Integrating social justice advocacy into a family health team

Successes and lessons learned

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Abstract

Problem addressed Health is largely determined by socioeconomic factors. Health care providers can potentially address these factors through social justice advocacy. However, many individual providers and teams have not taken on this role in Canada.

Objective of program To address identified barriers in integrating social justice advocacy into the practice of individual health care providers and interdisciplinary teams.

Program description An Advocacy Tool Kit was created in 2017 to build individual capacity for social justice advocacy. An advocacy framework was adopted in 2018 that reiterated the commitment of the Department of Family and Community Medicine at St Michael's Hospital in Toronto, Ont, to social justice advocacy and outlined 2 new processes: to adopt and implement specific departmentwide campaigns to advocate for social justice; and to respond to inquiries about social justice issues and external advocacy campaigns.

Conclusion The initiatives have helped integrate social justice advocacy into the core activities of the interdisciplinary primary care team and can likely be replicated by other interested groups across the country.

Editor's key points

- Investing in organizational advocacy infrastructure in primary care has great potential to fulfil the advocacy responsibilities of health care providers as defined by the College of Family Physicians of Canada and other professional organizations. Fulfilment of these responsibilities is a step toward substantively changing the socioeconomic factors that impair health in disadvantaged communities.
- The Advocacy Tool Kit, framework, and committee structure of the St Michael's Hospital Academic Family Health Team provide examples of the practical elements required to embed social justice advocacy within academic primary care teams.
- Leaders in other primary care groups are encouraged to build a coalition of interested colleagues, seek to understand current comfort levels and needs around advocacy capacity within their organizations, and to deliberately take steps to integrate social justice advocacy into clinical work.

Intégrer la promotion de la justice sociale dans une équipe de santé familiale

Réussites et leçons apprises

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Points de repère du rédacteur

- L'investissement dans une infrastructure organisationnelle de promotion de la justice sociale dans les soins primaires peut aider considérablement les professionnels de la santé à assumer leurs responsabilités en matière de plaidoyer, comme les définit le Collège des médecins de famille du Canada et d'autres organisations professionnelles. L'accomplissement de ces responsabilités représente un pas de plus pour changer de manière substantielle les facteurs socioéconomiques qui nuisent à la santé dans les communautés défavorisées.

- La trousse d'outils, le cadre d'action et la structure des comités de l'Équipe universitaire de santé familiale de l'Hôpital St Michael servent d'exemples des éléments concrets nécessaires pour ancrer la promotion de la justice sociale dans les équipes universitaires de soins de première ligne.

- Les dirigeants d'autres groupes de soins primaires sont encouragés à former une coalition de collègues intéressés, à chercher à comprendre les actuels niveaux de confort et besoins relatifs à la capacité de plaider en faveur de la justice sociale dans leurs organisations, et à prendre délibérément des mesures pour intégrer la promotion de la justice sociale dans le travail clinique.

Résumé

Problème à l'étude La santé est largement déterminée par des facteurs socioéconomiques. Les professionnels de la santé pourraient lutter contre ces facteurs en plaidant en faveur de la justice sociale. Par ailleurs, de nombreux professionnels, à titre individuel ou collectif, n'ont pas exercé ce rôle au Canada.

Objectif du programme Éliminer les obstacles identifiés à l'intégration de la promotion de la justice sociale dans la pratique des professionnels de la santé à titre individuel et au sein des équipes interdisciplinaires.

Description du programme Une trousse d'outils sur la promotion a été produite en 2017 pour renforcer les capacités individuelles de plaider en faveur de la justice sociale. Un cadre de plaidoyer, adopté en 2018, réitérait l'engagement du Département de médecine familiale et communautaire de l'Hôpital St Michael à Toronto (Ontario) à l'égard de la promotion de la justice sociale et présentait 2 nouveaux processus : adopter et mettre en œuvre des campagnes spécifiques de promotion de la justice sociale, à l'échelle du département; et répondre aux demandes concernant les problèmes de justice sociale et appuyer les campagnes de promotion de l'extérieur.

Conclusion L'initiative a aidé à intégrer la promotion de la justice sociale dans les principales activités de l'équipe interdisciplinaire de soins primaires et peut probablement être imitée par d'autres groupes intéressés dans toutes les régions du pays.

Health is largely determined by socioeconomic factors. Social determinants of health (SDOH) are rooted in historic, cultural, and political power relations such as colonization, systemic racism, ableism, and gender inequality.[1]

Health care providers can tackle negative health outcomes by addressing SDOH through social justice advocacy in communities, institutions, and society. Health care providers' responsibility to engage in advocacy has been emphasized by the College of Family Physicians of Canada,[2] the College of Nurses of Ontario,[3] and the Canadian Association of Social Workers.[4]

The St Michael's Hospital Academic Family Health Team in Toronto, Ont, adopted the following definition of *social justice advocacy:*

> Social justice advocacy works for structural and enduring changes that increase the power of those who are most disadvantaged politically, economically, and socially. It tackles the root and avoidable causes of inequities for those who are systematically and institutionally disadvantaged by their race, ethnicity, economic status, nationality, gender, gender expression, age, sexual orientation, or religion.[5,6]

Advocacy by health care providers includes actions that promote changes to "ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise."[7]

Several frameworks exist to guide health advocacy and medical education[8,9]; however, taking action can be daunting for individual providers and teams owing to competing demands on time, inadequate resources, and system constraints.[10] Our review of the medical literature and an informal scan of advocacy efforts within primary care in Canada revealed high-level descriptions of advocacy work within community health centres (CHCs) but few details on organizational process or examples of advocacy in academic family medicine.

Our program was intended to address this gap by creating and implementing an interdisciplinary team–based framework for systemic advocacy within primary care. We describe below the history of the St Michael's Hospital Academic Family Health Team's (SMH AFHT's) formal involvement in social justice advocacy, steps taken to perform advocacy, and preliminary outcomes and challenges. Our aim is to help other primary care groups embed advocacy in their approach to health care.

Objective of program

The SMH AFHT is a multidisciplinary, multiclinic primary care organization in Toronto's downtown core serving approximately 50 000 rostered patients, including a higher-than-average proportion of people in the lowest income quintile and people who are vulnerably housed or experiencing homelessness.[11]

Building on a long history of commitment to community and social accountability, the SDOH Committee was created in 2013 by the SMH AFHT with a vision "to ensure the [SMH AFHT] is invested with the knowledge, skills, tools, and programs to advance health equity."[11,12] The SDOH Committee reports to the SMH AFHT leadership team. In 2016, an Advocacy Working Group was formed with the mandate to develop an equity-oriented advocacy framework for the SDOH Committee and the SMH AFHT. The membership of the working group has evolved as we sought to ensure appropriate diversity of professions and clinic sites. The average number of members at any one time has been 5.

Initial discussions with colleagues revealed diverse perspectives and some trepidation regarding our team's capacity to agree upon priorities, coordinate activities, and execute advocacy given our large, complex clinical environment. To more formally gauge staff buy-in, we delivered a presentation to staff and conducted a survey in October 2017 to determine departmental support for, comfort with, and barriers to systemic advocacy initiatives.

Forty-eight staff members responded to the survey, with representation from physicians (n=29), nurses (n=6), allied health care providers (n=5), and clerical staff members (n=6), among others. Of those surveyed, 83% (n=40) thought that system-level advocacy is probably or definitely a responsibility within their professional role, but only 56% (n=27) thought that it was definitely or probably part of their job description. Sixty percent (n=29) of respondents reported they had been previously involved in systemic advocacy. Ninety-three percent (27 of 29) of those reporting advocacy experience felt "somewhat" or "very" comfortable with advocacy. Most staff members without experience did not feel comfortable advocating social justice.

The most common barriers to engaging in systemic advocacy initiatives identified by respondents were a lack of knowledge or skills, lack of time to participate, and not knowing where to start. Several participants also identified lack of compensation as a barrier and a few identified concerns about repercussions from their managers or departmental leadership as a barrier. Several identified barriers are consistent with previously published reports on barriers to participating in advocacy.[10]

The Advocacy Working Group's subsequent initiatives were intended to address common barriers to participation in advocacy by disseminating knowledge and building skills within the SMH AFHT and by harnessing the collective interest and commitment of departmental staff toward advocacy for social justice as an organization.

Program description

The working group disseminated a 33-page Advocacy Tool Kit[13] for staff and learners at the same time as the staff survey in 2017. The Advocacy Tool Kit was created by the Advocacy Working Group, drawing on the

advocacy experiences of Toronto-based physicians and allied health care providers, as well as on models developed by the Registered Nurses' Association of Ontario and Physicians for Human Rights. The Advocacy Tool Kit introduces a rationale for social justice advocacy by health care providers, steps for launching or participating in an advocacy campaign (**Table 1**),[13] and resources for specific advocacy methods including examples.

Guidelines on how to identify one's professional affiliations while participating in advocacy campaigns and institution-specific limitations on participation were devised in consultation with Department of Family and Community Medicine (DFCM) leaders and communications personnel from St Michael's Hospital.

Following the launch of the Advocacy Tool Kit, the Advocacy Working Group proposed an advocacy framework (**Box 1**)[13] that outlined processes to expand advocacy from activities undertaken by individual members of the DFCM to activities organized, supported, and promoted by the DFCM as a whole. The framework was formally endorsed by the DFCM's leadership team in 2018. This framework reiterated the DFCM's commitment to social justice advocacy and outlined 2 new processes:

- for the SMH AFHT to adopt and implement specific, DFCM-wide social justice advocacy campaigns; and
- for the SMH AFHT Advocacy Working Group and leadership to respond to inquiries related to social justice issues and external advocacy campaigns.

Given the novelty of the framework, the Advocacy Working Group spent several months disseminating it in multiple formats including presentations at staff meetings, clinic team meetings, and electronic communications.

Departmental advocacy project. The first arm of the framework is the departmental advocacy project. This is a novel, detailed process for the SMH AFHT to solicit, collectively consider, debate, endorse, and assign

Table 1. Steps to launch an advocacy campaign included in the Advocacy Tool Kit

SUGGESTED STEPS	RECOMMENDED ACTION
Step 1: identify the issue	• Research the issue and explore the political climate • How does it relate to your organization's activities or mandate?
Step 2: connect with allies; join a coalition or build your own	• Identify peer partners and learn from people with lived experience • Are other team members working on similar issues? • Who else might be interested in the issue? -Community organizations and unions -Academic institutions and professional organizations -Media contacts
Step 3: set a campaign objective and target	• Set a SMART objective • Who can effect change? -Organization -Municipal, provincial, or federal government • Determine your available resources
Step 4: choose your strategy and tools	• Individual action vs coordinated campaign • Determine specific messaging • Choose a strategy and use advocacy tools based on your SMART objectives -Direct action, eg, rally, march, sit-in, demonstration -Editorials and blogs -Media releases, press conferences -Online or paper petitions, eg, Change.org -Public education or town halls -Lobbying of institutions and politicians -Deputations and submissions to government -Legal action, eg, human rights tribunal -Social media blitzes or campaigns -Clinical tools and education -Research, eg, participatory action research
Step 5: determine how you will identify yourself	• Determine how you will identify yourself -City-based health care provider -University affiliate -Organizational staff member
Step 6: implement and evaluate	• How will you measure success? • What are your intended outputs? • Evaluate strategies, messaging, and partnerships

SMART—specific, measurable, achievable, relevant, time-bound.
Reprinted with permission from the St Michael's Hospital Academic Family Health Team.[13]

Box 1. Novel advocacy tools developed by the SMH AFHT in Toronto, Ont

Departmental advocacy framework
Responsive advocacy process
- Process and criteria used to respond to time-sensitive advocacy requests from staff within the DFCM or from community partners, eg, request for the DFCM to sign a letter advocating increased affordable housing

Departmental advocacy project
- Proposals actively solicited from departmental staff
- Collectively considered, debated, and voted on through a formal process
- Dedicated departmental resources to support the selected project

Advocacy Tool Kit
The Advocacy Tool Kit[13] was created by physicians with extensive social justice advocacy and government policy experience. It builds off medical curricula and continuing medical education endeavours from the past decade. It provides stepwise guidance for launching an advocacy campaign and details methods that can be used such as letters, editorials, media releases, deputations, government submissions, direct action, public education, political lobbying, social media blitzes, medical education and research, and legal action

AFHT—Academic Family Health Team, DFCM—Department of Family and Community Medicine, SMH—St Michael's Hospital.

resources to a single large, well-coordinated campaign for social justice advocacy every 1 or 2 years. The aim is to leverage the resources and influence of the SMH AFHT to make a substantial and measurable difference on a social justice issue of importance to our team and community. In the October 2017 staff survey, most respondents supported the idea of a departmental advocacy project.

Over the course of several months in 2018-2019, the inaugural selection process for a departmental advocacy project was completed. A total of 5 proposals were received. The SDOH Committee reviewed the proposals in detail and selected 2, which were presented at a staff meeting and voted on in person or online for 1 week after the meeting. A 50% minimum departmental turnout was necessary for the results to be valid.

Sixty-eight percent (126 of 186) of the DFCM participated in the vote. The inaugural SMH AFHT departmental advocacy project was called "Healing Our Roots: A Health Equity Approach to Reconciliation." The project focused on supporting the SMH AFHT to take "concrete steps ... to create and become champions of culturally safe spaces and practices to promote the highest level of inclusion possible for Indigenous patients."[14]

The criteria used to evaluate each of the proposals throughout the process were the following:
- There is a need identified by the community.
- There are stakeholder partners.
- There are opportunities to engage patients in the campaign.
- The campaign aligns with the mission of St Michael's Hospital and the DFCM's strategic plan.
- The DFCM can bring a unique perspective and expertise to the issue.
- There is capacity within the DFCM.
- There may be an evaluation or research component.

Other departmental advocacy project proposals included a project to support decision making for patients with developmental disabilities, an initiative in support of pharmacare, and an initiative to assist older adults transitioning from provincial income support to senior-specific income support.

Responsive advocacy. The second novel process in the framework is the responsive advocacy process. The SMH AFHT members and leadership are often presented with community- or system-level issues that affect the health of our patients, along with requests from staff or community organizations to support campaigns or to intervene in these issues. The issues vary in their complexity and time sensitivity, as does the intensity of resources required to understand and respond.

To streamline the DFCM's ability to respond to these issues and to increase support for staff looking to engage in advocacy, the advocacy framework established a process to review these requests and provide support and mentorship where appropriate. Participation in this process is not mandatory and is meant to be supportive.

In the first year after the framework's release, 7 requests were made through this process. Dispositions of these requests included directing the requestor to the Advocacy Tool Kit, recommending that the idea be submitted through the departmental advocacy project, recommending petitions be circulated to individual practitioners in the DFCM for sign-on, and recommending signing of petitions as a department. The Advocacy Working Group made itself available to all requestors for discussion, mentorship, and support.

Discussion

Although advocacy has long been recognized as a professional obligation for health care providers[2-4] and numerous primary care organizations have stated they are committed to advocacy (eg, Inner City Health Associates[15]), a recent literature review suggests that processes created to facilitate organization-level advocacy in our framework are unique among primary care teams in Canada (G. Bloch, unpublished data, 2019), with the possible exception of CHCs. Many CHCs in Ontario have long embedded advocacy into their work (eg, Somerset West CHC[16]); however, little published information describes their organizational advocacy infrastructure[17] or evaluates this work.

Our project developed an organizational framework for social justice advocacy that was endorsed by the

DFCM's leadership and members. Its preliminary success was demonstrated by the execution of an inaugural departmental advocacy project focused on Indigenous health and reconciliation, which included funding and protected staff time from the SMH AFHT.

We believe the project's success was built on the following interconnected factors.

- The work built on and occurred within the context of a historic departmental commitment to social justice advocacy, formalized both individually and collectively through the creation of the SDOH Committee.[12] Importantly, the processes outlined were designed and communicated as complementary to, and certainly not restrictive of, any individual's or group's independent advocacy efforts. Some experienced advocates were concerned that this framework would become mandatory in some way and thus have the potential to stifle their ongoing independent advocacy efforts. This was not reported to be the case.
- The work engaged leadership and colleagues through a needs assessment and through both informal and formal continuing medical education.
- A commitment was made to democratic principles in selecting the departmental advocacy project, including the following:
  -a deliberate process for selecting the departmental advocacy project to ensure that staff had opportunities to raise concerns and provide input to promote buy-in and support for the initiative we eventually selected;
  -thresholds for minimum staff turnout and minimum overall support when voting on a project; and
  -transparency in the process and in membership of the committees involved in the process.

This groundwork has shown enough promise in terms of acceptability and feasibility within the SMH AFHT that advocacy now features prominently in all elements of our 2020 to 2025 strategic plan, including the mission, vision, and specific strategic objectives. For example, the vision of the SMH AFHT is now to be "global leaders in the teaching, study and practice of equity-driven primary health care and *advocacy*" [emphasis added],[18] whereas the vision in the previous strategic plan more generally mentioned excellence in urban primary health care.

Further evaluation will be considered, including qualitative interviews of those involved in departmental advocacy projects and a survey of DFCM members to gauge attitudes and comfort levels with advocacy. A challenge in carrying out such a survey will be ensuring a representative, non–self-selecting cross section of our large department. Another measure of impact over time could be the extent to which similar processes or frameworks are undertaken in various primary health care teams across Canada.

While the SDOH Committee has incorporated expert advisors who have lived experience, the Advocacy Working Group has yet to involve patients or community members in its deliberations. Involvement of people with lived experience is a priority for this group in the future.

Conclusion

Investing in organizational advocacy infrastructure in primary care has great potential to fulfil the advocacy responsibilities of health care providers as defined by the College of Family Physicians of Canada and other professional organizations. Fulfilment of these responsibilities is a step toward substantively changing the socioeconomic factors that impair health in disadvantaged communities. Our team's Advocacy Tool Kit, framework, and committee structure provide examples of the practical elements required to embed social justice advocacy within academic primary care teams.

We encourage leaders in other primary care groups to build a coalition of interested colleagues, seek to understand current comfort levels and needs around advocacy capacity within their organizations, and to deliberately take steps to integrate social justice advocacy into clinical work. Our experience demonstrates that if you build it, they will come.

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Contributors
All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

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None declared

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