Innovation in Primary Care:

Social Accountability in Action

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Introduction

Socially accountable care is guided by values such as equity, freedom from discrimination, and person-centred care, all core to family medicine, with a particular focus on addressing the specific health and social needs of marginalized and underserved groups.

Socially accountable care, provided through connection to a Patient's Medical Home and Patient's Medical Neighborhood, has been shown to enable more integrated and trauma-informed care that leads to improved access to services, greater patient adherence, fewer unmet care needs, and improved clinical outcomes.

Although social accountability is at the core of family medicine, it requires health systems and organizational structures that enable such care. Unfortunately, front-line health workers may unwillingly lose sight of this important priority when faced with impossible demands on their time, energy, and resources.

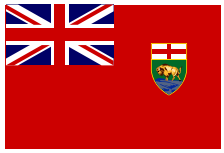
Nonetheless, family physicians can draw inspiration from peers across the country who have found ways to guard this important part of their identity, overcome obstacles, and breathe life into the socially accountable care that they provide which, in addition to improving health outcomes, also brings a sense of purpose and meaning that reinforces physician job satisfaction and well-being. Working upstream to better support underserved groups can strengthen population health, reduce the pressures on overburdened health systems, and build resilience against future threats to health (e.g., severe weather events, future pandemics). Considering the equal importance of interventions at the micro (clinical), meso (community), and/or macro (policies and public health) levels* may allow busy clinicians to see themselves reflected in this work.

The following are examples of such innovations illustrating how family physicians across Canada are managing to keep the spirit of socially accountable care alive in the face of increasing system demands and physician burnout.

*Buchman S, Woollard R, Meili R, Goel R. Practising social accountability – From theory to action. *Can Fam Physician*. 2016;62(1):15-18. Accessed May 1, 2023. https://www.cfp.ca/content/62/1/15

A Mobile Clinic:

Bringing traditional and contemporary healing practices to Treaty One people



Who was involved?

Lisa Goss, Dr. Alex Singer, Dr. Barry Lavallee, Dr. Camisha Mayes, Dr. Kathy Kisil, Della Herrera, and Arle Jones.

Manitoba College of Family Physicians (MCFP), Max Rady College of Medicine, Manitoba Primary Care Research Network, Keewatinohk Inniniw Minoayawin, Aboriginal Health & Wellness Centre of Winnipeg, Access Downtown, Winnipeg Regional Health Authority, the University of British Columbia Innovation Support Unit (ISU), the Office of Research and Quality Improvement (OR&QI) in the Department of Family Medicine at the University of Manitoba, and community members.

What needed improvement?

The most vulnerable citizens living in and near downtown Winnipeg required improved access to COVID-19 vaccinations and other primary care services that address their self-directed needs where they live. Locations included homeless encampments, bus shelters, grocery stores, inner city hotels, warming centres, and shelters.

What was done?

The MCFP worked with community members to co-design a program to address constituents' needs. This was accomplished through virtual facilitation of an Immunization Primary and Community Care (immPACC) Mapping workshop. There are three stages to immPACC Mapping: preparation, mapping, and feedback. During the session communities collectively explored how they could address structural barriers to immunization uptake. Those who were actively involved in immunization planning used a patient-centred approach to

prototype options to see how ideas could best serve the target populations. The feedback collected from the immPACC Mapping session informed community action to create a mobile primary care service.

Watch the immPACC General Introduction video at https://www.youtube.com/watch?v=XKI2oDH8axQ to learn more about immPACC Mapping.

The Mobile Clinic travelled to locations in and around downtown Winnipeg and provided COVID-19 vaccinations to Treaty One people alongside other primary care services, such as wound care.

What was gained?

Early observations indicate that the immPACC Mapping method accelerated and informed effective community action to increase immunization among Treaty One people in locations where vaccination uptake was low.

What were the main challenges?

- Networking across several organizations to recruit staff and acquire material resources to support the mobile clinic
- Understanding daily movement patterns of people in the targeted areas to position the mobile clinic to be as accessible as possible, and acquiring transportation to the clinic for constituents who needed it
- Arranging follow-ups and wellness checks with assistance from additional agencies that knew how to locate the patients
- Collecting data to help ensure sustained funding for primary care services

What was learned?

The pandemic highlighted the existing lack of available equitable and person-centred low barrier services in many communities. Services need to meet people where they live.

To find out more about this innovation, contact:

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Resources/links to additional information:

immPACC
https://www.youtube.com/watch?v=XKI2oDH8axQ

AHWC
Aboriginal Health & Wellness | www.ahwc.ca

H2SUM

(HIV, Viral Hepatitis, Substance Use, and Mental Health) UBC Enhanced Skills Program

Who was involved?

Val Montessori, Silvia Guillemi, Edward Rooke, David Hall, Tina Webber, and Cathy Puskas.

Clinical Education and Training Program, BC Centre for Excellence in HIV/AIDS, Vancouver Department of Family and Community Practice, Vancouver Coastal Health Authority, University of British Columbia (UBC) Enhanced Skills Program.

What needed improvement?

Many family physicians feel ill-equipped to care for patients with complex health care needs without additional training that addresses the complexity and interaction between the clinical and social aspects of care. The complex needs are the result of comorbid conditions and experiences of stigma, coloniality, trauma, vulnerability, and marginalization. An opportunity was identified to enhance skills, behaviours, critical self-reflection, and confidence to family physicians who work with marginalized and vulnerable populations in British Columbia.

What was done?

The HIV, Viral Hepatitis, Substance Use, and Mental Health (H2SUM) UBC Enhanced Skills Program was created to better equip family physicians through an integrated R3 preceptorship centred on five learning pillars: HIV, viral hepatitis, mental health, substance use medicine, and culturally safe and

humble care. Trainees grow into culturally safe and humble care providers through reflections, journalling, and discussions with mentors. They are also supported in drafting milestones specific to their individual learning needs.

Two main program clinical training sites are the John Ruedy Clinic and Hope to Health Clinic, which each offer comprehensive interdisciplinary care to people living with HIV and/or hepatitis C. In addition to attending these clinics, trainees receive placements with other clinics including those specializing in other infectious diseases and comorbidities, Indigenous health, women's and children's health, and transgender care. Elements of culturally safe and humble care are applied through all clinical placements.

What was gained?

The H2SUM program is bringing culturally safe and humble care into the forefront of training by naming it as a pillar of the program, rather than allowing it to remain as an undercurrent to the program. Work-based application of this pillar in various clinical settings shows the relevance and necessity to include it in practice.

What were the main challenges?

- Ensuring the depth of learning required at an R3 level was achieved across all learning pillars
  - H2SUM innovators partnered with Vancouver Coastal Health and the Provincial Health Service Authority clinics to ensure the settings facilitated the program objectives and learners' milestones
- Ensuring the learner was not left alone to navigate critical self-reflection
  - To overcome this, H2SUM innovators provided literature and learning materials. Regular meetings between learners and mentors were established to explore situations, feelings, attitudes, and challenges to incorporate the learnings into practice.

What was learned?

The first session was offered in spring 2022 and, though it is early for the innovators to state their experiences from that first session, they have been looking outside of their organization for clinics and content that would best meet their needs. Through development of the H2SUM program the innovators have gained knowledge about the complexities involved in the care of marginalized individuals with multiple comorbidities and how to provide a learning environment in that context.

To find out more about this innovation, contact:

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Resources/links to additional information

https://education.bccfe.ca/h2sum-trainee-portal

Please email cpuskas@bccfe.ca to receive access to the H2SUM portal.

Making Our Voices Heard:

A summary of two pop-up sites and an urgent call for warming shelters and overdose prevention sites in Alberta

Who was involved?

Dr. Bonnie Larson for Street CCRED, Euan Thomson of EACH+EVERY: Businesses for Harm Reduction, AAWEAR, Street Cats, Bear Clan, Boots on Ground (Now 4B) Harm Reduction Society, Canadian Association of People Who Use Drugs (CAPUD), Moms Stop The Harm, and Water Warriors.

What needed improvement?

Vulnerable Albertans are exposed to unlivable conditions and a dangerous illicit drug supply. These challenges are often compounded by trauma and social inequities and require a focused, coordinated, community-led response. As health services such as supervised consumption sites are closing, Albertans who are vulnerable as a result of policies and structural violence need more safe spaces for connections and support.

What was done?

On December 16, 2021, community leaders, health care providers, and people with lived and living experience of homelessness and substance use united in the inner cities of Calgary and Edmonton to set up temporary, tent-based warming stations that provided food, clothing, medical care, and overdose response teams. Though lacking sufficient

funds and equipment, the teams in each city created a temporary reprieve for people affected by the winter shelter emergency and the drug poisoning crises.

People were offered:

- Warm clothing, blankets, sleeping bags, and hand and toe warmers
- Hot food and beverages, and bottled water
- Supplies for safer drug consumption and safer sex
- Transportation to shelter and other community resources (Calgary only) provided by the Downtown Outreach Addictions Partnership (DOAP) Team Program
- Referrals to grief support programs, nutrition counselling, information on detox, options for opioid agonist treatments, wound care, and other resources

What was gained?

The teams connected with 300 vulnerable Albertans that day and mobilized a community response. In Calgary, 56 visitors were assisted by 15 volunteers who provided care for 15 Overdose Prevention Service clients and successfully prevented one overdose event. In Edmonton, 250 visitors were hosted and assisted by 14 volunteers.

This initiative was documented in a community report, produced by Street CCRED, that has served as a basis to advocate for more warming shelters and overdose prevention services in Alberta and has subsequently been reviewed by local and provincial decision makers.

What were the main challenges?

- Obtaining resources without funding
  - The innovators relied heavily on donations including health and outreach services, medical supplies, equipment, clothing, and food from local businesses. Community organizing oversight provided by Each + Every and local harm reduction outreach groups helped overcome this challenge.
- Working in bad weather
  - Wind and blowing snow required tents and heaters to be weighted down, and propane tanks in heaters to be refilled numerous times
- Being without washroom facilities

What was learned?

A grassroots community-based response is possible and necessary, along with strong coordination, when formal policies and strategies exclude the people at highest risk of poor health outcomes. Shelter structures that are more solid would better withstand the local winter weather conditions but would be difficult to transport to areas of highest need; a vehicle or trailer are possible solutions.

Participants and stakeholders value a community-accessible report that highlights successes and can be used for ongoing advocacy, fundraising, and raising awareness, as was the case in this innovation. This type of artifact communicates and disseminates information about the urgency and the problem, and provides opportunities for identifying ways to improve community services and policies.

To find out more about this innovation, contact:

Dr. Bonnie Larson, Faculty Lead,
Street CCRED Collaborative

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Resources/links to additional information

Street CCRED website

MUN Med Gateway Program

Who was involved?

Dr. Christine Aubrey-Bassler; Jill Alison, PhD; Shree Mulay, PhD; Maisam Najafizada, PhD; Desai Shan, PhD; Dr. Petra Joller; Barbara Albrechtsons, RN (founding PHN, retired); Dr. Pauline Duke (founding physician, retired).

The Faculty of Medicine at Memorial University of Newfoundland (MUN), Association for New Canadians (ANC), and Eastern Regional Health Authority (Eastern Health).

What needed improvement?

Integration of newcomer refugees into the local health care system, which required teaching medical students about the complexities of refugee medicine and getting them involved with the newcomer community.

What was done?

The MUN Med Gateway Program began in 2005 as a volunteer undergraduate medical student initiative that introduced medical students to newcomer medicine and service-learning. It also linked newcomer refugees to local primary health care. Weekly intake clinics took place, and non-clinical initiatives in collaboration with the local settlement agency (ANC) were overseen.

Resources have been successfully restructured and, as of March 2022, the clinical aspect of the program is delivered through the Eastern Health Refugee Health Collaborative. Using in-person or phone interpreters, teams of first- and second-year students conduct full intake histories and brief physical exams, arrange bloodwork, address urgent health care needs, and document details using the clinic electronic medical record (EMR) system.

What was gained?

Students have become familiar with navigation challenges and newcomer medical conditions and are comfortable using medical interpreters in clinical practice. Together with Dr. Aubrey-Bassler they have made presentations at the CFPC's Family Medicine Forum (FMF).

What were the main challenges?

The COVID-19 pandemic presented many challenges:

- Varying degrees of public health and university restrictions affected clinical encounters, in-person learning, and learners' availability to attend clinics
- Fewer provider resources resulted in the Gateway clinics and newcomer refugee health intake clinic appointments being integrated at the first intake clinic appointment
- Many in-person non-clinical initiatives were put on hold and some projects were transitioned to virtual formats

Routine programming restarted in 2022 with a combination of virtual and in-person options.

What was learned?

Many medical students are very enthusiastic about newcomer refugee medicine, and those who work and teach in the program have found they can encourage this interest by working with and teaching learners about:

- Evidence-based resources
- How to become comfortable with and successfully work with interpreters
- How to collaborate with the settlement agency and refugee sponsors
- How to adapt clinical practice to navigation challenges

To find out more about this innovation, contact:

Dr. Christine Aubrey-Bassler, Assistant Professor, Faculty Lead, MUN Med Gateway Program; Discipline of Family Medicine, Faculty of Medicine, Memorial University
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Resources/links to additional information

Duffley L, Nguyet N, Aubrey-Bassler C, Duff K, Bessell J. Encouraging Engagement with the Refugee Community through MUN Med Gateway. Family Medicine Forum, October 30, 2019; Vancouver, BC.

Aubrey-Bassler C, Joller P. Refugee Health in St. John's - Gateway and Beyond. Newfoundland and Labrador College of Family Physicians Annual Family Medicine Conference, September 28, 2019; St. John's, NL.

Duffley L, Nguyen N, Duff K, Joller P, Allison J, Guigné F, et al. Beyond the clinic: The evolution of refugee health education towards holistic care, community engagement, and interaction within MUN MED Gateway. North American Refugee Health Conference, June 15, 2019; Toronto, ON.

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Nguyen J, Duffley L, Aubrey-Bassler C. Behind the curtain: Reflections on experiential learning in refugee health. CFMS Annual Review. April 2019;29-30. https://www.cfms.org/files/annual-review/annualreview2019.pdf

The Provision of Resources and Supports for Primary Care Providers Who Care for Transgender and Gender Diverse Patients

Who was involved?

Dr. Thea Weisdorf; Suza Hranilovic, NP-PHC; Lisa Miller, EMR Systems Administrator.

Dr. Karen Weyman, Chief of St. Michael's Hospital Department of Family and Community Medicine; Linda Jackson, St. Michael's Hospital Academic Family Health Team Executive Director.

What needed improvement?

The St. Michael's Hospital Academic Family Health Team (SMHAFHT) needed a more efficient way to provide resources and gender-focused care to transgender and gender diverse patients. Transgender and gender diverse (TGD) patients often face barriers to accessing resources. Many family physicians and nurse practitioners at SMHAFHT have a small number of TGD patients, but only a few have larger numbers and an expertise in TGD care. Those with more expertise receive many requests for support.

What was done?

The gender affirming tool bar (GATB; see Figure 1) was created for the EMR to improve care for TGD patients at SMHAFHT by enabling providers to connect TGD patients more easily with resources that can often be challenging for patients to access on their own.

The GATB can be personalized and a variety of templates are available, including those related to cancer screening, transition surgeries, and change of name and gender markers. Resources for housing, safe binding and tucking, and mental health are also available.

Figure 1. The main menu of the GATB is triggered to appear when a diagnosis is entered. Each purple tab provides access to resources that can be appended to a patient's record.

What was gained?

The GATB has been activated for approximately 635 SMHAFHT patients tagged with the gender-affirming ICD-9 code. Many issues can now be addressed by the patient's most responsible provider, further enhancing this provider-patient connection. This also alleviates the need for referrals to providers with an expertise in TGD care, enabling them to focus on issues unique to their skillset. These changes contribute to improved overall care for all TGD patients.

Providers and learners reported the GATB was helpful for accessing resources to ensure patients have the best information and support in a timely and sensitive manner. Patients and their families report that they also find the many resources helpful in accessing community services.

What were the main challenges?

The collection and organization of resources and updating the GATB were the main challenges. Some useful resources exist in formats that could not be posted in the GATB because, for example, of their large size. The GATB must be updated as new resources become available and others become obscure or outdated to remain clinically relevant and to help provide the best care available. Many FHT health disciplines contributed to the GATB.

What was learned?

- The GATB addresses significant barriers in accessing gender affirming primary care
- Making educational resources available at the point of care to the most responsible provider can improve that care and reduce the need to refer patients to providers with more expertise in TGD care
- Access to resources may be required at the point-of-care during any visit with a primary care provider, regardless of the reason for the visit
- Faculty will use this tool more readily when paired with TGD clinical care. For this reason, continuing education of gender affirming care in conjunction with faculty development was important to the success of this innovation.

To find out more about this innovation, contact:

Dr. Thea Weisdorf, St. Michael's Hospital
Academic Family Medicine Associates

Email: thea.weisdorf@unityhealth.to

Resources/links to additional information

TransPulse Canada. Report – Health and health care access for trans and non-binary people in Canada. 2020. https://transpulsecanada.ca/results/report-1/. Accessed November 29, 2022.

The Palliative Education And Care for the Homeless (PEACH) Program

Who was involved?

Dr. Naheed Dosani, Dr. Donna Spaner, Dr. Alissa Tedesco, Dr. Trevor Morey, and Dr. Antoinette Mihaylova.

Inner City Health Associates, Kensington Health, Toronto Central Home and Community Care Support Services.

What needed improvement?

People experiencing homelessness have significantly worse health outcomes compared to people who are housed. This population is five times more likely to have heart disease, four times more likely to have cancer, and 28 times more likely to have hepatitis C. While housed Canadians live an average life expectancy ranging from 77 to 82 years old, the average for people experiencing homelessness is 34 to 47 years old. Across Canada many community-based palliative care systems are unable to deliver "home care" for people experiencing homelessness because the system that should be able to care for them is not designed to meet them where they live. For this reason, people experiencing homelessness often have suboptimal medical and psychosocial care, and lack supports related to social determinants of health at the end of life.

What was done?

To meet the needs of this population, the PEACH team pioneered a new model of integrated care that focused on primary care outreach through a palliative approach. They conducted community education to make both health care and social care partners aware of the palliative care role so that referrals to the program would be made. A new rotation called Palliative Care in the Inner City was developed to support medical trainees learn about social accountability in palliative care. The program offers integrated care through a harm reduction approach to palliative care, a trauma-informed/anti-oppression approach, and an interdisciplinary case management model that is comprehensive and operates 24/7.

What was gained?

The program started in 2014 as a one-day-a-week clinical service and has since become Canada's largest mobile palliative care program. It provides care for people wherever they live, including on the streets, in shelters, in encampments, and under bridges. The PEACH Program now has between 110 to 120 clients on caseload at any given time and features a team consisting of a PEACH coordinator (nurse), health navigator (master of social work), five family physicians who have a focus in palliative care, a home care coordinator, and a psychiatrist.

A one-year retrospective chart review of the PEACH program effectiveness in its first year (2014–2015) revealed that 64 per cent of clients never went to the hospital or emergency department, 80 per cent died in their preferred end-of-life location, and 83 per cent who wanted to reconnect with family and friends were reconnected. A more thorough retrospective chart review on the PEACH Program was conducted in 2021 and published in the *Journal of Palliative Medicine*.

What were the main challenges?

- Siloed funding made it difficult to build a team with the unique skills necessary for the services and supports provided through the PEACH program. Multiple organizations leveraged their respective expertise and funding to overcome the challenge.
- Trauma, oppression, and discrimination, including within the health care system, are common experiences for this population. The PEACH program established training and support to ensure team members apply trauma-informed and anti-oppressive approaches to care to facilitate effective and meaningful person-centred care and health system navigation.
- Many community and social service providers do not have sufficient experience and skills to identify palliative care needs, which are unique and nuanced, for referral among clients in the community. The PEACH program made community educational supports a pillar of its model to ensure the broadest equitable access and impact.

What was learned?

An integrated and interdisciplinary approach that includes an intensive case management model that also addresses housing issues can deliver highly effective tailored palliative care services for people experiencing homelessness. Instead of allowing these community members to continue to fall through the cracks of health systems, they can get the compassionate care they need in a timely fashion, where they want it.

To find out more about this innovation, contact:

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Phone: (905) 334-7478

Dr. Donna Spaner, Inner City Health Associates

Email: donna.spaner@icha-toronto.ca

Resources/links to additional information

Inner City Health Associates. Palliative Care in the Inner City Elective. 2021. https://www.icha-toronto.ca/palliative-care-in-the-inner-city-elective. Accessed November 1, 2022.

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Huq S. Trailblazing a Path to Quality Care: Canada's Supportive Palliative Service for the Unhoused. Coalition to Transform Advanced Care. July 14, 2021. https://thectac.org/asset/blog/trailblazing-a-path-to-quality-care-canadas-supportive-palliative-service-for-the-unhoused/. Accessed November 1, 2022.

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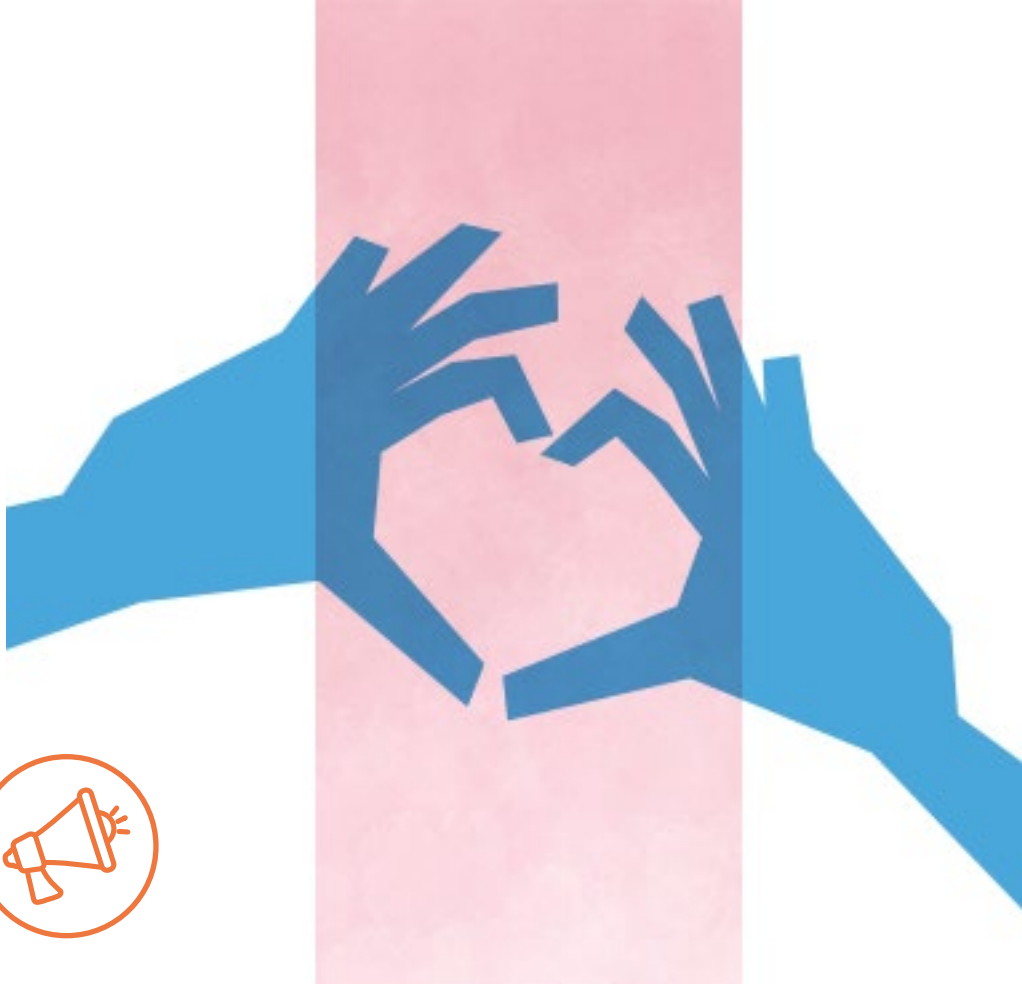
The TRANS Project:

Trans research and navigation Saskatchewan



Who was involved?

Dr. Megan Clark, Dr. Carla Holinaty, Dr. Lori Schramm, and Dr. Ginger Ruddy.

The Saskatchewan Trans Health Coalition, community-based organization representatives, and health care providers. A research team consisting of family physicians who provide trans health care, researchers from physiotherapy, nursing, and policy studies, representatives from the primary 2SLGBTQ+ organizations in the province, and people with lived experience.

Trans Care BC, Dr. Greta Bauer, and Dr. Ayden Scheim with Trans PULSE; CLASSIC Law were involved as advisors, mentors, and partners.

What needed improvement?

Access to health care is challenging in Saskatchewan for people who are TGD. Wait times for gender-affirming hormone therapy prescriptions and surgeries are long, and general health care experiences have been culturally unsafe. Saskatchewan primary care providers have identified a lack of knowledge and comfort working with people who are TGD.[1]

What was done?

Two people, who are TGD and have experience working in the health care system, were hired as TRANS peer health navigators and to provide education to health and social service providers on health care access and cultural safety for people who are TGD. A one-year pilot commenced in April 2021 to assess the state of health care for people in Saskatchewan who are TGD as well as the

navigators' impact. The evaluation on experiences with health care access and post-service surveys included two focus groups with people who are TGD.

What was gained?

From April 2021 to March 2022, TRANS navigators connected with 259 new clients, had 248 repeat contacts, and had 293 requests for information, including:[3]

- Connection to a validating family physician
- Help preparing for a health care appointment
- Connection to culturally safe mental health support
- Support for coming out
- Legal assistance for name or gender marker changes

TRANS navigators connected with 70 health care providers—including family physicians, other specialty physicians, nurse practitioners, and mental health professionals—and had 36 repeat contacts. Providers requested information, education, and connection to another health care professional for mentorship in gender-affirming care.[3] Requests for educational presentations exceeded the TRANS navigators' abilities to complete requests and, collectively, the TRANS navigators presented to over 1,800 people.

What were the main challenges?

Challenges included:

- Ensuring that members of the group who are TGD were heard
  - Feedback on project activities from team members who are TGD was encouraged and used to inform necessary changes
- Finding family physicians who provide culturally safe care and would accept TGD patients
  - Request letters were sent to all family physicians in Saskatchewan
- Experiencing episodes of transphobic harassment at presentations
  - To deal with this, navigators agreed to disagree with transphobic health care providers, and the navigators stopped publicizing their own last names to avoid personal harassment
- Maintaining research productivity as team members' capacity to participate fluctuated
- Securing long-term funding for the navigator positions

What was learned?

Focus group participants overwhelmingly indicated positive feelings for health care providers who validated their gender identities and were knowledgeable about the health care needs unique to people who are TGD. Conversely, because of a lack of validating providers and long wait times, participants also reported negative associations with health care when they lacked access to culturally safe care.[2]

The project reinforced the importance of peer health navigators and kept everyone open to learning about community needs. Partnering with the TGD community to make the health care system a safer, more affirming place is worthwhile and requires centring the voices of people who are TGD, in keeping with the Canadian Professional Association of Transgender Health's research ethics guideline—nothing about us without us[4]—requiring difficult but necessary conversations within the research team.

To find out more about this innovation, contact:

Dr. Megan Clark, Department of Family Medicine, University of Saskatchewan

Email: megan.clark@usask.ca

Resources/links to additional information

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Out Saskatoon. Trans Health Navigator Project. 2021. https://www.outsaskatoon.ca/trans-health-navigator/. Accessed November 1, 2022.

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2. Rose G, McCarron M, Reid M, Madill S, Clark M, Gulka E, et al. An investigation of the healthcare needs of individuals who are transgender or gender diverse in Saskatchewan [poster presentation]. World Professional Association of Transgender Health, 18 Sept 2022.
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Trees for Hamilton

Who was involved?

Dr. Myles Sergeant; Lorraine Ironside (biologist with the Ministry of Natural Resources).

Hamilton Conservation Authority, Royal Botanical Gardens, Hamilton Health Sciences, St. Joseph's Health Care, long-term care facilities, Six Nation's Land of the Dancing Deer, Green Venture, Hamilton Naturalists Club, Environment Hamilton, City of Hamilton, McMaster Sustainability department, McMaster Climate Change department, McMaster medical school environmental group, and the Hamilton Tree Equity Committee.

What needed improvement?

Many populations do not have access to nature spaces with trees. Environment Canada considers a healthy tree canopy to be more than 30 per cent geographic coverage, yet Hamilton's tree coverage is only 19 per cent and in some inner-city wards is even lower than 10 per cent.

One of the innovators recognized an opportunity to bring forests to populations that otherwise would be unable to travel to forests to reap the mental and physical health benefits that forests can provide.

What was done?

A volunteer-based charity called Trees for Hamilton was created to raise money and plant trees in urban and rural locations.

Health care facilities are among some of the locations where trees are planted, essentially bringing the forest to the patient and creating a "health care forest" within Hamilton.

This allows patients to enjoy the health benefits associated with green exposure by looking at nature from their windows or by taking a short trek outside their health care facility.

Plantings have been arranged specifically for medical students, residents, and health care staff to learn the benefits of tree planting and exposure to forests. Many understand the urgency of mitigating climate change, so this opportunity also helps alleviate climate angst.

What was gained?

Since the program was founded in 2012 the innovators have co-organized 70 events and planted 5,000 trees with the help of more than 500 volunteers. The innovators have given presentations to community and academic groups about the benefits of trees, the importance of addressing climate change, and to encourage others to initiate similar projects.

Patients, learners, and community members have enjoyed nature and given back to their community. For example, thanks to a relationship with a local in-patient addiction facility, Trees for Hamilton has provided an opportunity for patients and staff to travel to conservation areas to plant trees and enjoy nature. For some, this activity provides them their first experience to enjoy a large nature space and to give back to their community.

This work has led to another health care forest (Trees for Health), co-founded by Trees for Life and the PEACH Health Ontario project (www.peachhealthontario.com) in partnership with Forests Ontario, eco-Health Ontario, One Bench One Tree, Landscape Ontario, and Ontario Parks Association. This project aims to make it easier for clinicians and administrators to facilitate tree plantings at their health care sites.

What were the main challenges?

Logistical challenges to urban planting exist:

- To plant a tree beside a sidewalk requires demolition to create enough root space for a tree, which costs approximately $4,000
- Some communities do not want trees planted in green spaces due to potential safety issues related to impeded visibility
- There were many other challenges to urban planting; planting at health facilities provided a great opportunity to plant trees in urban spaces

What was learned?

- Planting at a health facility is possible through partnerships
- Planting trees is a wellness initiative—people want to give back and to help with climate action
- Tree equity is paramount—all neighbourhoods can benefit from trees, shade, and beauty

To find out more about this innovation, contact:

Dr. Myles Sergeant, President, Trees for Hamilton

Partnership Lead, PEACH Health Ontario

Assistant Clinical Professor, Family Medicine, McMaster University

Email: sergean@hhsc.ca

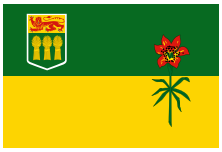
Phone: (289) 237-3153

Dr. Elizabeth Muggah, OCFP

Email: president@ocfp.on.ca

Wellness Wheel:

A community-partnered initiative to improve care access in Saskatchewan First Nations Communities



Who was involved?

Dr. Sarah Liskowich, Dr. Thanh Luu, Dr. Lori Schramm, Dr. Candina Beaurivage, Dr. Kieran Conway, Dr. Brian Geller, Dr. Rosemary Courtney, Dr. Carla Barkman, Dr. Megan Clark; and RNs Susanne Nicolay, Vicky Schultz, Erin Nielsen.

Health directors from involved communities, the Tribal Council, Band Council members, Chiefs, community elders, Wellness Wheel (WW) nurses and nurse coordinator, communities' health centre staff (including home care and community health nurses), First Nations and Inuit Health Branch (FNIHB) of Health Canada, First Nations and Métis Services - Regina in the Saskatchewan Health Authority, and Regina-based physicians in family medicine and other specialties.

What needed improvement?

Due to effects of ongoing colonialism, including systemic and structural racism, First Nations people have reduced health care access and they mistrust the health care system, which contributes to poorer health outcomes. In addition to jurisdictional issues between provincially and federally funded services, First Nations people face challenges related to a lack of access to culturally safe and comprehensive primary care services.

What was done?

The initiative started with community members with lived experience in chronic disease, who wanted to be able to access care closer to home, approaching their health administrators. Innovators and colleagues from nursing and other medical specialties met with representatives from the First Nations' leadership. Health administration and communities identified kidney disease, diabetes, HIV, and hepatitis C as priority chronic diseases to address. In early 2021 women's health and prenatal care were also identified as priority services to be provided.

Band Council resolutions were passed in each community prior to the start of the WW clinics in 2016. The partnership was grounded in ceremony with communities in accordance with cultural protocols.

Clinics were then held in communities on a monthly to biweekly basis. Family physicians attended the same community for each clinic to ensure continuity of care, while other specialists visited multiple communities based on need. Family physicians in the prenatal clinics cared for pregnant people, their newborns, and sometimes whole family units from multiple communities throughout pregnancy and the postpartum period, and participated in delivery when available.

Registered nurses performed phlebotomy, which otherwise would not have been available in the communities. They also operationalized community health education initiatives, advocacy and funding work, coordination and relationship-building with health care staff in partner communities, and coordination of patient care needs.

What was gained?

From early 2018 to fall 2021 in the Touchwood Agency Tribal Council area, the WW team saw 990 patients and conducted 2,565 appointments; the most common condition seen was diabetes. Through program evaluation and interviews, the WW clinics were identified as helpful and 53 per cent of patients said they would not have accessed health care at the time if not for those clinics.

Knowledge was gained regarding the perspectives of First Nations people and their barriers to health care access. Six themes were identified:

- Lack of access to primary care
- Barriers including limited/no transportation available, limited health knowledge, and lack of service consistency
- Logistical challenges in health care delivery
- Importance of community engagement
- Strategies that worked well including nursing coordination, health care provider commitment, and phlebotomy
- Impact of clinics, including reallocation of medical transportation services as well as timely diagnosis and treatment

What were the main challenges?

- Building relationships with the communities
- Attaining sustainable funding for nurses
- Coordinating patient care between clinics
- Expanding the project to meet client and community needs
- Maintaining meaningful community engagement though research and project evaluations amid other demands
  - Including the ceremony and formal Band Council Resolutions at the onset of the project and providing data back to the communities in accordance with ownership, control, access, and possession (OCAP) principles for ongoing feedback and program modification have been both challenging and key components to the success of this project

What was learned?

- Meaningful partnership and cultural responsiveness in communities is key, including through ceremony and conversations with community members and leadership
- Nurses provide a vital link both for day-to-day clinical care and ongoing clinic planning
- Community strengths, connectivity, and needs are even deeper than we originally anticipated

To find out more about this innovation, contact:

Dr. Megan Clark, Wellness Wheel and Department of Family Medicine, University of Saskatchewan

Email: megan.clark@usask.ca

Resources/links to additional information

Pandey M, Nicolay S, Clark M, Desjarlais V, Clay A, Skinner S. Wellness Wheel Mobile Outreach Clinic: A Community-Led Care Model Improving Access to Care in Indigenous Communities. *Ann Fam Med*. 2020;18(5):466.

McEwen A, Yunus M, Clark M, Pandey M, Nicolay S, Skinner S, et al. Primary care access on select Saskatchewan First Nations. Family Medicine Forum. November 5, 2020.

Beresh E, Nilson S, Pandey M, McCarron M, Desjarlais V, Clark M, et al. Evaluation of Wellness Wheel clinics: A community partnered care model to improve access to care on reserve. Family Medicine Forum. November 14, 2018.

Conclusion

The innovations presented here are a small subset of the many ways in which family physicians are providing socially accountable care across Canada.

Each innovator identified a need within their local community and then collaborated within interdisciplinary teams, partnering with local communities, to better understand that need and pilot an innovative approach for providing more tailored and integrated care in a trauma-informed way.

Along the way, these socially accountable care champions overcame challenges associated with recruiting and retaining human resources and acquiring funding and material resources. They did so by networking across local organizations, leveraging their respective expertise and funding, or securing long-term funding for key roles. They ensured that family medicine learners were well supported with useful readings and mentorship, and they built relationships of trust with local communities.

Many important lessons were learned:

- Being open to learning about community needs
- Developing integrated and interdisciplinary approaches
- Creating meaningful local partnership
- Learning how to work with interpreters and in local support systems
- Valuing the role of peer navigators
- Making sure of cultural responsiveness
- Acknowledging the complexities involved in, and providing a learning environment for, the care of marginalized and underserved individuals with multiple comorbidities

In addition to the cases featured in this report, more are listed in the following section, More Innovations. Instances of socially accountable care are reflected in the day-to-day work of family physicians across Canada who seek to respond to specific, locally-driven community needs through clinical care, research, and teaching, as well as advocacy, policy and program development, and political engagement at the micro (clinical), meso (community) and/or macro (policies and public health) levels at which we all work.

Social accountability has long been and must continue to be a core tenet of family medicine, to drive the transformation of health care systems to be engines and enablers of wide-scale provision of socially accountable care.

More Innovations

An Undergraduate Medical Education Framework for Refugee and Migrant Health: Curriculum development and conceptual approaches

An undergraduate medical curriculum framework was created to address the need for the next generation of physicians to acquire the knowledge, skills, and attitudes to manage the health care needs of refugees and migrants.

Dr. Douglas Gruner, Associate Professor, Department of Family Medicine University of Ottawa
Email: dgruner@bruyere.org

Breaking Down the Walls: Providing primary care for incarcerated women

The MUN Care of Underserved Populations Enhanced Skills Program partnered with social workers at the Just Us Women's Centre (a Stella's Circle program) in St. John's to enhance residents' knowledge of incarcerated women's primary care needs.

Dr. Françoise Guigné, MUN Discipline of Family Medicine
Email: fguigne@mun.ca

Building Capacity for Equity-oriented Primary Care in British Columbia

The Basics for Health Society provides a place for people to share knowledge, better understand structural conditions influencing inequities in British Columbia, and to mobilize—the BC Benefits Navigator is one of their projects.

Dr. Vanessa Brcic, Basics for Health Society
Email: vanessabrcic@gmail.com
Phone: 604-313-7237

Toby Achtman, BCCFP
Email: toby.achtman@bccfp.bc.ca

Caring for Schizophrenia and Schizoaffective Disorders in the Community: Online learning to increase treatment options by community providers

The Treatment Optimization of Psychosis Collaborative and the BC Centre for Excellence have developed a free-of-charge online course for health care professionals in British Columbia to guide learners in the assessment and management of schizophrenia and schizoaffective disorders and treatment options.

Cathy Puskas, Clinical Educator, BC Centre for Excellence in HIV/AIDS
Email: cpuskas@bccfe.ca

Clinique Mauve: A service for sexually and gender diverse racialized, immigrant and asylum-seeking individuals

Clinique Mauve was created to provide integrated medical, psychosocial, sexual health, and mental health care to sexually and gender diverse racialized, immigrant, and asylum-seeking individuals. It offers training to health and social services professionals and evaluates the impacts of its initiatives.

Pierre-Paul Tellier, CLSC Cote des Neiges
Email: pierre-paul.tellier@mcgill.ca

Community Oriented Primary Care (COPC) at McGill: An innovative approach to incorporating social accountability into family medicine residency training

The McGill Community Oriented Primary Care Committee organizes an annual common core teaching session for all incoming family medicine residents at urban training sites. It provides ongoing teaching throughout the year on how to partner with resources in the community to provide improved social support and services for patients and their families.

Dr. Anne Andermann, McGill University
Email: anne.andermann@mail.mcgill.ca

Curing Hepatitis C: A proactive, team-based approach in primary care

The St. Michael's Academic Family Health Team conducted an intervention to increase Hepatitis C Virus (HCV) treatment rates. This involved development of clinical team knowledge and skills, development of an internal treatment pathway and EMR decision support tool, and proactive outreach to patients with untreated or unknown HCV status.

Dr. Ann Stewart, St. Michael's Hospital
Academic Family Health Team
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ESS Outreach to Northern Indigenous Communities

In an area where patients frequently needed to travel four or more hours for basic care, access to prenatal and women's health care was improved in northern Indigenous communities through implementation of on-site clinics held multiple times per month (with a focus on prenatal patients) by the same family physician with enhanced surgical skills.

ESS Outreach to Rural Communities

In an area where patients previously had to travel up to four hours for basic care, clinic space was opened in southeast Saskatchewan with dedicated staff and protected operating room time to enable procedures to be performed closer to patients' homes by a family physician with enhanced surgical skills.

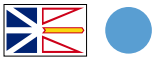
Dr. Brian Geller
Email: brian.geller@usask.ca

FM Vax: An international survey on the integration of public health and primary care in COVID-19 vaccination campaigns

An international survey on the integration of public health and primary care in COVID-19 vaccination campaigns was launched in 2021 by the Besrour Centre for Global Family Medicine at the College of Family Physicians of Canada with a focus on low- and middle-income countries to help inform future COVID-19 vaccination campaigns, including how to reach priority populations to ensure coverage at regional and national levels.

Dr. David Ponka, Besrour Centre for Global Family Medicine
Email: dponka@cfpc.ca
Phone: 613-790-3849

From the Ground Up: Piloting managed alcohol programming in St. John's



The St. John's Status of Women Council/Women's Centre partnered with Newfoundland and Labrador Eastern Regional Health Authority to launch a pilot managed alcohol program (the first of its kind in the province) with a focus on women and persons who are non-binary. They hope to expand the program beyond its initial population focus.

Dr. Françoise Guigné,
Downtown Health Collaborative
Email: fguigne@mun.ca

Improving Access to Evidence-based Precarious Housing Clinical Guidelines and Curriculum Innovations

The Campbell and Cochrane Equity Methods team developed evidence-based Homeless Health Guidelines for family physicians to help care for individuals facing precarious housing, and a student-led curriculum framework to support design, delivery, and evaluation of homeless health within undergraduate medical curriculum.

Dr. Kevin Pottie
Email: kpottie@uwo.ca
Phone: 519.661-1211 Ex 85722

Dr. Anne Andermann, Chair, CFPC Social Accountability Working Group
Email: anne.andermann@mail.mcgill.ca

Integrating Legal Services with Primary Care

To address gaps in access to affordable, appropriate, and timely legal services related to social factors that affect health, the Health Justice Program was developed through a partnership between St. Michael's Hospital Academic Family Health Team, St. Michael's Hospital, and several legal clinics.

Dr. Nav Persaud
Email: nav.persaud@utoronto.ca

Integrating Social Justice Advocacy Into a Family Health Team

Two initiatives—an advocacy tool kit and an advocacy framework—have helped integrate social justice advocacy into the core activities of the interdisciplinary primary care team at the Department of Family and Community Medicine at St. Michael's Hospital in Toronto.

Dr. Rami Shoucri
Email: rami.shoucri@unityhealth.to

Moved to Act: Influencing public policy in a drug poisoning crisis

Members of the Edmonton Zone Medical Staff Association created the Opioid Poisoning Committee to create recommendations to address policy gaps and strategies to address the drug poisoning crisis in Alberta.

Dr. Ginetta Salvalaggio, University of Alberta
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Phone: (780) 492-2890

Refugee Health Collaborative

Eastern Health, MUN Family Practice, and the Association of New Canadians have partnered to provide medical services to meet the unique needs, including navigation and language challenges, of new Canadians who are refugees.

Dr. Christine Aubrey-Bassler, Assistant Professor, Discipline of Family Medicine, Faculty of Medicine, Memorial University of Newfoundland, and Clinic Lead, Eastern Health Refugee Health Collaborative
Email: cbassler@mun.ca

Working With Patients to Improve Cancer Screening for People Living with Low Income

To reduce disparities in cancer screening, an outreach program was designed and piloted at St. Michael's Hospital Academic Family Health Team with a focus on and input from patients with low-income.

Dr. Tara Kiran, St. Michael's Hospital Academic Family Health Team, Unity Health Toronto, and the University of Toronto
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