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Practising equity-focused health care

How St. Michael's Hospital Academic Family Health Team works to address the social determinants of health

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St. Michael's Hospital

St. Michael's Hospital provides compassionate care to all who enter its doors. The hospital also provides outstanding medical education to future health care professionals in 27 academic disciplines. Critical care and trauma, heart disease, neurosurgery, diabetes, cancer care, care of the homeless and global health are among the hospital's recognized areas of expertise. Through the Keenan Research Centre and the Li Ka Shing International Healthcare Education Centre, which make up the Li Ka Shing Knowledge Institute, research and education at St. Michael's Hospital are recognized and make an impact around the world. Founded in 1892, the hospital is fully affiliated with the University of Toronto. For more information visit **www.stmichaelshospital.com**

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ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN PRIMARY CARE

Introduction

The St. Michael's Hospital Academic Family Health Team has become a national and global leader in developing and implementing primary care-based programs to address social determinants of health and health inequities. Over the past 15 years, building on a history of providing care to Toronto's residents who experience social marginalization, the team has integrated a focus on the social risks to health into the core of its clinical and academic programs. The team is in the midst of a unique cultural transformation. Action on health and social inequities is now well on the way to being embedded in patient care provision, teaching, research, and strategic direction.

This narrative captures the story of that transformation – its evolution, lessons learned, and what still needs to be done.

St. Michael's Hospital Academic Family Health Team

St. Michael's Hospital serves multiple communities experiencing social marginalization in downtown Toronto. Since its inception in the early 1970's, the family medicine department has also worked specifically to address the health of communities experiencing social marginalization. It has been at the forefront of care for people living with HIV, people who use drugs, people who experience homelessness, the lesbian, gay, bisexual, transgender and queer (or questioning) and others (LGBTQ+) community, and refugees and new immigrants.

At the primary care level, the work of St Michael's Hospital is largely carried out by the Academic Family Health Team, with 78 family physicians, who are among 264 staff (including interprofessional and support staff), and dozens of resident physicians and medical students in interdisciplinary teams in six clinics serving more than 47,000 rostered patients in eastern downtown Toronto.

The Family Health Team's strategic plan specifically prioritizes developing, implementing and evaluating programs that will address the social determinants of patients' health. It lays out a mandate for the team to work towards correcting the health inequities that threaten the health of its socially disadvantaged patients.

Unique insight

From its community-based vantage point, the Family Health Team has unique insight into the health effects of poverty, substandard housing, homelessness, precarious and low-paid work, low education, racism, disability, early childhood deprivation and other social determinants of health. As a family medicine academic centre, it has been at the forefront of developing education, research, and novel clinical approaches to addressing the specific needs of the communities it serves.

Over the last 10 years, the St. Michael's Hospital Academic Family Health Team has put a deliberate focus on integrating initiatives that directly address the social determinants of health into its model of care.

Why does the St. Michael's Hospital Academic Family Health Team do this? Because its primary care providers have seen firsthand that they cannot effectively address the medical needs of patients experiencing social vulnerability and marginalization when their most basic social and economic needs are not being met. They are also acutely aware of the powerful body of scientific evidence linking social marginalization with poor health outcomes. And they know from experience, that even within the confines of the primary care setting, there are steps they can take as health care providers to work directly with patients to improve their socio-economic circumstances.

The Social Determinants of Health Committee

In 2013, a dedicated Social Determinants of Health Committee was established on the initiative of two physicians, and with the strong support of the St. Michael's Hospital Academic Family Health Team's leadership. This interprofessional committee meets every one to two months and has a full-day retreat every 12 to 18 months. It is co-chaired by a physician and the team's community engagement specialist, and includes about 25 members, representing all clinical sites, team leadership, most clinical disciplines, family medicine trainees, and advisors with lived experience.

The strong support of the Family Health Team's leadership has ensured the integration of the Team's initiatives and mandate into core operations and decision-making. The Team's leaders have also ensured the co-Chairs are funded, and that staff and physicians have protected time to engage in the Committee's activities.

Funding for the Committee's projects has come from government agencies including the Ontario Ministry of Health and Long-Term Care, Legal Aid Ontario, research grants, non-governmental foundation grants and targeted private donations. The Committee's work is also dependent on partnerships with many governmental, non-governmental and community organizations.

The Committee has overseen two major phases of the team's work to address the social determinants of health: the creation of targeted specialized programs, and then integration of this work into all team programs and services.

The Social Determinants of Health Committee now has dedicated working groups to assess all its programs and services through a health equity lens, ensuring: community engagement is equity-oriented and integrated throughout the team; a team-wide approach to advocacy; and a program dedicated to addressing racism as a threat to health.

PHASE 1

Income Security Health Promoters

Health Justice Legal Services Program

Community Engagement

Reach Out and Read

Sociodemographic Data Collection

PHASE 2

Equity in Programs and Services

Community Engagement

Advocacy

Racism and Health

Vision

The Committee will work to ensure the Family Health Team is invested with the knowledge, skills, tools, and programs to advance health equity. The Committee will promote equitable health outcomes for the Family Health Team's patient population and its community by supporting the development, implementation and evaluation of interventions aimed at directly reducing the negative health impacts of the social determinants of health.

Guiding principles

1. Health care providers and teams have a role in directly addressing the social determinants of health.
2. The committee will include members from across clinical disciplines and Family Health Team sites.
3. The Committee relies on strong support by leadership, and integration into the daily functioning of the department.
4. The voice of expert advisors with direct lived experience of social marginalization will be included as equal in the Committee's deliberations and decision-making.
5. As part of an academic team, the Committee will support the evaluation and research of its initiatives, and their incorporation into training programs for health disciplines trainees.

St. Michael's Hospital Academic Family Health Team Social Determinants of Health Committee

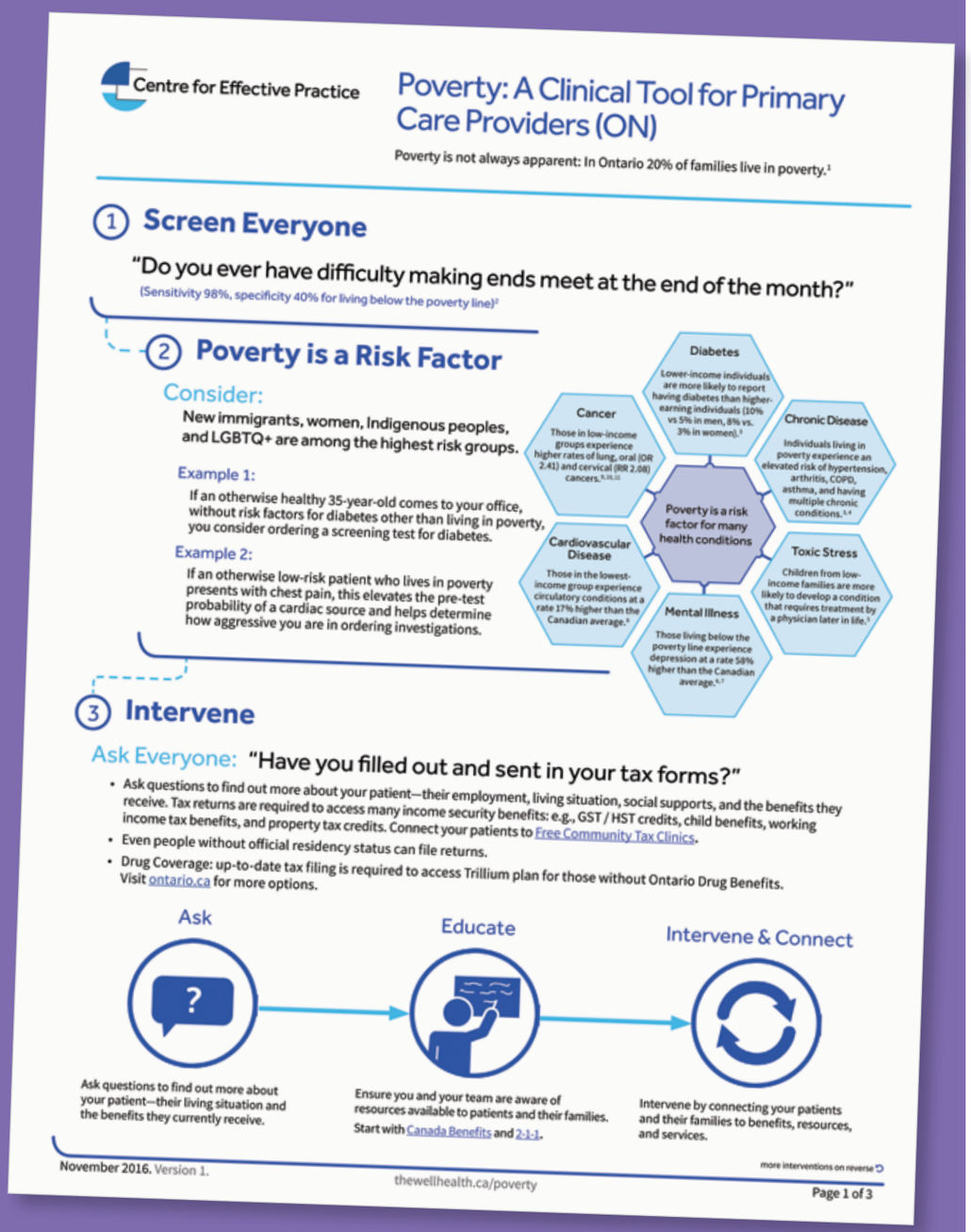
Identifying patients in need

The first step to working on patients' social needs is to identify those who would benefit from this support. In 2010 the team began to use a simple but highly effective poverty screening tool (see opposite).

The tool is a three-step process that first prompted primary care providers to ask patients: "Do you ever have difficult making ends meet at the end of the month?" A positive answer prompts step two: consider poverty a risk factor for a range of diseases, with new immigrants, women, Indigenous peoples, children and LGBTQ+ people among those at highest risk. Step three prompts the provider to intervene, by finding out more about the patient's socio-economic circumstances, connecting patients directly to benefits programs and services, and linking patients to other community resources.

In 2013, the team adopted an expanded tablet-based questionnaire, developed under the guidance of the local area health governing body, the Toronto Central Local Health Integration Network, to routinely collect sociodemographic data on patients, including income, home language, immigration status, literacy level and other information, which is fed directly into the patient's electronic medical record. Completion of the questionnaire is optional, but has been widely accepted by patients, with an approximate 50% response rate.

The Ontario poverty screening tool



Download it at:
www.cep.health/poverty

INCOME SECURITY HEALTH PROMOTION PROGRAM

For patients experiencing disadvantage, engaging with the social welfare, tax and other government systems can be overwhelming, and may often seem impossibly complex to navigate. Referring a patient to an external agency can be a hit-and-miss affair, with health providers never really knowing whether the patient was able to access the services they need. In 2013, the team successfully advocated for funding from the Ontario Ministry of Health and Long-Term Care for a health promoter, and chose to focus this role on income security. The team now has two full-time income security health promoters.

The promoters work within the practice, directly with patients on improving their income security, for example by helping them file taxes in order to access social assistance. They advocate on a client's behalf with social welfare agencies, consolidating and reducing debt, and providing financial literacy education. Within the team, the promoters educate health care providers on the resources available to their patients. In the community they engage with other organizations focused on improving income security through interventions and advocacy.

From July 1 2018 to June 30 2019

1,034 referrals

95% of patients self-reported an increase in their financial literacy

27% received assistance in filling out an application for an income increase

46% of patients reported an income increase

$3,219 median income increase

Client impact: Income Security Health Promotion Program

A physician in the team knew that an elderly patient was having trouble adhering to the prescribed medication regimen because he could not afford his medications. They referred him to an income security health promoter, who met with him the same day, and discovered that he had not yet filed his taxes, which affected his eligibility for benefits.

In four sessions, the team was able to have the patient's taxes completed, forms filled out and sent in. The patient no longer has to pay for any of his medications. He was also able to access a higher level of seniors' income supports due to his low declared income. The team was able to remove a significant barrier to medication adherence and has committed to continue supporting this patient in attaining his financial goals, which include learning to budget and taking control over his finances.

HEALTH JUSTICE LEGAL SERVICES PROGRAM

The legal needs of low-income patients can be a significant barrier to dealing with illness and improving their health. In 2013, after years of joint advocacy and informal collaboration, a group of health and legal service providers came together to discuss individual and systemic issues common to their clients from communities experiencing disadvantage. Their discussions over the following year resulted in the creation of the Health Justice Legal Services Program, a partnership between a group of Legal Aid Ontario clinics and the St. Michael's Academic Family Health Team.

Now, when a primary care provider discovers that a patient is facing legal problems, they can refer them to an on-site lawyer. Legal issues related to housing account for approximately one fifth of referrals, such as chronic health effects due to disrepair and environmental health hazards, lack of accommodation for disabilities and risk of eviction. Family law is another key area. Clients sometimes disclose, for the first time, sexual, physical or emotional abuse and only do so because they are meeting a lawyer within a safe and trusted setting of their family doctor's practice.

Legal education for staff

To increase the level of collaboration, and to raise the skill level of health team providers in identifying legal issues that pose a barrier to health for their clients, the Health Justice Program also holds one-on-one and group teaching sessions for team staff and family medicine trainees. In 2018, the program introduced a regular education series, Health Justice Tuesdays, directed at primary care and legal professionals.

From April 2017 to March 2019

50%
of patients referred to social worker have at least one legal issue[1]

676
new case intakes

28
cases per month.

Client impact: Health Justice Legal Services Program

A senior faced great personal loss when her spouse, whom she had cared for during his final years, died. She and her spouse had separated years before but remained friends, and lived in the same building. Upon his death she was finally able to turn her attention to her own unit which had fallen into an unacceptable state of disrepair, exacerbated by the accumulation of decades of personal possessions. Her doctor referred her to the Health Justice Legal Services Program.

The team was able to navigate the high emotions she and her children faced, while explaining their right to safe housing yet no legal right to the deceased's larger unit. Through negotiations with the landlord, however, they were able to mediate a suitable arrangement for all: the client moved into her deceased husband's more accessible unit and avoided a stressful tenant application for repairs in her previous unit.

This negotiation was made possible by the extra supports the Family Health Team were able to provide for her personal care needs in the home. She, her family, her health care providers and the landlord were pleased by the agreeable outcome for all. This case is a good example of preventive, wrap-around service before a matter cascades into crisis.

REACH OUT AND READ LITERACY PROGRAM

Reach Out and Read, a program pioneered in the 1990s by Boston City Hospital, has generated strong evidence to show that this child literacy intervention improves pre-school vocabulary and language use, particularly for the most socially marginalized children.

In 2015, the St. Michael's Hospital Academic Family Health Team adopted the Reach Out and Read model, managed by a physician with training in child literacy. Currently, the program is delivered to all children aged 5 years and younger and their families at well-child visits at all six family medicine sites.

The program takes a three-pronged approach: literacy-rich waiting rooms; counselling families regarding the importance of reading in the infant, toddler and preschool years and giving them information on local literacy resources; and giving an age-appropriate, culturally diverse book to each child at each one of 10 well-child visits. The program operates in partnership with the Children's Book Bank, Toronto Public Library and First Book Canada.

As of June 2019:

Approx.
4,000
children aged 5 years and below cared for by the team

Program delivered to
3,216
children

Approx.
50%
of their families live in the two lowest income quintiles

A book given to a child during every one of their
5,376
clinic visits

Client impact: Reach Out and Read Literacy Program

Toronto is currently the child poverty capital of Canada , a fact borne out within the population of families attending the Academic Family Health Team. Relative to the team's overall patient population, a higher proportion of families with children aged five years and under are living on low income.

After assuming custody of her grandchild, a grandmother of a 2 year old remarked to the nurse after her well-child visit:

> ***"I didn't realize reading to kids at this age was so important. My doctor gave my granddaughter a book!"***

COMMUNITY ENGAGEMENT

Beyond the individual patient

In the St. Michael's Hospital Academic Family Health Team catchment area, community-based organizations, social welfare agencies and other organizations have long been working on the social determinants of health. Engagement with these entities is key to understanding a community's needs, and to successfully improving access to health care.

In 2014, the St. Michael's Hospital Academic Family Health Team identified a need for community outreach to engage with patients who did not have a long term primary care provider in the catchment area, improve access to primary care and quality of care for people experiencing disadvantage, and build community-informed programs and services addressing the social determinants of health.

Since 2015, the team has had a community engagement specialist to build partnerships with organizations and community members. Formal partnerships prioritize meeting populations where they are, and bringing clinical services into community settings, or creating formalized warm referral pathways to care. The community engagement specialist has also built informal partnerships with community agencies, schools, and networks. In these ways, St. Michael's Hospital partners with communities experiencing social marginalization, recognising that the local and regional communities are primary stakeholders.

Engagement strategy

Part of the community engagement process is to develop a robust engagement strategy that includes patient and community voices on optimizing primary care service design, delivery and organizational governance of primary care services, health professional education and research. The specialist has fostered community relationships and partnerships in priority neighbourhoods, in particular Regent Park, Moss Park and St. James Town. She has also identified the common barriers to accessing primary care faced by rostered patients and unattached people in the catchment area, and integrated the voice of patients and families in redesigning the practice's patient appointment booking system.

In 2015, the team opened its sixth clinic site, the Sumac Creek Health Centre, with a specific mandate to serve three underserved communities: Regent Park, Moss Park, and St. James Town. The community engagement specialist is tasked with ensuring these communities feel invested in the development of this clinic, and have an ongoing voice in its functioning. To date, the new clinic has rostered over 8,000 patients, mostly from these priority neighbourhoods, who did not previously have a primary care team.

GOING DEEPER: EQUITY, ADVOCACY, PARTNERSHIP

From work in addressing the social determinants of health through targeted programs, the logical next step for the St. Michael's Hospital Academic Family Health Team was to embed a systemic approach to equity in all of its operations and services. In 2017, the Social Determinants of Health Committee established working groups in four key areas: equity in programs and services, community engagement, advocacy, and racism and health.

The stages of health equity impact assessment

Icons: Flaticon.com

Source: Government of Ontario Ministry of Health and Long-Term Care

With a focus on the piloting and implementation of tools to assess all programs and services through a health equity lens, the first step was to gather information on the specific tools and approaches that can be used to inform equity-focused decision-making in a health care setting. What stood out in the literature on health equity impact assessment was the need for good data, which requires the team to dig deeper into patients' experiences and better identify the gaps in their care that result from their socio-economic circumstances.

Specific tools can be used to assess how a program and service is meeting the needs of populations that experience disadvantage. They have been used in other parts of the health system, including the Government of Ontario's Health Equity Impact Assessment. The working group reviewed the literature and others' experiences, and developed a team-specific assessment tool, which was piloted with the team's diabetes program. They then trained a wide range of health team members at a full-day workshop, and are now supervising its rollout throughout the health team.

The team is committed to mainstreaming the use of equity-oriented assessment tools and outcome evaluations throughout its programs and services, and is currently developing an infrastructure to embed this approach into day-to-day operations.

ADVOCACY

Social justice advocacy aims to work upstream from the family practice, to address the structural barriers facing those who are the most disadvantaged politically, economically, and socially, by the meta-determinants of health: not including structural racism, homophobia, transphobia, classism, colonialism, and ableism. Staff, primary care providers and trainees within the St. Michael's Hospital Academic Family Health Team have a long history of health promotion through social justice advocacy at the community and systems levels.

The Income Security and Health Justice Legal Services Programs' mandates include specific calls to engage in advocacy and law reform efforts, in collaboration with health team members, based on the issues being seen with clients. These programs have advocated on many issues, including access to harm reduction services, maintenance of income supports for people with disabilities, access to affordable housing, and improving pathways to citizenship for refugees.

Making advocacy available to all

The Social Determinants of Health Committee created an advocacy committee, tasked with making advocacy for healthy social change more accessible to all staff across the organization. It developed an advocacy framework that provides guidelines, a structured approach, and access to mentoring for health team members interested in engaging in advocacy.

The advocacy committee also developed a process to create a department-wide social justice advocacy campaign. The first advocacy campaign, called Healing Our Roots, launched in February 2019, focused on improving health care and cultural safety for people of Indigenous ancestry.

Healing Our Roots: A health equity approach to reconciliation

A critical barrier to high-quality primary care for Indigenous people and their families is the lack of culturally safe, trauma-informed health care designed in response to their needs.

Using the framework of the Calls to Action from two landmark national inquiries, the Truth and Reconciliation Commission of Canada and the National Inquiry into Missing and Murdered Indigenous Women, Girls and LGBTQ2+, the Healing Our Roots departmental advocacy campaign developed the following action plan:

- Consulting with Indigenous people to understand the structures that perpetuate the current status quo.
- Institutional transformation towards culturally safe clinical spaces for Indigenous people
- Offering Indigenous cultural safety training for all Family Health Team staff with ongoing expectations that all in our department understand Indigenous rights/anti-Indigenous racism.
- Building a community by fostering relationships for reconciliation, including traditional knowledge keepers, elders, and artists.
- Working with our hospital colleagues, especially the Emergency Department, and Indigenous communities to create pathways to care that meet Indigenous people's needs.
- Ensuring we teach essential knowledge of Indigenous health priorities to our medical learners.

RACISM AND HEALTH

Racism and health committee

Exploring and addressing how racism affects health is a new area of specific focus for the St. Michael's Hospital Academic Family Health Team. This focus on racism directly aligns with the strategic priorities of St. Michael's Hospital and the Truth and Reconciliation Commission. It also complements the ground-breaking work on addressing racism through Indigenous cultural safety training.

Since the Racism and Health committee was formed in 2017, foundational work on how the department can develop and implement anti-racial discriminatory practices and approaches at the learning and clinical levels has been funded. The Racism and Health committee aims to position the team as a primary care leader that embeds a lens of anti-racism and anti-racial discrimination in how it provides access to care, health outcomes and its learning and clinical environment. This work on addressing racism is led by a powerful group made up primarily of racialized women.

One of the main objectives of this new focus is to identify strategies to address racism in the learning and clinical environment. In 2019, the team conducted a scoping review that identified and synthesizes existing anti-racism interventions in health care settings. It is also supporting the capacity development of leadership, staff and learners in adopting an anti-racism lens to understand and transform views, practices and interactions with patients and staff. Another key objective is to assist with embedding racism as a determinant of health in the department's understanding of patient experience and in the development of primary care interventions.

EDUCATION, RESEARCH AND QUALITY IMPROVEMENT

Leading education on social determinants of health for health care providers

At the medical undergraduate level, the University of Toronto focuses on teaching about health inequities, advocacy and the social determinants of health through lectures, workshops, and in a hands-on way via partnerships with community agencies.

During the third year Family Medicine clerkship rotation at St. Michael's Hospital, students build competence in recognizing and addressing the social determinants of health.

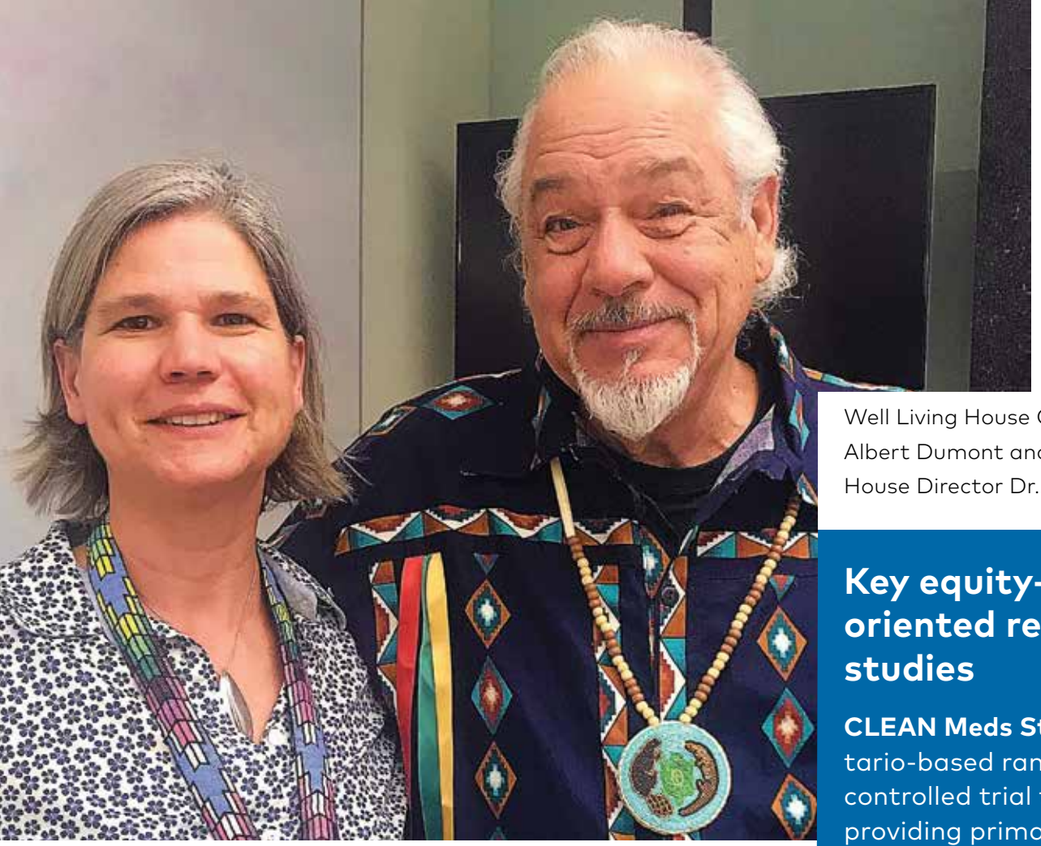
Trainees work in clinic with patients facing a wide range of diagnoses that often intersect poverty and other social determinants of health, including HIV, Hepatitis C, LGBTQ+ care, Indigenous health, and refugee health. An innovative homeless health experience has been created in which clerks spend two half days providing care at a homeless health drop-in or shelter setting, working with multidisciplinary teams to provide low barrier, evidence based medical care.

Direct experience

Students also develop an advocacy project that focuses on patients from communities experiencing disadvantage and attempts to provide real-time solutions to common issues facing their patients. Students are required to formally reflect on these experiences to further develop their skills and knowledge base in the field of health equity, social justice and vulnerable populations.

For postgraduate family medicine trainees, training exposes residents to high volumes of direct clinical exposure to individuals and groups experiencing social marginalization, including those affected by homelessness and poverty, LGBTQ+, those with serious mental health conditions and substance use disorders, Indigenous people, and new Canadians and refugees.

They are offered opportunities to work directly with the Family Health Team's unique social determinants-focused specialists, in income security and health justice, and to develop quality improvement and research projects focused on social determinants and health inequities. Seminars and mentorship opportunities throughout the residency program further reinforce learning in this area.



Well Living House Grandparent, Albert Dumont and Well Living House Director Dr. Janet Smylie

Equity-oriented research

The St. Michael's Hospital Academic Family Health Team benefits from the St. Michael's Hospital Department of Family and Community Medicine's primary care research program, the largest in Ontario among family medicine teaching sites. The team's researchers lead significant work in diverse areas, including global and international health, social determinants of health, immigrant and refugee health, Indigenous health, homelessness, primary care, pediatrics, and specific diseases including HIV and diabetes.

The Department supports eight clinician-scientists and many additional clinicians and interprofessional staff are actively involved in research. The Department also actively collaborates with external research partners in Ontario and beyond.

In 2018, there were 161 publications from the Department, which received over $6.5 million in research funding with departmental staff as primary investigators.

Key equity-oriented research studies

CLEAN Meds Study: Ontario-based randomized controlled trial that is providing primary care patients who can't afford their prescriptions with access to essential medications for free.

Screening for Poverty And Related social determinants and intervening to improve Knowledge of and links to resources (SPARK) Study: Multi-province randomized controlled trial to evaluate interventions to help address poverty.

Reconciling Relationships: Randomized trial involving multi-disciplinary health professionals (e.g. physicians, nurses, clerks, students) at St. Michael's Hospital using Indigenous Cultural Safety Training as an intervention.

QUALITY IMPROVEMENT

Integration into quality improvement programs

The team strives to improve the quality of care patients receive through a robust quality improvement program. The team has funded quality improvement specialists and lead physicians at all clinical sites. The quality improvement team has fostered its ability to focus on barriers to care for patients who experience social marginalization and vulnerability, and on improving equity in care. Initiatives include a specific focus on the health needs of disadvantaged groups, including patients living with HIV, patients with hepatitis C, and those who use opioids.

The team can now collect and cross-reference equity-relevant patient data on housing and employment status, income, language, and immigration status. These factors are correlated with common medical conditions to see if they may be contributing to barriers to care. For example, many patients with poorly controlled diabetes and those who have not completed regular screening for colon, breast or cervical cancer have been identified as more likely to live under the poverty line.

Client impact: Quality improvement programs

To improve cancer screening, the team realised that a system of sending reminder letters failed to support patients without a fixed address. With input from patients experiencing vulnerable housing and employment, the team ran a co-designed, patient-centered information workshop. It included information about cancer screening and provided on the spot cervical and breast screening and a meal. This change idea generated an equitable approach to improving cancer screening care for patients.

WHAT'S NEXT

One of the most note-worthy aspects of the Social Determinants of Health Committee is the high impact its programs have had relative to the modest level of funding they have received. However, over the years, many other initiatives and strong ideas have not come to fruition due to a lack of human and material resources. Most of the work of the Committee itself is undertaken in addition to members' regular job responsibilities, often on a volunteer basis.

Connect, invest, learn

The next phase of its work will have three major goals:

1. To ensure the Family Health Team prioritizes outreach to individuals and communities who are most in need of improvements in health. These include individuals experiencing homelessness and people of Indigenous background.
2. To further embed a systematic approach to identifying and addressing health inequities in every program and service the Family Health Team offers.
3. To disseminate its learnings to other primary care teams across Ontario and Canada in order to make health team action on the social determinants of health and health inequities a core, routine element of Canadian primary care.

The team warmly welcomes opportunities to partner with others wishing to invest in the health of Toronto's diverse communities experiencing disadvantage to create a more equitable, healthier and sustainable city.

Beyond its own neighbourhood, the St. Michael's Hospital Academic Family Health Team Social Determinants of Health Committee also encourages others who are working to address the social determinants of health and health inequities in health care settings – whether they are in Ontario, elsewhere in Canada, or in other countries – to reach out, connect, and learn from its novel expertise.

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Awards

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Award of Excellence in Creative Professional Activity, University of Toronto Department of Family and Community Medicine, 2019

Bright Lights Award for Patient and Family Centered Care, the Association of Family Health Teams of Ontario, 2019.

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I'm very excited that a group of clinicians are taking seriously what I've been arguing about the social determinants of health, which at first glance sound like they have not much to do with doctors. The team recognise that they have a mixed population in that part of Toronto, and that the hospital has a community it serves. It's important to get the evidence to see what works and what doesn't, but I was very impressed with what they're trying to do."

Sir Michael Marmot, Director, The UCL Institute of Health Equity and chair of the WHO Commission on Social Determinants of Health

The St. Michael's Academic Family Health Team has been at the forefront of Canadian and international efforts to create, evaluate and implement approaches to addressing the social determinants of health and health inequities for front line health providers. They are paving the way for a new approach to medical care, especially in primary care, that will enable us to ensure every patient has a solid social foundation from which to improve and maintain their health."

Dr. Sandy Buchman, President, Canadian Medical Association, 2019-2020

The St. Michael's Academic Family Health Team has been instrumental in demonstrating the potential for family physicians and their teams to directly address health inequities and the social determinants of health – important elements of the College of Family Physicians of Canada's Patient's Medical Home. Their work is being discussed and replicated throughout the family medicine community in Canada, and I expect will affect the culture of Canadian family medicine for years to come."

Dr. Paul Sawchuk, President, College of Family Physicians of Canada, 2018-2019