IMPROVING CARE AND SUPPORT FOR NEWCOMERS DURING PUBLIC HEALTH EMERGENCIES

Learnings from the COVID-19 Pandemic

ASSOCIATION CANADIENNE DES CENTRES DE SANTE COMMUNAUTAIRE

CANADIAN ASSOCIATION OF COMMUNITY HEALTH CENTRES

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- Access Alliance Multicultural Health and Community Services (Toronto, ON)
- Mount Carmel Community Clinic (Winnipeg, MB)
- REACH Community Health Centre (Vancouver, BC)
- Somerset West Community Health Centre (Ottawa, ON)
- Umbrella Multicultural Health Co-operative (New Westminster, BC)

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1. INTRODUCTION

When emergencies happen at the local, provincial, or federal level immigrants and refugees, racialized and ethnic minorities, and lower-income people are often disproportionately affected. This holds true for the COVID-19 pandemic. Statistics Canada data from July 2020 shows that Canadians - who are not Indigenous or a visible minorities - have an unemployment rate of 9.3%. However, the unemployment rate for South Asian and Arab Canadians stood at 17.8 and 17.3 percent respectively.[1] Black Canadians had an unemployment rate of 16.8 percent. Even more strikingly, in Toronto, 83% of people who tested positive for COVID-19, are racialized, while only making up 53% of the population. Torontonians in the lowest income bracket ($0-$29,999) are 14% of the population yet make up almost one third of cases.[2] COVID-19 has clearly exposed and increased many long-standing inequities that these groups experienced prior to the pandemic including access to equitable healthcare, and other key social determinants of health, such as: affordable food, housing, and employment.[3, 4]

Newcomers[5] are at higher risk of being impacted negatively by COVID-19 for several reasons. There is a recognized lack of culturally appropriate and translated health-related information available.[6] They also face additional barriers when trying to access and use virtual care options because of lack of access to the internet, poorer computer literacy and language barriers. Newcomers, who often have fewer social contacts when compared with Canadian born people, are faced with an increased risk of social isolation, leading to poorer mental health.[7]

Community Health Centres (CHCs) are recognized leaders in providing culturally competent care, which addresses the social determinants of health.[8] CHC staff are trained and sensitive to challenges faced by many groups experiencing health inequities, including newcomers, and as such, they are well-positioned to continue to provide quality care during health emergencies like COVID-19. Furthermore, many CHC clients are racialized, newcomers, and/or are population groups that experience disproportionate rates of poverty.

This project engaged CHC staff and their clients with the following key goals:

- Improving understanding of the risks facing newcomers in terms of experiencing poorer outcomes during public health emergencies like COVID-19;
- Documenting experiences at CHCs in providing continuous care and support for newcomers during the pandemic, including highlighting gaps and lessons learned;
- Developing promising practices to help all CHCs across Canada to improve effectiveness and quality of services and supports for newcomers during public health emergencies.

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The project draws upon previously developed guidelines for immigrants and refugees such as Evidence-based clinical guidelines for immigrants and refugees (2011) which practitioners from CHCs, such as Access Alliance Multicultural Health and Community Services, helped to create.[9] These and other guidelines/educational resources[10, 11, 12] reinforce the importance of supporting newcomers equitably, particularly those who are non-English or French speaking, non-European, and/or lower income newcomers. This is because they are at even greater risk of poorer health in a variety of areas including access to appropriate prevention, care and treatment services.

2. PROJECT ACTIVITIES

This project was conducted between June 2020 and July 2020. At the start of the project, an expression of interest was sent out to ten CHCs across the country, which explained the scope of the project, its aim and the necessary time commitment, including reaching out to and engaging one/two newcomer clients to participate in the project.13 Based on replies to the expression of interest, five CHCs, with significant experience in immigrant and refugee health, participated in the project:

1. Access Alliance Multicultural Health and Community Services (Toronto, ON)
2. Mount Carmel Community Clinic (Winnipeg, MB)
3. REACH Community Health Centre (Vancouver, BC)
4. Somerset West Community Health Centre (Ottawa, ON)
5. Umbrella Multicultural Health Co-operative (New Westminster, BC)

At the first project meeting, the CHC representatives brainstormed issues that, in their experience impact the provision of effective and high-quality healthcare to newcomers during health emergencies, such as COVID-19. These issues became the areas of focus that framed the project:

- Addressing literacy and language
- Providing access to interdisciplinary, community-based primary care
- Making available in-person and virtual communication methods (interpretation and national repository for translated materials)
- Creating trusting environments by committing to cultural competency, safety and humility
- Ensuring that inter-CHC communications are clear, consistent and transparent

Distinct interview guides, one for CHC staff and one for clients were created (see appendix for interview guides). The guides, which included open ended questions and scales, enabled the project team to collect quantitative data and qualitative information to:

- Describe the experiences of CHC staff and clients in providing and receiving care during COVID-19, and the activities and strategies used to improve care and support for newcomers during COVID-19
- Identify promising practices that can inform the care and support provided to newcomers during future health emergencies

Overall, five CHC staff, including managers and frontline employees, and nine newcomer clients participated in the interviews. They eagerly and willingly provided a wealth of information in a relatively short period of time and their experiences provided a foundation from which to describe the promising practices outlined below.

3. WHAT WE HEARD FROM CLIENTS AND STAFF DURING THE PROJECT

The section which follows presents findings grouped into the five areas of focus.

LANGUAGE ACCESS AND LITERACY

> ***"It would be great if CHCs provided some resources or links to support that would help me learn English, because I've been so isolated, I want to work to improve my English."***
>
> —SWCHC Client

When asked to rate their ability to obtain and understand health-related information during COVID-19, clients noted that they received some information from their CHC but would have appreciated more. Average ratings for obtaining and understanding health information were 7/10. Some clients noted that the news, YouTube, daily briefings, and newspapers were their primary sources of information regarding the pandemic. Where information was unavailable in their native language, clients often searched for information on social media (e.g., Facebook). Mainstream media often only provided information in English. Services like Google Translate and YouTube allowed clients to receive information in their native languages.

From the perspectives of CHC staff, while one-on-one interpretation was often readily available, there were sometimes challenges with securing interpretation for Zoom group programming, particularly when interpretation was required for more than one language. One CHC staff member noted, "It is challenging to get different language interpreters in one zoom call due to time constraints".

CHC staff noted that they needed to spend a significant amount of time to find and provide information to clients about COVID-19, including COVID-19 financial support programs (e.g. CERB). They also noted that they needed to spend a great deal of time reading and reviewing COVID-related information shared internally by CHC colleagues or by other organizations and that this became overwhelming as time went on. They suggested appointing one person from the organization with responsibility for collecting and disseminating the most relevant COVID-19 information to both staff and clients, using standardized messages.

ACCESS TO ONGOING, INTERDISCIPLINARY, COMMUNITY-BASED PRIMARY CARE

> ***"Sometimes I want to see the doctor. During the pandemic, it was hard to make an appointment. I want to see someone face to face, not over the phone."***
>
> —Access Alliance Client
>
> ***"They treat me like home" "I can say Access Alliance, anytime I knock, they open for me and I just go in."***
>
> —Access Alliance Client
>
> ***"There are some things I want to see my doctor in person for, so I will wait to see him until later."***
>
> —REACH Client

During the pandemic access to and delivery of care varied among the participating CHCs. As a result, clients reported variable experiences and satisfaction with their care during COVID-19. For example, not all of the CHCs involved in this project were able to deliver primary care to clients via telephone check-ins; and some clients reporting having to wait a long time to make contact with their care team by telephone.

While core primary care services (physician and nursing care) remained available at all of the CHCs, clients stated that there should have been greater access to information and services from allied health providers. One client noted, for example, that "there was not specific information available about mental or social health", while another client stated that the "CHC did not provide assistance for connecting with food and housing". Clients also expressed concern and confusion about the impact of COVID on important processes and services, for example, prescription filling and refilling.

Finally, clients reported that it has been challenging to see a doctor in-person/face-to-face during

COVID. One patient who was undergoing colon cancer treatment explained how grateful she was to continue to receive in-person support and care and was very grateful that a nurse from her CHC came to her home to provide the care she needed.

AVAILABILITY OF BOTH IN-PERSON AND VIRTUAL COMMUNICATION OPTIONS

"It was not clear to me right away that there was an option for virtual care... would have loved to be able to see the doctor via Zoom".

—UMHC Client

"Telephone and video conference [are] available, but difficult because you can't fully express how you feel (they don't take temperatures or vitals); particularly with language barriers."

—MCCC Client

During the pandemic, technology provided important opportunities for service and program continuity. The CHCs that participated in the project had to pivot quickly in response to the pandemic, with most transitioning to the use of virtual platforms for communication and service delivery. For example, a rapid transition was made from in-person clinical consultations, appointments, and group programs to ones conducted by telephone or video platforms such as Zoom.

CHC staff discussed the different virtual programs that they were using to support clients, including newcomers, during the pandemic, and felt that the transition to virtual programs were having a positive impact on newcomers.

However, immigrants and refugees who do not have access to adequate internet services or technology or who have low digital fluency are at risk of being further marginalized and isolated during health emergencies when traditional in-person interactions are severely limited.

CULTURAL COMPETENCE, SAFETY AND HUMILITY

CHC staff stated that the pandemic did not change their capacity to provide culturally supportive and safe spaces.

The newcomers that were interviewed for the project stated that they are grateful to be CHC clients. Many stated that, in comparison to their previous experiences with other health service providers, they feel more respected, cared for, understood and appreciated at their CHC.

Feedback from clients suggests that, despite some of the challenges, CHCs have remained trusted service providers during COVID. Feedback from clients indicates that CHCs remained client centered and attuned to their client's unique cultural and social determinants of health needs and priorities.

"They smile, and receive me well and accept me for who I am."

—SWCHC Client

"The health care team is understanding, and I am happy with the services. I do not feel any difficulty due to my culture from my family doctor"

—REACH Client

"They value your culture. Especially, Vancouver, is very multi-cultural. People in the center [CHC] are diverse in their staffing. People respect you and understand the differences. When you go, someone talks to your language, you feel... It's kind of relieving."

—UMHC Client

CONSISTENT, TRANSPARENT AND CLEAR INTRA-CHC COMMUNICATION

Good communication between staff members within CHCs is crucial, particularly during health emergencies when there are constant changes and newly emerging information. Furthermore, there are many sources of information across all levels of government that can be challenging and overwhelming for healthcare agencies to navigate.

4. PROMISING PRACTICES

This section describes promising practice for promoting and supporting the health of immigrant and refugee populations during public health emergencies. It is hoped that these practices will eventually become recognized best practice and will also provide guidance and support to CHCs and other agencies across Canada during health emergencies as well as in everyday practice when providing care and support to vulnerable communities and populations. A tool for implementing some of these practices is found in Appendix B.

In the context of COVID-19, these promising practices will be of particular importance in how treatments and vaccines are introduced.

LANGUAGE ACCESS AND LITERACY

Delivering quality health care to immigrant and refugee clients during a public health emergency, such as COVID-19, includes providing access to and/or delivering information that is clear, concise, evidence-based and provided in the language and format (text, speech) preferred by the client. Clients should be able to obtain, understand and use information easily.

To improve practice in this area, CHCs can:

- Develop a regular process for identifying the languages that their clients understand, speak, and read. CHCs across Canada can refer to their database and the most recent census data to determine the newcomer languages most prevalent not only in their roster but also in their region.
- Provide professional interpretation for clients who speak languages other than those of CHC staff. CHCs can use data to plan for and secure trained and qualified interpreters that match the language needs of their clients and should avoid using family members or friends as interpreters. CHCs can leverage the diversity of service channels that are now available, such as face to face, telephone, and video to secure language access services for clients.
- Provide clients with a list of evidence-based and/or reputable written resources that they can read to inform themselves about public health developments, recommendations, and guidelines.
- Deliver accurate and consistent responses in the client's preferred language to requests related to government support programs (e.g. income supports) enacted or introduced during the emergency.
- Create a hotline that clients with different language needs can use to access information or ask questions about the public health emergency. Advertise the hotline with clients through a range of accessible communications vehicles such as email, telephone or website.
- Make available documents or resources that are written in clear/plain language.
- Make key resources available in the different languages spoken by clients served by the CHC
- Use translated materials that are accurate and culturally-appropriate, and which use links (e.g., to municipal, provincial, or federal health websites) that contain information that has been translated to the client's language.
- Disseminate weekly updates that provide an overview of highlights/key messages to clients.

ACCESS TO ONGOING, INTERDISCIPLINARY, COMMUNITY-BASED PRIMARY CARE

Delivering quality health care to immigrant and refugee clients during a public health emergency, such as COVID-19, includes providing ongoing access to an interdisciplinary team of primary care professionals that can provide wrap around services that address biopsychosocial needs. Clients should know how their care will or will not change during the emergency period and how to access members of their care team.

To improve practice in this area, CHCs can:

- Create communication plans within the organization that will foster connection, collaboration and coordination between diverse practitioners and team groups, within the primary care team (i.e., between physicians, nurses, dietitians, social

workers, et al) and across programs (i.e., between primary care, mental health outreach, food security, housing support, et al) during the emergency.

- Create streamlined referral pathways to facilitate timely and smooth access by clients to the full range of primary care, health promotion, and social support services and programs that they may need during the emergency.
- Develop and implement Integrated Client Care Plans during the emergency. Care plans can include processes for assessing/triaging clients to guide the team in providing appropriate levels of care to different clients during the emergency. For example, clients with complex health conditions, or vulnerable and isolated clients may be contacted more regularly during the emergency
- Redeploy staff from administration or health promotion to check in on clients, especially those identified as high need, during the emergency
- Provide clear information right from the outset of a public health emergency explaining to clients how timely access to their medications will be facilitated.
- Clearly communicate to clients how their access to interdisciplinary care and support will work/change during the pandemic.
- Ensure that all providers and CHC management deliver a consistent message to clients and that communications are reviewed and updated to reflect real time changes throughout the emergency.

AVAILABILITY OF BOTH IN-PERSON AND VIRTUAL COMMUNICATION METHODS

Delivering quality health care and support to immigrant and refugee clients during a public health emergency, such as COVID-19, includes making face-to-face and digital options available to maximize access to the full range of primary health care services that newcomers need.

To improve practice in this area, CHCs can:

- Assess the service access needs of every client, particularly those at highest risk of isolation
- Offer clients options for face-to-face, telephone, and other virtual interactions, based on their access needs.
- Develop a Virtual Care Plan with clients who have digital access and fluency. Clearly discuss with the client what virtual care will mean for their health care experience and steps/processes that are involved.
- Remind clients regularly of the opportunity to continue their care with the CHC using virtual options, and provide instruction as to HOW to do this.
- Redeploy staff (i.e., from administration or health promotion) to work with clients who require additional support (i.e., skill building/education) to improve their digital literacy or fluency.[14]
- Continue to deliver group programming where possible by employing digital platforms such as Zoom where in person programming is not possible.
- Develop and make available social support groups in languages spoken by the clients served by the CHC.
- Equip staff with the skills required to facilitate groups either digitally and/or in person for clients who are particularly isolated and who would benefit from social connections during the emergency. In addition, help staff to effectively use interpretation for digital group programming
- Set up processes to help clients who do not have access to the internet contact the CHC to ask questions and to receive real time information. For example, create a telephone hotline at the CHC that clients can call if they have questions about the public health emergency, allowing them to ask questions in the language that they are most comfortable speaking.
- Personally check-in with all clients regularly, using the client's preferred communications option, (ideally once every two weeks; once a week for older clients or clients with complex needs who live alone) to inquire about their health and well-being. Include questions such as:
  - » What day to day needs are you feeling/ experiencing right now?
  - » How are you maintaining social connections?

CULTURAL COMPETENCE, SAFETY AND HUMILITY[15]

Delivering quality care to immigrant and refugee clients during a public health emergency, such as COVID-19, includes providing an environment that is welcoming, inclusive, and free from discrimination and racism.

To improve practice in this area, CHCs can:

- Provide staff with on-going opportunities for anti-racism and anti-oppression training
- Support staff to examine biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided to every client during the emergency
- Validate and address the social determinants of health and inequities that are impacting clients. For example, income, housing, digital access and fluency, racism and discrimination
- Inform clients, particularly vulnerable newcomer clients that their unique individual needs will continue to be addressed throughout the emergency.
- Equip CHC staff with tools, training and evidence-based information to promote and counsel individuals in ways that are culturally appropriate. In the context of COVID 19, this will including helping newcomers to understand the importance of vaccination, feel confident in receiving vaccines, and to know where/how to access them as they become available.
- Develop appropriate screening questions to enable staff to check in with clients and to better understand how clients' beliefs, attitudes, values, and traditions influence their understanding of and experience with health and wellness in the context of the emergency.
- Clarify that client autonomy, rights, and confidentiality will continue to be promoted and protected throughout the emergency.
- Redeploy staff as required to make sure that all clients are connected to culturally relevant resources, services, programs and supports during the emergency.
- Continue to providing services and supports in a culturally appropriate manner and in the client's own language.[7]

CONSISTENT, TRANSPARENT AND CLEAR INTRA-CHC COMMUNICATION

Delivering quality care to immigrant and refugee clients during a health emergency, such as COVID-19, means that the communications between staff at the CHC should be regular, consistent, clear and transparent.

To improve practice in this area, CHCs can:

- Develop a plan for internal communication processes that benefits both staff members and clients.
- Implement a weekly touch point for all CHC management and staff during a pandemic/health emergency to discuss the week's goals, identify and address emerging issues and provide updates.
- Create spaces that enable staff to bring forward issues and propose solutions.
- Continue to hold regular department level meetings with time on the agenda allocated to the emergency so that front line staff can share experiences and promising or best practices in service delivery; identify problems, and brainstorm potential solutions.
- Create a cross agency communications team that meets regularly during the emergency to share best practices, solutions and barriers.
  - » Identify staff member to be the information leads, with responsibility for ongoing collection and timely sharing of up to date and accurate information about matters related to the emergency in formats that are appropriate for staff and for clients.
- Implement short, daily briefings (huddles) for teams.
- Create a list of community leaders that can help to distribute/reinforce messages/public health information to clients.

5. FUTURE DIRECTIONS FOR PRACTICE AND POLICY

This project aimed to identify and recommend promising practices that CHCs can use to more consistently support newcomers during health emergencies, such as COVID-19. Through engagement with CHC staff and CHC newcomer clients, a number of practices have been highlighted, which may be useful, not only during health emergencies, but in a CHC's day to day service delivery with immigrants and refugees. It is hoped that CHCs across Canada will discuss, review and advance these and other promising practices as recognized standards - best practice - for the delivery of high quality and effective care for immigrants and refugees.

In addition to testing and adopting promising practices, CHCs can play an important role as influencers of healthy public policy. As community-based health service providers, CHCs are ideally positioned to communicate with and on behalf of populations, such as recent immigrants and refugees, who are at increased risk during public health emergencies. As such, CHCs may consider developing key messages to communicate with different levels of government in advance of and during public health emergencies. This may include, for example: appealing to governments to apply an equity approach in developing federal, provincial and municipal policy and funding responses to the emergency; and, advocating for necessary funding for CHCs and other agencies to scale up practices such as professional interpretation and linguistically and culturally competent outreach with communities.

Specific to COVID-19, CHCs are ideally positioned to promote and counsel vulnerable populations, such as newcomers on the importance of COVID 19 vaccines. This project provides insight into strategies that can be leveraged to help newcomer populations feel confident in receiving vaccines, and to know where and how to access them.

APPENDIX A: A TOOL FOR IMPLEMENTING PROMISING PRACTICES

This is a tool that CHCs can use to help deliver high quality and effective care to immigrants and refugees during a health emergency.

AREA OF FOCUS	QUESTIONS CHC'S CAN ASK TO ADVANCE PROMISING PRACTICES
1. Language access and literacy	A. Do you offer free interpretation services? B. Do you offer translated material? Are translated materials accurate and culturally? C. Are the interpretation and translation services available in multiple languages? D. Do you have a way to identify the languages needed by your clients? E. Are your interpreters professionally trained?
2. Access to ongoing, interdisciplinary, community-based primary care	A. Do you have a plan to ensure connection and collaboration between diverse practitioners, including how clients will be supported? B. Has this plan been adapted and communicated to clients? C. Are there ways for clients to provide feedback? D. How is this feedback being communicated to the rest of CHC staff members? E. Does this plan include different ways that clients need to be supported (with their medication or other complex health conditions)?
3. Availability of in-person and virtual communication methods	A. Do you have a Virtual Care Plan that includes clients who may have accessibility issues? B. Have clients been offered the option of participating in an over-the phone or digital healthcare appointments? C. Have plans been developed to create additional supports who (including identifying) may be more vulnerable to social isolation than other clients?
4. Cultural competence, safety, and humility	A. Do staff have on-going opportunities for anti-racism and anti-oppressive training? B. Are there clear ways that anti-racism and anti-oppressive practices can continue to be provided to clients when there is a health emergency?
5. Consistent, transparent and clear intra-CHC communication	A. Is there a clear plan that allows all CHC management and staff to communicate regularly? B. Is there a framework to allow staff to provide feedback and constructive criticism to upper management that ensures confidentiality and accountability? C. Is there a staff member that has been appointed to be an information gathering lead that will be responsible for the on-going collection of data?

APPENDIX B: INTERVIEW GUIDES

INTERVIEW GUIDE - CLIENT

INTRODUCTION

Several Community Health Centres (CHCs) across Canada are working on a small project to improve newcomer health during health emergencies like COVID-19. To do this, we are looking to speak with CHC clients, like yourself, to better understand your experiences and challenges/barriers you may face/ faced during health emergencies such as COVID-19.

Confidentiality:
Everything you say today will be kept confidential. Your identity will remain anonymous, meaning your responses will not be linked to you personally. This also means that your doctors and nurses at _____ CHC will not know what you share with me today. Your care at _____ CHC will not be affected.

1. Icebreaker: What do you look forward to most, after COVID is over?
2. How have you been coping (in general) during this time?
3. When did you arrive to Canada?
4. Describe your experiences at _____ CHC?
    a. How did you find _____ CHC?
    b. How long have you been a client?
5. What have been some positive and negative experiences (ask one at a time) in accessing care at your CHC during the pandemic?
6. What has changed (before and during COVID) in terms of access to healthcare?
    a. How has COVID-19 affected your ability to access healthcare?
7. What existing supports, at your CHC, were most useful to you during COVID-19?
    a. What additional supports would you have found useful during the pandemic?
    b. How have these supports allowed you to manage your health during the pandemic?
8. What are some positive and negative experiences from your friends/family, in relation to accessing health care?

INTRODUCTION TO GOOD PRACTICES

There is a lot of evidence that says CHCs across Canada should implement certain guidelines during health emergencies such as COVID-19, to support the newcomer population. These include:

1. Literacy and Language
2. Access to interdisciplinary, community-based primary care
3. Availability of in-person and virtual communication methods (interpretation and national repository for translated materials)
4. Cultural competence, safety, and humility
5. Access without fear

1. Literacy and Language

A. Literacy

One of the guidelines is about **health literacy**, which is the ability of a person to obtain, read, understand and use basic health information to make an appropriate health decision.

a. On scale a 1 to 10 (10 = very easily), to what extent do you feel that you are able to get/ obtain health information about COVID-19?
b. What are the ways in which you get COVID-19 related health information?
c. On scale a 1 to 10 (10 = very readable), to what extent do you feel that you are able to read the information you provided?
d. What language(s) were available to you?
e. On scale a 1 to 10 (10 = very understandable), to what extent do you feel that you understood the information provided?
f. On scale a 1 to 10, to what extent do you feel that you were able to use the health messaging during COVID-19 to make decisions for you/your family?

B. Language

Language do you use any language supports at the CHC now? What language supports did you use during COVID-19? What additional supports do you wish you had during COVID?

2. Access to interdisciplinary, community-based primary care

In addition to your physical health, how were your health, wellness and social needs were met at the CHC? (e.g. Mental health, food, housing, access to employment opportunities, social interaction)

Prompt: Did you find these other supports/services helpful? What could have been improved?

3. Availability of in-person and virtual communication methods (interpretation and national repository for translated materials)

How did your interactions with your healthcare provider change because of COVID?

Prompt: Virtual care?

Prompt: Did you find these supports helpful? What could have been improved?

4. Cultural competence, safety, and humility

On scale a 1 to 10 how much do you trust your healthcare providers. Do you feel like they understand and value your culture? How do they do this in practice?

Prompt: do you feel like this trust changed at all during COVID-19? Did it get better or worse?

5. Access without fear

Besides the coronavirus itself, what other fears did you have around accessing healthcare at _____CHC (e.g. fears around discrimination, denial of care) ?

Prompt: If none, what does your CHC do to make you feel safe during this time?

Final Question

Are there other thoughts you would like to share regarding these standards?

INTERVIEW GUIDE - CHC STAFF

Preamble: Hi everyone, thank you for meeting with us today, including those of you who are new. We want to remind everyone that the thoughts that you share today and throughout the project will remain anonymous.

Our conversation today will focus on the standards that we had discussed last week. They include:

1. Language/literacy,
2. Access to interdisciplinary and community-based primary care,
3. Availability of in-person and virtual communication methods (interpretation and national repository for translated materials),
4. Cultural competence, safety, and humility,
5. Access without fear

To start, can we do a quick round table introduction?

1. Please describe your organization in terms of mandate/vision, services offered, and your role?
    a. Population served?
2. How has your agency been responding to the COVID-19 pandemic?
    a. With respect to delivering client care in alternative methods?
    b. With respect to supporting staff?
    c. With respect to communication?
        i. How has your CHC communicated well/ not well with you? What did this look like?
3. What successes and what challenges have you encountered during your agency's response to the pandemic?
4. What have you been hearing from clients about their challenges in receiving care/ accessing health services/accessing health-related information during the pandemic?

Appendix A: Interview Guides

5. The following standards have been proposed as criteria for CHCs to uphold at the national level:
    a. Language/literacy
    b. Access to interdisciplinary, community-based primary care
    c. Availability of in-person and virtual communication methods (interpretation and national repository for translated materials)
    d. Cultural competence, safety, and humility
    e. Access without fear
6. Language and Literacy: what language supports exist now? Do you feel these supports were adequate to support clients during COVID? What additional supports do you wish you had during COVID?
    a. Health literacy: Do you believe clients were able to obtain, read, understand and use the information provided to them during COVID?
    b. How do you think clients could have been better support in terms of language and literacy?
7. Access to interdisciplinary care: what supports do you wish existed to support interdisciplinary care during COVID? How could they be enhanced?
8. Availability of in-person and virtual communication methods: How are patients accessing health information? What additional supports could enhance the provision of alternative communication methods with patients?
9. Cultural competence, safety, and humility: What term do you use in your agency? How do you define this? What does this look like in practice? How could these practices be enhanced?
10. In our initial meeting, the proposed standard of: "Access without fear" was brought up as important criteria for a pandemic response at the national level. What would this look like in practice? How could CHCs create environments of access without fear?
11. What requirements would need to be in place to ensure that these standards are applied in practice?
12. Are there other thoughts you would like to share regarding these standards?

ENDNOTES

1 Statistics Canada, Labour Force Survey Supplement, July 2020.

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5 Within the context of this report, newcomer is a broad term that refers to people who are not born in Canada and arrived in the country within the last 5 years. We recognize that there are narrower and broader definitions for this term. In the context of data derived from Census Canada, newcomers are landed immigrants who came to Canada up to five years prior to a given census year.

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11 Caring for Kids New to Canada, Canadian Paediatric Society: A guide for health professionals working with immigrant and refugee children and youth. Retrieved from: https://www.kidsnewtocanada.ca

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13 Newcomers were defined as having arrived in Canada less than five years. Each newcomer was provided $50 for a one-hour interview.

14 Digital fluency is the aptitude to effectively and ethically interpret information, discover meaning, design content, construct knowledge, and communicate ideas in a **digitally** connected world; https://www.region10.org/programs/digital-learning/digital-fluency/

15 *Cultural Competence:* A complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care.

Cultural Safety: Cultural safety requires healthcare professionals and their associated healthcare organizations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organizations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organizations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organizations to influence healthcare to reduce bias and achieve equity within the workforce and working environment. (Curtis, Jones, Tipene-Leach, Walker, Loring, Paine and Reid, 2019)

Cultural Humility: A process of inquisitiveness, self-reflection, critiquing, and lifelong learning. In contrast to the idea of cultural competence, cultural humility is never mastered-it's an ongoing process, shaped by every encounter we have with every person, as long as we maintain an open mind and heart. (Fahlberg, Foronda and Baptiste, 2016)