allergies including dairy, eggs, sesame, and nuts. His mother, Dr. Sarah Reid, a family doctor at Toronto Western Hospital and an Assistant Professor at the University of Toronto Department of Family and Community Medicine (DFCM), first noticed that he might have food allergies when he was only six months old.

“When I introduced cereal into his diet at around six months, he cried and wouldn’t eat it. I tried feeding it to him again, and I started noticing something like hives around his mouth on the third try. After looking at the ingredient list, I noticed it had milk powder in it and I thought maybe he was allergic to milk,” says Dr. Reid.

To confirm her suspicions, Dr. Reid brought Matthew in to see his family doctor, Dr. Anne Wideman, who practices at Sunnybrook Academic Family Health Team and is an Assistant Professor at DFCM. Dr. Wideman coordinated an allergy test, which verified Dr. Reid’s suspicions.

“Dr. Wideman has been very helpful—not just when he was a baby, but even now,” Dr. Reid said. “She has been Matthew’s family doctor since he was born. She knows our family and our history, so whenever she sees Matthew, we don’t have to explain everything from the beginning. She knows everything about him—from his allergies to his asthma.”

Since confirming Matthew’s allergies, both Matthew and Dr. Reid have been careful about managing the food that Matthew eats.

“Most of the time, we eat at home so we can prepare food that’s safe for Matthew, but it’s definitely something we have to take into consideration—especially when we’re traveling,” says Dr. Reid.

Speaking from a family doctor’s perspective, Dr. Reid says, “As family doctors, we try to help patients access the resources they need to be informed. For example, my role for kids like Matthew with severe allergies is to try to help the parents understand the lifestyle changes required to manage their child’s allergies and reinforce when and how to use the EpiPen. Although we don’t provide specialist care, we definitely help patients access certain resources and coordinate specialist care.”

Family doctors provide the critical link between patients and specialty care, acting as the patient’s anchor in a siloed health care system that can be difficult to navigate. Effective patient care coordination helps to ensure a seamless transition for patients between care settings throughout their life. This allows family doctors to develop a comprehensive understanding of their patient’s health across different life stages and build a relationship with them over time that is unique to the discipline of family medicine.



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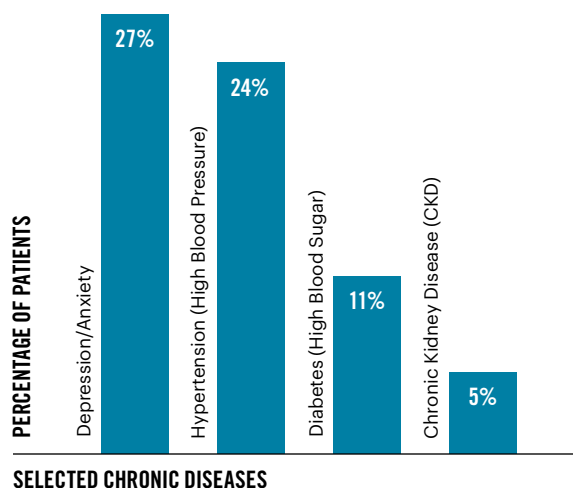
CHAPTER 4

Meeting the Needs of People Living with Chronic Disease

AUTHOR:
Pauline Pariser

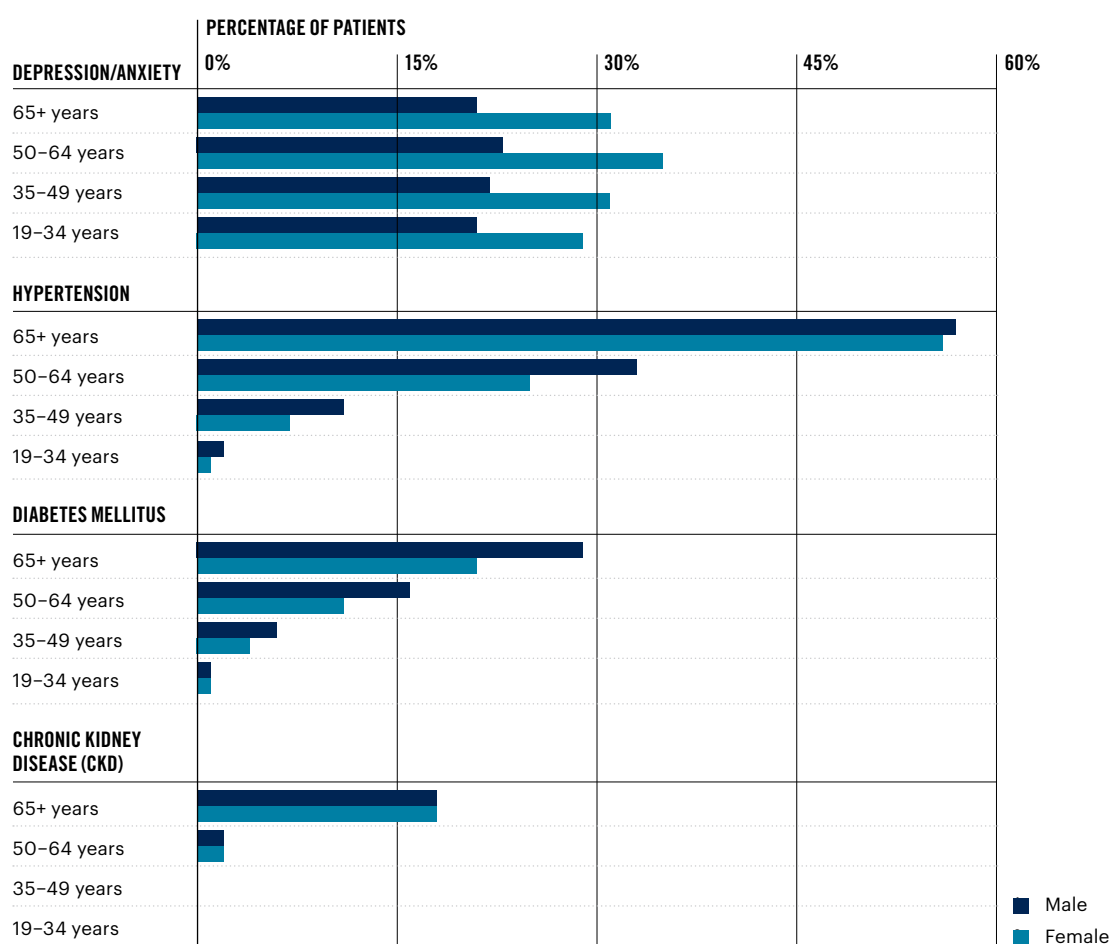
In Canada, one in three people live with one or more chronic diseases and in Ontario four conditions account for 75 percent of all deaths (Roberts et al., 2015 ; Doty et al., 2019). Our aging population combined with advances in medical technology have contributed to people living longer with one or more chronic diseases (Shields et al., 2010; Marengoni et al., 2011). These conditions can be associated with physical and mental health ailments (depression, substance use (e.g., alcohol or drugs)), using more than one prescribed drug (polypharmacy) or living in poverty (Boyd et al., 2010; Pefoyo et al., 2015). Meeting the multiple needs of these people, who are at increased risk for emergency department visits and hospital admissions (Kirby et al., 2010; McCusker et al., 2010) can be challenging for their family doctors (National Physician Survey, 2014; Grant et al., 2011).

FIGURE 1: PERCENTAGE OF SELECTED CHRONIC DISEASES IN ADULTS*



**Based on 326,725 adult patients age 19 years and older*

FIGURE 2: PERCENTAGE OF PATIENTS WITH SELECTED CHRONIC DISEASES BY AGE AND SEX*



*Based on 141,266 male patients and 185,459 female patients age 19 years and older

The prevalence of chronic diseases increases as people age. Hypertension and diabetes are more common in adult males, while depression/anxiety is clearly more common in females (Figure 2).

Family doctors are best suited to guide people who experience multiple interactions with the health care system because they form strong relationships with their patients over time. (Caley, 2013). However, managing more complex cases can be difficult for doctors who practice by themselves in small community practices (Holmboe et al., 2005) and do not have support from nurses or other health professionals. A recent survey confirmed that 42 percent of family doctors lack adequate staffing to make referrals and coordinate care (Doty et al., 2019).

One common limitation in office practice is inadequate time to address multiple conditions within a typical 15-minute appointment (Smith et al., 2017). Despite the advantage of health team-based care (Wagner, 2000; Grumbach & Bodenheimer, 2004), the majority of practices in Ontario (approximately 7,800 in Ontario and 924 in Toronto) (Toronto Central LHIN, 2019), are unaffiliated with teams. With the withdrawal of many family doctors from active hospital care, there has been a growing separation between family doctors and specialists. This separation impacts care coordination: only 58 percent of family doctors are informed of changes to medication or care plans by specialists and even fewer – 16 percent receive results of specialist consultations within a week (Doty et al., 2019).

Seamless Care Optimizing the Patient Experience (SCOPE)

The SCOPE program seeks to repair this separation and lack of coordination between family doctors, specialists and community services to help treat a variety of illnesses, including chronic diseases. Launched in 2012 in partnership with the Toronto Central Local Health Integration Network (TCLHIN), Women's College Hospital and University Health Network, the program began with the simple premise that family doctors know what they need to look after their most vulnerable patients but may have difficulty accessing the necessary services.

Patients and family doctors were involved early in the design of SCOPE (Dickinson & Ham, 2008). They told us their biggest need was a single point of access to a nurse navigator, medical specialists, radiologists, and home and community care coordinators for timely hospital and community-based care. They also needed timely communication of hospital-based test results (Pariser et al., 2016).

"A simple referral from my doctor to SCOPE evolved into a network for complete support for every aspect of my life—counselling, financial, housing, legal—emotional and medical accompaniment." —F. Zentilli, SCOPE patient

Since launch, SCOPE has expanded across Toronto to register 620 family doctors and other health care providers, or 64 percent of small practices. Of the nearly 22,000 contacts since 2012, 40 percent were able to divert patients from emergency rooms.

Furthermore, wait-times for specialist care improved by 20–50 percent compared to usual practice.

Another fundamental shift was increased connections. Previously isolated small family practices became a connected community of practice: a coalition that shared information, participated in testing new programs, and became invested in improving health care delivery (Lockhart et al., 2019).

"SCOPE has had a profoundly positive effect on providing care to my patients, a decreased sense of practicing in isolation and an increased feeling of connectivity to the medical community." —Dr. Claudio Borgono

Ultimately, SCOPE identified service gaps, and offered opportunities to work in tandem with specialists to treat people with chronic disease.

SCOPE has developed both a program of services and a platform to feature the family doctor as the key integrator of care, especially for patients living with chronic disease. This has reduced the isolation for small practices and enabled responsive, coordinated co-management for those who need it most.

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Diabetes distress or burnout from medication management and side effects—a risk for all diabetes patients



When Marna was diagnosed with Type 1 diabetes eight years ago, she was shocked. Before her diagnosis, she had not experienced any symptoms that would indicate she had the disease. At the time, however, she had no idea just how much her life would change.

“At first, I was determined to manage it without medication and I drastically improved how I was eating and exercised more,” says Marna, a retired communications executive in Toronto.

But after a year of adjusting her lifestyle, her diabetes had not improved—in fact, it had gotten worse. It was difficult for her to accept that her chronic disease was out of her hands.

“I felt discouraged and got really down for a while. At that point, the true reality of my diagnosis set in.”

Marna now takes three insulin shots with every meal. But determining the dosage is a balancing act: each meal requires her to regulate her insulin dosage based on her blood glucose levels, what she’s eating, the timing between meals and other factors.

“Even with all my support, I have still found this condition physically, mentally and emotionally exhausting. Many people do not understand just how life-limiting this disease can be—I don’t travel like I used to for fear of being too far away from quality medical services, I’m often fatigued, I have to monitor my health carefully all the time, and when my blood sugar is too low or too high it can be very scary. I need to be very vigilant, and that brings a certain level of anxiety.”

While Marna—a well-educated woman with financial means and an extensive support system—has been able to educate herself about her condition and keep on top of her medications and appointments, she worries about others with the disease who are not in such a fortunate position.

“I wonder about people without support to manage this disease. Even with everything I have, I can feel overwhelmed at times so I can’t imagine how hard it would be for those without family nearby, or who struggle with other diseases, or have financial or other constraints.”

But Marna is giving back. She’s a patient member of SCOPE’s patient advisory committee, designed to provide patients who need multiple medical services with access to a streamlined, one-stop-shop by connecting their doctors with specialists as necessary. She says several patients on the advisory committee received a rapid diagnosis—including several life-saving diagnoses—because of SCOPE.

“Diabetes distress—where you just get burned out and depressed from dealing with this disease—can happen to anyone of any background,” says Marna. “People truly don’t understand the extent many of us have to go to manage this disease. But support for those who are living with this disease who are also facing other challenges is particularly needed—SCOPE can, at the very least, help identify and treat potential complications faster and smoother.”



5



CHAPTER 5

Recognizing the Complexity of Care for Older Adults

AUTHORS:

Michelle Greiver, Sid Feldman & Ross Upshur

Attention to the care of older adults (65 years old and over), particularly those over the age of 80, has taken greater prominence in health policy in the early 21st century. Demographic trends in Canada have resulted in an unprecedented number of older adults.

There has been considerable policy focus on healthy aging and initiatives to increase preventive interventions in older adults at all levels of government and at the World Health Organization. However, the reality is that most older adults will have ongoing health care needs.

The rapid growth of the population of older adults also raises concerns over who will care for the most elderly people in our community. Many of these patients are frail, less able to care for themselves and are among the most vulnerable in our communities. In order to remain in their own homes and be as independent as possible, they require support from family, other community services and expert medical care. Family doctors are ideally suited to provide this care, as they have often journeyed with their patients through the aging process.

People tend to develop more health conditions as they age; this can include diabetes, osteoarthritis or high blood pressure. Many health conditions are managed through medications, which means that people with several medical problems may also be taking multiple medications. Some drugs are focused on reducing risks (for example, of another heart attack) and do not treat symptoms or help people function better in their daily lives. Taking more medications than needed can create a problem called polypharmacy.

Polypharmacy has risks, especially in frail older people

Peoples' ability to tolerate medication side effects may worsen with age and with increasing frailty. We know that the risk of drug interactions (one medication interfering with another) increases with the number of medications taken. Polypharmacy is common in older adults: two thirds of Canadians aged 65 or older are on five or more medications—and over one quarter are taking 10 or more medications.

Using data from UTOPIAN, we found that each family doctor looks after, on average, 25 older adults that received prescriptions for 10 or more different drugs. There were 9,075 complex patients among 360 family doctors. Some patients received even larger numbers of prescriptions for different drugs with 443 (4.9 percent) of the older adults who received prescriptions for 10 or more different drugs actually receiving prescriptions for 20 or more different drugs over 12 months (Figure 1). We compared these complex patients to those with fewer than 10 different drug prescriptions. We found that, on average, the most complex patients were older (21 percent were

85 years of age or older) (Figure 2) but similar in sex distribution (Figure 3). They were more likely to live in lower income areas: 25 percent of these patients live in the poorest neighborhoods (Figure 4). 32 percent of these complex patients saw their family doctor 10 times or more in a year, compared to only five percent of older adults on less than 10 medications (Figure 5). Complex patients have more mental health visits compared to non-complex patients (Figure 6).

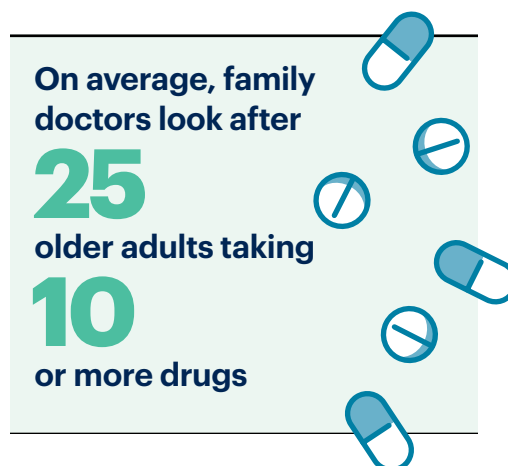
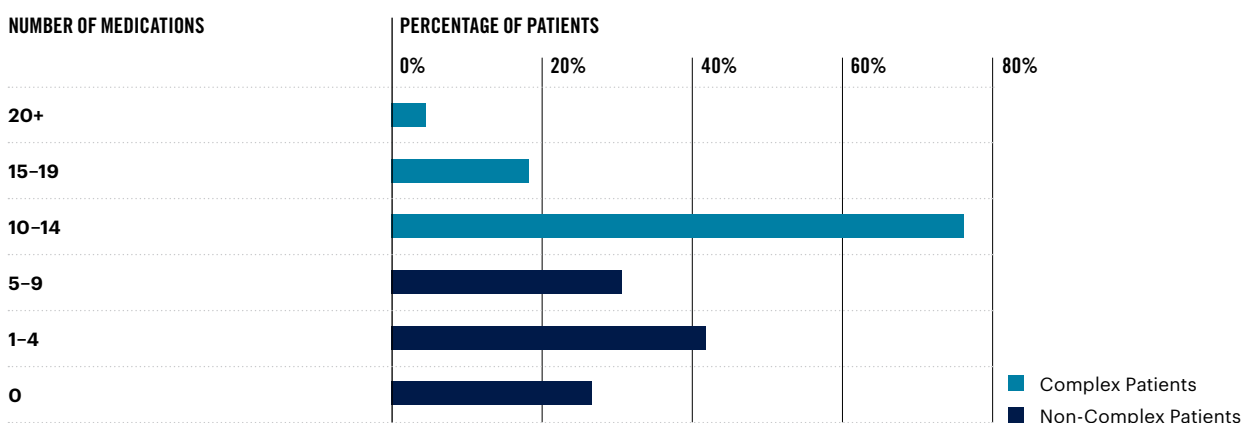
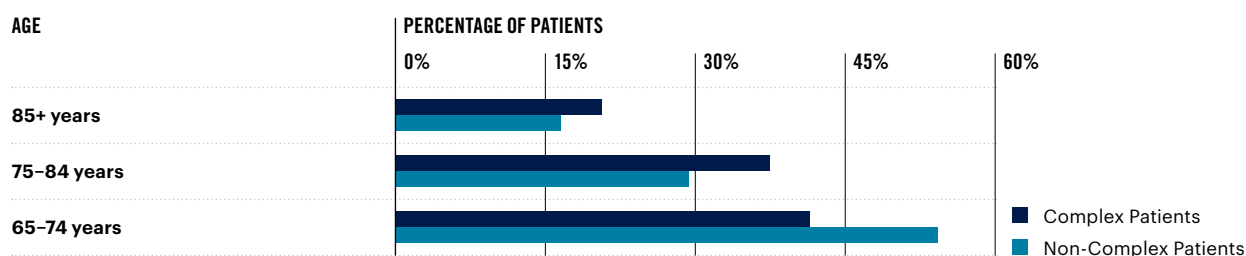


FIGURE 1: COMPLEX AND NON-COMPLEX PATIENTS BY NUMBER OF MEDICATIONS IN 2018*



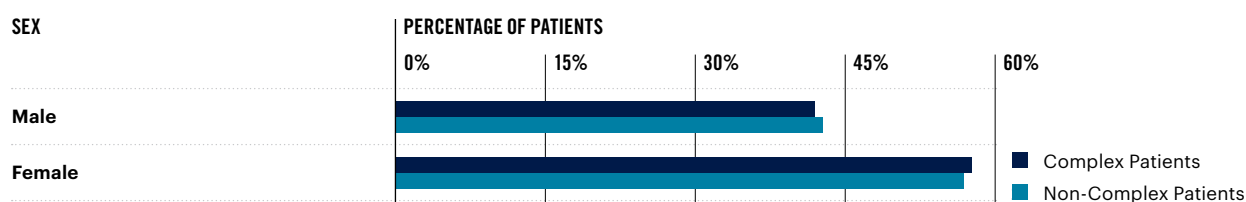
*Based on 9,075 complex patients and 71,363 non-complex patients age 65 years and older

FIGURE 2: COMPLEX AND NON-COMPLEX OLDER ADULTS BY AGE*



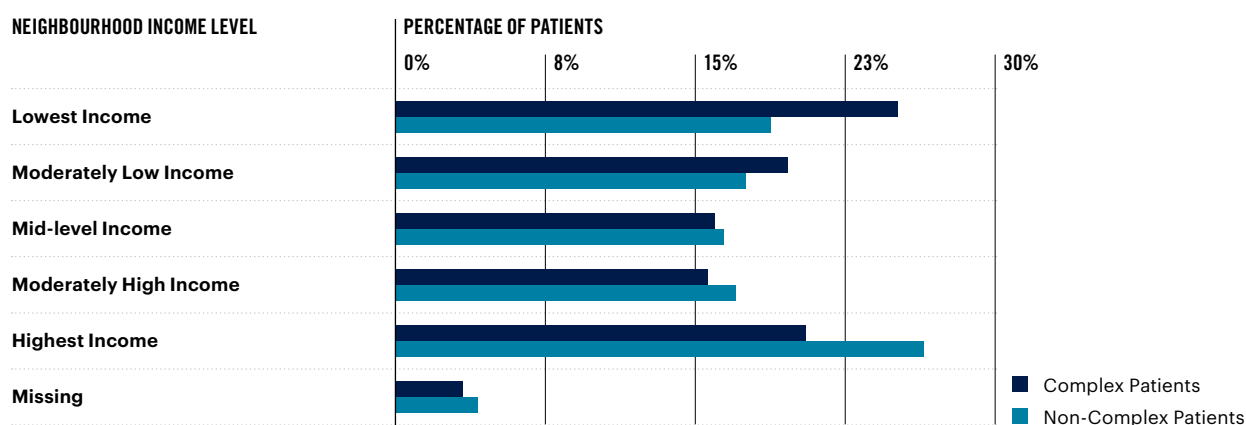
*Based on 9,075 complex patients and 71,363 non-complex patients age 65 years and older

FIGURE 3: COMPLEX AND NON-COMPLEX OLDER ADULTS BY SEX*



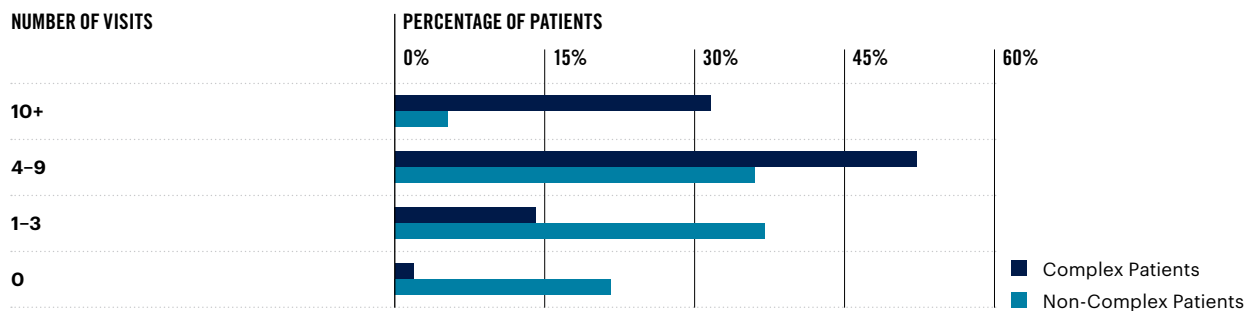
*Based on 9,075 complex patients and 71,363 non-complex patients age 65 years and older

FIGURE 4: COMPLEX AND NON-COMPLEX PATIENTS BY NEIGHBOURHOOD INCOME LEVEL*



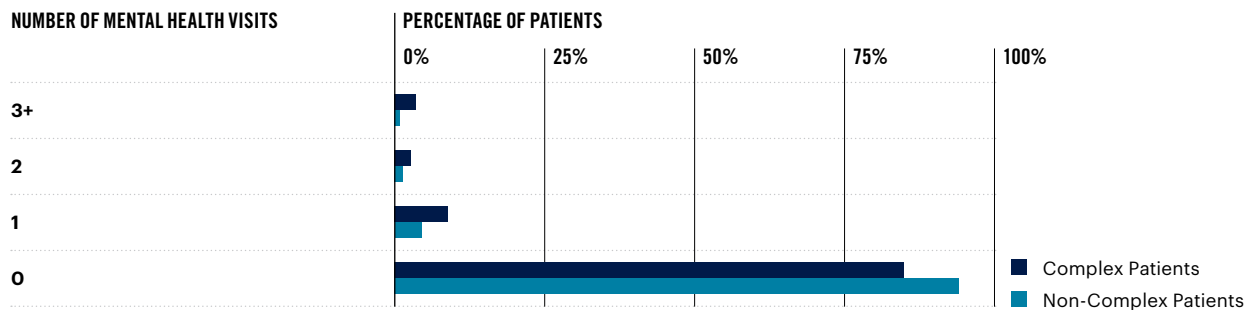
*Based on 9,075 complex patients and 71,363 non-complex patients age 65 years and older

FIGURE 5: COMPLEX AND NON-COMPLEX PATIENTS NUMBER OF VISITS TO A UTOPIAN FAMILY DOCTOR IN 2018*



*Based on 9,075 complex patients and 71,363 non-complex patients age 65 years and older

FIGURE 6: COMPLEX AND NON-COMPLEX PATIENTS NUMBER OF MENTAL HEALTH VISITS TO A UTOPIAN FAMILY DOCTOR IN 2018*



*Based on 9,075 complex patients and 71,363 non-complex patients age 65 years and older

The most prescribed medication among complex patients was Pantoprazole, a drug that reduces acid in the stomach (Table 1). This was prescribed to over a third of patients. While this type of medication can be helpful over the short term for some people, over longer periods of time, it increases the risk of pneumonia, hip fractures and diarrhea. Though sometimes needed for longer periods, the drug is costly and there may be safer alternatives. Often, the medication may no longer be needed.

TABLE 1: TOP 10 MEDICATIONS PRESCRIBED TO COMPLEX PATIENTS IN 2018*

Medication	Purpose	Number of complex patients prescribed	Percentage of complex patients prescribed
Pantoprazole	Stomach and esophagus problems such as heartburn	3,140	35
Atorvastatin	Lowers cholesterol	2,919	32
Amlodipine	Lowers blood pressure (hypertension)	2,870	32
Rosuvastatin	Lowers cholesterol	2,832	31
Metformin	Lowers blood sugar (diabetes)	2,195	24
Levothyroxine	Underactive thyroid (hypothyroidism)	2,078	23
Acetaminophen (Tylenol)	Fever and pain relief	2,070	23
Salbutamol	Inhaled medication to treat asthma	1,993	22
Furosemide	Reduces fluid in the body	1,974	22
Acetylsalicylic Acid (Aspirin)	Anti-platelet, pain relief	1,853	20

* Based on 9,075 complex patients age 65 years and older

A DFCM project tackling polypharmacy in older patients

Family doctors in the University of Toronto Department of Family and Community Medicine (DFCM) want to work with their older patients on safer prescribing. Stopping medications that may be harmful could improve health. DFCM researchers are leading a national project called SPIDER (Structured Process Informed by Data, Evidence and Research). The goals of this project are to support family doctors by providing tools, collaborative learning sessions, and practice coaching to help them and their patients stop medications that may not be of benefit. SPIDER principles are now being tested as part of a large research project, which will measure whether this results in positive changes.

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Dr. Ross Upshur is a Professor at the University of Toronto Department of Family and Community Medicine, the Head of the Division of the Clinical Public Health at the Dalla Lana School of Public Health at the University of Toronto, the Associate Director Lunenfeld Tanenbaum Sinai Health and a family doctor at Bridgepoint.

When the cure is causing the illness

In her 70s, Judith Maxwell lived a very active life traveling, teaching music, participating in a band and spending time with her family. However, that changed in July 2008 after a visit to a health specialist sent her on an eight-year journey with polypharmacy and prescription cascade.

“I was on minimal medications at the time—I had mild type 2 diabetes and a very mild condition of high blood pressure. My family doctor referred me to a specialist for my diabetes and after spending ten minutes with me, she increased the dosage of my prescription and added additional medications to my drug plan,” said Judith. “I was already right into polypharmacy, although I didn’t know it at the time.”

Polypharmacy refers to patients who use multiple medications concurrently. Taking multiple medications is not necessarily ill-advised, but there are instances where it can lead to negative outcomes such as in Judith’s case.

Judith started to experience adverse reactions to taking so many medications such as irregular and

rapid heart rate, pain, confusion, disorientation, fatigue, depression, anxiety, and many more. These reactions led to many visits to hospital emergency departments where her new symptoms that arose because of her new prescriptions were treated with even more medications, a process known as prescription cascade. Eventually, Judith needed to move her home closer to her family for assistance and support in everyday life.

After multiple visits to over 22 doctors over eight years, Judith’s doctor informed her that the symptoms she was experiencing may have been a result of adverse drug interactions between the many medications she was taking. She then started to slowly reduce her medications, and now she has been able to return to participating and enjoying her life to its fullest.

“I have to say that in all of this, I only once had a doctor or nurse who didn’t try their very best to try to solve the problem that I was having,” says Judith. “A lot of people really cared about me—including my family doctor.”



6



CHAPTER 6

Addressing Challenges for People with Disabilities

AUTHOR:

Laurie Green

The definition of disability is complex, controversial and, ultimately, individual. It is a common societal and health term applied to children and adults whose “medical” conditions, in the context of personal factors and the limitations of their environment, result in impairments, activity limitations and participation restrictions. It is a highly contextual definition, one that ignores strengths and is best created and informed by those who are affected. International estimates place the prevalence of ‘disability’ worldwide at 15 percent (WHO, 2011) and Canadian estimates are at 24 percent of women and 20 percent of men (Statistics Canada, 2017); these rates are increasing. As a group, those with disability have a higher rate of premature death, unhealthy behaviours and are at increased risk of exposure to violence and unintentional injury (WHO, 2011). They are more likely to have co-morbidities, particularly mental health concerns, than people without a disability.

Disability status also has an impact on social determinants of health. People with a disability, in general, have lower incomes, lower educational achievement, and higher unemployment rates. They are less likely to live in adequate, affordable, accessible housing.

They are also less likely to have preventive care screening or access to health care services, and more likely to experience unmet health care needs (WHO, 2018). In spite of this, this population is also a high user of medical services. For example, adults with intellectual and developmental disabilities in Ontario are three times more likely to have a repeat hospitalization, 6.5 times more likely to remain in hospital despite recovery and 17.5 times more likely to live in a long-term care facility (Lin et al., 2019). A study of patients with spinal cord injury reported that although they were only six percent of a primary care provider’s caseload, they consumed 33 percent of the practice’s resources (McColl et al., 2012).

Adults with intellectual and developmental disabilities in Ontario are 3x more likely to have a repeat hospitalization, 6.5x as likely to remain in hospital despite recovery, and 17.4x as likely to live in a long-term care facility

(Lin et al, 2019)



Challenges accessing and using health care

People with disabilities identify challenges with accessing and using health care. These include the physical accessibility of the office, transportation availability and timing, provider knowledge of their condition, adequate appointment time and willingness to complete forms/applications (McColl et al., 2015). A study of women with disabilities identified three broad themes that impeded access to care: 1) complicated health service systems, 2) assumptions, attitudes, and discriminatory practices of health and social services providers, and 3) inadequate sexual health or reproductive services and supports (Gibson & Mykitiuk, 2012).

Family doctors identify challenges in health care provision for their patients with a disability. Studies have identified several key barriers to quality health care provision, including challenges with physical space and equipment, providers' attitudes and expertise, and knowledge of system supports, resources and navigation (McColl & Shortt, 2006). Patients with disabilities were also perceived by family doctors to be more challenging, more complex and require more time during an appointment than standard (McColl et al., 2015). They also reported a lack of training specific to patients with disabilities, a lack of exposure due to low incidence, and felt they lacked expertise (McColl et al., 2008).

Due to the complex nature of caring for people with disability, Dr. William Sullivan, an Associate Professor at the University of Toronto Department of Family and Community Medicine and family doctor in Medical Services at Surrey Place, created the Primary Care Guidelines* to advise primary care providers on how to provide care for this population. This guideline was developed through a consensus process of peers who have experience and expertise in the care of people with disability, and outlines standards of care to support clinical decision making. It also provides advice and recommendations on considerations that primary care providers may not normally take into account when they are not accustomed to caring for people with disability, and points to other resources and clinical tools that can help them understand how to provide the best care for this population.

Although these guidelines can educate family doctors on how to provide better care for people with disability, the most important aspect of care is

not found in the guideline: it is actually the human dimension that is most important, argues Dr. Sullivan.

"It's the dimension of actually just getting to know and appreciate people with developmental disabilities. And it doesn't even have to be in a medical context—in fact, it might even be more important outside of a medical context."

Role of family medicine in addressing these challenges

Family medicine is well-placed to address barriers given the focus on patient-centred, longitudinal, comprehensive and coordinated care. This is in keeping with the College of Family Physicians of Canada's vision for the future of family practice in Canada—the Patient's Medical Home. This is a model of comprehensive, coordinated and continuing care across the patient's lifespan through a family doctor working with the patient, caregivers and health care professionals to provide team-based care (including health disciplines such as social workers, dietitians, nursing, occupational therapists, speech language pathologists, etc.).

Academic family medicine programs are similarly well-placed to address the education gap consistently reported by both practicing and resident doctors. Their involvement of patients, caregivers and local doctor champions in this process is key to creating change. Currently, the University of Toronto undergraduate medical education program and post graduate program have incorporated curricula on providing care to adults with developmental and intellectual disabilities, and includes presentations from people who are living with disabilities themselves. Clinical experiences with adults with disability also appears to be important in increasing the comfort level and confidence of family medicine residents.

**<https://ddprimarycare.surreyplace.ca/guidelines/guidelines-about/>.*

Dr. Laurie Green is a Lecturer at the University of Toronto Department of Family and Community Medicine and a family doctor at St. Michael's Hospital.

Living with an intellectual disability

When you talk to Donna*, who is 65 and has lived with an intellectual disability her entire life, the conversation often turns to finances: about how challenging it is to live off her monthly cheque from the Ontario Disability Support Program (ODSP), about how much transit and food costs, and generally how she has to count every cent.

“I was born with a disability, I’m a slow learner and I didn’t get the education like a lot of people,” says Donna with a mix of sadness and anger in her voice. “I don’t know much about money, math, reading and writing, I can do a little bit but not a whole lot and it’s stopped me from getting a job. That’s why I’m on disability support, because I’m not able to get a job.”

Donna is representative of many who live like her: those with physical and intellectual disabilities are twice as likely as other Canadians to live below the poverty line (Gaetz et al., 2016). Donna also suffers from multiple health issues, including obesity, hypertension and depression: health concerns that are all-too-common to those living in poverty or living with a disability.

“Donna uses foodbanks and frequents places that give out cheap or free meals,” says Dr. Ann Fudge Shormans, a Professor in the School of Social Work at McMaster University whose research is with

people with intellectual disabilities and has worked with Donna on numerous studies. “Without proper nutrition, good medical care and somebody to support Donna and encourage her to exercise, manage her weight, and attend to various physical concerns, her health deteriorates, which means she walks less and her health deteriorates even further.”

The already complex and interrelated relationship between poverty and poor health is even further compounded when one lives with a disability. Those with an intellectual disability, for instance, often experience stigma throughout their entire life and are given few chances and supports to better their situation.

“There were assumptions, especially when Donna was young, that people like her couldn’t read or write, so they didn’t receive an education or were poorly educated leading them to rely on ODSP, putting them in poverty, necessitating foodbanks—it’s not surprising that they’re dealing with all these mental and physical health challenges,” says Dr. Fudge Shormans. “Sometimes they’re able to access adult support services when they’re older, sometimes they are homeless, sometimes they go back to their families—but nearly all of them experience tremendous social isolation and health issues as a result.”

Through teaming up with Dr. Fudge Shormans and Dr. Laurie Green, her family doctor who also conducts research on people living with a disability, Donna has begun to speak out about what it’s like to live with a disability. While it has not brought her much money, it has brought her a sense of pride and purpose.

“I was able to talk to groups of doctors about my disability. I want to do more in front of students and people like that,” says Donna. “I feel happy and proud of myself when I do that.”

And what it is like to live with a disability?

“It’s not fun to live with a disability. Sometimes I wish I wasn’t born like that. Sometimes people just stare at me or I get called names—sometimes by people on the street. It’s not nice to be called names. Sometimes if I sit down beside someone on the bus or streetcar or something, people will move away from me. When that happens, it makes me very upset—it makes me cry.”

All Donna asks is for people to be understanding and nice to everyone they meet—you never know what someone is going through.

**Last name removed for confidentiality*

7

The background is a solid orange color. Overlaid on this are several large, organic, wavy shapes in various colors: a large yellow shape at the top, a dark blue shape with a white dot pattern at the top right, a green shape at the top right, a large dark blue shape in the middle right, a smaller orange shape below it, and a circular shape at the bottom right divided diagonally with blue and white stripes on top and orange and white stripes on the bottom.

CHAPTER 7

Serving People who are Homebound

AUTHORS:

Sabrina Akhtar & Andrew Sparrow

“We define family medicine in terms of relationships, and continuity of the patient-doctor relationship is one of our core values. How can we justify breaking our long-term relationships with patients whenever, in sickness and old age, they become housebound?”

—**Dr. Ian R. McWhinney**, one of the founders of modern family medicine in Canada

Historically, doctors routinely delivered medical care to sick patients in their own homes. Indeed, house calls still accounted for the vast majority of doctor-patient encounters at the turn of the previous century. Political, social, and cultural shifts have contributed to a steady decline in the delivery of primary care through home visits in Canada over the last 50 years. While this change in part reflects an appropriate response to urbanization, population growth, and increasing reliance on non-portable technologies in medicine, there is a population who has consequentially become underserved and marginalized by this shift: the elderly homebound.

Who needs primary care at home?

The University of Toronto Department of Family and Community Medicine’s (DFCM) home-based primary care programs define a homebound elder as patients over 65 years old who, due to medical, cognitive, and social barriers, cannot access office-based primary care. In Canada, 93 percent of adults over age 65 live at home, and 87 percent of these individuals want to stay at home for as long as possible (Statistics Canada, 2006). Many in this rapidly growing segment of the population have complex health and social problems that render them poorly served by office-based primary care delivery models. As their conditions evolve, the challenges these patients face in accessing care increases until they are forced to rely on emergency department visits or are admitted to hospital. These care settings are not the right care in the right place for them, as it can lead to rapid functional decline, reduced capacity for independent living, and permanent undesired institutionalization. Family medicine can prevent these and future escalations in their condition, as the continuity of care provided by family doctors can provide context and better recommendations for the type of care that they receive.

In Canada,

93%

of adults over age 65 live at home

87%

of these individuals want to stay at home for as long as possible

(Statistics Canada, 2006).

Caregiver and system effects

Between 75 to 90 percent of care offered by caregivers in Canada is unpaid: family members or friends undertake the arduous task of providing nursing and clinical care to their loved ones (Hollander et al., 2009).

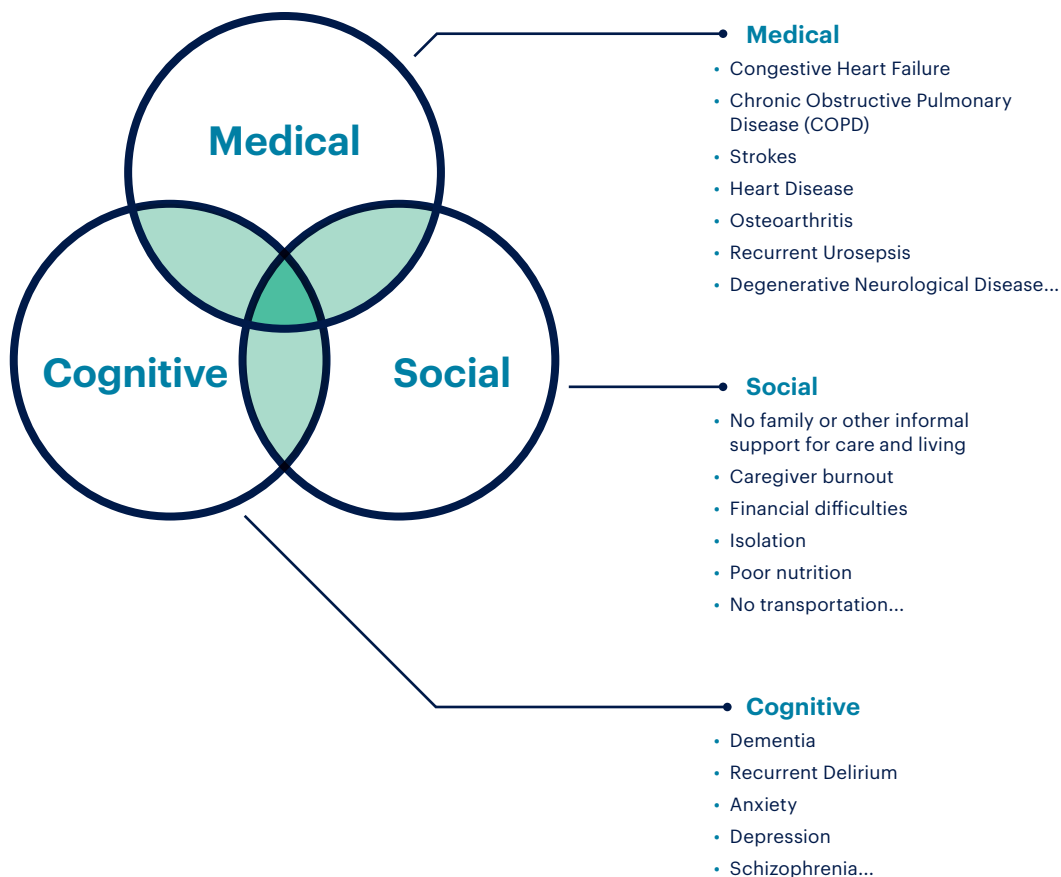
Without support, these informal caregivers for complex elderly patients often see their own health deteriorate in the form of burnout. Beyond the health of the caregiver, this can also trigger a hospitalization or institutionalization of the person they care for, resulting in skyrocketing health care costs, since older adults use a disproportionate amount of hospital services when admitted since their stays are typically longer (CIHI, 2019).

The “homebound”

For homebound patients, home-based primary care is a necessity, not a convenience.

The term “homebound” fails to encompass the multitude and complexity of issues that can leave an elderly patient without primary care. This can lead to a ‘perfect storm’ of access-to-primary-care issues when patients face challenges within two or more of these three barrier categories (Figure 1).

FIGURE 1: IDENTIFYING HOMEBOUND PATIENTS THROUGH THEIR MEDICAL, COGNITIVE, AND SOCIAL BARRIERS TO CARE



(Akhtar et al., 2011)

Home-Based Primary Care at the Department of Family and Community Medicine

Home-Based Primary Care has been shown to significantly improve the quality of life of patients and their caregivers, while decreasing health care costs by enabling patients to age at home and avoid hospitals and long-term care (Hughes et al., 2000). Home visits have gained interest from Canadian health care providers and policy makers as one way to meet the needs of high-risk elders. DFCM, in partnership with community care service agencies, has grown a network of Home-Based Primary Care teams within hospital and community family medicine teams, including:

- UHN Toronto Western Hospital
- South East Toronto
- Sunnybrook Hospital
- St. Michael's Hospital
- Mount Sinai Hospital
- Taddle Creek
- Women's College Hospital

Additionally, among 263 of the 360 UTOPIAN family doctors in 2018, 2,315 patients received 6,279 home-based visits, including palliative care.

The number of Home-Based Primary Care teams at the University of Toronto continues to grow annually. Though referred to as an old-fashioned solution to an emerging problem, these modern DFCM Home-Based Primary Care models must be distinguished from the traditional house call. Home-Based Primary Care delivers family doctor-led team-based inter-professional care with the specific objectives to:

- Provide access to longitudinal comprehensive primary care for elderly people with advanced chronic disease and multiple comorbidities
- Maximize patient independence and function
- Reduce emergency department and hospital admissions
- Enhance patient quality of life
- Link patients to integrated home-care services

The models of care delivery are heterogeneous, with each unit's team design and processes reflecting the unique local needs, resources, and relationships with community and specialty providers.

2,315

patients received

6,279

home-based visits in 2018



**Among 263 UTOPIAN family doctors*

Educating the Next Generation on Home-Based Care

To ensure integration into future care, all Home-Based Primary Care models at DFCM have been designed with teaching capacity and have produced scholarly work that provides evidence to support the growth of these modern house calls. Since their inception in 2011, the academic Home-Based Primary Care teams have offered over 700 medical residents training in care of complex frail elders at home through clinical exposure to team-based care and opportunity to care for their own homebound patients.

For faculty members, workshops aimed at refining home-based care clinical and teaching skills have been offered regularly. In 2016, through leadership from faculty members, DFCM produced the first formalized curriculum promoting education in Home-Based Primary Care. This flexible and practical curriculum was disseminated across the Department's 14 academic teaching hospitals to further the vision that home care be viewed as an integral part of family medicine, and that all DFCM graduates will demonstrate competency in managing patients in their homes. "Housecalls: Essential Art in Family Medicine" was published in Canadian Family Physician in 2018 and provided insights from DFCM Home-Based Primary Care education leaders to support Canadian family doctors in mentoring trainees through performance of house calls (Pham et al., 2018).

Dr. Sabrina Akhtar is an Assistant Professor at the University of Toronto Department of Family and Community Medicine and the Physician Lead of the Home-Based Care Program and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Dr. Andrew Sparrow is an Assistant Professor at the University of Toronto Department of Family and Community Medicine and a family doctor at the University Health Network's Toronto Western Hospital Family Health Team.

Home-Based Care not only improves quality of life, but gives peace of mind



Prior to enrolling her 91-year-old grandmother in the Home-Based Care Program at Toronto Western Hospital, Andrea and her family were not able to leave the country for ten years out of worry that something would happen to her grandmother while they were away.

“We couldn’t take a vacation or a day off because she would get ill and we would have to be with her. She would always have to be in the hospital as an inpatient, so my family would take shifts being with her—even on the weekends.”

Andrea’s grandmother has multiple health problems including type 2 diabetes and recurrent urinary tract infections (UTIs). These recurrent UTIs were particularly problematic: by the time her grandmother was able to get an appointment with her doctor to address the issue, her UTI would have escalated to the point where she would end up in the emergency department or being admitted to hospital as an inpatient, where she would stay for days or even months. Additionally, 14 years ago, her grandmother suffered from a stroke, which left her with aphasia – a condition which impairs ability to communicate – and paralyzed her right side. As a result, Andrea’s grandmother uses a wheelchair, which made her frequent trips to the hospital even more difficult.

“It was always a big production to take her out of the house and go to the doctor. We had to make sure to dress her appropriately for the weather, bring food that suits her diet as a diabetic, and bring a change of clothes and incontinence products in case an accident happened. Then we would have to take her to the hospital using the Wheel-Trans bus, which was always an issue—either her appointment would run late and she would miss the bus, or the bus would be delayed and she wouldn’t be able to make her appointment. So, she would always get very stressed and anxious on those days.”

Due to her frequent admittance to the hospital as an

inpatient, Andrea’s grandmother was recommended as a candidate for the Home-Based Care Program that operates through the Family Health Team at Toronto Western Hospital. Through this program, she is able to receive care in the comfort of her own home, as the care providers work together with her and her family to provide the care that she needs in the setting that best meets her needs. Keeping her out of hospital settings also eliminated her exposure to bacteria and viruses that could potentially cause further health complications in her state of frailness.

“The process of a home visit isn’t too different from a clinic visit—it just takes place in your home instead of the clinic. There’s a lot of procedures that can be done at home, and if you can do it at home, then you might as well—particularly at my grandmother’s age. It’s just easier on her and is a bit more respectful. She’s already not feeling so great, but at least she can be home where she feels safe and comfortable. And with her aphasia as well, she might not completely understand what is going on at all times, so having that constant is reassuring.”

There are still times when Andrea’s grandmother needs to go into the hospital, as there are procedures that cannot be completed at home. However, Andrea can confidently say that her grandmother’s quality of life has drastically improved, and that she is much healthier and happier now—as is Andrea and her family.

“At home, she’s got security and comfort. She has her garden, her Portuguese radio, and her own food that suits her diet. She knows all the cracks and corners of her house, and she’s able to sleep in her own bed at night. Before there were more days in the hospital than at home, so there was no quality of life – not for us, but especially not for her. But now, she’s stable, and she’s able to stay at home for long periods of time, so we have peace of mind and we’re able to live our own lives. She gets her quality of life, but we also get our quality of life.”



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CHAPTER 8

Helping People with Severe Mental Illness

AUTHORS:

Osnat Melamed, Braden O'Neill & Peter Selby

For those with a severe mental illness, managing their mental health can be a life-long struggle. In addition to their mental illness, many suffer from poor physical health. In fact, those with a severe mental illness die eight to ten years sooner than the general population, mostly due to heart disease (Walker et al., 2015).

Severe (or serious) mental illness refers to a mental, behavioural, or emotional disorder resulting in serious functional impairment, substantially interfering with or limiting one or more major life activities (SAMHSA, 2018). The most common conditions included in severe mental illness are schizophrenia and related disorders, bipolar disorder and severe forms of depression (NIMH, 2019).

Severe mental illness linked to heart disease

Cardiovascular disease, commonly referred to as heart disease, is the most common cause of death and poor health among individuals with severe mental illness, although people with these conditions also have an increased risk of many other health issues, including lung conditions and cancers (Hayes et al., 2017).

Many factors contribute to the increased risk for heart disease amongst people with severe mental illness. Severe mental illness itself is believed to be linked with abnormalities in a number of bodily systems, including the endocrine and immune systems, which can increase the risk for heart disease (Pillinger et al., 2019). Antipsychotic medications, which are part of the typical treatment plan, can increase the risk of weight gain, high blood pressure and elevations in blood sugar (De Hert, 2012). Many individuals with severe mental illness also experience significant social disadvantages, including unemployment, unstable housing and poverty, all of which interfere with establishing regular contact with their family doctor. Being socially disadvantaged is also strongly linked with physical inactivity and poor diet, which can be found in high rates in this group (Scott & Happell, 2011). Lastly, a high proportion of people with serious mental illness are addicted to tobacco smoking, which is one of the key risk factors for heart disease (Parikh et al., 2016).

Most common conditions within severe mental illness include:

- Schizophrenia and related disorders
 - Bipolar disorder
 - Severe forms of depression
-

While advances in the screening, identification, and management of heart disease and its risk factors have resulted in fewer people dying from the disease in the general population, people with severe mental illness have not equally benefitted from these advances (Gatov et al., 2017). Overall, people with severe mental illnesses often receive inadequate health care due to individual and systemic factors. Individual factors include intellectual impairment that can interfere with effective communication with their doctor. For instance, many patients have difficulty describing their symptoms and also have difficulty in understanding and acting on the advice given to them by their doctor. Also, ongoing symptoms of mental illness, such as depression, can lead to missed appointments and disengagement from care (Melamed et al., 2019). At the health system level, many people with mental illness do not have a family doctor, especially those experiencing social disadvantage (Ross et al., 2015). Furthermore, the disconnect between specialist mental health services and primary care adds to the problem because the fact that people have these conditions is often not documented in health records (O'Neill et al., 2019). There is also uncertainty about who is responsible for diagnosing and managing a patient's risk factors for heart disease and in many cases, these are left untreated.

Why is this important to family medicine?

Family doctors see many patients with severe mental illness and more than one-third of antipsychotic prescriptions (both oral and depot injection forms) originate from family doctors (Mark et al., 2009). Prevention of the key causes of death for patients with severe mental illness, such as heart disease and cancer, is a core activity of family medicine practices.

Efforts should be focused on improving the identification and management of risk factors for heart disease in patients with severe mental illness who attend family medicine practices. Team-based health care delivery models - in which family doctors work together with nurses, social workers and other providers - are best positioned to deliver holistic care for people with severe mental illness.

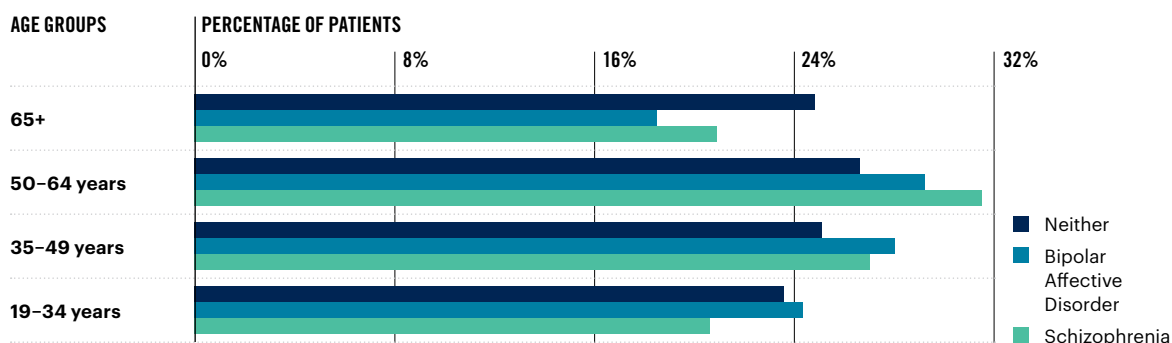
What the data shows

Among UTOPIAN practices, the percentage of patients with severe mental illness including schizophrenia and bipolar affective disorder is 1.3 percent and 2.0 percent, respectively (Figure 1). There is a higher percentage of males with schizophrenia whereas there is a higher percentage of females with bipolar affective disorder (Figure 2). Patients with schizophrenia or bipolar affective disorder visit family doctors more frequently than those without these diseases (Figure 3). Smoking rates are at least twice as high among patients with schizophrenia and/or bipolar affective disorder relative to those without these diseases (Figure 4).

Implications for family doctors

Many patients with severe mental illness have a long-term relationship with their family doctors and see them frequently. Comprehensive family medicine provides an ideal opportunity to enhance health equity for patients with these conditions, including identification and treatment of leading risk factors for heart disease, such as smoking, diabetes and high blood pressure. They also have a role to play in preventive health care including immunizations. Improvements in the health of people with severe mental illness can be achieved by supporting family doctors' ability to deliver high quality care to this group.

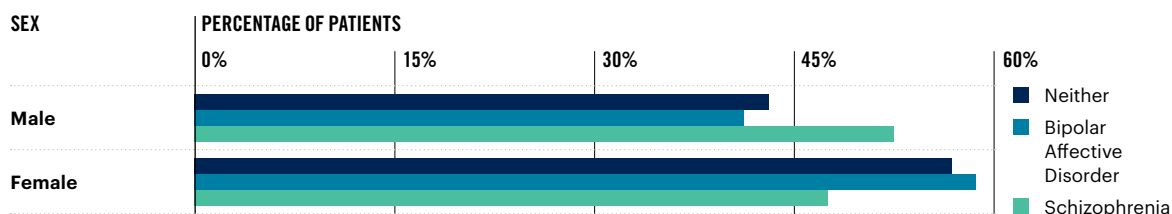
FIGURE 1: PATIENTS WITH SCHIZOPHRENIA OR BIPOLAR AFFECTIVE DISORDER IN 2018 BY AGE*



*Based on patients age 19 years or older with a documented/probable diagnosis of schizophrenia in 4,129 patients, bipolar affective disorder in 6,655 and neither in 318,115

Note: 2,174 patients were identified as having both bipolar affective disorder and schizophrenia reflecting possible schizoaffective disorder, or evolution of the diagnosis overtime, or potential mis-attribution

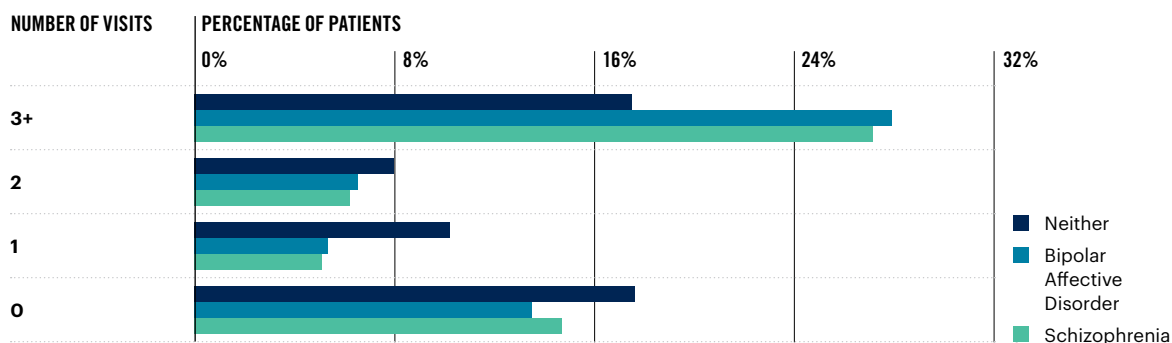
FIGURE 2: PATIENTS WITH SCHIZOPHRENIA OR BIPOLAR AFFECTIVE DISORDER IN 2018 BY SEX*



*Based on patients age 19 years or older with a documented/probable diagnosis of schizophrenia in 4,129 patients, bipolar affective disorder in 6,655 and neither in 318,115

Note: 2,174 patients were identified as having both bipolar affective disorder and schizophrenia reflecting possible schizoaffective disorder, or evolution of the diagnosis overtime, or potential mis-attribution

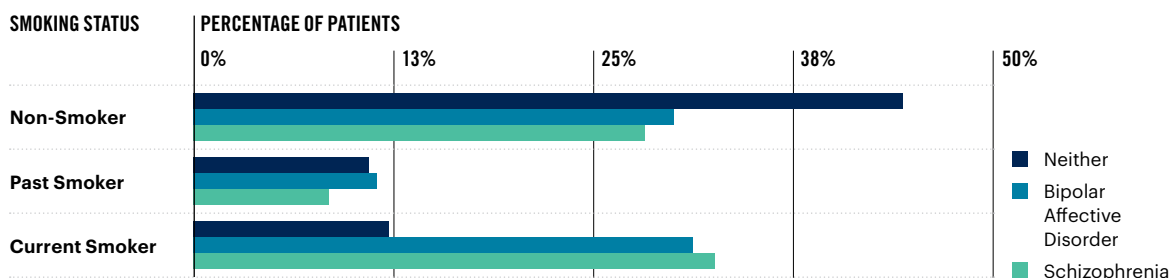
FIGURE 3: VISITS TO A UTOPIAN FAMILY DOCTOR FOR PATIENTS WITH SCHIZOPHRENIA OR BIPOLAR AFFECTIVE DISORDER IN 2018*



*Based on patients age 19 years or older with a documented/probable diagnosis of schizophrenia in 4,129 patients, bipolar affective disorder in 6,655 and neither in 318,115

Note: 2,174 patients were identified as having both bipolar affective disorder and schizophrenia reflecting possible schizoaffective disorder, or evolution of the diagnosis overtime, or potential mis-attribution

FIGURE 4: PERCENTAGE OF PATIENTS WITH SMOKING STATUS AMONG PATIENTS WITH AND WITHOUT SCHIZOPHRENIA AND/OR BIPOLAR DISORDER IN UTOPIAN IN 2018*



Note: Smoking status missing for 31 percent, 27 percent and 32 percent of patients with schizophrenia, bipolar affective disorder, or neither respectively

*Based on patients age 19 years or older with a documented/probable diagnosis of schizophrenia in 4,129 patients, bipolar affective disorder in 6,655 and neither in 318,115

Dr. Osnat Melamed is an Assistant Professor at the University of Toronto Department of Family and Community Medicine and a family and addiction medicine doctor at the Centre for Addiction and Mental Health.

Dr. Braden O'Neill is an Assistant Professor at the University of Toronto Department of Family and Community Medicine and a family doctor at North York General Hospital Family Medicine Community-Based Teaching Site.

Dr. Peter Selby is a Professor at the University of Toronto Departments of Family and Community Medicine, Psychiatry and the Dalla Lana School of Public Health, a Clinician Scientist in the Addictions Division and Campbell Family Mental Health Research Institute, a Senior Medical Consultant at the Centre for Addition and Mental Health a family doctor.

Living with a severe mental illness often linked to job insecurity, joblessness

Doug* was 27 when he found out he had schizoaffective disorder, a chronic mental health condition characterized primarily by symptoms of schizophrenia. It was 1975 and he had felt symptoms for several years.

“I was studying electrical engineering and doing really well,” Doug explains. “But in my third year, I broke down during a work term. I couldn’t function and found nothing relatable so I left school and escaped to Europe for over a year.”

When he came back, Doug’s family doctor referred him to a psychiatrist. Finding a medication that helped him balance his moods took time, including a brief time in a psychiatric ward. Even once they found something that helped, Doug faced a lifelong battle with the disease.

After his diagnosis, Doug got a job as an insurance inspector, married and had two daughters. But the combined stress of work and kids was overwhelming. Eventually, he and his wife separated.

“It was a really difficult time. I lived on the streets for two years before finding HouseLink.”

HouseLink is a nonprofit organization in Toronto that works to provide housing for people living with mental illness and at risk of homelessness. Housing, the organization attests, is the first step in providing participants with a sense of security, after which they can focus on their mental health. The program also provides other supports, such as recreation, food and employment programs.

For Doug, HouseLink provided him with the stability he needed. After securing a bachelor apartment, he was able to focus on his mental health. He also used the employment program, working as an office

cleaner for 17 years. For Doug, work brought a sense of self-worth.

“Society looks down at people who aren’t able to work. All they see is that you’re just not working – they don’t understand why, especially if you look physically capable. You’re really low on the social hierarchy when you’re not able to be employed.”

Recently Doug also joined the PACE program at the Centre for Addiction and Mental Health, which provides psychiatric consultation for patients over 60 with mood disorders. He has also quit smoking after 51 years thanks to a family-doctor led program. He believes family doctors play a big role in giving patients proactive ways to stay mentally and physically well.

While Doug acknowledges times have changed since his diagnosis, he does have some advice for those struggling with a mental illness.

“Family doctors can advise, motivate and help people like me find simple, low-cost activities, like exercise, to improve our condition. When I lived with people who had conditions like mine, I saw very few of them exercising or eating well. Family doctors have credibility and can really make an impact if they help with that.”

Now retired at 72, Doug has never felt better. He has a close relationship with his daughters and grandchildren, religiously walks 10,000 steps a day and is keeping his mind active by learning guitar and Korean.

**Last name removed for confidentiality*

9



CHAPTER 9

Improving Care for People with Addictions

AUTHORS:

Peter Selby, Osnat Melamed, Danielle Dawson & Nikki Bozinoff

Tobacco accounts for most of the burden of substance use in Canada, followed closely by alcohol. More recently, a rise in opioid-related overdose deaths and cannabis legalization have led to an increased need for health care providers skilled in substance use treatment. In Ontario, 16 percent of the adult population drink alcohol in excess of the low risk guidelines, with six percent reporting symptoms of alcohol dependence (Ialomiteanu et al., 2017). In addition, 11 percent smoke tobacco daily. Over 1.5 million people take opioids for pain (i.e. narcotic painkillers) in Ontario which poses a risk for opioid medication diversion and opioid misuse. Opioid Use Disorder (OUD) affects about one percent of the population. In Ontario in 2018, there were approximately 63,000 people receiving treatment with either buprenorphine or methadone for opioid use disorder (ODPRN, 2018).

The number of people struggling with addiction and substance use is growing. The harms from substance use—whether from alcohol, opioids, cannabis or other drugs—can be a result of the toxic effects of the drug itself, contaminants within the drug, or how the drug is ingested, inhaled or injected. A person is diagnosed as having a substance use disorder when their substance use becomes an addiction.

Addiction should be understood as the result of a mix of genetics, environment, and a person's experiences (ASAM, 2019). Addiction is not a choice. Those with an addiction engage in these behaviours compulsively and continue in spite of suffering negative effects. Thankfully, addiction is treatable and considered a chronic medical disease with treatment options that are generally as successful as treatments for other chronic illnesses.

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The role of family doctors in treating addiction

Family doctors have an important and critical role to play in the prevention, screening, and treatment of addiction in their patients. Addiction affects all socioeconomic, ethnic, and age groups, though it becomes less common as we age. Left untreated, addiction can be fatal. In 2014, there were an estimated 67,515 Canadian deaths attributed to substance use, of which more than half were due to tobacco (Canadian Substance Use Costs and Harms Working Group, 2018). More recently, opioid overdose deaths in young men has stalled the increase in life expectancy in Canada (Statistics Canada, 2019).

Effective treatment for people suffering from addiction do exist, however, several barriers continue to prevent patients from accessing evidence-based addiction treatment. There is dual stigma surrounding addiction treatment: the patient is afraid of disclosing addiction to their family doctor, and the family doctor is afraid of treating the patient due to lack of knowledge of evidence-based interventions. Despite the availability of effective medications for substance use disorders in Canada and being listed on the Ontario Drug Benefit formulary to minimize any financial barriers, some family doctors feel uneasy treating patients with substance use disorders.

For instance, there are effective medications that double the chances of long-term smoking cessation. Similarly, naltrexone and acamprostate are evidence-based treatments for alcohol use disorder. Both methadone and buprenorphine are evidence-based treatments with a reduction in mortality for people with opioid use disorder compared with no treatment. The special exemption to prescribe methadone or buprenorphine was eliminated by Health Canada. There is accessible and affordable continuing medical education to assist prescribers available. Most have been developed and offered by several members of our department. Opioid treatment may be provided in specialty or primary care settings with patient satisfaction with care being almost twice as high in primary care settings (Perry et al., 2019; Korownyk et al., 2019). This indicates the important role family doctors can play in offering these therapies as part of their regular practice.

UTOPIAN Data

Currently, UTOPIAN data does not provide the rates of screening, intervention, or treatment for alcohol and tobacco use disorders. For the purposes of this report, we examined the presence of any prescription for the treatment of addiction as a proxy. These include varenicline and bupropion for tobacco use disorder, naltrexone, acamprostate, or disulfiram for alcohol use disorder, and buprenorphine and methadone for opioid use disorder. We found that less than one percent of UTOPIAN patients had a prescription for an alcohol, tobacco or opioid use disorder in 2018.

What the Department of Family and Community Medicine (DFCM) is doing to address the problem

This information provides support for calls to enable family doctors to treat their patients with substance use disorders (Korownyk et al., 2019). Every family doctor needs the core knowledge and skills required to effectively prevent and treat people with substance use disorders. These would include appropriate training and support for family doctors to: screen systematically and recognize red flags of substance use and gambling; motivate patients to take action and involve their preferences in their care; prescribe evidence-based treatments for tobacco, alcohol, and opioids effectively; and systematically provide all preventive general health measures including the treatment of hepatitis C and HIV where appropriate. In addition, family doctors must be aware of both addiction treatment and harm reduction resources and be able to refer accordingly.

Toward this end, several members of our department are leaders in addiction medicine at the provincial, national, and international level. There is a Community of Practice at the College of Family Physicians Canada with an approved Certificate of Added Competence in Addiction Medicine. At the University of Toronto, each year, the Enhanced Skills in Addiction Medicine Program welcomes two to four family doctors for additional training in addiction medicine. Our program draws on diverse members across the University of Toronto family medicine network to offer learners access to innovative learning environments championed by family doctors, including inpatient addiction consultation services, pregnancy and substance use clinics, nicotine dependence services, and rapid access addiction medicine clinics. Many of our former residents have gone on to be leaders and academics at the University of Toronto and beyond.

Dr. Peter Selby is a Professor at the University of Toronto Departments of Family and Community Medicine, Psychiatry and the Dalla Lana School of Public Health, a Clinician Scientist in the Addictions Division and Campbell Family Mental Health Research Institute, a Senior Medical Consultant at the Centre for Addiction and Mental Health a family doctor.

Dr. Osnat Melamed is an Assistant Professor at the University of Toronto Department of Family and Community Medicine and a family and addiction medicine doctor at the Centre for Addiction and Mental Health.

Danielle Dawson is a Research Coordinator for the Nicotine Dependence Service at the Centre for Addiction and Mental Health.

Dr. Nikki Bozinoff is the Program Director of Enhanced Skills in the Addiction Medicine Program at the University of Toronto Department of Family and Community Medicine and a family and addiction medicine doctor practicing in Toronto.

Addressing the gaps in addiction medicine knowledge among family doctors



Although Dr. Jennifer Wyman – a Toronto-based family doctor and Associate Director at the Substance Use Service at Women’s College Hospital – did not start her career in addiction medicine, as she started working with more patients with opioid use disorder, she became more interested in and involved with addiction medicine at the primary care level. As she got more involved, she noticed that there was a lack of knowledge and awareness among doctors in managing patients who need help in overcoming an addiction.

“I think many family doctors feel like there must be special skills or knowledge when working with patients who have substance use disorders, but they already have the skills and knowledge about managing complex health conditions, whether diabetes or depression, they’re just not used to applying it to this context,” says Dr. Wyman. “There’s a role for specialists for patients with complex disorders, but primary care is a great place for people to receive care because there’s so much depth and longevity in the relationship between patients and their family doctors. They often know their families and family context, which is really helpful.”

To help address this gap in knowledge and awareness of managing patients with addiction disorders, Dr. Wyman developed a new curriculum to teach family medicine residents about the treatment of addiction disorders, including alcohol and cannabis use, and safer opioid prescription, which launched as a pilot program at Sunnybrook Health Sciences Centre in 2018. Residents who participated in this program reported an increase in comfort level of managing

and treating patients with addiction disorder. There was also an increased level of interest in addiction medicine among these residents, as many of them decided to take additional electives or get more clinical experience with addiction medicine. Although the pilot program has been completed, Dr. Wyman is continuing to work with DFCM around supporting individual sites with implementing addictions training for their residents.

Dr. Wyman also co-developed the Opioids Clinical Primer, an accredited online program that is designed to provide effective tools for primary care providers around managing the complexities of opioid use. This primer includes six courses organized into two streams and can be found on machealth.ca.

Through these educational opportunities, Dr. Wyman hopes that family doctors can develop more local expertise and confidence in managing patients with substance use disorders.

“I think the reality is that family doctors make up the vast majority of doctors who are providing addiction care to patients—not only across the province, but across the country. It’s simply not an option to think that addictions care is going to be provided by addictions specialists. I think family doctors without any specific formal training can manage a lot of alcohol use and less complex opioid use within primary care. But even if they’re not comfortable treating these patients, they can still make sure they are supporting them by referring them—not alienating them but working as a team with the clinics that provide more addictions care.”



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CHAPTER 10

Prescribing Opioids and Cannabis for People with Chronic Pain

AUTHORS:

Abhimanyu Sud & Amol Deshpande

Chronic pain—defined as pain lasting more than three months—affects almost one in five Canadians, with older people and women more likely to have chronic pain. For example, over 30 percent of females over 65 years of age experience chronic pain (Schopflocher et al., 2011). Chronic pain is estimated to cost Canadians \$6 billion in direct health costs and \$37 billion in productivity loss annually (Lynch, 2011).

In addition to chronic pain, many patients also struggle with associated mental health conditions, such as anxiety and depression. While there is no single best remedy, the ideal treatment for most individuals is a holistic combination of drug and non-drug therapy. Unfortunately, many non-drug therapy options are expensive and—in some cases—difficult to access. The limited availability of alternative options has led to many patients relying on medications—likely contributing to the current opioid crisis and the rise in cannabis use.

Prescribing opioids for chronic pain

The opioid epidemic has focused a spotlight on how doctors prescribe opioids, resulting in a number of measures to curb prescribing and reduce the impact of opioid misuse. According to UTOPIAN data, approximately three percent of patients in 2018 had an opioid prescription documented in their family doctor electronic medical record chart. When looking at the entire province and all prescribers, including those outside of family medicine, about 10 percent of people had received an opioid prescription in 2018 (ODPRN, 2018). Those over the age of 50, females and people with lower incomes were more likely to be prescribed opioids in the UTOPIAN database, similar to trends in other large databases.

Moreover, if patients had been prescribed opioids in 2018, they were three times more likely to be prescribed an antidepressant (selective serotonin reuptake inhibitor) or an anti-anxiety medication (benzodiazepine) compared to those who had not received an opioid. This suggests that people who have been prescribed opioids may have much higher rates of mental illness such as depression or anxiety, although occasionally these medications may also be used to treat pain rather than depression or anxiety.

Between 2016 and 2017, Canada has seen an overall decrease in opioid prescribing by 10 percent, including a 23 percent decrease in the prescribing of fentanyl (a strong opioid) (CIHI, 2017). This decrease, however, has not necessarily impacted opioid-related deaths. Despite large reductions in opioid prescribing in Ontario, deaths from opioids rose from 6.2 per 100,000 in 2016 to 10.2 per 100,000 in 2018. The continued increase in deaths, sadly, appear to be driven mainly by the increased use of non-medical opioids, particularly illicit fentanyl and fentanyl analogues. Over the same time, the rate of emergency room visits for opioid-related causes has doubled from 31.7 per 100,000 to 63.4 per 100,000 (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020).

The role of cannabis

Our understanding of cannabis is still in its infancy. While cannabis will likely have a role in pain management, based on present clinical research, there is—at best—mixed evidence for its benefits in pain. Medical cannabis was first legalized in Canada in 2001, and the number of registrants grew from less than 500 to almost 38,000 by 2014. Over the next four years—leading up to the legalization of cannabis for non-medical purposes in Canada—the number of registrants for medical cannabis exploded by almost 10-fold to over 340,000 (Health Canada, 2019).

The number of Canadian doctors who have provided a medical document for a patient to be registered to receive medical cannabis almost doubled from 9,726 to 18,086 in the short span of 13 months prior to legalization (Health Canada, 2019). With the legalization in Canada of smoked cannabis in 2018 and edible forms in 2019, more patients may visit family doctors and emergency rooms with acute side effects of cannabis, such as anxiety and paranoia, or chronic effects like psychosis, addiction, and ongoing vomiting.

Enhancing safe prescribing

Family medicine continues to play a key role in the front-line of pain management. To improve prescribing knowledge and practice, collaborative groups such as Medical Mentoring for Addictions and Pain (MMAP) have been formed. Family medicine members at the University of Toronto have also created innovative education programs for family doctors and residents, such as Safer Opioid Prescribing. These programs benefit patients with chronic pain by providing doctors and other health care providers with the most up-to-date knowledge of chronic pain care and prescribing practices. However, managing chronic pain in its entirety will require primary care to be better resourced, especially to deliver evidence-based physical, behavioural and psychological treatments.

Strengthening the future of family medicine and pain

A survey of nine Canadian Faculties of Medicine reported an average of 16 hours of formal pain teaching compared with 87 hours of pain education for veterinary medicine (Watt-Watson et al., 2009). To enhance pain education and care, the University of Toronto Centre for the Study of Pain created a three-day formal interfaculty curriculum addressing current research and understanding of pain, and clinical practice in pain management. As well, through the Ministry of Health in Ontario, several programs—including distance education, self-study modules, academic detailing and implementation projects—were funded and are available at no or low cost to all doctors. These programs and resources can be found on Health Quality Ontario’s website*.

The integration of a core training program into family medicine residency training that includes the basics of assessing and treating chronic pain, as well as education around appropriate non-drug and drug therapy (including the safe prescribing of all pain medications), could strengthen the already holistic person-centred care foundation employed in primary care (McCarberg, 2011). Advanced training could also lead to the further development of designated ‘secondary pain’ centres where the majority of people with chronic pain could be supported by family doctors in the community (Fogelman et al., 2018). This could allow for the incorporation of holistic evidence-based approaches throughout the natural history of pain care to achieve the most significant benefit for people living with chronic pain.

*<https://www.hqontario.ca/Quality-Improvement/Practice-Reports/Partnered-Supports-for-Helping-Patients-Manage-Pain>

Dr. Abhimanyu Sud is an Assistant Professor at DFCM, Director of Safer Opioid Prescribing and a Research Fellow with the Medical Psychiatry Alliance, both at the University of Toronto and a family doctor practicing chronic pain medicine at Trillium Health Partners.

Dr. Amol Deshpande is an Assistant Professor at DFCM and is a family doctor with a focused practice in chronic pain medicine at University Health Network’s Toronto Rehabilitation Institute.

Finding the right doctor to help manage chronic pain makes a world of a difference

When you ask Julia* about the number of health conditions she has dealt with over the last 30-plus years, she would need to review a pre-written list. There's too many to remember, she explains, without writing them down. These conditions have left her with lifelong, often debilitating pain.

The main source of this pain is Ehlers-Danlos Syndrome, a group of 13 genetic conditions that affects the connective tissue holding your body together—mainly in the skin, bones, joints, and blood vessels—causing them to be fragile and stretchy. As a result, Julia's joints are very loose and can easily dislocate—many of which have dislocated over the years—leaving her in nearly constant pain. A car crash she experienced in 1984 only exacerbated the condition and resulted in Julia having to end her competitive badminton career and undergo several surgeries.

Her syndrome is compounded by other health issues, including type 2 diabetes, endometriosis and various others. In all, she has received 22 surgeries for her Ehlers-Danlos Syndrome and other conditions.

To manage this pain, her doctors have prescribed various opioids over the years. At one point, Julia recalls taking up to six Percocet and 80 milligrams of Oxycontin every day. The side effects became overwhelming: mentally, Julia had experienced bouts of depression and anxiety and, physically, she began having digestion problems, and all her teeth had to be replaced.

"I tried everything to reduce the pain and I had tried to wean off the opioids myself but found the pain too much—it was too hard," she says, noting that many

of her doctors expressed concern about her long term opioid use but were unable to find something else to help her.

It was in 2019 that the side effects became too much: while on vacation she collapsed. Her bowels, from years of digestive issues, were obstructed. At one point, she even became septic. When she finally recovered, she was referred to DFCM faculty member, Dr. Abhimanyu Sud, to help manage her pain. Dr. Sud is the director of the Safe Opioid Prescribing course at the University of Toronto, which was created to assist doctors in assessing complex chronic pain, prescribing opioids, and addressing challenges and addiction.

"He's been amazing. He's found options other than opioids for me to manage my pain. I'm now exercising, and I'm finding new ways to manage the physical and mental side effects of my condition. I feel better than I have in a long time."

For Julia, having a family doctor who knows you and is able to accommodate a patient's unique needs is essential for anyone dealing with complicated health issues. For instance, doctors need to be willing to lengthen a visit time, as it may take Julia longer than other patients to review her history and explain her conditions.

"You have to do your work to find the right family doctor. I interviewed so many doctors before I found the one I have now—and now I couldn't do it without him."

**Last name removed for confidentiality*

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CHAPTER 11

Assisting People Experiencing Homelessness

AUTHORS:

Andrew Bond & Deborah Pink

Homelessness rates in Toronto are continually on the rise: in Toronto's 'Street Needs Assessment' conducted in 2018, there were 8,715 homeless individuals in Toronto, which is a stark increase compared to 2013, where the same assessment found there were 4,806 homeless individuals (City of Toronto, 2018; Canadian Observatory on Homelessness, n.d.).

Homelessness is defined as "the situation of an individual, family or community without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it" (City of Toronto, 2018).

There are many different types of homelessness, including people who are unsheltered and living outside, others who are provisionally sheltered and staying in emergency shelters, and individuals who are precariously housed and at risk of homelessness due to spending greater than 50 percent of their income on housing or living in housing that has health or safety issues.

The increase in homelessness in Toronto can be attributed to various factors, including a lack of new affordable housing in the city, the increased cost of living, low vacancy rates, and an influx of refugees to Canada. When homeless individuals were asked what would be most helpful to support them out of homelessness, they responded that having increased social assistance, having more affordable housing available and a housing allowance/subsidy available would be most beneficial (Gaetz et al., 2014).

Health implications of homelessness

With average life expectancies below 50 years (Canada's average life expectancy is 82 years) and very high rates of physical, mental health and substance use disorders (Fazel et al., 2014), individuals and families experiencing homelessness in Toronto use hospital services at a cost over 10 times greater than non-homeless community members. This is due to increased emergency department visits, hospital outpatient clinic visits, prolonged medical-surgical admissions and psychiatric hospitalizations (Aldridge et al., 2018).

For instance, 10 percent of people experiencing homelessness account for 60 percent of the emergency department visits by all homeless individuals, 80 percent of medical-surgical hospital admissions by all homeless individuals, 43 percent of hospital ambulatory/outpatient clinic visits by all homeless individuals and 86 percent of psychiatric hospitalizations by all homeless individuals, making up 90 percent of the cost of homeless health utilization. As a result, this subset of homeless individuals, many with mental health issues, have been designated

health system 'super-users', those who would benefit from a more targeted approach to care (Hwang et al., 2013).

These health service use patterns demonstrate a health system that is failing people with overlapping complex medical and social needs. Relying on high-cost, non-patient-centered emergency and inpatient care predictably results in emergency department and hospital overcrowding (Hwang et al., 2011).

Public Health Ontario identified specific health outcomes associated with homelessness, including infectious diseases, mental health issues (including substance use disorders), cognitive impairments, chronic diseases (e.g., hypertension, diabetes) and injuries (Public Health Ontario, 2019; McCormick & White, 2016).

Homelessness, with its associated health implications, is costly for our society; our current ways of managing homelessness do not help those who most need help.



60%
of emergency
department visits

80%
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hospital admissions

43%
of hospital ambulatory/
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86%
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making up 90% of the cost of homeless health utilization

(Hwang et al., 2011)

What is the role of family medicine?

Studies have shown that patients who experience poor accessibility to a family doctor and lack the continuity of care that primary care provides are more likely to visit the emergency department (Roberge et al., 2010). Evidence has also demonstrated that targeted, specialized and person-centered outreach medical care that is integrated with social services is a highly effective way of treating people experiencing homelessness and ‘super-users’ more generally. This integrated care model has shown to improve the experience, effectiveness and cost-efficiency of care (Roberge et al., 2010).

Many faculty members at the Department of Family and Community Medicine (DFCM) have recognized the health challenges that people experiencing homelessness face and are doing their part in trying to improve the health outcomes of this population. In Barrie, the Royal Victoria Regional Health Centre Family Medicine Teaching Unit have partnered with Youth Haven Barrie, a local shelter for youth experiencing homelessness, to open a health care clinic at the shelter. Since 2013, many Royal Victoria Regional Health Centre Family Medicine Teaching Unit faculty members and residents have visited Youth Haven on a weekly basis to provide health care services through this clinic such as physical examinations, immunizations, and referrals to specialty care.

Royal Victoria Regional Health Centre Family Medicine Teaching Unit are not the only ones who are working to improve the health care experience of people experiencing homelessness. The Inner City Health Associates is Canada’s largest and leading homeless health organization and is closely affiliated with DFCM (Inner City Health Associates, n.d.). As a specialized transitional health care organization, Inner City Health Associates has deep ties with hospitals and community health and housing organizations to fulfill its role in promoting health care that is focused on the unique needs and values of each patient. Through collaborating with Inner City Health Associates’ partners, this care is delivered at various shelters and drop-ins across Toronto, with the goal of bringing an end to homelessness (Moinedden et al., 2011).

Inner City Health Associates’ doctors also engage in numerous research projects and programs, including funding the first Canadian guidelines on the health of people experiencing homelessness (one guideline for Indigenous Peoples living in Canada and one for non-Indigenous Canadians). Inner City Health Associates is developing growing communities of practice in the care of Indigenous Peoples, Newcomers and Refugees, Palliative Care, Addictions Medicine, Transitional Age Youth, Mental Health and Justice, and Medical-Legal Programs.

Residents at both Inner City Health Associates and Royal Victoria Regional Health Centre Family Medicine Teaching Unit are able to spend time working with people experiencing homelessness under supervision of DFCM faculty members. While working in homeless clinics, these medical trainees are exposed to the many social determinants of health that make up the current reality of homelessness in Toronto and lead to so many health implications, and better understand the real impacts of homelessness on health.

Dr. Andrew Bond is the Medical Director of Inner City Health Associates, a Lecturer in the Department of Family and Community Medicine at the University of Toronto, a Staff Physician and Health Justice Program Faculty at St. Michael’s Hospital, and the Co-Chair, Canadian Network for the Health and Housing of the Homeless (CNH3).

Dr. Deborah Pink is the Education Lead at Inner City Health Associates, a Lecturer in the Division of Adult Psychiatry and Health Systems in the Department of Psychiatry at the University of Toronto and a staff psychiatrist at St. Michael’s Hospital working at various Inner City Health Associate homeless sites.

Clinic wraps support around patients experiencing homelessness

When Peter* first went to the Inner City Health Associates - a health clinic in downtown Toronto that serves people experiencing or at risk of homelessness - he felt like, finally, he was getting the physical, mental and emotional support he needed.

“Everyone here treated me different than other medical clinics had before,” says Peter. “They asked me different questions and looked at me with genuine concern on their faces. It felt nice to have my concerns truly taken seriously.”

Peter was referred to the Inner City Health Associates through his support worker at Seaton House, a shelter for homeless people in Toronto. Peter, who is 48 years old, found himself at the shelter after going through a painful divorce, experiencing crippling depression and losing his job as a consultant at an HR services company. For him, Seaton House provided a respite at a time of life that he found “too much”. Though life at the shelter could be tough, he was able to form a group of friends and support system. Today he wants others to know that people who find themselves homeless come from various backgrounds and situations.

“There are a lot of people who do drugs in shelters, but there are some of us who are educated, don’t do a lot of drugs or alcohol but found ourselves in a bad situation. Addicts can come from various backgrounds too. It’s complicated.”

Peter stayed at Seaton House for two years before finding housing through the Home First Foundation, which provides safe, affordable housing for the chronically homeless, people with complex mental health and addictions issues, and seniors. He still regularly visits Inner City Health Associates to see his family doctor, a social worker and other specialists. For Peter, having all this support in one place has been a real advantage.

“My family doctor here is amazing and can give me referrals to specialists that are just down the hall,” says Peter, who admits to having a hard time keeping appointments when he went through particularly hard times.

Peter also participates in various support groups provided by the Inner City Health Associates, including groups around health and wellness, mindfulness and meditation and healthy cooking classes. These groups and other supports provided by the Inner City Health Associates have allowed him to begin to fully treat his depression—an illness he was diagnosed with at 14—though he still takes it “one day at a time.”

“Right now, I have good relationships at Inner City Health Associates who are helping me minimize the bad days and increase the number of good days I have. I’m grateful to everyone here.”

**Last name removed for confidentiality*



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The background is a solid teal color. In the top right corner, there are several overlapping organic shapes. These include a dark blue shape, an orange shape, a light blue shape with white diagonal stripes, a solid blue shape, and a yellow-green shape with a dark blue dotted pattern.

CHAPTER 12

Supporting Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Questioning, and Two-Spirit (LGBTQ2S+) People

AUTHORS:

James Owen, Sue Hranilovic & Devan Nambiar

The LGBTQ2S+ (lesbian, gay, bisexual, transgender, transsexual, queer, questioning, and Two-Spirit) community represents a diverse population of sexual and gender minorities. Historically, the health needs of LGBTQ2S+ people have been poorly addressed in the medical system. These needs are as varied and diverse as the individuals themselves, and their intersectional identities. While many LGBTQ2S+ people live in urban areas, many others live in rural areas where there is often even less access to health care.

What do the terms in “LGBTQ2S+” mean? The 519 Glossary of Terms is an excellent resource to learn more (The 519 Glossary of Terms, n.d.):

Lesbian – A woman who is emotionally, physically, spiritually and/or sexually attracted to women.

Gay – A person whose enduring physical, romantic, spiritual, emotional, and/or sexual attractions are to people of the same gender. The word can refer to men or women, although some women prefer “lesbian.” Sometimes used as an umbrella term for the LGBTQ community.

Bisexual – A person who is emotionally, physically, spiritually and/or sexually attracted to people of more than one gender, though not necessarily at the same time.

Trans/Transgender – Umbrella terms that describe people with diverse gender identities and gender expressions that do not conform to stereotypical ideas about what it means to be a girl/woman or boy/man in society. “Trans” can mean transcending beyond, existing between, or crossing over the gender spectrum. It includes but is not limited to people who identify as transgender, transsexual, cross-dressers or gender non-conforming (gender variant or gender-queer).

Transsexual – A person whose gender identity differs from their sex assigned at birth. They may or may not undergo medically supportive treatments to

align their bodies with their gender identity, such as hormone therapy, sex reassignment surgery or other procedures or changes.

Queer – Formerly derogatory slang term used to identify LGBT people. Some members of the LGBT community have embraced and reinvented this term as a positive and proud political identifier when speaking among and about themselves.

Questioning – A period where a person explores their own sexual and/or gender identity, reflecting on such things as upbringing, expectations from others, and inner landscape. The person may not be certain if they are gay, lesbian, bisexual, or trans and may be trying to figure out how to identify themselves.

Two-Spirit – A term used by Indigenous People to describe from a cultural perspective people who are gay, lesbian, bisexual, trans, or intersex. It is used to capture a concept that exists in many different Indigenous cultures and languages. For some, the term two-spirit describes a societal and spiritual role that certain people played within traditional societies; they were often mediators, keepers of certain ceremonies; they transcended accepted roles of men and women, and filled a role as an established middle gender.

The “+” sign is there to “represent all of the other identities that you may have already heard of: Non-binary, pansexual, asexual and intersex” (Treasury Board of Canada Secretariat, 2019).

In many ways, LGBTQ2S+ people have worse health outcomes than the overall population in areas such as mental health, physical health, and access to health care services. Just a few examples:

- 43 percent of trans Ontarians attempted suicide in their lifetime, compared with 3.5 percent of the general Canadian population (Bauer et al., 2013);
- Three out of every five new diagnoses of HIV in Ontario were in men who have sex with men (OHESI, 2019);
- Greater than one-third of trans Ontarians reported having a negative interaction with their family doctor because they were trans (Bauer et al., 2015);
- In general, LGBTQ2S+ people are around two to four times more likely to use alcohol, tobacco and other substances than the general population (Queensland Association for Healthy Communities, n.d.);
- 21 per cent of trans patients avoid accessing emergency medical services because of a fear of transphobia and 52 per cent of survey respondents indicated they had negative experiences in emergency rooms related to transphobia (Trans PULSE, 2010)

Issues like these are not just because a person is part of the LGBTQ2S+ community. They are a result of stigma, marginalization and discrimination experienced by LGBTQ2S+ people (think homophobia, transphobia or biphobia). Due to the experiences of stigma, prejudice, discrimination, marginalization and impact of homo/bi/transphobia, LGBTQ2S+ people feel they are less important than cisgender heterosexual people. The experience leads to shame, isolation, lack of self-esteem and confidence and often trauma. Due to this, they may also suffer from acute and chronic stress such as anxiety, physical illness, depression, eating disorders, and suicidal ideation (National LGBTI Health Alliance, 2014). There are also connections to the broader social factors that negatively impact health, like poverty. For example, half of trans people in Ontario live on less than \$15,000 a year (Trans PULSE, 2010). Lack of awareness in the health care system about the health needs of LGBTQ2S+ people can also contribute to poorer health outcomes.

Greater than 1/3 of trans Ontarians reported having a negative interaction with their family doctor because they were trans

(Bauer et al., 2015)



In general, LGBTQ2S+ people are around 2 to 4x more likely to use alcohol, tobacco and other substances than the general population

(Queensland Association for Healthy Communities., n.d.)



21% of trans patients avoid accessing emergency medical services because of a fear of transphobia

(Trans PULSE, 2010)



What are we doing to improve the health of LGBTQ2S+ people?

Creating inclusive spaces

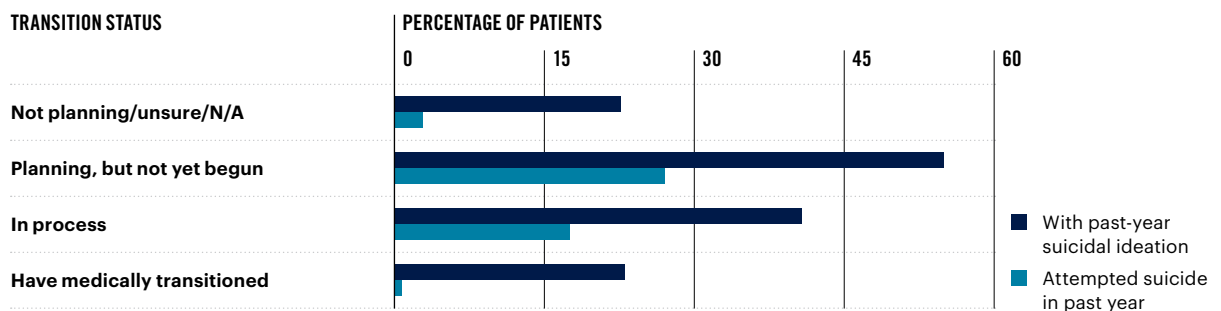
Many hospitals and clinics recognize the importance of inclusive and welcoming spaces for LGBTQ2S+ patients. This is very important in family medicine, since everyone should have inclusive health care with doctors whom they are comfortable. Further training and resources are available at Rainbow Health Ontario* for health care providers.

**<http://www.rainbowhealthontario.ca>*

Trans health

Trans and gender non-binary patients face disproportionate barriers to accessing trans affirming primary health care. Family doctors and nurse practitioners are well suited to offer all aspects of gender affirming care, which can include prescribing hormone therapy and, since 2016, supporting patients in preparing for and accessing funding for transition-related surgeries (Community-Based Research Centre, 2019). Providing care that supports a patient who is medically transitioning can greatly improve mental health, including risk of suicide (Figure 1).

FIGURE 1: MEDICAL TRANSITION STATUS AND RISK OF SUICIDE IN THE PAST YEAR



(Bauer et al., 2013)

Starting from the ground up

The University of Toronto MD Program has recognized that all future doctors must learn the foundation of cultural and clinical competencies of LGBTQ2S+ health needs. Since its inception, the LGBTQ2S+ Health Education Theme Lead position has been held by a family doctor from the University of Toronto Department of Family and Community Medicine (DFCM). Teaching around LGBTQ2S+ health has been integrated across the curriculum, and includes such things as:

- How to talk with patients about their gender identity and sexual orientation;
- Creating an inclusive and welcoming environment for LGBTQ2S+ people;
- Addressing specific health care needs (for example, hormone therapy or surgical access for trans people).

DFCM offers a self-directed enhanced skills program for family medicine trainees in LGBTQ2S+ health for access to elective experiences in LGBTQ2S+ health at clinics in the city that focus on care for this population.

Dr. James Owen is an Assistant Professor at the University of Toronto Department of Family and Community Medicine, the LGBTQ2S+ Education Theme Lead and the Complexity & Chronicity Course Director for the MD Program at the University of Toronto and a family doctor at St. Michael's Hospital.

Sue Hranilovic is a nurse practitioner at St. Michael's Hospital.

Devan Nambiar is the Program Manager at Rainbow Health Ontario, Sherbourne Health.

Providing inclusive care to the trans community

Thea Weisdorf and **Sue Hranilovic** specialize in providing primary care to non-binary and transgender individuals as part of the health team at the Health Centre at 410, St. Michael's Hospital. Weisdorf is an Assistant Professor at the Department of Family and Community Medicine and has been working as a staff doctor at the Health Centre at 410 since 1996. Hranilovic—a Primary Health Care Nurse Practitioner—has called it her clinical base since 1994. Over the course of their careers, Weisdorf and Hranilovic have seen trans care change significantly. They spoke to writer Julia Soudat about their practice, the need for more inclusive care and the hurdles still facing trans and non-binary communities.

What got you interested in specializing in providing health care to trans and non-binary individuals?

Thea: It originated from a desire to help a friend navigate a health care system that was not very accessible to her gender questioning child. I identified a large gap in providing primary health care to transgender and gender non-binary youth and adults. With the incredible support of my department and colleagues, I have helped provide education to faculty members and learners alike in the needs and care of this population, and that has been very rewarding.

Sue: As a queer-identified, white settler, I have professionally wanted to support members of my larger community, particularly folks who experience disadvantage and challenges in accessing care. I don't work with many pediatric patients, but I feel I have the opportunity to watch people being born into who they have always been, and bearing witness is incredibly powerful for me.

What is the focus of your practice?

Thea: I provide primary care and gender-affirming care to my patients. This may include routine primary care and preventive screening, or initiation of gender affirming hormones, hormone blockers or support for transition-related surgery. My past fellowship training in substance abuse and addiction assists in identifying high-risk behaviours that may be seen in all patients but have a higher than average prevalence in the transgender community.

Sue: I consider myself an “old nurse” of 30 years and a newer Nurse Practitioner of seven years. I've been a consultant trainer with Rainbow Health Ontario since 2014, expanding capacity provincially by teaching about trans and gender diverse medical and surgical primary health care. My incredibly supportive work environment has provided the time and space needed to develop this clinical expertise. I feel very lucky that my current clinical practice is almost exclusively devoted to the overall primary care needs of trans and gender non-binary folk, which I endeavour to provide from an anti-oppressive, harm reduction, sex positive and health promotion perspective.

How has trans health care changed in the past few years?

Thea: Over the past few years, I have seen that providing gender affirming care and respecting our patients with things as simple as using proper pronouns, asking about supports and challenges faced throughout one's gender journey and educating one about the specific health care needs not routinely taught in medical school, can enhance the trust and health of our patients. Providing patient-centered LGBTQ2S+ care has routinely been absent due to an environment

of lack of experience, fear in doing the “wrong thing” and even a lack of interest in wanting to learn.

Sue: Trans and gender non-binary care has changed significantly, even in just the last five years. March 1, 2016 marked the beginning of primary health care leading the way in decreasing barriers to patients being able to access gender-affirming Ministry of Health (MOH) -funded surgeries in a timely way. I recall that day well, and I’ve taken a lead both provincially and at St. Mike’s Hospital to provide that training to staff and other Ontario providers. This shift marked the movement of trans and gender non-binary health care from solely a specialist level of care, to being integrated and fully within the scope of primary health care. Prescribing of gender-affirming hormones has become more of an individualized art in the last few years, as opposed to being solely guideline driven. The visibility and inclusion of folks with non-binary identities has fueled this informed consent model of care provision and is a welcome change.

Do you think health care providers are getting better at addressing the needs of the trans and larger LGBTQ2S+ community?

Thea: Yes, I do see very positive changes in how people in health care are providing services to our LGBTQ2S+ populations. However, I also recognize that I work in a very unique environment where there are more resources, and more providers who see it as a priority to serve this community as well as other marginalized and under-served populations. It is not uncommon for me to be asked about accepting new transgender and non-binary patients into my practice when I speak to parents in the community who are trying to provide support for their children. Often, they say their child’s family doctor or paediatrician is not comfortable in addressing the needs of these youth. One of my biggest goals is to mentor young doctors in their confidence and competence in the provision of primary care to these individuals and demystify and destigmatize their health care. As my respected colleague Sue has said, providing affirming and respectful health care is a human right.

Sue: I feel that we are moving in the right direction in Ontario, particularly with the amazing work being done by Sherbourne Health Centre and Rainbow Health Ontario in educating care providers. Toronto is a particularly resource-rich setting and I do worry about the paucity of services outside of large urban centres, where folks may experience significant social isolation, in addition to barriers to accessing care.

Creating networks of dedicated, gender-supportive practitioners and continuing to advocate for the inclusion of LGBTQ2S+ health care needs within our professional school curriculums is a positive step in creating more access and ultimately improving health outcomes in the future for LGBTQ2S+ folk.

What are some of the hurdles still facing the community?

Thea: I believe more providers need to be knowledgeable in the care of trans and non-binary folk. Hormone prescribing for those seeking transition should be within the scope of primary care and support for surgical transition should be as well. Discussions with our patients around sexuality, fertility, preventive screening, aging, and dying should be inclusive and welcoming. Support for families of transgender and gender non-binary individuals needs to be part of our care and team-based care is essential. Finding trans-affirming services, consultants and mental health services for this population is in dire need and the absence of this significantly prevents our patients from receiving the care they deserve.

Sue: Ongoing hurdles include systemic barriers to respectful, validating and non-traumatizing care that are evidenced in all systems, including health care. Humane health care is a basic human right. Trans and non-binary folk deserve barrier-free access to gender-affirming care. Advocacy in the areas of access to safe, affordable housing, employment equity and access to additional MOH-funded gender-affirming surgeries and procedures (such as hair removal and facial feminization surgery) are needed. Integrating trans and non-binary care basics into all health care curriculum would further raise the bar. There is still a way to go, but in the meantime, I hope to continue nurturing the resilience of the clients I walk with, learn from and serve.

Julia Soudat is the Communications Assistant at the Temerty Faculty of Medicine.

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CHAPTER 13

Providing Comprehensive Care for Individuals Living with HIV

AUTHORS:

Ann Burchell, Tony Antoniou, Megan Landes, Gordon Arbess, Ioana Nicolau, James Owen & Sumeet Sodhi

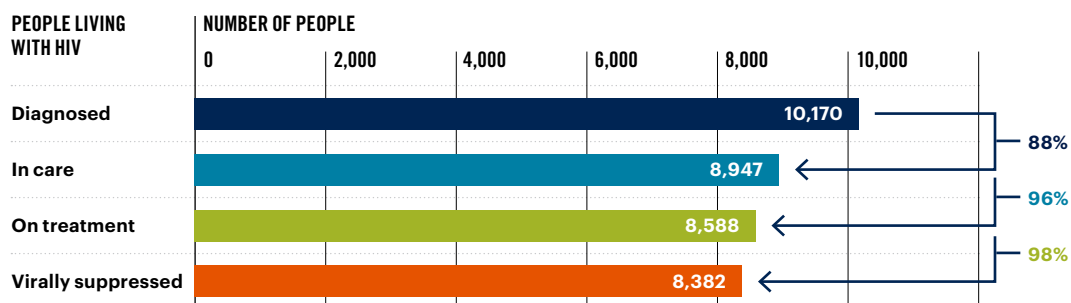
HIV or human immunodeficiency virus is a virus that makes copies of itself using the body's immune system cells. These immune system cells are the body's built-in defense system against disease and illness. As a result, HIV can weaken the immune system. Over time if left untreated, the virus can badly damage the immune system and can lead to a condition called acquired immunodeficiency syndrome or AIDS. Thanks to effective antiretroviral treatment, the viral load is reduced to a level no longer detectable by current tests and people are no longer getting AIDS. Today, someone diagnosed with HIV and receiving treatment can live nearly as long as someone who does not have HIV.

Toronto is home to 10,170 individuals living with HIV, which account for about half of all people diagnosed in Ontario (OHESI, 2018). Findings from a 2015 Ontario study confirm the important role played by family doctors in the care of people with HIV (Kendall et al., 2015). The vast majority of people living with HIV have a family doctor, and about half of them have most, if not all, of their HIV care visits with their family doctor (Kendall et al., 2015).

Advances in combination antiretroviral therapy (ART)—which works to suppress the HIV virus—have transformed HIV into a chronic illness amenable mostly to outpatient management. People living with HIV who receive regular care and are on ART have a life expectancy approaching that of the general population (Deeks et al., 2013; Burchell et al., 2018; Kendall et al., 2015; Burchell et al., 2019). Reducing someone's HIV viral load also eliminates the risk of them transmitting the virus to others.

Critical steps in HIV care include becoming diagnosed with HIV, finding care, initiating ART, and becoming virally “suppressed” such that one’s viral load is reduced to a level no longer detectable by current tests (UNAIDS, 2017; Gardner et al., 2011). In Toronto, in 2018, of the 10,170 people who were diagnosed with HIV, 88 percent (8,947) were receiving care. Among those in care, 96 percent were on ART, of whom, nearly 98 percent were virally suppressed (Figure 1) (OHESI, 2018).

FIGURE 1. NUMBER AND PERCENT OF PEOPLE LIVING WITH HIV WHO ARE DIAGNOSED HIV, IN CARE, ON ANTIRETROVIRAL TREATMENT AND HAVE VIRAL SUPPRESSION, TORONTO, 2018



(OHESI, 2018)

The role of family doctors and the DFCM in HIV care

Primary care encompasses the entire spectrum of HIV care. The critical first step is learning that one has an HIV infection so that ART can be quickly initiated. Yet, HIV-associated stigma remains an important barrier to HIV testing. The longstanding and trusting relationships forged between family doctors and their patients can facilitate HIV testing. Family doctors can also become involved in the initiation of ART, and support patients to maintain lifelong adherence to treatment.

Because people with HIV are living longer, there is a growing number of people aging with HIV. In UTOPIAN, over half of the patients living with HIV are over the age of 50, whereas the population of adult patients without HIV is more evenly distributed between the ages 19 to 65+ years. Screening and management of co-morbid illnesses associated with aging, such as cancer and cardiovascular disease, have therefore assumed increased importance in the management of people with HIV.

Other contemporary challenges in HIV care include stigma, mental health illness, addictions, and social determinants of health such as precarious work, food and housing insecurity. All pose barriers to HIV testing and engagement in care. Central to this is ensuring continuous drug coverage for ART, given the lack of a universal pharmacare model in Ontario.

To respond to these challenges, family doctors are often supported by interdisciplinary teams that deliver comprehensive HIV primary care. In Canada, compared to specialist HIV care in tertiary settings, team-based models in primary care tend to offer more variety of services particularly for mental health and addictions (Kendall et al., 2018). Working together with family doctors, nurses, nurse practitioners, pharmacists, social workers and others provide counselling, ART access and comorbid disease prevention and management. Participating UTOPIAN sites are national leaders in such team-based models of HIV care delivery.

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CHAPTER 14

Acknowledging the Importance of Reconciliation for Indigenous Health and Wellbeing

AUTHORS:

Janet Smylie, Suzanne Shoush & Amanda Sauvé

Reconciliation is a fundamental priority of the University of Toronto Department of Family and Community Medicine (DFCM), as we strive to respond to the health-related Calls to Action from two landmark national inquiries: The Truth and Reconciliation Commission (TRC), and the National Inquiry into Missing and Murdered Indigenous Women and Girls as well as the UN Declaration on the Rights of Indigenous People.

Indigenous Peoples in Canada are not at an equal starting point for accessing health care services. This is a direct result of previous Canadian laws, policies and structures that intentionally perpetuated systems of exclusion. DFCM is in a position to address this in a substantial manner as research shows that primary care is the most significant variable related to better health status (Starfield & Shi, 2007). Improved delivery of culturally safe primary care by providers who have a strong understanding of historical and present-day systems that perpetuate inequities can play a critical role in improving health outcomes.

In May 2019, two new DFCM leadership positions were created to help create transformative spaces in which our department can work towards a greater knowledge and awareness of Indigenous Health priorities: Dr. Suzanne Shoush was appointed the Indigenous Health Faculty Lead and Dr. Janet Smylie was appointed the Indigenous Health Research Lead. Their goal is to work across the department to help all sites, learners, faculty members and leadership move towards Reconciliation.

In last year's inaugural Family Medicine Report (2019) (Tu et al., 2019), we presented some key facts about Indigenous population health in Toronto, drawing from the findings of the Our Health Counts: Urban Aboriginal Health Database Research Projects (Smylie et al., 2011). We highlighted new evidence demonstrating that Toronto has an Indigenous population of approximately 70,000 people, representing one-third of the total Indigenous population in Ontario. We also unmasked striking disparities in health service access, including gaps in access to regular primary

care providers and a disproportionate burden of unmet health needs, compared to non-Indigenous people.

This evidence challenges common misconceptions that there are only a small number of Indigenous people living in Toronto and that their health needs are relatively well met. We also presented important findings regarding the strengths of Toronto's urban Indigenous communities, including strong social networks and resilience of language, culture, and Indigenous identity. This is particularly noteworthy given that 87 percent of the Indigenous population in Toronto is living under the low-income cut-off and there is a cross-cutting disproportionate burden of chronic disease and mental health conditions compared to the overall Canadian population.

Helpful links:

The Truth and Reconciliation Commission:
<http://www.trc.ca/>

National Inquiry into Missing and Murdered Indigenous Women:
<https://www.mmiwg-ffada.ca/final-report/>

UN Declaration on the Rights of Indigenous People:
https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

How can DFCM respond to the Health-Related Calls to Action from the Truth and Reconciliation Commission and the National Inquiry into Missing and Murdered Indigenous Women and Girls?

The Truth and Reconciliation Commission and the Missing and Murdered Indigenous Women and Girls National Inquiry have stressed the importance of culturally safe health care, informed by Indigenous peoples (TRC Calls to Action 18, 22, 23, 24, and MMIWG 7.6). In response to this we have undertaken an environmental scan of DFCM hospital teaching sites to help identify community partners and assess our various strengths and opportunities for improvement. We are prioritizing ongoing Indigenous Cultural Safety training for faculty members, staff and medical learners across the DFCM by working with education partners across the city and country, as well as with the Indigenous Physicians Association of Canada, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. We want to ensure our department has a strong foundation in essential Indigenous Health Competencies in our resident program, and that our learners have an opportunity to thrive in Indigenous health. This requires collaboration with Elders, Traditional Knowledge Keepers and Indigenous Health Agencies. Additionally, critical to the Truth and Reconciliation Commission Calls to Action (TRC CTA) 23, is the recruitment, retention and training of Indigenous learners and faculty members, which is a priority in the DFCM.

It is also essential that we as a department understand our gaps in care so we can work to close them (TRC CTA 19, 20, MMIWG 7.1). This is in line with our strategic vision of social accountability. Through the Our Health Counts project, Dr. Smylie continues to work in partnerships with First Nations, Inuit and Métis people and organizations to focus on further documenting existing gaps in care for Indigenous peoples in Toronto and surrounding area, such that we can develop strategic visions to address them (Firestone et al., 2018).

Finally, it is vital that the care we provide is accessible. This requires sites across DFCM to engage with the community to develop innovative models for delivery of care, which may be community-based, and are culturally informed by the wealth of healing knowledge of Indigenous peoples (TRC CTA 22, MMIWG 3.2, 3.4 and 7.1).

Current Gaps in Health Care Access and Quality for Indigenous People, City of Toronto (Firestone et al., 2018)

• **Experiences of Racism in Health Care:**

28 percent of Indigenous adults in Toronto reported that they had been treated unfairly by a health care professional because of their Indigenous identity. Of those experiencing racism 71 percent said it prevented, stopped or delayed them from returning to health services and 72 percent said it had occurred more than once over the past five years.

• **Unmet Health Needs in Past 12 Months:**

28 percent of Indigenous adults in Toronto reported unmet health needs in the past 12 months. This is almost three times the rate for Ontario (10 percent) and Canada (11 percent).

• **Continuity of Primary Care:** 63 percent of Indigenous adults in Toronto have a regular family doctor or nurse practitioner, compared to 90 percent of the general population of Toronto adults.

• **High Intensity and High Proportional Use of Emergency Room Care:** Indigenous adults in Toronto were 3-4+ times more likely to be admitted to downtown emergency rooms (St. Michael's Hospital, University Health Network and Mount Sinai Hospital) in 2016-2018 than Torontonians generally. Our preliminary estimates indicate that Indigenous adults represent > 25 percent of all ER patient admissions to the St. Michael's Hospital during this time period.

• **Dissatisfaction with Quality of Emergency Room Care:** 42 percent of Indigenous adults who had accessed emergency room care in the past 12 months rated their care as fair or poor.

For more detailed information, please see the Our Health Counts Toronto Fact Sheets on the Well Living House website*.

*<http://www.welllivinghouse.com/wp-content/uploads/2018/02/Our-Health-Counts-Toronto-Factsheets-28-Feb-2018.pdf>

Truth and Reconciliation Commission Health Related Calls to Action 18–24 (Truth and Reconciliation Commission of Canada (2015):

- 18.** We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.
- 19.** We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends.
- 20.** In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.
- 21.** We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.
- 22.** We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.
- 23.** We call upon all levels of government to increase the number of Aboriginal professionals working in the health

care field, ensure the retention of Aboriginal health care providers in Aboriginal communities and provide cultural competency training for all health care professionals.

- 24.** We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices.

Final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG): Calls to Action: Health and Wellness (National Inquiry, 2019)

- 1.** Ensure the rights to health and wellness of Indigenous Peoples, and specifically of Indigenous women, girls and 2SLGBTQIA* people, are recognized and protected on an equitable basis.
- 2.** Provide adequate, stable, equitable, and ongoing funding for Indigenous-centred and community-based health and wellness services that are accessible and culturally appropriate, and meet the health and wellness needs of Indigenous women, girls and 2SLGBTQIA people.
- 3.** Support First Nations, Inuit and Métis communities to call on Elders, Grandmothers and other Knowledge Keepers to establish community-based trauma-informed programs for survivors of trauma and violence.
- 4.** Ensure all Indigenous communities receive resources for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wraparound services, including mobile trauma and addictions recovery teams to be paired with other essential services such as mental health services and sexual exploitation and trafficking services.

5. Establish culturally competent and responsive crisis response teams in all communities and regions, to meet the immediate needs of an Indigenous person, family and/or community after a traumatic event, alongside ongoing support.
6. Ensure equality in the funding of services for Indigenous women, girls and 2SLGBTQQIA people, as well as equality for Indigenous-run health services.
7. Provide continual and accessible healing programs and support for all children of missing and murdered Indigenous women, girls and 2SLGBTQQIA people and their family members. Specifically, we call for the permanent establishment of a fund akin to the Aboriginal Healing Foundation and related funding.

**In the MMIWG report, the term 2SLGBTQQIA people is used to refer to two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual people. In other sections of this report, we have used a similar analogous term, LGBTQ2S+, which refers to lesbian, gay, bisexual, transgender, queer or questioning and two-spirit, and also other gender and sexual minorities.*

Dr. Janet Smylie is a Professor at the University of Toronto Department of Family and Community Medicine and in the Dalla Lana School of Public Health and a family doctor and research scientist in Aboriginal health at St. Michael's Hospital, Centre for Research on Inner City Health (CRICH), where she directs the Well Living House Applied Research Centre for Indigenous Infant, Child and Family Health.

Dr. Suzanne Shoush is a Lecturer and the Indigenous Health Lead at the University of Toronto Department of Family and Community Medicine and a family doctor at St. Michael's Hospital.

Dr. Amanda Sauvé is a University of Toronto Family Medicine Resident at Royal Victoria Regional Health Centre.

MMIWG: Health and Wellness Services Providers (National Inquiry, 2019):

1. Recognize that Indigenous Peoples are the experts in caring for and healing themselves, and that health and wellness services are most effective when they are designed and delivered by the Indigenous Peoples they are supposed to serve.
2. Ensure that health and wellness services for Indigenous Peoples include supports for healing from all forms of unresolved trauma.
3. Support Indigenous-led prevention initiatives in the areas of health and community awareness.
4. Provide necessary resources to support the revitalization of Indigenous health, wellness and child and Elder care practices.
5. Provide resources for specialized intervention, healing and treatment programs, and services and initiatives offered in Indigenous languages.
6. Ensure all persons involved in the provision of health services to Indigenous Peoples receive ongoing training, education and awareness in areas including the history of colonialism, anti-bias and anti-racism, local language and culture, and local health and healing practices.
7. Encourage, support and equitably fund Indigenous people to train and work in the area of health and wellness.
8. Create opportunities and provide socio-economic incentives to encourage Indigenous people to work within the health and wellness field and within their communities.
9. Develop and implement awareness and education programs for Indigenous children and youth on the issue of grooming for exploitation and sexual exploitation.

Simulation ‘Stand Up for Indigenous Health’ allows medical learners to walk in the shoes of an Indigenous Person in Canada



When Dr. Amanda Sauvé, then a medical student, heard Senator Murray Sinclair speak about the Truth and Reconciliation Commission of Canada findings and recommendations, she was inspired.

“Senator Murray [the Chief Commissioner of the Truth and Reconciliation Commission] implored us to read the calls to action in the report and pick one that we could work within our capacity to try to impact and live through. You can’t do everything, but you can at least choose one to live by and push forward.”

That night Dr. Sauvé, now a family medicine resident at Royal Victoria Hospital in Barrie, did just that: she read all of the call to actions and chose one that she felt she could influence. That call to action is number 23, which calls on government to increase the number of Aboriginal professionals working in the health care field, ensure the retention of Aboriginal health-care providers in Aboriginal communities and to provide cultural competency training for all health care professionals.

At the time, Dr. Sauvé was in medical school, where she said the amount of curriculum devoted to Indigenous Health and overall social determinants of health was very little.

It was also around this time that Sauvé began working with Dr. Latif Murji, the founder of Stand Up for Health, an immersive simulation program that allows medical trainees to gain a better understanding of the social determinants of health through experiential learning. Leveraging the technology of a mobile app, participants are placed in the role of Canadians living in poverty and must interact, make choices, and solve challenges within their given set of circumstances.

“He was running the simulation for the first time at a conference. I got to experience the simulation and I thought ‘this is amazing—why couldn’t we have an Indigenous version of this experience?’”

Dr. Sauvé and fellow medical student, Dr. Adriana Cappelletti (now a family medicine resident at McMaster University), set forth to develop scenarios specific to the Indigenous experience. To ensure they included authentic, diverse Indigenous scenarios, Drs. Sauvé and Cappelletti and other Indigenous Health researchers conducted five sharing circles within Indigenous communities across Ontario, from rural and remote communities to urban centers. Within these sharing circles, participants were asked questions related to their social determinants of health, such as the living conditions, employment, the food situation in the community, experience of health care, and much more.

“What we heard varied based on where they were from,” says Dr. Sauvé. “We heard stories of many being hesitant to seek health care in fear of it being assumed they are seeking drugs. We also heard about people not receiving medicine for basic ailments, or doctors missing a common diagnosis because they refused to do testing.”

Other stories included those of pregnant women in remote communities, forced to travel hours from their homes weeks prior to their due date because they were unable to deliver in their home communities.

“We were very aware of the possibility of perpetuating stereotypes of Indigenous Peoples in Canada,” says Dr. Sauvé. “So instead of creating one or two Indigenous scenarios to be added to the original program, we were inspired to create a program devoted entirely to Indigenous Peoples. I’m Métis and I only have that experience; however Indigenous Peoples’ experiences vary so widely across the country.”

All of this research led to Drs. Sauvé and Cappelletti to create Stand Up for Indigenous Health, an Indigenous-specific offering of Stand Up for Health.

Thus far, the Stand Up for Indigenous Health team has run the program with an Indigenous Health advocacy group at Western University, and with family medicine residents at Royal Victoria Hospital in Barrie and McMaster University. They also ran the program at the Canadian Conference on Medical Education to Indigenous faculty members, medical students and Elders from 15 of the 17 medical schools across Canada.

Dr. Rebecca Stepita, also a family medicine resident in Barrie, said the experience of participating in the session was “eye-opening”.

“I think it really made me appreciate the complexity of our patients and a lot of the things we take for granted in our own lives and our patient’s lives,” says Stepita. “They provided local resources for us and showed us the differences in how health care is delivered to Indigenous patients and things to be aware of, it was all really helpful. It highlighted a lot of things that we probably didn’t fully realize.”

So far, an initial analysis of evaluations shows the simulation is working: participants are shown to have significantly more empathy for their patients, are more open to seeing Indigenous patients and have an increased knowledge of the social determinants of health that Indigenous patients face. For Dr. Stepita, the simulation aspect of the program is key.

“I think the interactivity part of it really made a bigger impact because you not only got to go through what your character was going through, but to see what others in the simulation were going through simultaneously and the decisions they made. It’s very powerful.”

Drs. Sauvé and Cappelletti are now looking to expand the program by including more Indigenous identities, including Inuit and Métis. They are also developing a facilitator training program that is training more indigenous medical students and allies to deliver the program at more locations through Ontario and, hopefully, eventually across Canada.



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CHAPTER 15

Facilitating Access to Care for Refugees and Newcomers to Canada

AUTHORS:

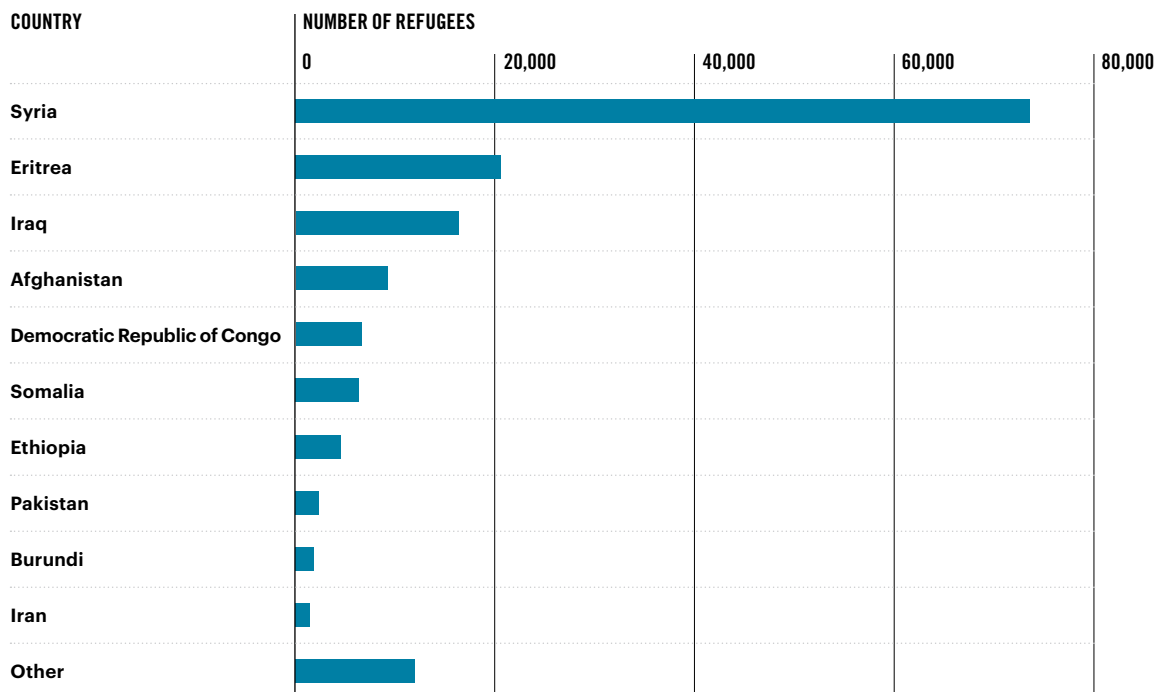
Meb Rashid, Praseedha Janakiram & Vanessa Redditt

According to the 1951 United Nations Geneva Convention Relating to the Status of Refugees, a refugee is defined as an “individual with a well-founded fear of persecution who, for reasons of race, religion, nationality, membership of a particular social group, or political opinion, find themselves outside the country of their nationality, and are unable or unwilling to avail themselves of the protection of that country any longer” (UNHCR, 1951).

Globally, the migration of refugees has continued to rise. In 2018, a total of 25.9 million refugees were forcibly displaced globally - the highest numbers ever recorded (UNHCR, 2019). The source countries of the world’s refugees vary from year to year, reflecting

the contemporaneous geopolitical climate. In 2019, Canada accepted 48,510 refugees, approximately 14 percent of the total 341,180 newcomers who arrived that year (Immigration, Refugees and Citizenship Canada, 2020a).

FIGURE 1: TOP 10 SOURCE COUNTRIES FOR NUMBER OF RESETTLED REFUGEES TO CANADA, JAN. 2015–MAR. 2020



(Immigration, Refugees and Citizenship Canada, 2020b; Immigration and Refugee Board of Canada, 2020)

The needs of refugees in Canada are broad: they face many challenges shaped by both their pre-migration experiences and the gradual process of resettlement. Post-migratory stressors include health care access, housing instability, food insecurity, education challenges, and language barriers. They also contend with the broader implications of stigma, social isolation, and resettling into a new socioeconomic and cultural infrastructure as they strive to rebuild their lives.

Family medicine and refugee and newcomer health

Although each person's journey through the refugee process is different, there are a number of common challenges. In terms of health concerns, many patients have had limited access to primary care pre-migration. Thus, it is not uncommon for adult women to have never had a pap test, for example (Ferlay et al., 2015). Often diabetes and hypertension have existed for many years without recognition or management. Many patients originate from areas of the world where there is an increased rate of infectious disease. Rates of hepatitis B, for example, can be five to ten percent in refugee populations (Rossi et al., 2012). Almost all have endured some form of trauma and some studies estimate that 10-20 percent struggle with Post-Traumatic Stress Disorder (PTSD) and many more grapple with other mental health conditions and emotional distress (Pottie et al., 2011). The process of acculturation can be particularly challenging where there is limited English proficiency, family separation, and social isolation.

Family doctors and other primary care professionals are uniquely poised to address the issues that confront refugee populations. Connecting refugees to a primary care provider early after migration allows identification and management of health conditions before they become more significant. It can also foster therapeutic relationships, which provide patients with opportunities to express mental health concerns.

Crossroads Clinic

The Crossroads Clinic was founded in 2011 at Women's College Hospital to provide culturally safe and sensitive, tailored care for refugees, responsive to the nuanced issues that confront these populations. It aims to connect and orient newly arrived refugees to primary care early in their migration process, with the recognition that despite the tremendous hardships they have endured, most refugees do very well in Canada when they are provided support. The clinic provides full primary care that includes chronic disease management, disease prevention and screening, as well as mental health support. Patients are served at the Crossroads Clinic for a minimum of two years after which they are transitioned to primary care providers in their community. Crossroads Clinic has seen over 4,000 individuals since it opened, with approximately 8,000 clinic visits each year.

Alongside clinical care, an important mandate of the Crossroads Clinic is to provide support for other family doctors and primary care providers serving refugee patients. The clinic has published over 20 research articles that reflect the health issues that refugee populations face. Each year, staff do over 30 presentations to colleagues, learners, and community members. In May 2019, the Crossroads Clinic, in collaboration with the Department of Family and Community Medicine, jointly offered the first-ever Refugee Health Primer. A one-day conference, the primer provided family doctors and other primary care providers who serve refugees and newcomers with up-to-date information on medical care for refugees, including health system navigation. The second offering of this one-day primer is currently being planned for 2021.

The Crossroads Clinic has also advocated for refugee populations on both individual and systems levels. It was at the forefront in challenging cuts to refugee health insurance. Staff members have presented in numerous policy forums to support the rights of refugees to access health care, including the Parliamentary Standing Committee on Citizenship and Immigration, the Senate Committee on Human Rights, and the Toronto Board of Health.

The Crossroads Clinic is fortunate to be housed within the academic teaching department at Women's College Hospital. As such, medical students, medical residents and nursing students are a key element of the clinical environment as the clinic mandate upholds a robust educational focus inclusive of social determinants of health learning objectives.

COVID-19 : The Crossroads Clinic Response

In response to the unprecedented COVID-19 global health pandemic, the Crossroads Clinic has had to be agile to meet the needs of a population that has been affected in unique ways by the pandemic. Housing conditions for many refugees is frequently complicated by multiple shared spaces and limited feasibility to practice physical distancing optimally. Many refugees work in low-paying and precarious employment for which they rely on public transit for transportation. Many are also at risk for occupational exposures through their work as cleaners, personal support workers, staff at grocery stores and other essential services. The Crossroads Clinic has transitioned to a high proportion of virtual visits while recognizing that some patients may not have access to reliable phones or internet connections. This rapid transition to virtual medical and mental health services runs the legitimate risk of leaving a proportion of our patient population more marginalized than before as they struggle to use virtual tools with known language, literacy and accessibility obstacles. The clinic has also identified and contacted higher risk individuals, conducted mobile outreach and testing to refugee shelters and continues to highlight how the pandemic has amplified the pre-existing barriers that challenge refugee populations.

Despite the immense challenges refugees face, most do very well in Canada and demonstrate tremendous resilience, courage, and strength in overcoming obstacles. Early connections to patient-centered health care is foundational to addressing unidentified health needs and plays an important role in supporting refugee newcomers' long-term integration and empowerment.

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CHAPTER 16

Understanding Race, Racism and Health

AUTHORS:

Ritika Goel, Onye Nnorom, Aisha Lofters, Julia Rackal

Canada is home to people from many different countries of origin and cultural backgrounds along with Indigenous peoples. We remain a nation where race significantly influences health and experiences in the health care system. Racism plays out in both society and our health system on an interpersonal and structural level. Canada's historical laws, policies and procedures, which continue to shape our institutions and attitudes, impact the day-to-day lives of racialized people and, consequently, their health. This history includes the impact of colonization and the Indian Residential School System on Indigenous people, enslavement of Africans, historic immigration policies that have at various points selectively excluded Black, East Asian and South Asian people, and ongoing labour and immigration policies that disproportionately harm Black, Latinx and Filipino communities.

Race and racism are complex to study as the impact on particular communities are specific to the history, the stereotypic notions and images depicted. For example:

- Indigenous communities in Canada face the effects of colonization, abuse and violence in the Indian Residential School System, further family separation due to the Sixties Scoop—a practice beginning in the late-1950s to early 1990s which saw thousands of Indigenous children taken from their homes and communities, and placed with non-Indigenous families (Sixties Scoop Settlement Agreement, 2017)—and segregated hospitals with differential standards of care.
- Black communities in Canada deal with ongoing impacts of this country's participation in the trans-Atlantic slave trade—a lesser known part of our history—and immigration policies aimed at discouraging permanent immigration of Black peoples, as well as racist negative media depictions of Black people.
- East Asian and South Asian communities have faced historic policies discouraging immigration to Canada and tend to be treated as perpetually foreign despite their histories in Canada.
- Temporary foreign worker programs disproportionately bring in low-income Latinx men from Mexico and South America, Black men from the Caribbean and women from the Philippines to engage in low-wage labour or child and seniors care work.
- There is also a growing population in Canada of people who are undocumented or living with precarious immigration status from a number of racialized communities.

These histories mean different things for different communities. It impacts differentially how they experience our health care system and how health care providers may view and engage with them, despite their best intentions.

Many do not understand the extent to which racism continues to be an issue across Canada and take our universal health care system as a cure-all for health inequity. Yet racism continues to be a driver of Canadian health inequities, as described by Toronto Public Health in their report on racism and health (Toronto Public Health, 2013). Specifically, “racism is insidious and affects all aspects of life. It is correlated to poorer health outcomes for those subject to the behaviour, with the strongest and most consistent findings (from the United States) associating the results of racist behaviours with negative mental health outcomes, negative physical health outcomes (hypertension, low birth weight, heart disease and diabetes), and negative health-related behaviours (cigarette smoking, alcohol use and substance use)” (CPHA, 2018).

Unconscious bias in health care: Learning to bring an equity lens

As health care providers, we are taught to be objective in our assessments. However, we are all shaped by the biases we internalize because of societal images and attitudes themselves shaped by historical laws, policies and practices. Race, in particular, is such a visible part of someone’s identity and often holds strong ideas in our mind, often unconscious. We know, however, that better understanding our biases and their origins through greater exploration and critical reflection, as well as learning to challenge ourselves and our assumptions can in fact help to mitigate and re-train our biases.

Research on race and racism

We can better meet the needs of those most marginalized by taking an equity lens to health care provision and research. In Canada, unlike the United States, we historically have not collected race-based data making it often challenging to even clarify the inequities being discussed. As well, in Canadian health care we often fail to serve—and therefore fail to count—those who are without health insurance or with precarious immigration status, often folks from Latinx and Black communities.

The lack of standardized race-based data collection by the Canadian health care system prevents a broader analysis of health inequities on the basis of race—and may be putting the health of many Canadians at risk. For instance, research done by University of Toronto Department of Family and Community Medicine (DFCM) faculty members have found that there is a lack of research on mortality or incidence of breast and cervical cancer in Black Canadian women, even though evidence from the U.S. and U.K. indicates Black women may be predisposed to worse outcomes from these conditions (Nnorom et al., 2019). This study illustrated the importance of not assuming that all racialized people or all immigrants have the same experience. Despite a large body of evidence demonstrating that immigrants in Canada are less likely to be screened for cancer, this study found that Black Caribbean women were more likely to get screened than the white population, after living in Canada for several years.

Although data around race and ethnicity is available from some of the DFCM Academic Teaching sites, more widespread uniform documentation is needed. Better data could help identify differences between racial/ethnic minority health disparities.

While race-based data collection is important, we must also take into account Canada’s history of collecting race-based data to stigmatize and harm marginalized communities (e.g., Indigenous communities). As such, racialized communities must be included throughout the process to help determine how data is collected, stored and used.

What DFCM is doing

As primary care providers, we are often on the front-lines of the health care system. It is important for us to learn to examine our own unconscious biases by learning to critically reflect on our daily interactions with patients. Most importantly, we must understand how our clinical policies, procedures and work cultures can impact and potentially worsen racial inequities. We can support racialized patients in their health care journeys and create safer spaces that allow for stronger trusting relationships and therefore, better patient outcomes. We also can learn how to support our racialized colleagues and trainees who may experience interpersonal discrimination from others in the line of work.

In understanding the importance of racism, both as it impacts our patients and also our trainees and staff, DFCM has created a position to focus on issues of Equity, Diversity and Inclusion, which includes in its mandate, an explicit focus on creating a safer, anti-racist space for patients, providers and trainees, alike.

Members of DFCM have recognized the important role racism can play in the care of our patients and in the day-to-day experiences of faculty members, staff and learners. Many of our academic teaching hospital sites are working to collect data on race. At the St. Michael's Family Health Team, a Racism and Health Committee, formed in 2017, is conducting a scoping review of anti-racist interventions in out-patient health care settings. This will help inform their work as they help drive the department to intentionally and explicitly look at its structures, policies and procedures to promote an anti-racist workplace and patient care environment.

Race is complex as it interacts with various other aspects of identity. Race can often be linked to immigration status, language proficiency, religion and ethnicity and the experience of racism can be further exacerbated by these factors, as well as other identities people hold. This complexity speaks to the importance of representation in positions of leadership of people with lived experience from various racialized backgrounds to be able to lead anti-racist work in our institutions, including academic and health care spaces. We similarly need those in positions of power to create space for these conversations and this work, including putting resources behind it in a meaningful way.

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Dr. Aisha Lofters is an Associate Professor and Clinician Scientist at the University of Toronto Department of Family and Community Medicine and a family doctor at Women's College Hospital.

Dr. Julia Rackal is an Assistant Professor at the University of Toronto Department of Family and Community Medicine and a family doctor at the Unity Health St. Michael's Hospital Academic Family Health Team where she co-leads the Racism and Health Committee.



Family Medicine Announces New Equity, Diversity & Inclusion Lead

In February 2020, Dr. Onye Nnorom began her two-year term as the University of Toronto Department of Family and Community Medicine's (DFCM) first-ever Equity, Diversity and Inclusion Lead. In this position, Dr. Nnorom will play a key role in advancing equity, diversity and inclusion by providing advice and making recommendations to the DFCM Chair and Core Executive Leadership on matters of policy interpretation and practice concerning diversity, equity and inclusion for faculty members, residents, students and staff.

Dr. Nnorom believes this position is an inspiring sign of change at DFCM and throughout the Temerty Faculty of Medicine at the University of Toronto.

"When I started as a resident at the University of Toronto, I knew that I wanted to address issues of discrimination that affect people working in health care and, in particular, how discrimination affects patients and communities. But the opportunities to do this kind of work did not exist or were not made very clear to me at the time."

She is currently the Black Health Theme Lead in the MD Program at the Temerty Faculty of Medicine at the University of Toronto, where she provides guidance and develops educational content around Black population health. She is also the President of the Black Physicians Association of Ontario, an organization focused on equitable representation of Black people in medicine and improving health outcomes for Black Ontarians. Her new role as DFCM's Equity, Diversity & Inclusion Lead adds to this expanding portfolio and aligns with her own personal passion for increasing health equity in medicine.

As the Equity, Diversity & Inclusion Lead, Dr. Nnorom intends to establish a committee of people who are already engaged with equity, diversity and inclusion work within the department.



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CHAPTER 17

Ensuring Care for People Living in Rural and Remote Areas

AUTHORS:

Nadia Incardona, Erika Catford, Jeff Golisky & Stuart Murdoch

There are unique benefits and challenges to practicing family medicine in rural and remote regions of Ontario, where family doctors are often the only source for medical care. Beyond their own medical offices, these family doctors often are also the ones providing care in the emergency department and the hospital, delivering babies and providing care at the end of life. What's more, rural and remote family doctors also communicate, refer and transfer patients to specialists in larger communities for care that cannot be provided locally.

Recruiting and retaining family doctors to practice in rural and remote Ontario communities is an ongoing challenge. Graduating family medicine residents often set up their practice in the area where they complete their medical training, where they feel comfortable and where they have ties to friends and families. As the program which trains the most family doctors in Canada, the University of Toronto Department of Family and Community Medicine (DFCM) established three programs with the goal of exposing family medicine trainees to remote and rural practice: the Rural Residency Program, the Rural Northern Initiative and the Teaching Practices program. Residents who have been exposed to or trained in these communities are more likely to include rural practice in their career (McCready et al., 2004).

The Rural Family Medicine Residency Program

The Rural Residency Program at DFCM is an innovative two-year program designed to prepare residents for rural family medicine. The first year of training takes place in a Greater Toronto Area community-based teaching hospital (Toronto East Health Network—Michael Garron Hospital or North York General Hospital) where residents see the full scope of family medicine that they may not be able to experience in a smaller town. The second year takes place in one of four rural communities—Midland, Orillia, Port Perry, or Orangeville. Residents are able to take advantage of the resources and learning opportunities of the local community hospital and its specialists, and network with residents from other streams.

Residents are able to take their experience from their first year to augment their learning from rural family doctors in their second year. All Rural Family Medicine Residency Program residents are required to live in the community to which they are assigned for their second year. Emergency shifts, in-patient care and intra-partum obstetrics are included as core experiences. This program is the perfect training ground for those who are interested in working in a rural environment after graduation and plan to maintain a comprehensive practice in the future.



DFCM RESIDENCY TEACHING SITES

GREATER TORONTO AREA STREAM

- 1 Mount Sinai Hospital, Sinai Health System
- 2 Unity Health Toronto, St. Michael's
- 3 Sunnybrook Health Sciences Centre
- 4 Toronto Western Hospital, University Health Network
- 5 Credit Valley Hospital, Trillium Health Partners
- 6 Markham-Stouffville Hospital
- 7 Mississauga Hospital, Trillium Health Partners
- 8 North York General Hospital
- 9 Women's College Hospital
- 10 Scarborough Health Network
- 11 Toronto East Health Network
- 12 Unity Health Toronto, St. Joseph's

BARRIE/NEWMARKET STREAM

- 13 Royal Victoria Regional Health Centre, Barrie
- 14 Southlake Regional Health Centre, Newmarket

RURAL STREAM

- 15 Headwaters Health Care Centre, Orangeville
- 16 Georgian Bay General Hospital, Midland
- 17 Lakeridge Health Network, Port Perry
- 18 Orillia Soldiers' Memorial Hospital, Orillia

The Rural Northern Initiative

The Rural Northern Initiative was established in 2005 as a joint initiative between DFCM and the Ontario Ministry of Health. The program has two purposes: 1) provide respite medical care for the most underserved communities in Ontario and 2) expose family medicine residents in their final year of training to a rural or remote practice with the goal of increasing rural practitioners.

As part of the program, a DFCM faculty member and a second-year resident travel to these communities to provide care for two weeks at a time. Often, faculty members will choose to return several times to the same community where they have established relationships with the local health care providers. Since its inception, the program has completed 74 trips to provide care in rural communities across Ontario. Many of the residents who participated in this program have continued to provide care to rural communities across Ontario once they complete their residency training.

The Teaching Practice Program

Through the Teaching Practice program, family medicine residents at the University of Toronto complete two months of their residency program training in rural communities around Ontario. The Teaching Practices network consists of a roster of over 70 experienced family doctors who have approximately 30 community practices throughout rural Ontario. As part of the program, DFCM supports these doctors with professional development and they become part of the University of Toronto faculty members.

Teaching Practice Program residents complete training in sites that range from rural southern Ontario to as far north as Moose Factory, an island in the Moose River leading to James Bay and Red Lake, in northwest Ontario. The program enhances the learning experience for University of Toronto residents by involving them in the care of patients from communities based on agriculture, mining, forestry, wilderness conservation and recreation. Additionally, some of the teaching practices are inclusive of First Nations, Mennonite, Amish peoples and others.

From a community in need of doctors to helping train Ontario's future doctors: Red Lake, Ontario

In November 2006, the first Department of Family and Community Medicine (DFCM) faculty member and resident pair travelled to Red Lake, a small community situated 535 km northwest of Thunder Bay, for a Rural Northern Initiative trip. This marked the beginning of a 14-year relationship that continues today between the community of Red Lake and DFCM.

At the start, faculty members and residents travelled over 1,900 km from Toronto to provide much-needed service to a remote and underserved community. Eventually, this relationship evolved as the local doctors expressed an interest in contributing to the education of DFCM residents. In 2008, Red Lake became a DFCM teaching practice site and since has provided core family medicine training for 64 family medicine residents.

"We are so happy with the continuation of this program," says Pat Delf, the Executive Director of the Red Lake Family Health Team. "We have residents that come up from University of Toronto who come back to work with us part-time or even for a couple of years. They have basically been our only source of new doctors."

When the Rural Northern Initiative first started going to Red Lake, the community was facing a severe shortage of doctors. When Red Lake was at its greatest need, Rural Northern Initiative members and residents went up 14 times. Two of the residents from these trips became Rural Northern Initiative faculty members and continued to take additional residents to Red Lake.

Despite their remote location, residents travel and continue to return to Red Lake to practice, demonstrating the long-term value of educating Ontario's future family doctors. Since 2013, residents have returned to Red Lake to work: five joined the practice, seven work part-time and six have done short term (locum) work.

Teaching Practices Provides Exposure to the Advantages of Small Town Practices

Lion's Head—a Department of Family and Community Medicine (DFCM) Teaching Practice site—is a community of approximately 600 people located on the Northern Bruce Peninsula, halfway between Owen Sound and Tobermory. Despite being only three to four hours northwest of downtown Toronto, the health care and patient experience is distinctly different: their rural location means they do not have the ability to sustain and access the resources normally available to those living in the city.

For example, access to specialty care and backup presents a challenge. If patients require specialty care, they often have to travel a minimum of an hour to an hour and a half to Owen Sound or further. However, this lack of access to such care is a blessing in disguise, as it presents rich learning opportunities for residents who are able to do things they may not have had the chance to do if they were in the city.

"Patients are more willing to see us for things that often they would insist on seeing specialists for if they lived in the city because access to specialist care is easier in the city. Here, patients are very

happy and grateful for us to try to deal with these issues and save them an hour and a half trip or further." says Dr. Ali Appelton, a family doctor who has practiced in Lion's Head for the past ten years and faculty development representative on the Professional Development program at the DFCM. "And since there aren't multiple levels of learners lined up to try to get their first crack at something, residents who come here get to do whatever is available. So, they get to have a really involved experience: they get to do a lot, see a lot, and get a lot of hands-on experience as opposed to their time in the city."

As was the case for Red Lake, positive learning experiences in this rural community have led University of Toronto residents to return to Lion's Head for work after graduation. Some for short-term work and some permanently: in fact, Dr. Appelton is one of two University of Toronto graduates who are currently practicing in Lion's Head at Peninsula Family Health Team.

"I'd say past residents are our greatest tool for recruitment. I think it's a lot easier for people to return somewhere they've had some experience," says Dr. Appelton. "There are probably people like myself who had absolutely no intention of practicing rurally until the experience here completely changed my life."

Dr. Nadia Incardona is the Rural Northern Initiative Coordinator, Assistant Professor at the University of Toronto Department of Family and Community Medicine and an Emergency Physician at Toronto East Health Network's Michael Garron Hospital.

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Dr. Jeff Golisky is a Lecturer and the Rural Residency Program Director at the University of Toronto Department of Family and Community Medicine and a family doctor.

Dr. Stuart Murdoch is an Assistant Professor and the Postgraduate Program Director at the University of Toronto Department of Family and Community Medicine and a family doctor at Royal Victoria Regional Health Centre.

Sending AEDs to rural community emergencies with drones



When a cardiac arrest happens, the best way to improve a person's chances of survival is the use of an automated external defibrillator (AED). While public access AEDs are increasingly common in Ontario and across Canada, the level of access is disproportionate across the country: fewer AEDs exist in rural areas, which often means people have no choice but to wait for emergency medical services (EMS)—during which the risk of a poor outcome increases with every second.

"A lot of Canada is in fact, rural," says Dr. Sheldon Cheskes, an Associate Professor with the Division of Emergency Medicine at the University of Toronto Department of Family and Community Medicine and a scientist at the Li Ka Shing Knowledge Institute at St. Michael's Hospital. "The trouble when you get to rural areas is you can wait a long time for an ambulance. And it's well documented that survival from cardiac arrest in these areas is quite poor because we can't get to them fast enough."

Dr. Cheskes is working with engineers at the University of Toronto to use drones carrying AEDs to augment EMS response and get defibrillators to patients in need—particularly in these rural communities.

"We did some mathematical modelling and found that by using drones, we could really cut response time in urban areas by about six minutes, and in rural areas by almost 11 minutes by implementing a drone solution in Southern Ontario," says Dr. Cheskes. "We know that cardiac arrest survival decreases by 10 percent for every minute of cardiac arrest—theoretically—cutting the response time has the potential to save a large number of lives."

To put their math to the test, Dr. Cheskes, who is also the Medical Director for the Regions of Halton and

Peel, worked with Drone Delivery Canada, a leader in drone technology in Canada. They first tested the ability to put an AED on a drone and then sent it to a mock cardiac arrest in a rural area simultaneously with an EMS vehicle starting from the same point. After the team's first four test flights in Caledon, ON, they found that the drone with the AED got there quicker than EMS in every case. The same results were found when the AED carrying drones were tested in Renfrew, ON, where the drones arrived three to four minutes earlier on average than EMS. This suggests that it is not only mathematically possible but feasible to bring AEDs to the scene of a cardiac emergency real life. More importantly, the three to four additional minutes of having an AED on site can be the difference in the successful outcome experienced by the patient.

While these initial results are positive, Dr. Cheskes and his team will need to continue testing the drones by increasing flight distances and seeing if response times are consistently improved as well as improving the ease by which a bystander may use an AED when delivered by a drone.

So, will we be seeing drones delivering AEDs soon? Maybe in rural communities, but it is unlikely that we will see it in urban centres like downtown Toronto, says Dr. Cheskes.

"Some people think, 'This is so cool—we're going to see drones flying around downtown Toronto,' but there's too many skyscrapers and areas that would make it difficult to both fly and land a drone, so it's very unlikely. The emergency response times are also quite good in urban centres, so there isn't the same pressing need that you have in the rural community. I see the use of drones expanding more in rural centres and areas that are just hard to get to."

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CHAPTER 18

Using Social Accountability to Address Global Health Challenges

AUTHORS:

Praseedha Janakiram, Abbas Ghavam-Rassoul & Katherine Rouleau

“It’s time for the global community to take humanity closer to health and wellbeing for all through bold steps.... Progress will require courage and determination. Clearly the time is now” (WHO & UNICEF, 2018).

The Department of Family and Community Medicine (DFCM) at the University of Toronto is known globally as a key academic voice in advocating for family medicine and primary care as a mechanism for achieving equity and social accountability for all. This sentiment was strengthened when the World Health Organization (WHO) adopted the Declaration of Astana, which was signed in Astana, Kazakhstan by the world’s Ministers of Health in October of 2018. The Astana Declaration recognizes the role primary health care plays as the foundation to creating a sustainable health care system aimed at meeting “all people’s health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care” (WHO, 2018).

Improving family doctors’ skills in global health and the care of vulnerable populations

A third year family medicine residency program in Global Health and the Care of Vulnerable Populations has evolved over 11 years to include a robust Toronto-based six-month program where trainees embed themselves in learning opportunities focused on refugee health, tropical medicine, inner city health, addictions, and other selective experiences. Family medicine residents have engaged in our long-standing partnership with Brazilian colleagues in family medicine at Santa Marcelina University in São Paulo Brazil. In the 2019-2020 year, learning offerings were expanded to include a World Health Organization internship and a team-based capacity

building experience with the Toronto Addis Ababa Academic Collaboration in Family Medicine where the resident role is a valued and unique contribution. As COVID responses and impacts are felt globally, this training program will adapt to meet learners’ needs in the virtual care realm, the virtual teaching and learning space, and with an ongoing focus on care relating to global inequities in health.

Impacting family medicine and primary health care practitioners globally

DFCM offers collaborative educational and leadership programs for international health professionals from around the world. All of the international leaders and professionals who participate in our programs now lead health care advances to address the needs of underserved populations in their communities. In this unprecedented time, each of these leaders is tasked with new challenges to be overcome, and we hope their experiences with DFCM Global Health and Social Accountability offerings will stand them in good stead as we continue to liaise with them.

The Toronto Addis Ababa Academic Collaboration in Family Medicine: In 2013, DFCM supported the launch of the first family medicine training program in Ethiopia. The program aims to support the training of family doctors for the Ethiopian health care system—a country where family medicine previously did not exist. Since its creation, 18 Ethiopian family doctors have graduated from the program and many have taken leadership roles in clinics and

hospitals across the country where they continue to advance the discipline. As 2020 unfolds, virtual education and remote capacity building will launch a new focus for this program until such time as face-to-face teaching engagements can resume.

Chilean Interprofessional Program in Primary Care and Family Health: For the past 17 years, DFCM has welcomed Chilean health professionals—including family doctors, nurses, social workers, midwives and others—from primary care settings across Chile. While, overall, Chilean health care providers express keen interest in how we organize and deliver primary care in Canada, in recent years there is also a demand to better address the health of immigrant and indigenous populations in Chile with additional focus on mental health supports and care strategies for their most disenfranchised patients. DFCM offers a wealth of experience and learning in these areas. Determined to persist in our efforts to support and share lessons with our Chilean colleagues, we have started hosting regular virtual sessions with previous participants of our Chilean program. During these sessions, we address some of the salient issues, challenges and solutions, that arise in the course of providing robust primary care in the context of COVID-19.

Toronto International Program in Strengthening Family Medicine and Primary Care (TIPS): Annually, DFCM hosts emerging family medicine leaders from around the world to learn more about research in family medicine. Our most recent international delegation included family medicine and primary care leaders from Brazil, Nigeria, Ethiopia, Egypt, and Japan. Past TIPS participants endorse the program recognizing their enhanced ability to undertake leadership roles and responsibilities while spearheading research in family medicine in their local settings. Recognizing the heightened importance of coming together to learn and share our experience addressing the needs of patients and communities in these challenging times, we launched “CO-TIPS”, a weekly learning and exchange session on a range of primary care issues in the context of the COVID response for past TIPS participants and those who were planning to join this year.

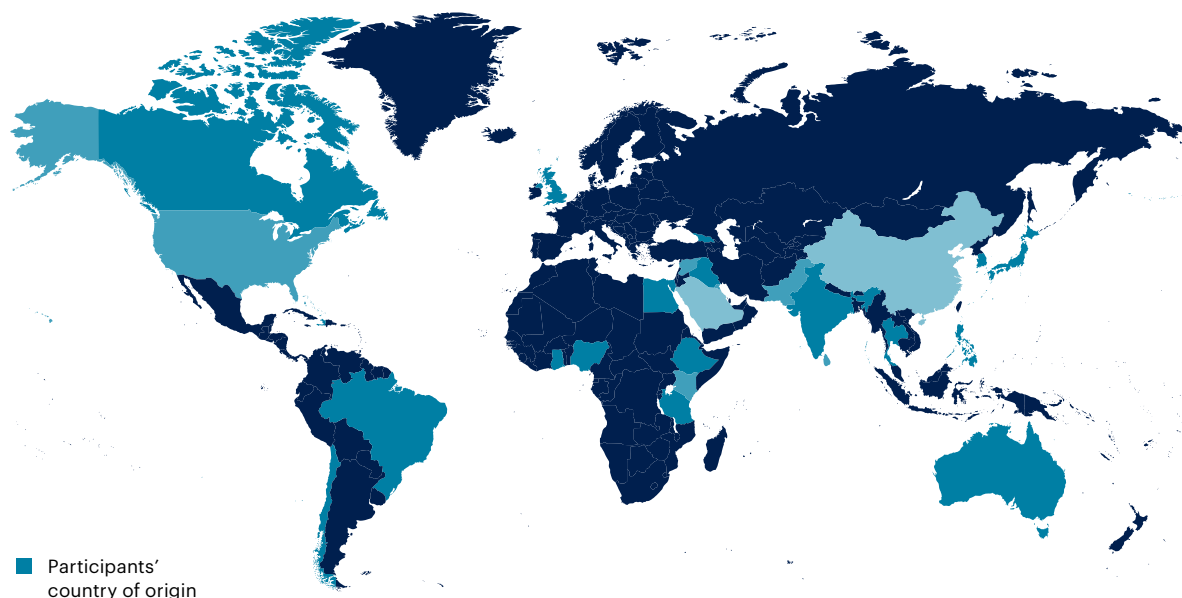
Toronto Program in Strengthening Family Medicine and Primary Care – PUDONG: Since 2013, DFCM has welcomed young family medicine leaders from the Pudong area of China to learn about family medicine leadership and Canada’s health systems. In 2019, 17 family doctors and doctors of Traditional

Chinese Medicine were welcomed to Toronto. This delegation placed a high priority on learning educational strategies to improve family medicine training programs in China, with a deep interest in team-based care and respectful patient-centered care and confidentiality.

COVID-19: The unfolding response

While no one could ever have imagined the ongoing waves of impact felt around the globe and here at home as COVID-19 took hold of every community in 2020, these turbulent times have called on everyone at DFCM to do their part, to stand strong, and to extend a hand in professional and personal solidarity to our family medicine partners everywhere. The impact on our most marginalized patients, who lack homes or secure housing, safe isolation spaces, supports, technology, and the financial and human resources to navigate the widespread public health measures required to maintain community safety—has been profound. DFCM Social Accountability Committee launched a Social Care Guidance tool in collaboration with the Upstream Lab and the Center for Effective Practice to empower community providers to address these needs (Centre for Effective Practice et al., 2020). All the partnerships highlighted here, each central to the Global Health and Social Accountability portfolio, reflect the presence of advocacy and ongoing academic partnership with a vital pivot in approach to our work. In this context of identified health inequities, our department is working to meet the demand for leadership, innovation, and learning through experience-based solutions for Canadian and international health professionals. Through innovation, we will aim to maintain a united focus on fulfilling our commitment to being socially accountable to those we serve.

FIGURE 1: COUNTRIES OF ORIGIN OF THOSE WHO HAVE PARTICIPATED IN DFCM INTERNATIONAL PROGRAMS TO DATE



Participants in our longstanding international educational programs have included a mix of clinicians, educators, policy leaders and administrators from China, Jamaica, Haiti, Brazil, Ethiopia, Nigeria, Kenya, Iraq, Thailand, Chile and the United States. Invited international faculty have included educators from Nigeria, Brazil, Thailand and Kingdom of Saudi Arabia.

Dr. Praseedha Janakiram is an Assistant Professor at the University of Toronto Department of Family and Community Medicine, the former Program Director for the Enhanced Skills Program for Global Health and the Care of Vulnerable Populations and a family doctor at the Crossroads Clinic at Women's College Hospital.

Dr. Abbas Ghavam-Rassoul is an Assistant Professor, the Program Director for the MScCH in Health Practitioner Teacher Education, Medical Education Fellowship and Clinical Teacher Certificate programs at the University of Toronto Department of Family and Community Medicine and a family doctor at St. Michael's Hospital.

Dr. Katherine Rouleau is an Associate Professor, Vice-Chair, Global Health and Social Accountability at the University of Toronto Department of Family and Community Medicine and a family doctor at St. Michael's Hospital.

Supporting Primary Health Care Globally at the WHO

In 2019, the Department of Family and Community Medicine's newly designated WHO Collaborating Center on Family Medicine and Primary Care supported four family doctor members and residents to engage in family medicine/primary care-focused policy initiatives at the WHO headquarters in Geneva, Switzerland. Through their work, our faculty members and residents had the opportunity to contribute to the pivotal work of the WHO in the area of Primary Health Care building on the pillars of Canadian family medicine. We were able to speak with three of them about their experiences during their time at the WHO.

Kate Stead is a second year family medicine resident at Sunnybrook Health Sciences Centre. During her time at the WHO, she worked with the Primary Health Care team in planning and developing guidance documents for the implementation and advancement of primary care at a country level.

How was your internship experience?

Fabulous! It was an incredible opportunity to work with an organization where so many people are dedicated to global health, and at a time where there is such a focus world-wide on primary health care. It was a privilege to be able to learn about broader level changes and policy movement, while contributing the knowledge that I have from our day-to-day work with patients in clinical practice.

Why do you think it's important for family doctors to be involved in global health?

It is an invigorating time right now where there has been a lot of focus placed on primary health care in the last few years from prominent global leaders and organizations. I feel very strongly that this is where we are going to create change. Overall global health is going to improve because we are focusing on comprehensive care and all of the different issues that come along with being human, not just verticalized disease management.

Kelsey Lawson is a third year postgraduate student in Global Health and the Care of Vulnerable Populations here at DFCM. During her time at the WHO, she worked with both the Primary Health Care team and the Health and Migration team to create partnerships and links to improve migrant and refugee health.

How has this internship experience changed your perspective on global health?

I think this experience really showed me the importance of primary care worldwide, so it gave me a boost of confidence and pride in the work that we do as family doctors. It also made me realize even more the importance of being involved at a more societal level. Before I focused more on the patient in front of me and what I was doing one-on-one, but this experience really showed me the importance of thinking globally, and how these global policies may be influencing our patients.

Why do you think it's important for family doctors to be involved in global health?

Honestly at the end of the day—even in our local community—it is global health that exists, we just see it at a micro level. I think we're getting a more diverse population—especially in Canada. We have many refugees, migrants, and other populations that are at a higher risk of being marginalized, and it's these high-level policies that influence their health. So, it's important for us to be aware of that, so we know how to navigate the system and how we can help our patients the most.

Tarun Rahman is a second-year family medicine resident at St. Michael's Hospital. During his time at the WHO, he had the opportunity to meet and learn from peers and health experts from around the world and build on his public health expertise and knowledge by working on a project to help countries establish primary care into their own health systems.

How has this experience informed or changed your perspective on global health?

Having the opportunity to experience global health at the highest level of decision and policymaking was a brand-new experience. The World Health Organization is the centre of the global health world, and, simply having the opportunity to learn and understand how the WHO's new frameworks, tools, reports and policies are planned and implemented was enlightening. Knowing how higher-level decisions work with inevitable greater impact on larger numbers of individuals, is a pretty powerful understanding for future advocacy use.

Why do you think it's important for family doctors to be involved in global health?

Global health, in its broadest sense of addressing issues of health inequity and disparity both at home and abroad, is an inherent part of being a family doctor. To be a family doctor is to support the vulnerable and disadvantaged, whether that be through acts of individual advocacy or influencing policy.



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CHAPTER 19

Encouraging Innovation for Education and Training

AUTHOR:

Risa Freeman

Family doctors provide care to patients from diverse communities, and every patient brings a wide range of needs and challenges. In order to prepare our students for this work, it is essential that in their training they encounter and care for people from as many diverse patient groups as possible. In fact, the University of Toronto Department of Family and Community Medicine (DFCM) has encouraged addressing social inequities as a focus of attention for teaching, research and patient care. This chapter will describe some of the education programs for our medical students, residents and graduate students, which address the unique needs of our diverse communities, individuals and populations.

Medical students

At the University of Toronto, medical students are assigned to a teaching hospital for their family medicine rotation in the third year of medical school. They work with doctors in a family practice clinic in a hospital or in the community. Each of our hospitals and community practices serve a wide range of populations such as Indigenous people, the homebound and elderly, patients with chronic disease or mental illness, homeless, people living with HIV, refugees and immigrants, children, uninsured patients and the LGBTQ2S+ community. Our patients have health care concerns that intersect with many social factors, including poverty, and access to housing and education. Through their time spent with family doctors who are working with these communities, the students come to understand the essential role that family doctors play in this area of care and potentially be inspired to pursue family medicine as their future choice of practice.

“Addiction Medicine Week” is an excellent example of a course designed to teach about a specific at-risk group of people. In 2019, one of our medical students, Robin Glicksman, recognized that our students would benefit from more intensive training around addiction medicine. Together with her classmates, she collaborated with hospitals, community agencies, patients and family groups, and medical educators to create a one-week, extracurricular course. Participants were taught by experts in the field, visited treatment settings, and learned about the lived experience of individuals with substance use disorders. Thirteen students completed the course and rated it highly as an experience that will initiate a change in their future practice.

Family medicine residents

Family medicine residents are doctors who have finished medical school and are doing another two years of training to become certified family doctors. They are assigned to one of our 14 hospital sites for their training, where they are exposed to the same diversity of patients as our medical students. Outside the hospital, family medicine residents have many options to choose from as they learn to care for marginalized patients. For example, they can do placements in detention centres, schools, homeless shelters, teen and adult addiction medicine programs, and organizations that help refugees or street youth. They can also work at Crossroads Refugee Health Clinic, which is Toronto's first hospital-based refugee health clinic (see Chapter 15). Their time at this clinic provides them with valuable cross-cultural experiences.

We offer many rural training opportunities for our family medicine residents, including our Rural Residency Program and Rural Northern Initiative (see Chapter 17). We hope these experiences will encourage them to consider practicing in one of these high needs communities when they graduate.

Our family medicine residency program also offers learners an opportunity to explore the impact of the medical, social and spiritual determinants of health and well-being on Indigenous populations. Residents can choose to do electives at inner-city Aboriginal care centres, participate in faculty-led research on Indigenous health issues, and some may choose to do two months of their training on a reserve in Moose Factory where they are able to develop their knowledge and skills while caring for Indigenous patients.

In addition to learning to care for patients in clinical settings, the family medicine residents will study in seminar groups to learn about the care needs of underserved populations, transgender health, and immigrant and refugee health and the treatment of addiction disorders, including alcohol and cannabis use, and safer opioid prescribing.

After completing the two-year program, graduates can then choose to take an extra year of training to focus on the needs of specific populations. We offer these programs in addiction medicine, care of the elderly, global health and vulnerable populations, HIV care, indigenous health, palliative care and women's health. This additional year helps them become a resource to their patients and colleagues in this area of enhanced training.

Graduate students and academic fellows

Our Academic Fellowship and Graduate Studies Program offers advanced training to graduates of a family medicine program and other health care professionals who are seeking a deeper understanding of family medicine and its role in Canadian and global health care.

All of our graduate students are required to take courses that study the impact that social determinants of health, such as poverty, education, or race, can have on the populations we care for. Other courses offered by this program address social, political and scientific issues in family medicine, advocacy activities of family doctors and other professionals, the role of family medicine and primary care in responding to global health challenges, and gaining skills for motivating change in health behaviour.

Our Academic Fellowship and Graduate Studies Program is also addressing the needs of another group that has unique needs – doctors who are new to Canada and do not have a clinical license. Through a pilot and evaluation project we are admitting skilled health professionals into the Master of Science in Community Health in Family and Community Medicine (MScCH (FCM)) Program. The goal of the program is to provide these highly accomplished professionals with exposure to the Canadian system and increase their skill level to allow them to contribute to health care in Canada as researchers and administrators.

Through rich and varied learning experiences, at all levels of training, our students develop a deep understanding of the needs of diverse communities, individuals and populations in our country. These students will go on to careers in family practice in urban, rural and remote settings, many of them devoting their practices to serving the needs of a particular marginalized population. Some of our students will also become leaders and administrators in our country's health care system and, with their understanding of the health care needs of diverse populations, will seek to influence health policy to improve the care and treatment of all Canadians.

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CHAPTER 20

Improving Quality of Care, Experiences and Outcomes for Everyone

AUTHOR:
Tara Kiran

Our faculty members and learners are always striving to improve the quality of care family doctors deliver. Through Quality Improvement (QI), we measure the care we are providing, develop initiatives to improve the care, and then test whether implementing new practice methods makes a difference to patients. Often, our initiatives are designed for the average person in our practice. But we have realized that when we focus just on “the average person”, we may leave others behind.

We strive to take an equity lens in our work to ensure the new initiatives we develop help not just the “average person”, but also those who continue to face stigma and have traditionally been poorly served by the current health care system.

Where possible, we measure the quality of care we provide to our patients to better understand not just how well we are doing overall, but how well we are serving specific groups of people, including people with low income, new immigrants to Canada, people with disabilities and those with mental health conditions. If we find that care or outcomes are worse for a specific group, we delve further into the issue. Usually, that means understanding the particular needs and perspectives of people with lived experience. We then design and test an improvement initiative to see if we can reduce the gap in care or outcomes between groups.

For example, at St. Joseph’s Health Centre in downtown Toronto, the quality improvement team is currently examining ways to increase cancer screening rates amongst people with schizophrenia. Over the last several years, major steps have been undertaken at Mount Sinai Hospital to become more accessible to people with physical disabilities. Many of our teaching sites have been collecting data around income to better understand the socioeconomic circumstances of their patients so that they can provide supports. Several family medicine resident projects have focused on understanding and improving care for specific at-risk populations. Examples include improving immunization rates for newly arrived refugees and connecting people living with poverty to community resources.

Understanding and improving cancer screening among the trans population

As family doctors, we try and keep our patients healthy. That means ensuring our patients get recommended screening for diseases such as cervical, breast, and colorectal cancer. When we catch these cancers early, we are more likely to be able to treat them successfully, prevent complications, and help our patients live longer, healthier lives.

In 2014, our practice at the St. Michael's Hospital Academic Family Health Team began a quality improvement initiative to improve our cancer screening rates. We improved reminders in the chart that notified doctors when a patient was overdue for screening. We provided doctors with data about who in their practice was not screened. We also systematically and proactively reached out to patients who were overdue using letters and phone calls.

Our efforts were rewarded. Between March 2014 and December 2016, our cervical, breast, and colorectal cancer screening rates rose from 60 percent to 71 percent, 56 percent to 65 percent, and 59 percent to 70 percent, respectively (Feldman et al., 2017). When we took a closer look, however, we realized that not everyone was benefiting from our initiative.

Some of our doctors told us that people who were trans were often misclassified in our outreach efforts. Trans is an umbrella term used to describe people whose gender identity does not match their sex assigned at birth; it includes but is not limited to people who identify as genderqueer, genderfluid, and gender nonbinary. We realized our trans patients sometimes received outreach letters inappropriately and sometimes did not receive any outreach even though they were overdue for screening. For example, trans men who had changed their gender marker on their health card to male would not be noted in our system as needing cervical screening—even though they have a cervix.

These insights prompted us to do a chart audit to understand cancer screening rates among our trans population. We found that patients who were trans had lower screening rates compared to our cis (non-trans) population—and those differences persisted even after we adjusted for factors like age, neighbourhood income, and number of visits (Kiran et al., 2019).

We wanted to do better. Two of our resident doctors embarked on a quality improvement project to better understand the perspectives of our trans male patients about cervical cancer screening. They found that in most cases, not being screened was an informed choice. Trans men declined the test knowing the potential risk of getting cancer because the risk was outweighed by the discomfort of the procedure—a procedure that was highly gender dysphoric.

Our practice has since taken steps to respectfully include our trans patients in cancer screening initiatives. First, we include all age-eligible patients who are trans in the outreach lists we provide family doctors, regardless of the gender marker on a patient's health card. Family doctors know their patients and decide whether the patient should get a reminder letter for a test. Second, we are also moving to measure informed discussion of cancer screening, not just whether someone gets a test. We realize there are many good reasons why people may decline screening. Third, we hope our work has helped educate patients and doctors about trans cancer screening guidelines. For example, many family doctors and patients do not realize that trans women over 50 who have been taking prescribed estrogen for more than five years should be screened for breast cancer with a mammogram. Finally, our team has taken steps to make our practice more welcoming to people who are gender diverse, for example, by displaying positive-space posters in the waiting room, ensuring availability of gender-neutral bathrooms, and providing training on gender-inclusive and sensitive care to front-line clerical staff and our family doctors.

Through quality improvement, our primary care teams at the University of Toronto Department of Family and Community Medicine are helping to ensure that the care we deliver improves experience and outcomes for all our patients, not just the "average" person.

For more information on how a primary care practice can improve cancer screening and reduce related disparities, please visit the MAP Centre for Urban Health Solutions' website*.

*<https://maphealth.ca/cancer-screening/>

Dr. Tara Kiran is an Associate Professor, the Fidani Chair in Improvement and Innovation at the University of Toronto and the Vice-Chair of Quality and Innovation in the University of Toronto Department of Family and Community Medicine and the Institute for Health Policy, Management and Evaluation, a Scientist with the MAP Centre for Urban Health Solutions at St. Michael's Hospital and a family doctor at St. Michael's Hospital Academic Family Health Team.

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CHAPTER 21

Conducting Research at the University of Toronto Department of Family and Community Medicine

AUTHORS:

Eva Grunfeld & Paul Krueger

The University of Toronto Department of Family and Community Medicine (DFCM) hosts the largest family medicine research program in Canada and one of the largest in the world. The amount of research funding that faculty members have been awarded as principal or co-principal investigators has increased from a total of over \$9 million in 2013 to over \$50 million in 2018 (Table 1). In addition, DFCM faculty members participated in many other grants as co-investigators, where the principal investigators were not members of the DFCM (Table 1). The number of peer-reviewed publications has also increased from 222 in 2013 to 551 in 2018 (Table 2).

TABLE 1: UNIVERSITY OF TORONTO DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE GRANTS AND CAREER AWARDS

Grants	2013	2014	2016	2017	2018
Principal or Co-Principal Investigator Grants					
Number of peer-reviewed and non peer-reviewed grants	50	126	173	141	223
Amount of peer and non peer-reviewed grants	\$9,604,534	\$17,353,611	\$40,848,971	\$21,109,793	\$50,425,759
Co-Investigator Grants*					
Number of peer-reviewed and non peer-reviewed grants	36	113	147	160	104
Amount of peer and non peer-reviewed grants	\$5,437,933	\$45,990,347	\$33,318,482	\$44,875,099	\$27,119,870
Career Awards					
Number of awards	6	8	33	26	33
Amount of awards	n/a	\$727,000	\$997,263	\$1,215,500	\$1,506,000

**Includes grants where the principal or co-principal investigators are not Department of Family and Community Medicine faculty members*

n/a=not available

TABLE 2: PUBLICATIONS BY FACULTY MEMBERS AT THE UNIVERSITY OF TORONTO DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE

Publications	2013	2014	2016	2017	2018
Number of peer-reviewed publications	222	331	451	483	551
Number of non peer-reviewed publications	80	50	98	42	93

The DFCM Research Program and UTOPIAN held a Retreat in late 2019 to propose ideas on how to strengthen the Research Program and UTOPIAN. Faculty members from all programs in DFCM were invited to present “pitches” on various research ideas that they felt were important for family medicine, would resonate well across the DFCM, would appeal to donors/funders, and were topics they were personally interested in pursuing. After in-depth small group and large group discussions, those attending the Retreat were asked to vote on which research ideas they thought were most important to pursue. The discussions and subsequent voting revealed that there was a high level of interest and support for the following research ideas:

- Primary Care Centre of Excellence in Health Equity
- Multi-morbidity
- Combined Artificial Intelligence + Information Technology
- Transforming UTOPIAN from a Practice-Based Research Network into a Practice-Based Learning Network.

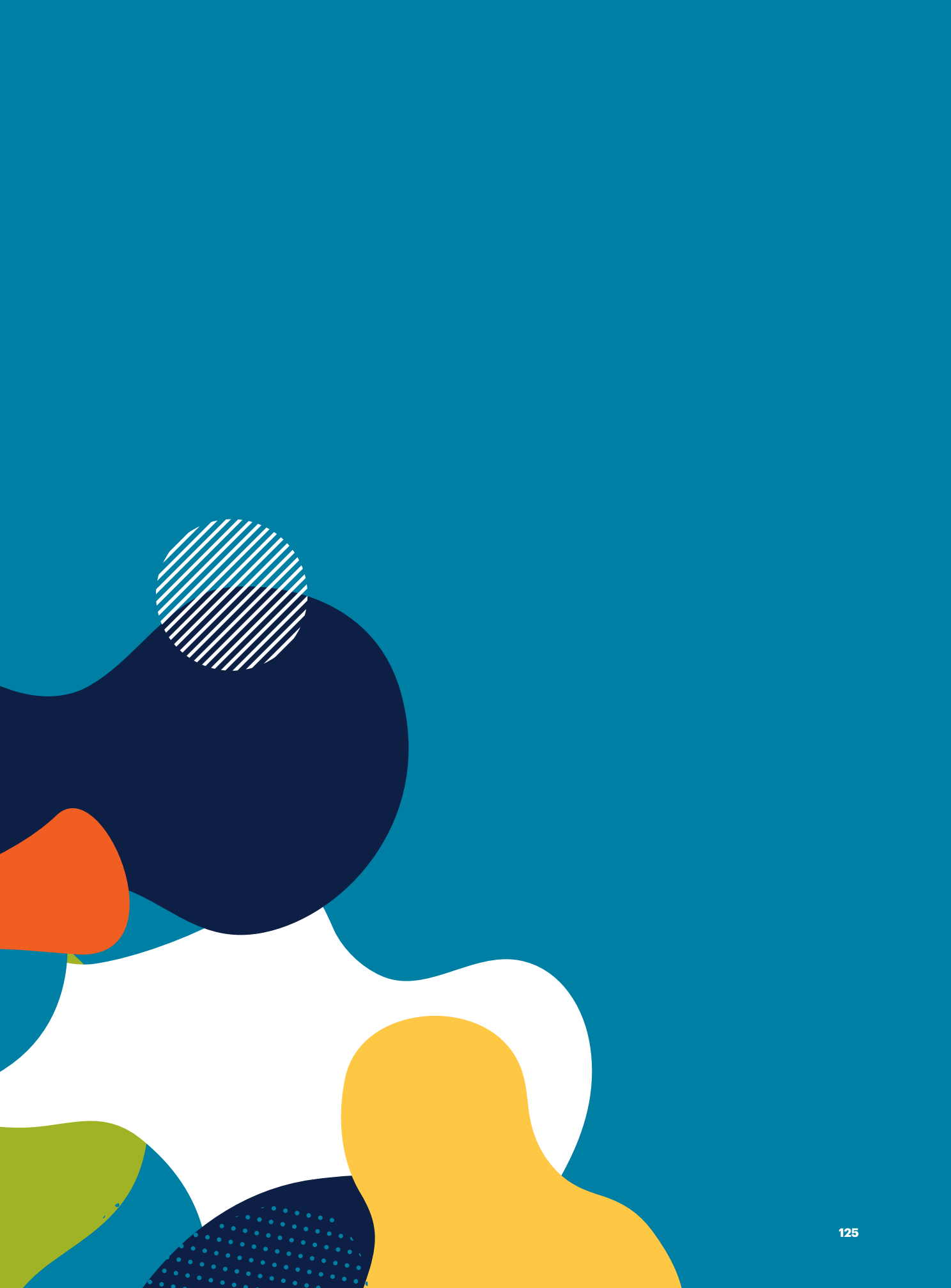
A Practice-Based Learning Network is a place for learning, where clinicians are encouraged to ask questions relevant to their daily practice, and where clinicians, patients, and academic researchers collaborate in the search for answers that lead to better care in practice (Roper, 2018).

DFCM will incorporate the findings from the Retreat into future strategic plans.

With the COVID-19 pandemic beginning in Canada in early 2020, family medicine researchers very quickly mobilized and developed research studies to answer important questions that are relevant to their patients in the family medicine setting. They have submitted many grant applications to a variety of funding bodies including provincial and federal government agencies, foundations, hospital and university initiatives, and private donors.

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CHAPTER 22

Transforming Health Care Through Social Policy

AUTHORS:

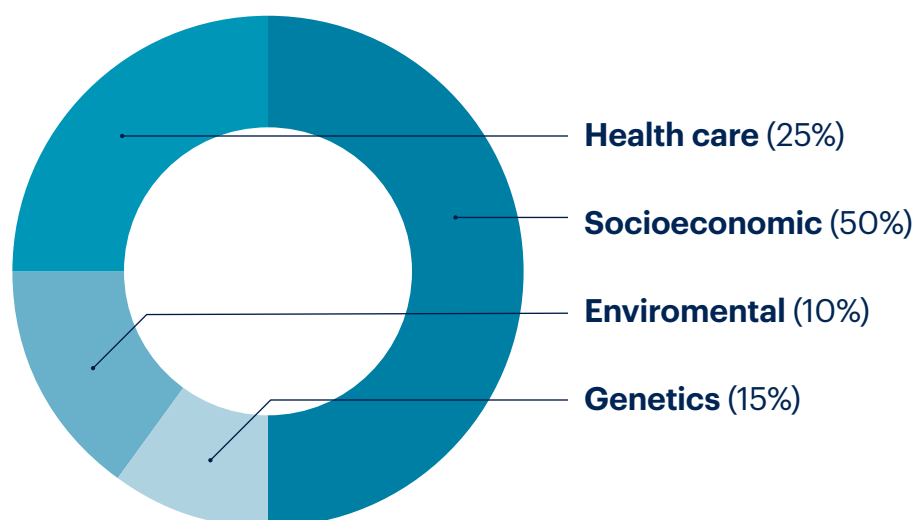
Andrew Boozary & Danielle Martin

The evidence is overwhelming that social determinants are the major drivers of health, and that social policy interventions offer one of the best ways to improve the health of populations (Marmot, 2005). Canada was an early leader in naming the critical need for attention to income, housing, employment and education, not just as social issues, but as health issues.

It is estimated that 15 percent of population health is determined by biology and genetics, 10 percent by physical environments, 25 percent by the actions of the health care system, with 50 percent being determined by our social and economic environment (Figure 1).

Yet in Canada, as is the case in most countries, health care has continued to dominate the discourse around health for decades (Lalonde, 1974). What's more, collaborations between social service and health care organizations are often fraught with mistrust: it has not escaped the notice of the social service sector that Canada has a tradition of over-reliance on health care services to address social inequities.

FIGURE 1: ESTIMATES OF THE CONTRIBUTION OF THE MAIN DRIVERS OF HEALTH STATUS



(Donkin et al., 2018)

The role of family doctors in changing the discourse

Doctors have held privileged positions when it comes to influencing the policymaking process, and at times the medical community has contributed to a conflation of health and health care. For doctors to be part of meaningful and innovative solutions in the future, there must be a broader recognition of the policies that improve the wellbeing of Canadians. Organizations representing organized medicine such as the Canadian Medical Association and the College of Family Physicians of Canada have taken significant steps to advance the dialogue, but high-level policy statements have not always found their way to the front lines, where the daily demand for health care services can sometimes obscure the root social causes of illness (Andermann, 2016; Buchman et al., 2016).

Family doctors, in particular, have a unique role in advocating for the wellbeing of their patients, and ultimately, a healthier society. The person-centered focus of the discipline, as well as the emphasis on relationships, naturally situates family medicine at the intersection of health and social policy. The downstream implications of changes to minimum wage or affordable housing availability are felt at the level of primary care. This underscores the importance of family doctors to advocate for disadvantaged populations—not just by improving access to health care or hospital services, but for improvements to the societal structures that are making certain populations sicker. There is a social responsibility for family medicine to help amplify the voices that have historically been silenced.

Making change through research, education, practice, and advocacy

The Department of Family and Community Medicine (DFCM) at the University of Toronto is home to academic family doctors and trainees who are working to bridge the gap between the health care sphere and the social policy sphere.

In the area of research, the CLEAN Meds trial was one of the first randomized trials on the effect of drug costs on medication adherence and any subsequent impact on patient reported outcomes or experience. The findings were clear: the personal cost of medicines in Canada is a serious barrier to evidence-based treatments (Persaud et al., 2020).

When it comes to education, there has been exceptional work by Drs. Ritika Goel and Katherine Rouleau to embed cultural safety and social justice activism in Department of Family and Community Medicine training.

In the area of clinical practice, the Upstream Lab led by Dr. Andrew Pinto has been launching how to best screen for social needs in the primary care setting. In addition, a number of academic family health teams, from St. Michael's Hospital to North York General Hospital have been utilizing a poverty screening tool to help support low-income patients in the clinical setting (Pinto & Bloch, 2017).

Research, education and good clinical practice must also be coupled with unapologetic advocacy. Department of Family and Community Medicine leaders like Drs. Meb Rashid and Philip Berger were instrumental in the change in the federal government's reversal of its "inhumane" removal of health insurance for refugees.

There have also been efforts to advance social policy interventions such as affordable housing and basic income guarantees at the macro level by the respective authors. It is becoming increasingly clear that for effective public policy to take shape, there must be a collective of expertise and experience to see meaningful change.

The future of Canadian health policy

Social conditions drive health. The future of Canadian health policy must therefore blur distinctions from social policy writ large. Trying to divide the two, or placing an emphasis strictly on health care, cannot yield better health. If family doctors are to participate in building that bridge, we will contribute to the growing understanding of the social determinants of health while always remembering the individuals and populations within our care. Upstream solutions from affordable housing to basic income guarantees are part of the family doctor's toolkit; inspiring examples of successful creative interventions exist and must continue to grow. And when it comes to health care delivery more specifically, family medicine must push at the forefront in helping bridge patients through the social barriers to effective and compassionate health care and treatment. DFCM members are helping to lead the way in identifying changes at the policy level, regional level, practice level and individual level that can meaningfully drive change and close health gaps.

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