Should Clinicians try to improve the social determinants of health of their patients?

Disclosure

- Dr. J. Haggarty
  - Employee of St. Joseph's Care Group
  - Faculty NOSM
  - No conflicts to report
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  - Employee of St. Joseph's Care Group
  - Faculty Univ. Toronto
  - No conflicts to report
- Some images: Sebastio Selgato (Google)

Issues

- How important are the social determinants of health in Canada?
- Do clinicians need to know the social situations of their patients/clients?
- Should clinicians ‘stick’ to care of the individual OR seek to influence policy and population health decisions?

Two Paths to Improve Health-Which to choose?

If one needs to choose…

Efficient/Evidence Based/ Algorithmic

The Story/Risks/SDOH/ Policy Influence

The Case Of Harriett

Harriett is a 58 yo woman who immigrated to Canada from Jamaica in her 20s. She worked in construction until 15 years ago when a back injury put her out of work. Harriett has an extensive medical history, including diabetes, hypertension, depression, and a prior heart attack.

Your team has done its best to optimize treatment for her physical and mental health conditions, however you do not feel that Harriett's health has really improved.

You decide to develop a more complete picture of the factors than may be impacting Harriett's health by taking a comprehensive social history.

In the beginning…

- Interviewing skills…
  - ‘so what brings you here?’
  - ‘How does that make you feel?’
  - Advanced: ’How was your relationship with your mother?’
- Pattern recognition
  - Risk Factors… to Protective Factors.. To…
  - Symptom clusters and ‘a diagnosis’
- For some, a rush to move to perceived ‘efficiency’ of
  - Fast to make a diagnosis,
  - Acute care/Urgent delivery,
  - Pressure of cost containment

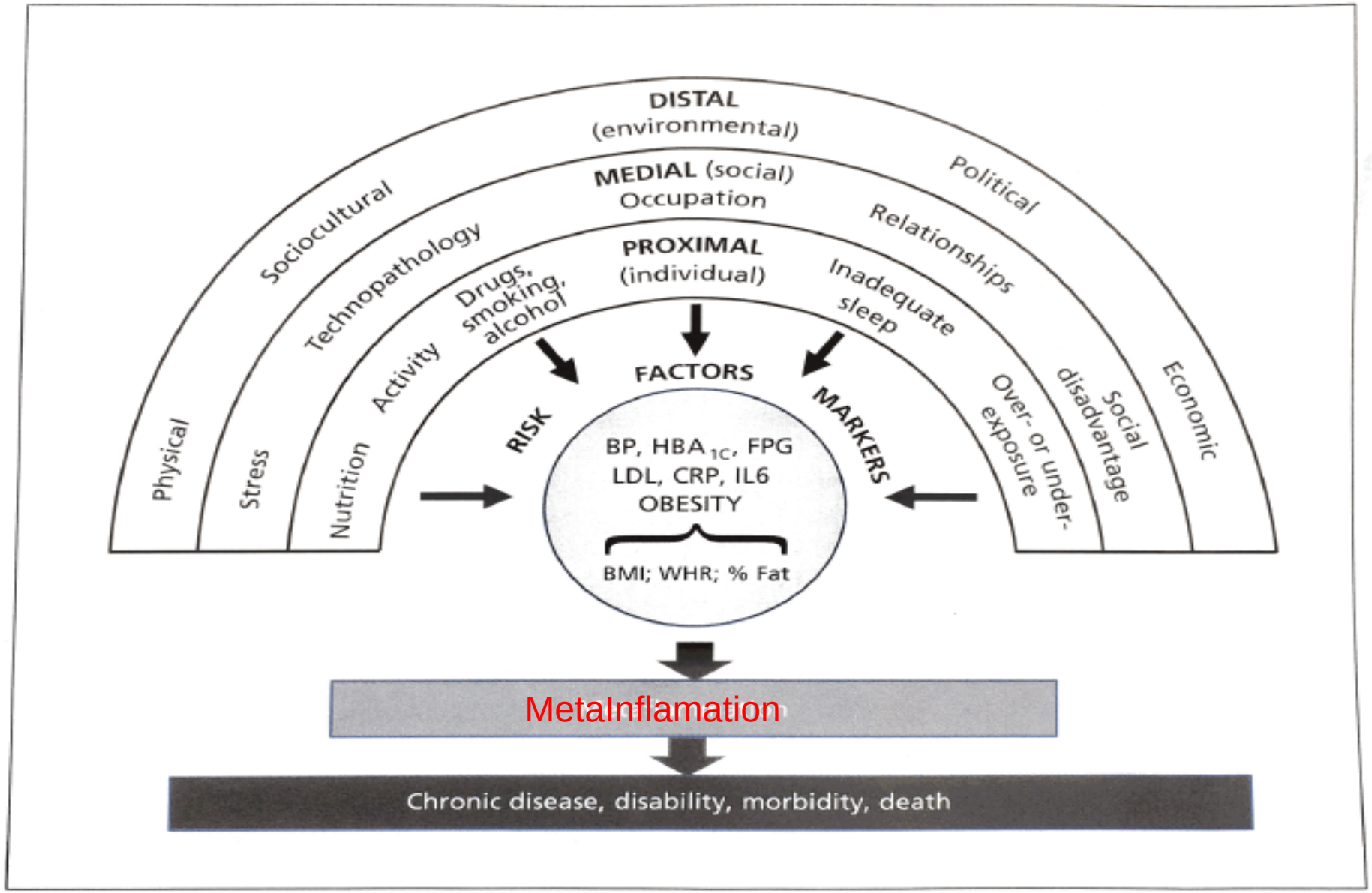


Figure 1: The link between "anthropogens," obesity, metaflammation and chronic disease. Although obesity is often a correlate, this does not necessarily indicate causality. Note: BMI = body mass index, BP = blood pressure, CRP = C-reactive protein, FPG = fasting plasma glucose, HBA_{1c} = alpha 1 hemoglobin, IL6 = interleukin 6, LDL = low-density lipoprotein, WHR = waist-to-hip ratio.

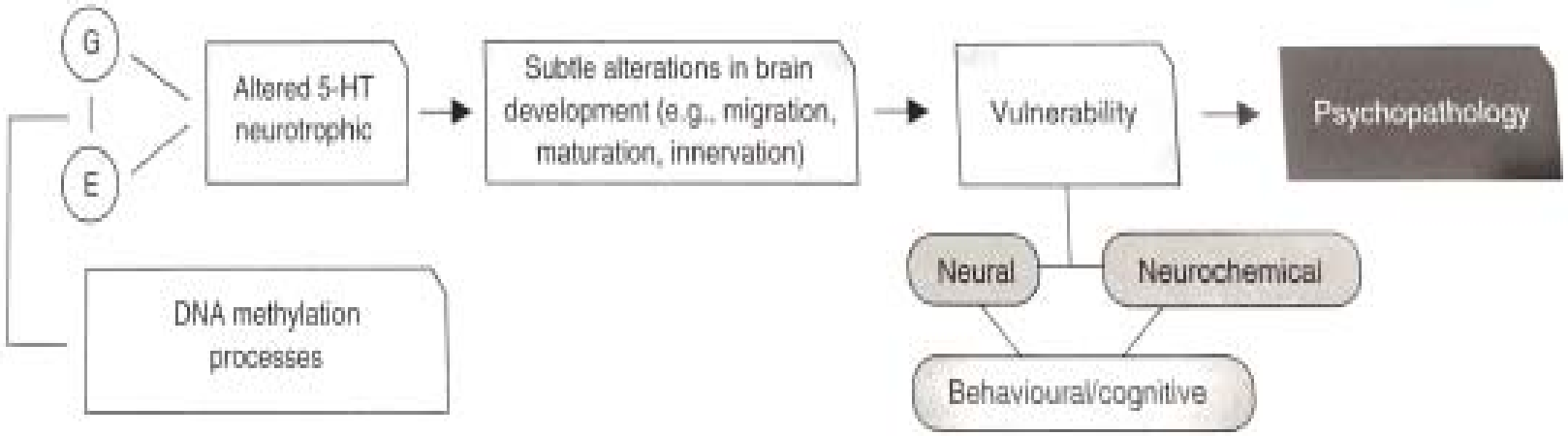
The Risks of addressing only risks. Eggers. Oct 7, 2014. CMAJ.

Epigenetics

Oct, 2014. CanJPsychia

Genetic and early environmental influences on the serotonin system: consequences for brain development and risk for psychopathology

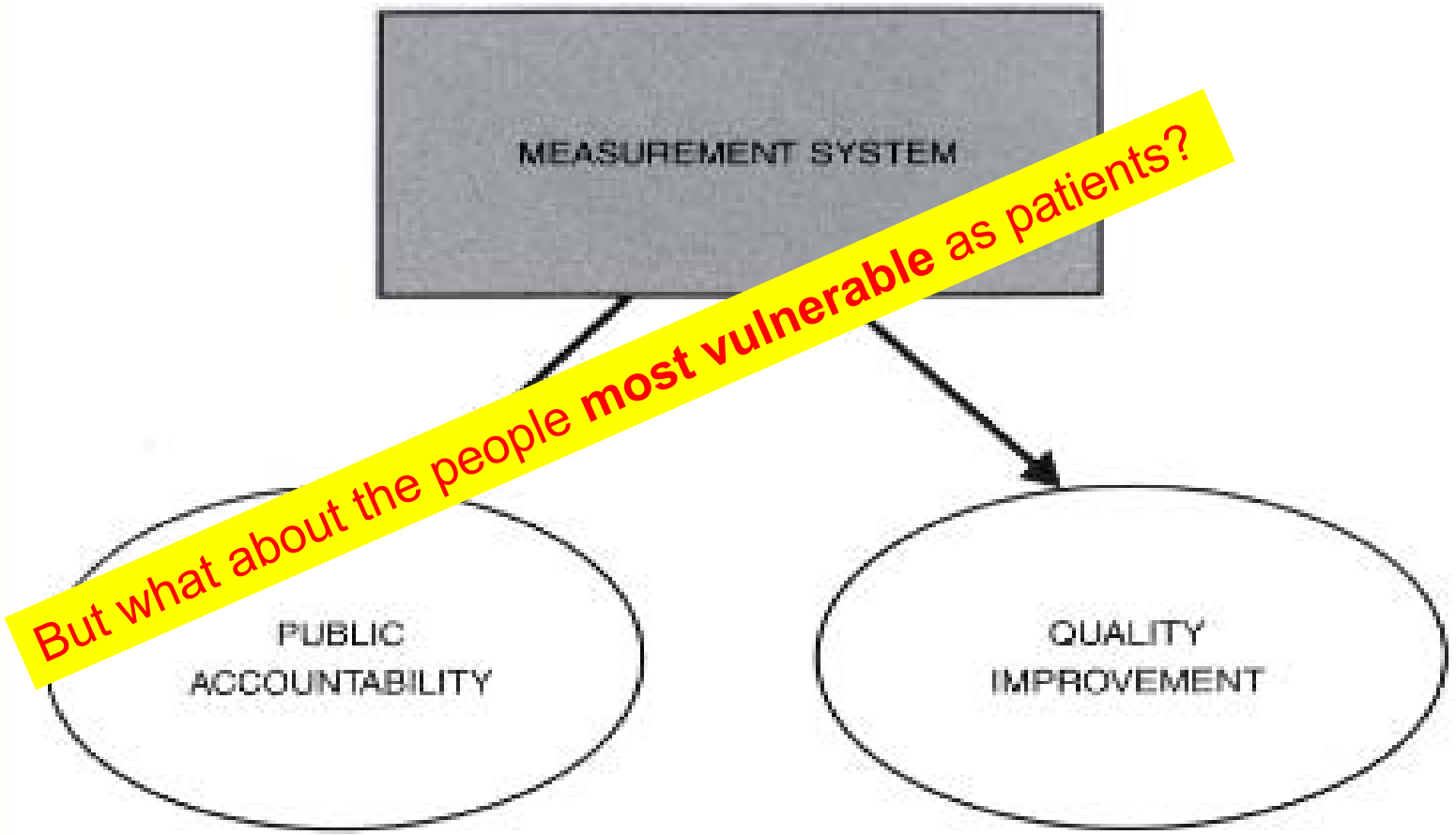
Linda Booij, PhD; Richard E. Tremblay, PhD; Moshe Szyf, PhD;
Chawki Benkelfat, MD, DERBH



5: Neurodevelopmental stress-diathesis model of psychopathology. 5-HT = serotonin; E = environment; G = gene.

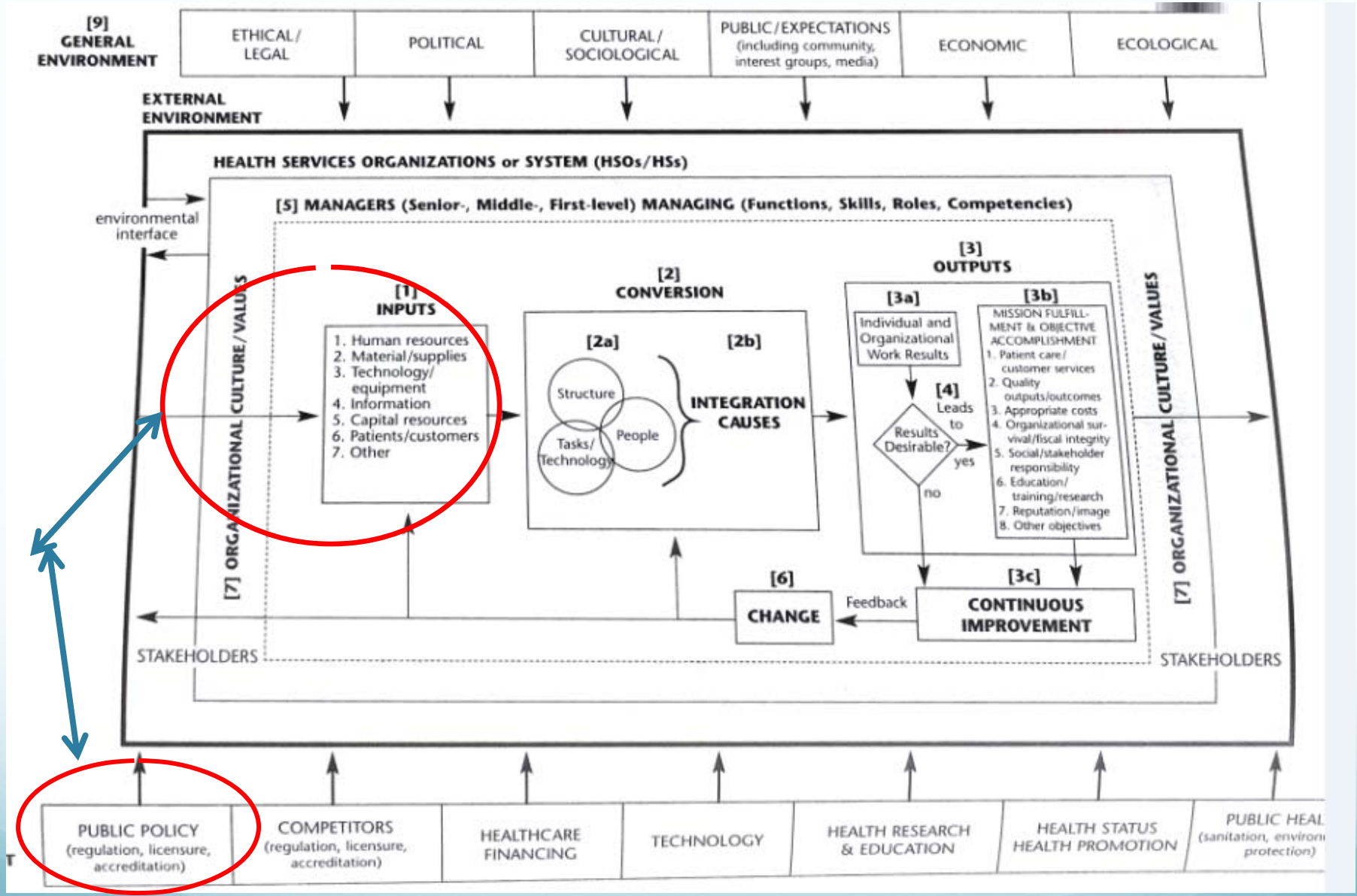
“ But we have to run an affordable health care system”

Measuring Quality in Health Care



But what about the people **most vulnerable** as patients?

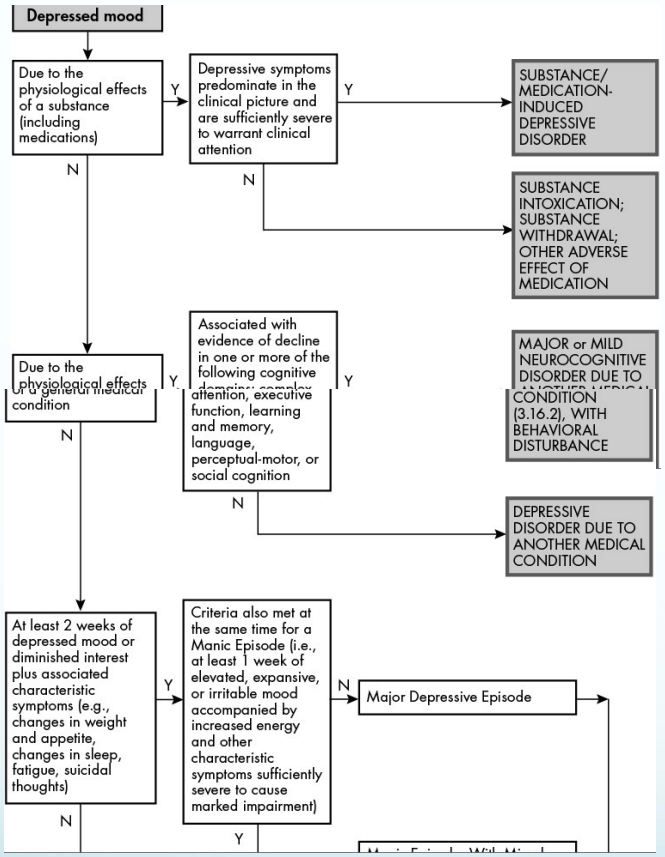
Figure 4.5. Objectives of measurement.



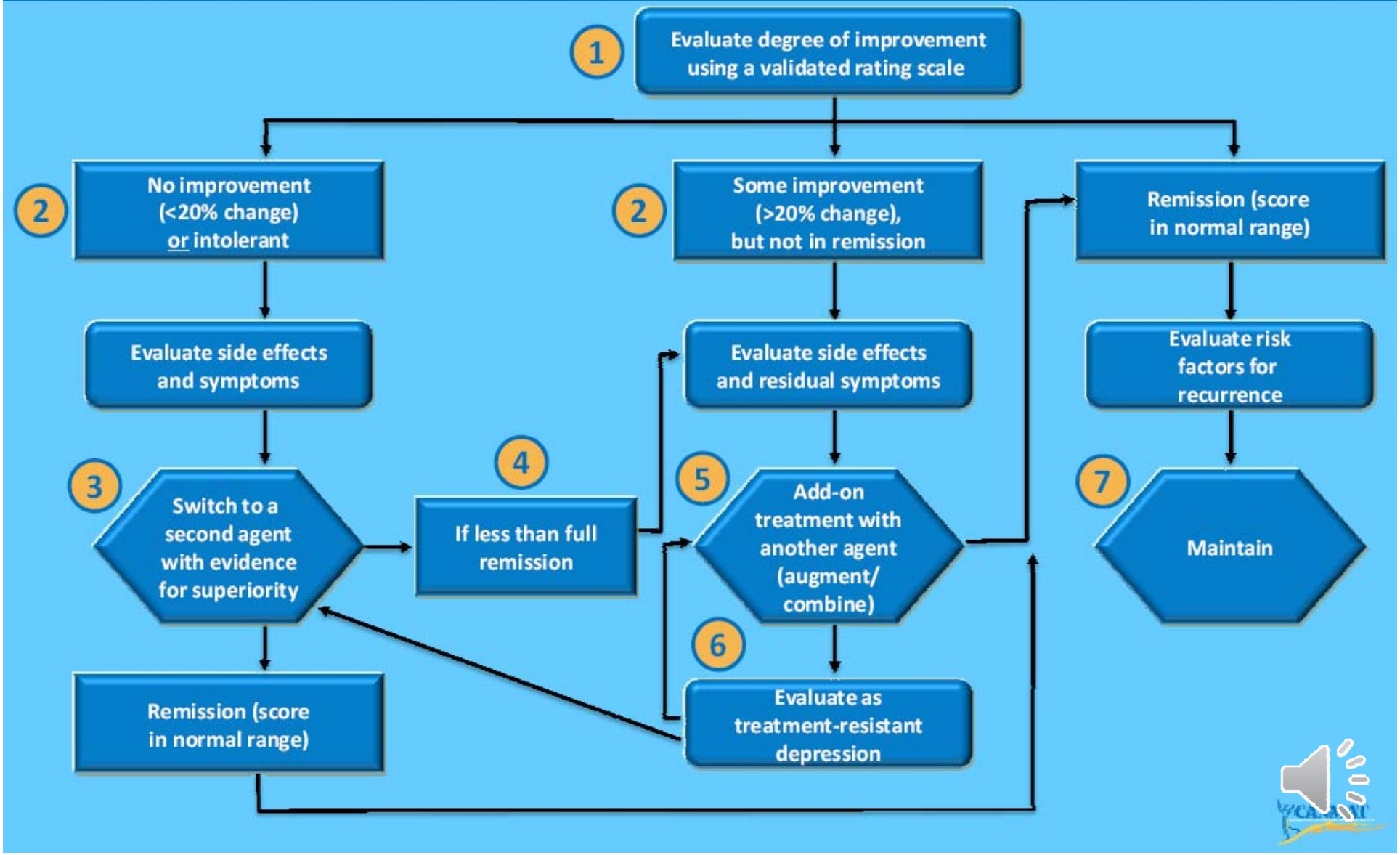
Managing health services organizations and systems. 6th Ed. Longest & Darr. 2014

DSM 5 Decision Tree: Depression

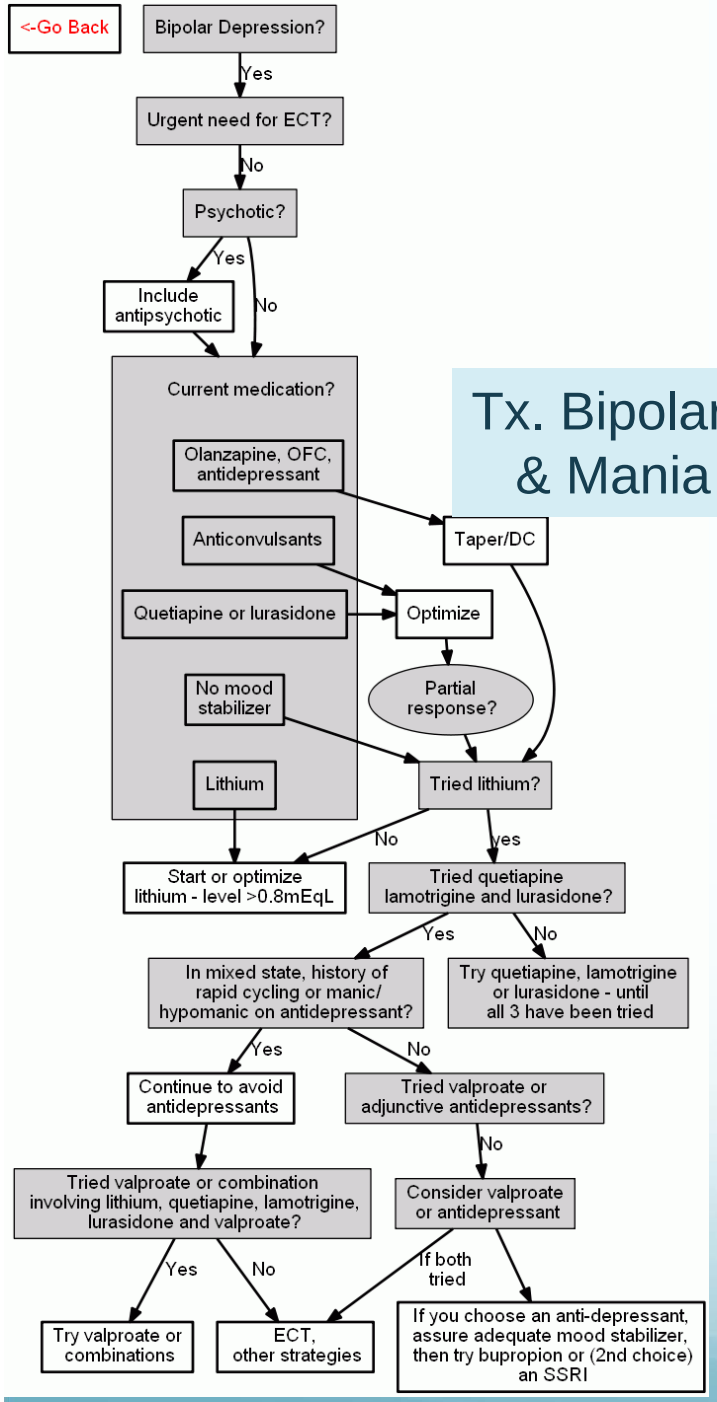
go to: nosm.ca to Psych On-Line to DSM5



Algorithm for Managing Limited Improvement with a First-line Antidepressant



Tx. Bipolar Depression & Mania



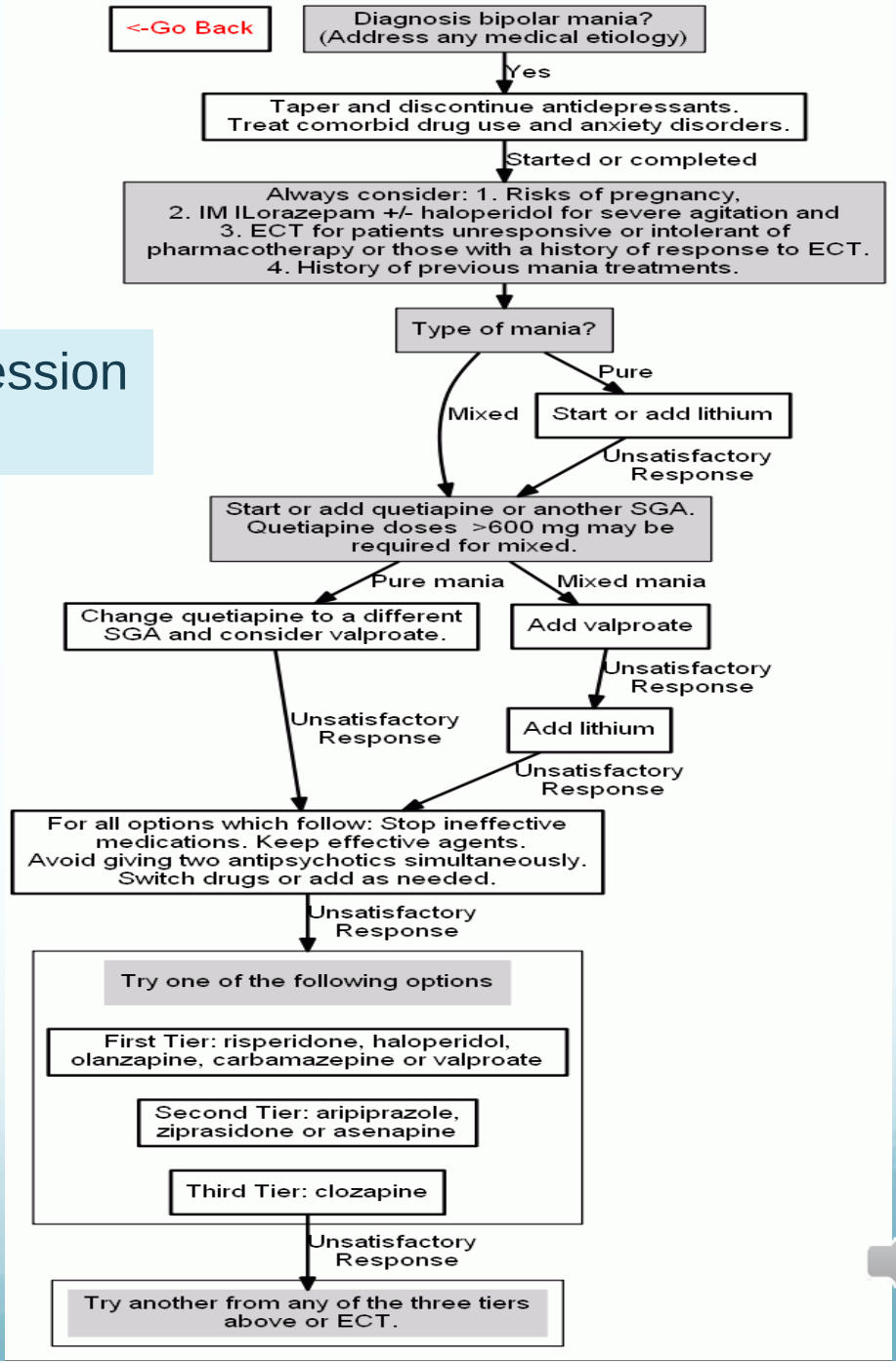


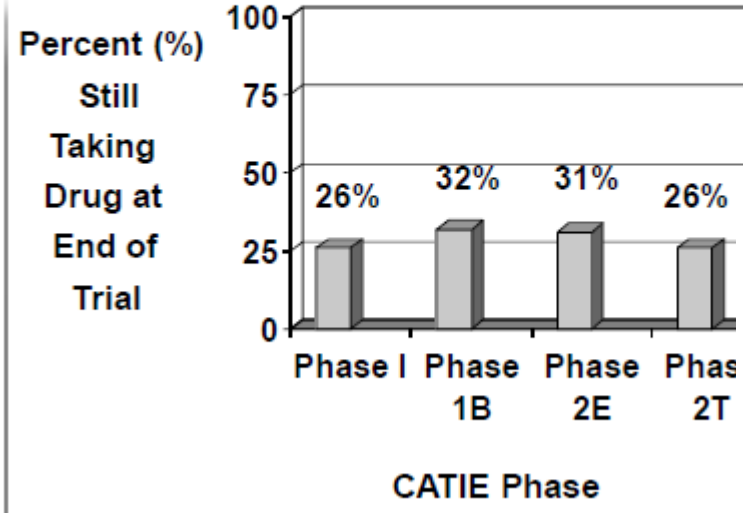
Table 1
Biopsychosocial formulation grid with examples of predisposing, precipitating, perpetuating, and protective factors in each of the formulation domains

Domains	BIOLOGICAL	PSYCHOLOGICAL	SOCIAL	
Factors	Genetic, developmental, medical, toxicity, temperamental factors	Cognitive style, intrapsychic conflicts and defense mechanisms, self-image, meaning of symptoms	Social–Relationships Family/peers/others	Social–Environment Culture/ethnicity, social risk factors, systems issues
PREDISPOSING	ıtric history, res in utero, birth complications, developmental disorders, regulatory disturbances	Insecure attachment, problems with affect modulation, rigid or negative cognitive style, low self-image	Childhood exposure to maternal depression and domestic violence, late adoption, temperament mismatch, marital conflicts	Poverty, low socioeconomic status, teenage parenthood, poor access to health or mental health care
PRECIPITATING	ness or g use of alcohol or drugs	Conflicts around identity or separation-individuation arising at developmental transitions, such as puberty onset or graduation from high school	Loss of or separation from close family member, family move with loss of friendships, interpersonal trauma	Recent immigration, loss of home, loss of a supportive service (eg, respite services, appropriate school placement)
PERPETUATING	functional :aused by cognitive deficits or learning disorder	Use of self-destructive coping mechanisms, help-rejecting personality style, traumatic re-enactments	Chronic marital discord, lack of empathy of parent, developmentally inappropriate expectations	Chronically dangerous or hostile neighborhood, trans-generational problems of immigration, lack of culturally competent services
PROTECTIVE	erage intelligence, nperament, specific talents or abilities, physical attractiveness	Ability to be reflective, ability to modulate affect, positive sense of self, adaptive coping mechanisms	Positive parent-child relationships, supportive community and extended family	Community cohesiveness, availability of supportive social network, well-functioning child/family team

Adapted from Barker P. The child and adolescent psychiatry evaluation: basic child psychiatry. Oxford, UK: Blackwell Scientific, Inc.; 1995.

Poor Compliance

Most Striking Finding in CATIE



Risk Factors for Medication Nonadherence

- **Illness-related**
  - Substance use comorbidity[1,2]
  - Symptom severity[1]
  - Lack of insight[3]
  - Subjective well being[2]
- **Treatment-related**
  - Tolerability[4]
  - Efficacy[3,5]
  - Regimen complexity[6]
  - Therapeutic alliance[2]
  - System factors[2]
- **Patient-related**
  - Previous medication adherence[7]
  - Demographic characteristics[1,5]
  - Subjective response to medications[8]
  - Medication supervision[6]

1. Valenstein M, et al. *J Clin Psychiatry*. 2006;67:1542-1550.
2. Olfson M, et al. *Psychiatr Serv*. 2000;51:216-222.
3. Novak-Grubic V, Tavcar R. *Eur Psychiatry*. 2002;17:148-154.
4. Lieberman JA, et al. *N Engl J Med*. 2005;353:1209-1223.
5. Nokonezny PA, Byerly MJ. *Schizophr Res*. 2006;82:107-114.
6. Grunebaum MF, et al. *J Clin Psychiatry*. 2001;62:384-389.
7. Ascher-Svanum H, et al. *J Clin Psychiatry*. 2006;677:1114-1123
8. Cabeza IG, et al. *Schizophr Res*. 2000;21:349-355.

Philip G. Janicak, M.D.

Is this enough?

- Evolution of Patient Story from
  - A good history
  - Analysis of Risk Factors
  - Recognition of Protective Factors
  - Full Grasp of ‘Social context’ (determinants) of health

  SDOH!!

SDOH: Wikipedia

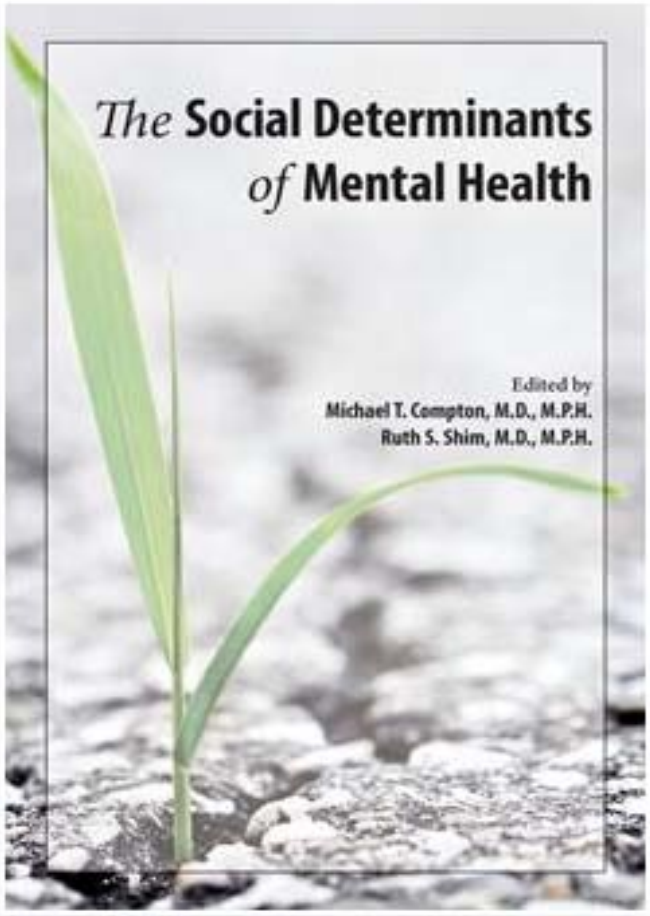
- The **social determinants of health** (**SDOH**) are the economic and social conditions and their distribution among the population that influence individual and group differences in health status. They are health promoting factors found in one's living and working conditions (such as the distribution of income, wealth, influence, and power), rather than individual risk factors (such as behavioural risk factors or genetics) that influence the risk for a disease, or vulnerability to disease or injury. According to some viewpoints, the distributions of social determinants are shaped by public policies that reflect the influence of prevailing political ideologies of those governing a jurisdiction.[1] The World Health Organization says, "This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies, unfair economic arrangements [where the already well-off and healthy become even richer and the poor who are already more likely to be ill become even poorer], and bad politics."[2]

In Canada, these social determinants of health have gained wide usage.

- Poverty and income distribution
- Education
- Unemployment and job security
- Early childhood development
- Race
- Disability
- Food insecurity
- Housing
- Social exclusion
- Social safety network
- Health services
- Aboriginal status
- Gender

2008 WHO Commission on Social Determinants of Health, report entitled "Closing the Gap in a Generation"

- Two broad areas of social determinants of health that needed to be addressed.
  - The first area was daily living conditions, which included healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to health care.
  - Distribution of power, money, and resources, including equity in health programs, public financing of action on the social determinants, economic inequalities, resource depletion, healthy working conditions, gender equity, political empowerment, and a balance of power and prosperity of nations.[2]
  - (for more, read Thomas Pogge)



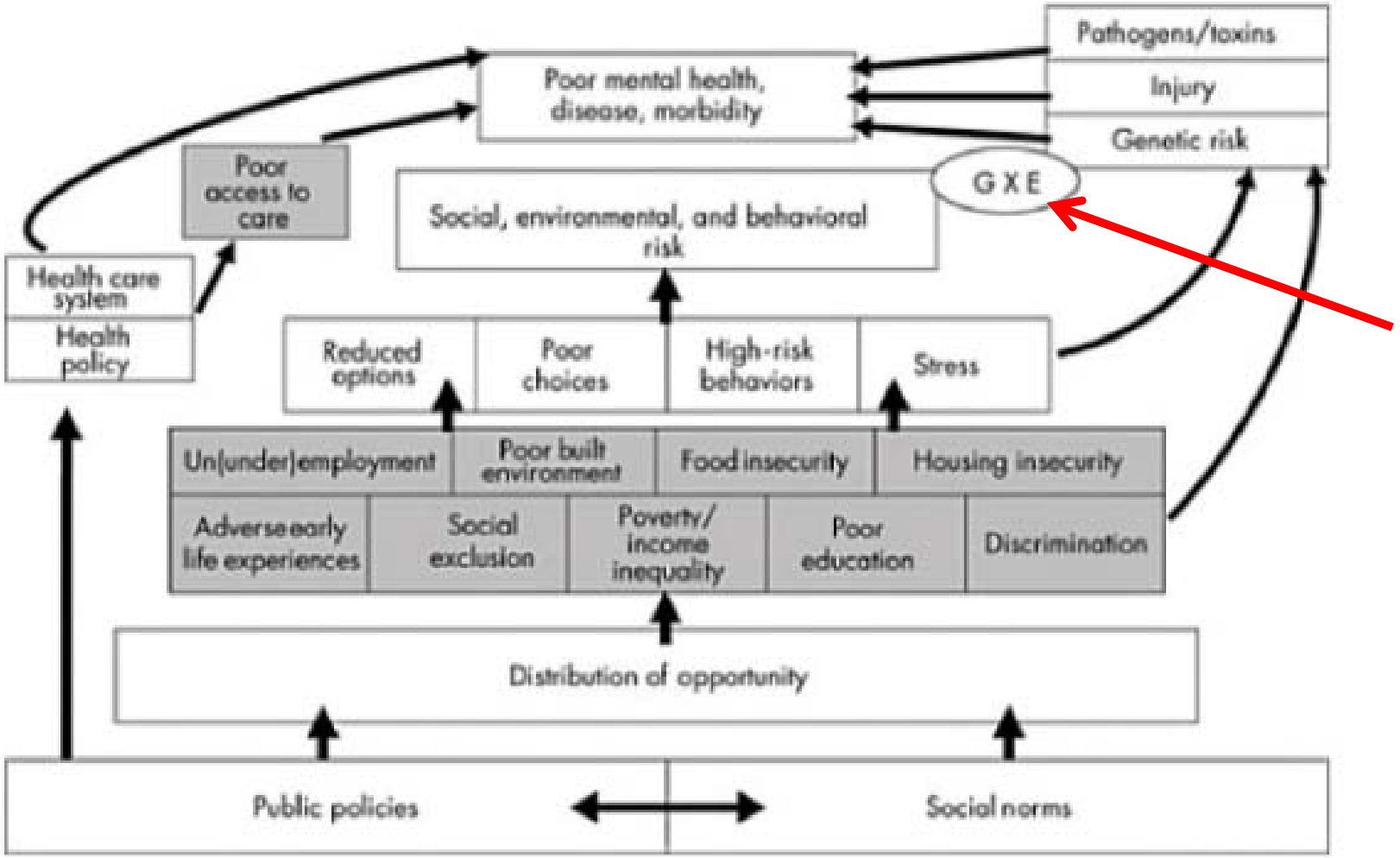
Compton, M. T., and Shim, R. S. (Eds.). (2015). *Social determinants of mental health.* Arlington, VA: American Psychiatric Publishing.

Overview

- Part of the social determinants of health approach is shifting to a public health, population-based approach.
- The factors that drive the social determinants of health are public policies and social norms, which set the stage for unequal distribution of opportunity.
- Psychiatrists and other mental health professionals have a responsibility to identify and address the social determinants of mental health.

Compton, M. T., and Shim, R. S. (Eds.). (2015). *Social determinants of mental health.* Arlington, VA: American Psychiatric Publishing.

Framework for understanding the social determinants of mental health



Compton, M. T., and Shim, R. S. (Eds.). (2015). *Social determinants of mental health.* Arlington, VA: American Psychiatric Publishing.

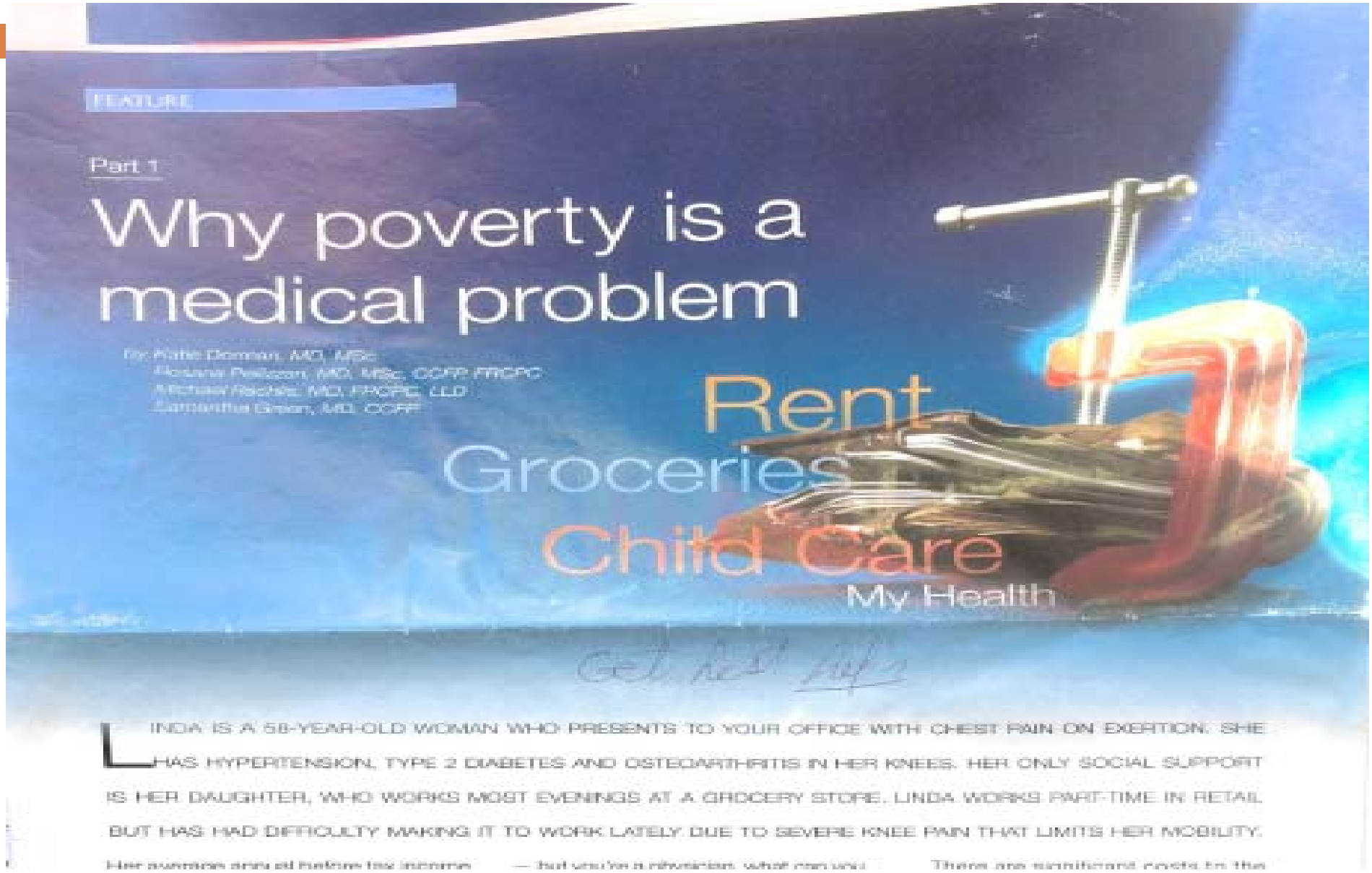
Associations between ACEs and mental health outcomes

	Depression[a]	Alcoholism[a]	Illicit drug use[b]	Hallucinations[c]	Attempted suicide[d]
Physical abuse	1.9 (1.7–2.1)	1.9 (1.6–2.3)	2.0 (1.8–2.3)	1.7 (1.4–2.1)	3.4 (2.9–4.0)
Sexual abuse	1.7 (1.5–2.0)	1.9 (1.6–2.4)	2.0 (1.8–2.3)	1.7 (1.4–2.1)	3.4 (2.9–4.0)
Emotional abuse	2.7 (2.3–3.1)	2.9 (2.3–3.6)	2.1 (1.7–2.5)	2.3 (1.8–3.0)	5.0 (4.2–5.9)
Parents separated/divorced	1.3 (1.2–1.5)	1.7 (1.4–2.1)	1.7 (1.5–1.9)	1.3 (1.1–1.6)	1.9 (1.6–2.2)
HM alcoholic or drug user	1.6 (1.3–2.0)	1.7 (1.2–2.4)	2.1 (1.8–2.4)	1.4 (1.1–1.8)	2.1 (1.8–2.5)
HM with a mental illness	2.5 (2.2–2.8)	2.0 (1.6–2.5)	1.9 (1.7–2.2)	2.5 (2.0–3.1)	3.3 (2.8–3.9)
HM incarceration	1.4 (1.1–1.8)	2.1 (1.4–3.0)	1.9 (1.5–2.4)	1.2 (0.8–1.9)	2.5 (2.0–3.2)
HM intimate partner violence	1.9 (1.6–2.1)	2.5 (2.0–3.1)	1.6 (1.4–1.9)	1.5 (1.1–2.0)	2.6 (2.2–3.1)

Compton, M. T., and Shim, R. S. (Eds.). (2015). *Social determinants of mental health*. Arlington, VA: American Psychiatric Publishing.

Poverty Series: Ont.Med.Review

Oct 2013



Treating Poverty As A Medical Problem

A Workshop

Prepared By: Drs. Gary Bloch, Katie Dorman, Ritika Goel, and Larisa Hausmanis
On behalf of the OCFP Poverty and Health Committee

What Is Poverty?

“Poverty Lines” for a Family of Four

Low Income Cut Off (LICO)	$30,945
Market Basket Measure (MBM)	$31,939

Is there a health poverty line?

Research Paper: Low Income Lines, 2011-2012. *Statistics Canada* 2012.

Poverty in Canada

- 1 in 7 children live in poverty in Canada[1]
- 12% of Ontarians live in poverty[2]
- As of 2012, there were over 156,000 Ontario households waiting for affordable, rent-geared-to-income housing[3]
- The number of Canadians assisted by food banks increased by 39% between 2002 and 2012[4]

Campaign 2000 Report (2012)

[1] Innocenti Report Card 10. *UNICEF Innocenti Research Centre.* Florence, Italy: 2012.
[2] CANISM Table 202-0802. *Statistics Canada*. Ottawa, Ontario: 2013.
[3] Ontario Non-Profit Waiting List Survey 2012. Ontario Non-Profit Housing Association, 2012.
[4] Hunger Count 2012. Food Banks Canada. Toronto, Ontario: 2012.

How much does an individual on social assistance receive through Ontario Works monthly?

A. $626

B. $714

C. $832

D. $1048

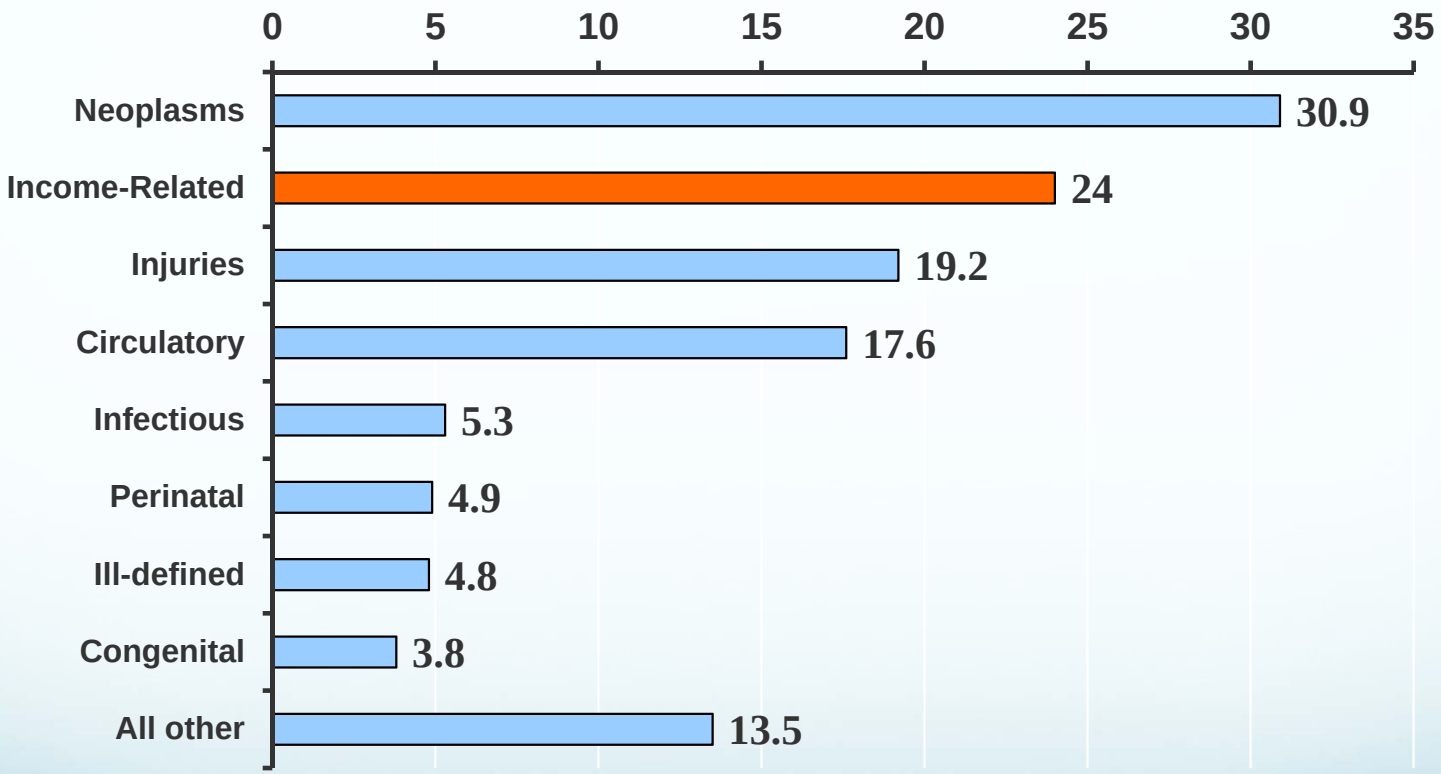
Making the Link: Poverty and Health

- **Poverty increases the prevalence and mortality of many diseases[1]**
  - Cardiovascular disease
  - Diabetes
  - Cancer
  - Depression
  - Chronic Obstructive Pulmonary Disease

[1] References in Poverty: A Clinical Tool For Primary Care in Ontario (available online)

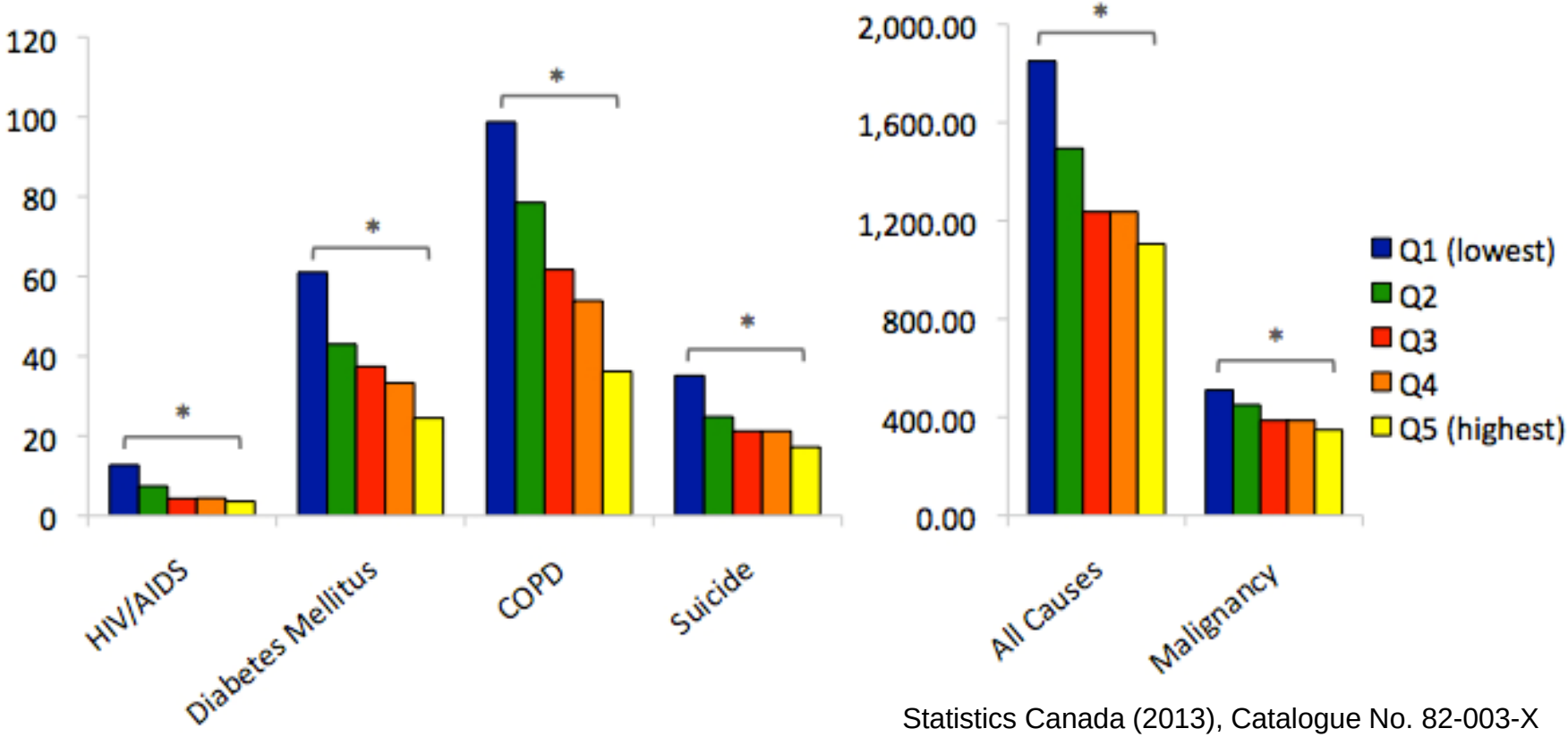
Making the Link: Poverty and Health

Poverty accounts for 24% of person years of life lost in Canada



[1] Wilkins, R, et al. Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996. *Statistics Canada* 2002:13; 10 (supp). Adapted from Dennis Raphael.

Making the Link: Poverty and Health



Statistics Canada (2013), Catalogue No. 82-003-X

Age-Standardized Mortality Rates For Selected Causes By Income Quintile Q1-Q5
Male cohort, age > 25. Significant interquintile rate differences (Q1-Q5) indicated by *

So … is there a health poverty line?

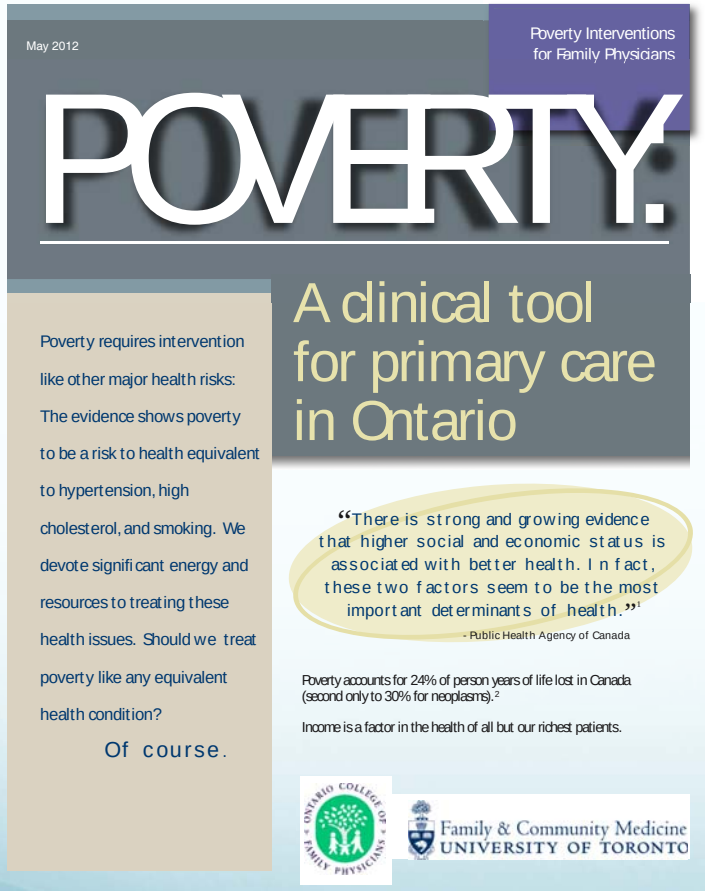
[1] Dorman, K et al. Ontario Medical Review. October 2013: 15-19.

Making the Link: Poverty and Health

"There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health."

Public Health Agency of Canada, 2004

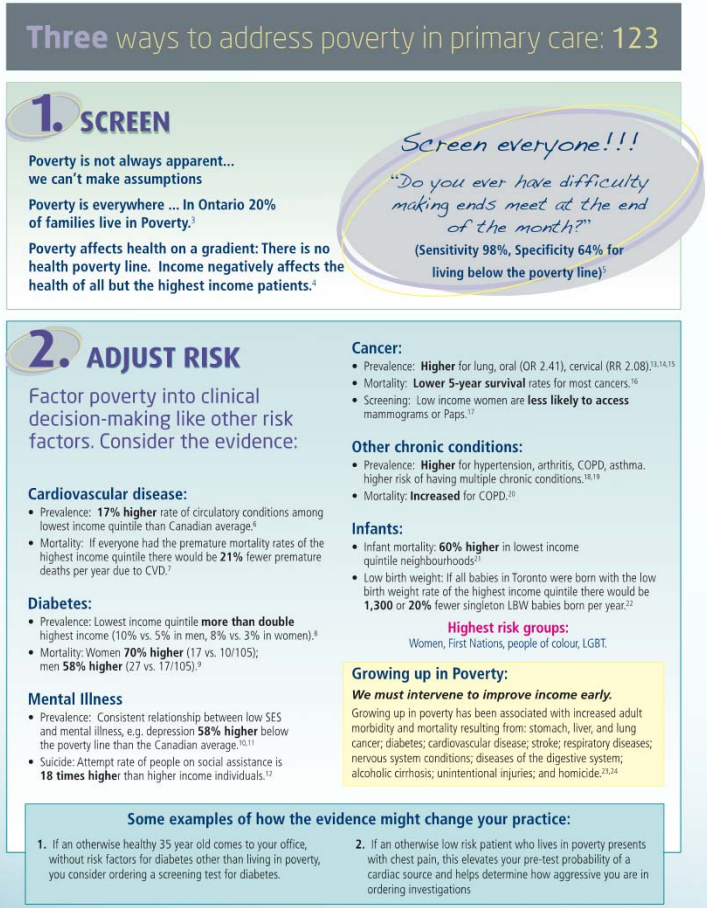
Three Steps To Addressing Poverty in Primary Care



1. Screen
2. Adjust Risk
3. Intervene

Available for download at http://www.healthprovidersagainstpoverty.ca/

STEP 1: Screen



Three ways to address poverty in primary care: 123

1. SCREEN

Poverty is not always apparent... we can't make assumptions

Poverty is everywhere ... In Ontario 20% of families live in Poverty.[3]

Poverty affects health on a gradient: There is no health poverty line. Income negatively affects the health of all but the highest income patients.[4]

Screen everyone!!!

"Do you ever have difficulty making ends meet at the end of the month?"

(Sensitivity 98%, Specificity 64% for living below the poverty line)[5]

2. ADJUST RISK

Factor poverty into clinical decision-making like other risk factors. Consider the evidence:

Cardiovascular disease:
- Prevalence: **17% higher** rate of circulatory conditions among lowest income quintile than Canadian average.[6]
- Mortality: If everyone had the premature mortality rates of the highest income quintile there would be **21%** fewer premature deaths per year due to CVD.[7]

Diabetes:
- Prevalence: Lowest income quintile **more than double** highest income (10% vs. 5% in men, 8% vs. 3% in women).[8]
- Mortality: Women **70% higher** (17 vs. 10/105); men **58% higher** (27 vs. 17/105).[9]

Mental Illness
- Prevalence: Consistent relationship between low SES and mental illness, e.g. depression **58% higher** below the poverty line than the Canadian average.[10,11]
- Suicide: Attempt rate of people on social assistance is **18 times higher** than higher income individuals.[12]

Cancer:
- Prevalence: **Higher** for lung, oral (OR 2.41), cervical (RR 2.08).[13,14,15]
- Mortality: **Lower 5-year survival** rates for most cancers.[16]
- Screening: Low income women are **less likely to access** mammograms or Paps.[17]

Other chronic conditions:
- Prevalence: **Higher** for hypertension, arthritis, COPD, asthma. higher risk of having multiple chronic conditions.[18,19]
- Mortality: **Increased** for COPD.[20]

Infants:
- Infant mortality: **60% higher** in lowest income quintile neighbourhoods[21]
- Low birth weight: If all babies in Toronto were born with the low birth weight rate of the highest income quintile there would be **1,300** or **20%** fewer singleton LBW babies born per year.[22]

Highest risk groups:
Women, First Nations, people of colour, LGBT.

Growing up in Poverty:

We must intervene to improve income early.

Growing up in poverty has been associated with increased adult morbidity and mortality resulting from: stomach, liver, and lung cancer; diabetes; cardiovascular disease; stroke; respiratory diseases; nervous system conditions; diseases of the digestive system; alcoholic cirrhosis; unintentional injuries; and homicide.[23,24]

Some examples of how the evidence might change your practice:

1. If an otherwise healthy 35 year old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.
2. If an otherwise low risk patient who lives in poverty presents with chest pain, this elevates your pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations

Screen everyone!

Poverty is often hidden, but affects 1 in 9 individuals in Ontario.

ASK: "Do you ever have difficulty making ends meet at the end of the month?"

Sensitivity 98%, Specificity 60% for those living below poverty line

Brcic, V et. al. *Int J Family Med* 2011; 2011: 812182. E-pub.

STEP 2: Adjust The Risk

Case

A 41-year-old woman who is a non-smoker, with no past medical history or family history of disease, presents with occasional chest pain on exertion, which is variably reproducible on chest palpation.

- Should she have a stress test?
- What if she were a smoker or had high cholesterol?
- What if she has no traditional risk factors but has lived on social assistance for 10 years?

STEP 3: Income Interventions

3. INTERVENE

7 simple questions to help patients living in poverty

FOR EVERYBODY:

Have you filled out and mailed in your tax forms?

- Tax returns are essential to access many income security benefits e.g. GST / HST credits, Child Benefits, working income tax benefits, and property tax credits.
- Even people without official residency status can file returns.
- **Drug Coverage:** Extended Health Benefits or Trillium for those without a Ontario Drug Benefits.

For seniors living in poverty:

Do you receive Old Age Security and Guaranteed Income Supplement?

- Most people over age 65 who live in poverty should receive at least **$1400/month** in income through OAS, GIS and grants from filing a tax return.

For families with children:

Do you receive the Child Benefit on the 20th of every month?

- This can get some low income single parents over **$8000 more per year**, and can lead to a number of other income supports.

For people with disabilities:

Do you receive payments for Disability?

- Eight major disability programs: ODSP, CPP Disability, EI, Disability Tax Credit (DTC), Veterans benefits, WSIB, Employers' long term protection, Registered Disability Savings Plan (RDSP).
- The DTC requires a health provider to copmlete the application form. It provides **up to $1100 per year** in tax savings (plus retroactive payments), and is required to receive other benefits including the RDSP.
- RDSP: **Up to 300%** matching funds. Or disability bonds **up to $20 000** for those without resources to save money.

For First Nations:

Are you Status Indian?

- First Nations with the Status designation may qualify for Non-Insured Health Benefits through the federal government. These pay for drugs and other extended health benefits not covered by provincial plans

For social assistance recipients:

Have you applied for extra income supplements?

- Mandatory Special Necessities Benefits (*MDs bill K054 for $25*):
  - Medical supplies and health-related transportation (includes e.g. AA, psychotherapy).
- Limitation to Participation (*MDs bill K053 for $15*): Disability can exclude a recipient from mandatory job search and training programs.
- Special Diet Allowance (*MDs bill K055 for $20*): some health conditions will qualify a recipient for extra income.
- Other benefits available: Employment supports, Drug & Dental, Vision, Hearing, ADP Co-payment, Community Start Up & Maintenance, Women in Transition/Interval Houses, Advanced age allowance, Community Participation ($100 per month extra for volunteering). "Discretionary Benefits".

Applications and benefits available through a patient's OW/ODSP worker

If you might qualify, have you applied for ODSP?

- ODSP application (MDs bill K050 for $100): provide as much information as possible, including about the impact of a person's disability on their lives.
  - Include all collateral, expedite necessary referrals, and write a detailed narrative on the last page. Consider obtaining a detailed functional assessment, and having an allied health provider assist with filling in details.
- If denied, refer to nearest legal clinic – acceptance rates on appeal are very high.

www.cleo.on.ca/english/pub/onpub/PDF/socialAsst/ods-prof.pdf for a good ODSP tip sheet for health professionals.

Remember:
Health providers are not the gatekeepers for income security programs. Our job is to provide complete and detailed information that accurately portrays our patients' health status and disability.

For references, please visit
www.ocfp.on.ca/cme/povertytool

- With individual patients
- Within our communities

STEP 3: Income Interventions

Can you help advise here?

Easy Questions, Big Impact

1. **For Everyone**

   Have you filled out and mailed your income tax forms?

2. **For Low Income Seniors**

   Do you receive Old Age Security and Guaranteed Income Supplement?

3. **For Families With Children**

   Do you receive the Child Benefit on the 20th of every month?

4. **For People With Disabilities**

   Do you receive Disability Benefits? Have you applied for ODSP?

5. **For Aboriginal People**

   Are you registered as a “Status Indian” / “Registered Indian”?

6. **For people on OW/ODSP**

   Have you applied for extra income supplements?

Filling Out A Tax Return…

Simple Intervention, Big Impact

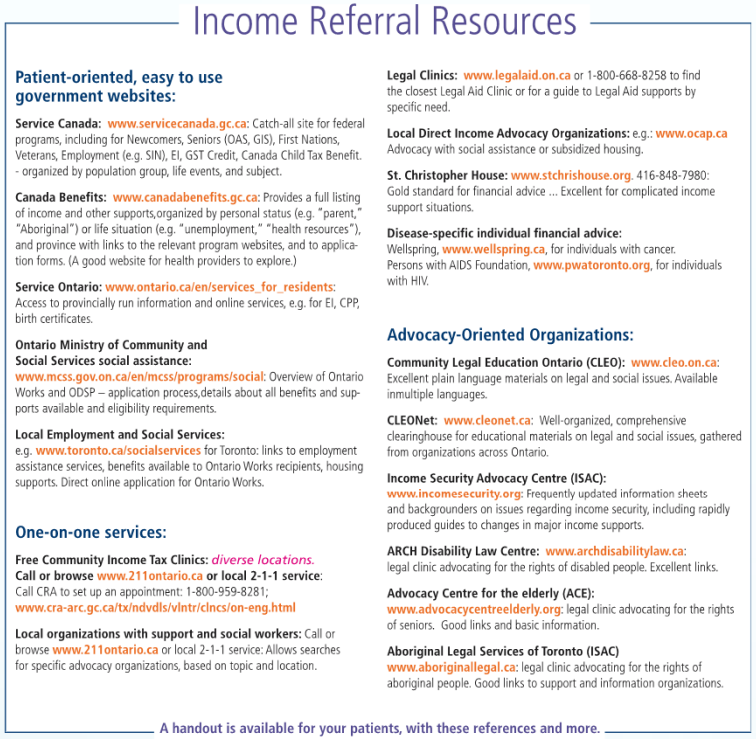
Monthly Income: $1,150

Example:
Single mother, two young children, **annual income $14 000**, monthly rent $800

Canadian Child Tax Benefit Basic Amount + National Child Benefit Supplement + Ontario Child Benefit	$ 9,470
Harmonized Sales Tax Credit	$ 808
Working Income Tax Benefit	$ 1,813
Ontario Trillium Benefit Ontario Sales Tax Credit + Ontario Energy and Property Tax Credit	$ 1,305
Ontario Children's Activity Tax Credit	$ 107
Total 2013 Tax Credits	**$13,503**

Ontario Refundable Tax Credit Calculator: http://www.fin.gov.on.ca/en/taxcredits/CalculatorQuestions.asp
CRA Child and Family Benefits Calculator: http://www.cra-arc.gc.ca/bnfts/clcltr/menu-eng.html

Know Where To Refer



Income Referral Resources

Patient-oriented, easy to use government websites:

Service Canada: www.servicecanada.gc.ca: Catch-all site for federal programs, including for Newcomers, Seniors (OAS, GIS), First Nations, Veterans, Employment (e.g. SIN), EI, GST Credit, Canada Child Tax Benefit. - organized by population group, life events, and subject.

Canada Benefits: www.canadabenefits.gc.ca: Provides a full listing of income and other supports,organized by personal status (e.g. "parent," "Aboriginal") or life situation (e.g. "unemployment," "health resources"), and province with links to the relevant program websites, and to application forms. (A good website for health providers to explore.)

Service Ontario: www.ontario.ca/en/services_for_residents: Access to provincially run information and online services, e.g. for EI, CPP, birth certificates.

Ontario Ministry of Community and Social Services social assistance: www.mcss.gov.on.ca/en/mcss/programs/social: Overview of Ontario Works and ODSP – application process,details about all benefits and supports available and eligibility requirements.

Local Employment and Social Services: e.g. www.toronto.ca/socialservices for Toronto: links to employment assistance services, benefits available to Ontario Works recipients, housing supports. Direct online application for Ontario Works.

One-on-one services:

Free Community Income Tax Clinics: *diverse locations.* **Call or browse** www.211ontario.ca **or local 2-1-1 service**: Call CRA to set up an appointment: 1-800-959-8281; www.cra-arc.gc.ca/tx/ndvdls/vlntr/clncs/on-eng.html

Local organizations with support and social workers: Call or browse www.211ontario.ca or local 2-1-1 service: Allows searches for specific advocacy organizations, based on topic and location.

Legal Clinics: www.legalaid.on.ca or 1-800-668-8258 to find the closest Legal Aid Clinic or for a guide to Legal Aid supports by specific need.

Local Direct Income Advocacy Organizations: e.g.: www.ocap.ca Advocacy with social assistance or subsidized housing.

St. Christopher House: www.stchrishouse.org. 416-848-7980: Gold standard for financial advice ... Excellent for complicated income support situations.

Disease-specific individual financial advice: Wellspring, www.wellspring.ca, for individuals with cancer. Persons with AIDS Foundation, www.pwatoronto.org, for individuals with HIV.

Advocacy-Oriented Organizations:

Community Legal Education Ontario (CLEO): www.cleo.on.ca: Excellent plain language materials on legal and social issues. Available inmultiple languages.

CLEONet: www.cleonet.ca: Well-organized, comprehensive clearinghouse for educational materials on legal and social issues, gathered from organizations across Ontario.

Income Security Advocacy Centre (ISAC): www.incomesecurity.org: Frequently updated information sheets and backgrounders on issues regarding income security, including rapidly produced guides to changes in major income supports.

ARCH Disability Law Centre: www.archdisabilitylaw.ca: legal clinic advocating for the rights of disabled people. Excellent links.

Advocacy Centre for the elderly (ACE): www.advocacycentreelderly.org: legal clinic advocating for the rights of seniors. Good links and basic information.

Aboriginal Legal Services of Toronto (ISAC) www.aboriginallegal.ca: legal clinic advocating for the rights of aboriginal people. Good links to support and information organizations.

A handout is available for your patients, with these references and more.
This can be ordered through the Ontario College of Family Physicians.

Developed by Dr. Gary Bloch MD CCFP,
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St. Michael's
Inspired Care. Inspiring Science.

HEALTH PROVIDERS AGAINST POVERTY

St. Michael's Hospital
Family Medicine Associates

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Research Assistant

For more information and references visit:
www.ocfp.on.ca/cme/povertytool

- Work in a team or network with services in the community
  - Social workers
  - Health promoters
  - Medical-legal partnerships
  - Community Agencies
  - Volunteer Tax Clinics
- Know online resources
  - 211 Ontario
  - Online Tax Credit Calculators
  - Canada Benefits
- Clinical Tool or Patient Brochure

The Case Of Harriett

Harriett is a 58 yo woman who immigrated to Canada from Jamaica in her 20s. She worked in construction until 15 years ago when a back injury put her out of work. Harriett has an extensive medical history, including diabetes, hypertension, depression, and a prior heart attack.

Your team has done its best to optimize treatment for her physical and mental health conditions, however you do not feel that Harriett's health has really improved.

You decide to develop a more complete picture of the factors than may be impacting Harriett's health by taking a comprehensive social history.

What else do you want to know?

Back To Harriett

In order to help Harriett you realize you must look into whether she might qualify for more money through the income security system. You realize however, that you have now have some ideas how to help her navigate this system.

Case Review

Harriett May Qualify For:

- ODSP $ 1086 per month
- Special Diet Allowance $180 per month
- Transportation Allowance $105 Metropass per month
- Ontario Trillium Benefit $56 per month

Total = $1427 per month

Other

- Disability Tax Credit **$7546** *Through her daughter*
- Registered Disability Savings Plan *If able to contribute*
- WSIB *For workplace injury*

* Benefits for July 2013 - June 2014

Dr. Vidal Presentation

Two Paths to Improve Health-Which to choose?

If one needs to choose: We need both!

Efficient/Evidence Based/ Algorithmic

- Know the evidence
- Optimally deliver care
- Always insert human story to the ‘pursuit of effieciency’
- Make ‘the Story’ (enquiry) of SDOH matter in patient care
- Use/Share the Poverty Toolkit

The Story/Risks/SDOH/ Policy Influence

- Paul Farmer’s Haiti Dam
- James Orbinski’s work on Dignity, MSF, now climate change
- Mondays CJ: Dr. Ryan Meili on climate change
- ?you and our LHIN? Hospital?
- Be a ‘Leader’ in your area
- Use the Poverty Toolkit!

Questions? Comments? Ideas?

Panel Discussion