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REFUGEES LIVING WITH CHRONIC ILLNESS: A GROWING CONCERN

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Who we are:

We provide *accessible, community-governed, and inter-professional* primary health care services to a highly diverse population of immigrants and refugees in the city of Toronto.

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Conflict of interest

- None

- Acknowledgment:
  - Reshma (Placement student) and Sydney supported with literature review

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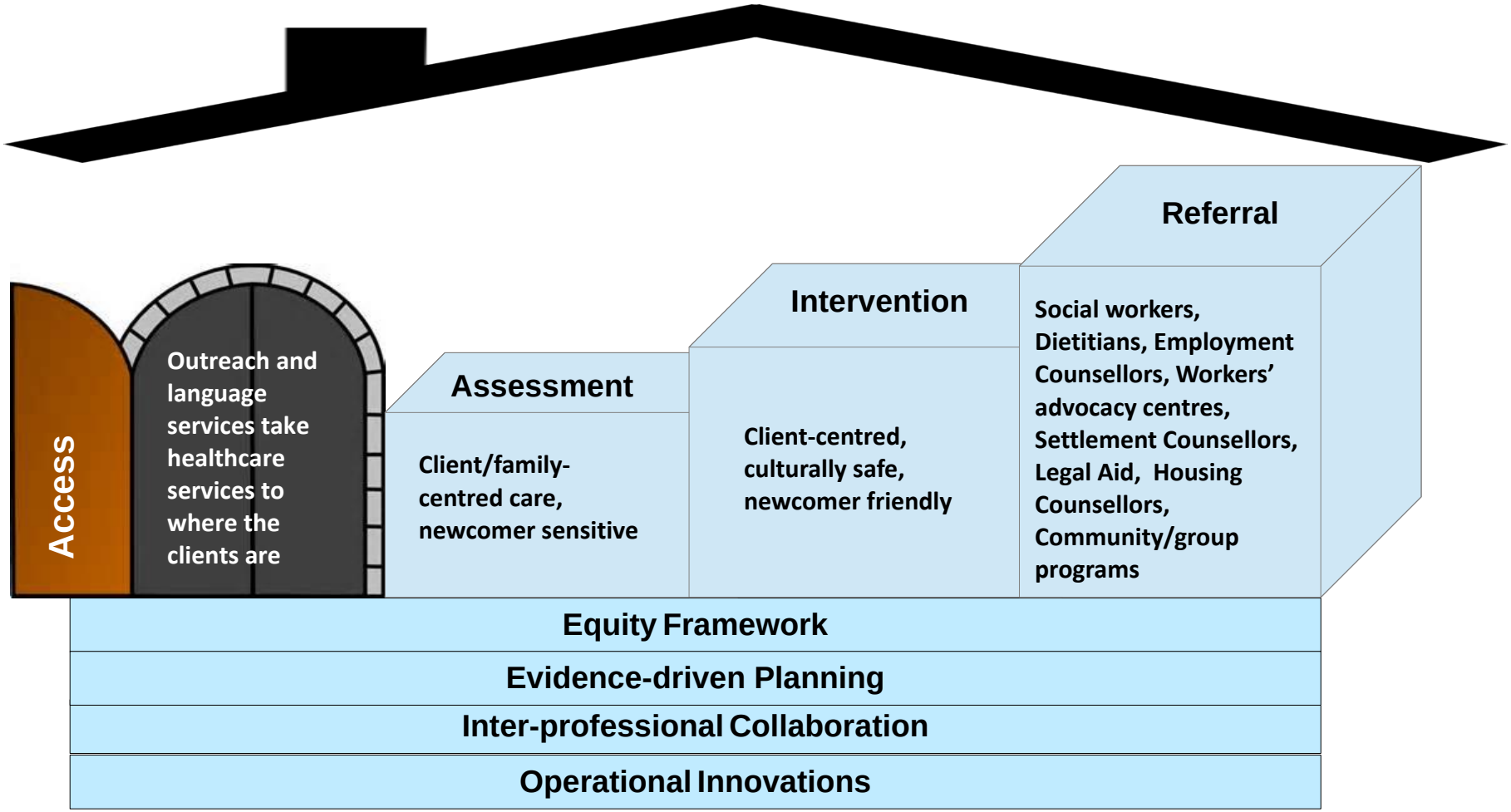
Access through Equity (ActE)



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The importance of chronic disease to the health of refugees is under-recognized.

Lets start talking!

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World Health Organization

- *Non-communicable diseases (NCDs), such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are the **leading cause of mortality** in the world…….*

- *The **burden is growing** - the number of people, families and communities afflicted is increasing……..*

- *The NCD threat can be **overcome using existing knowledge**. The solutions are highly cost-effective. Comprehensive and integrated action at country level, led by governments, is the means to achieve success.*

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Fig. 6.1 Age-standardized prevalence of raised blood pressure in males aged 18 years and over (defined as systolic and/or diastolic blood pressure equal to or above 140/90 mm Hg), comparable estimates, 2014

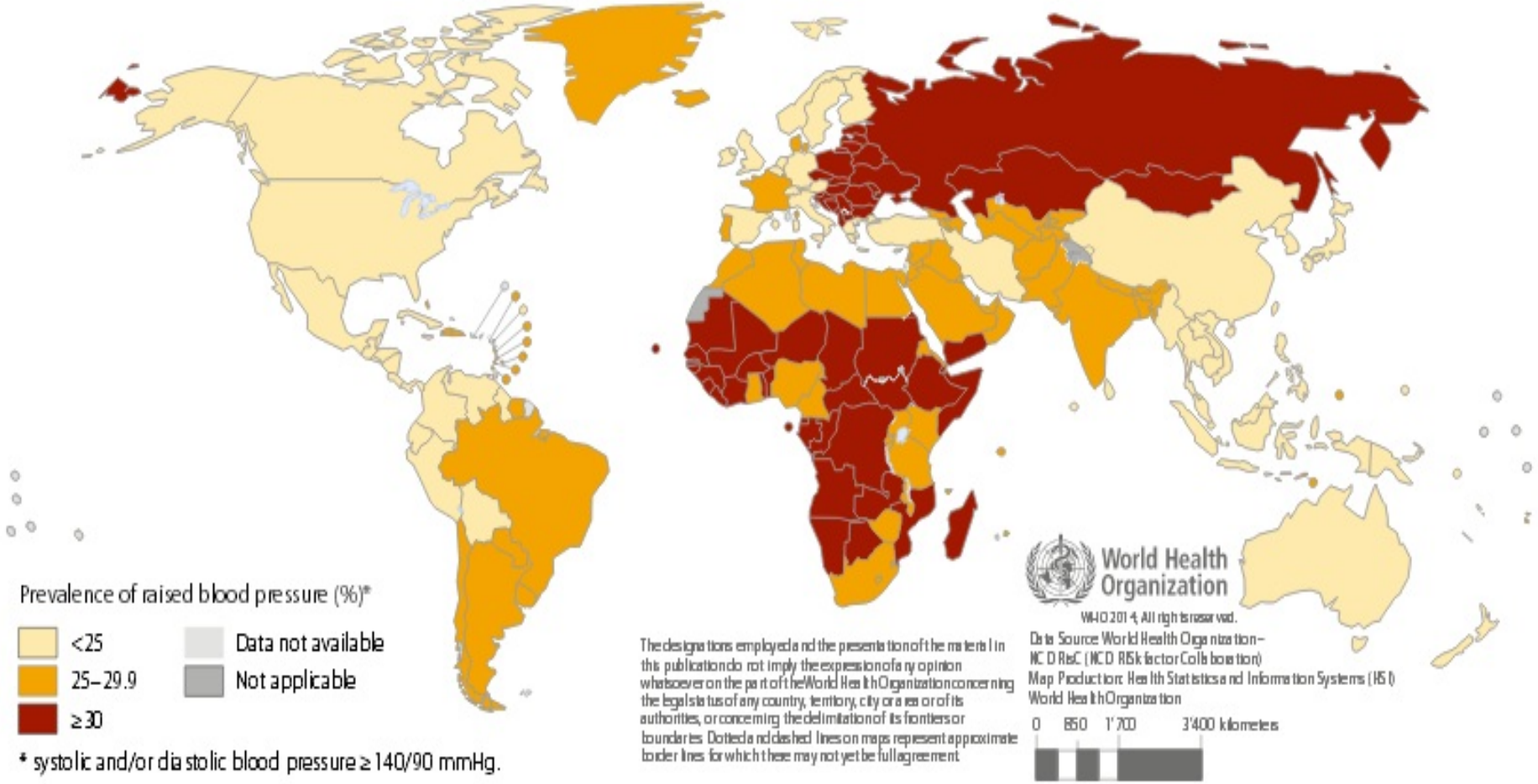
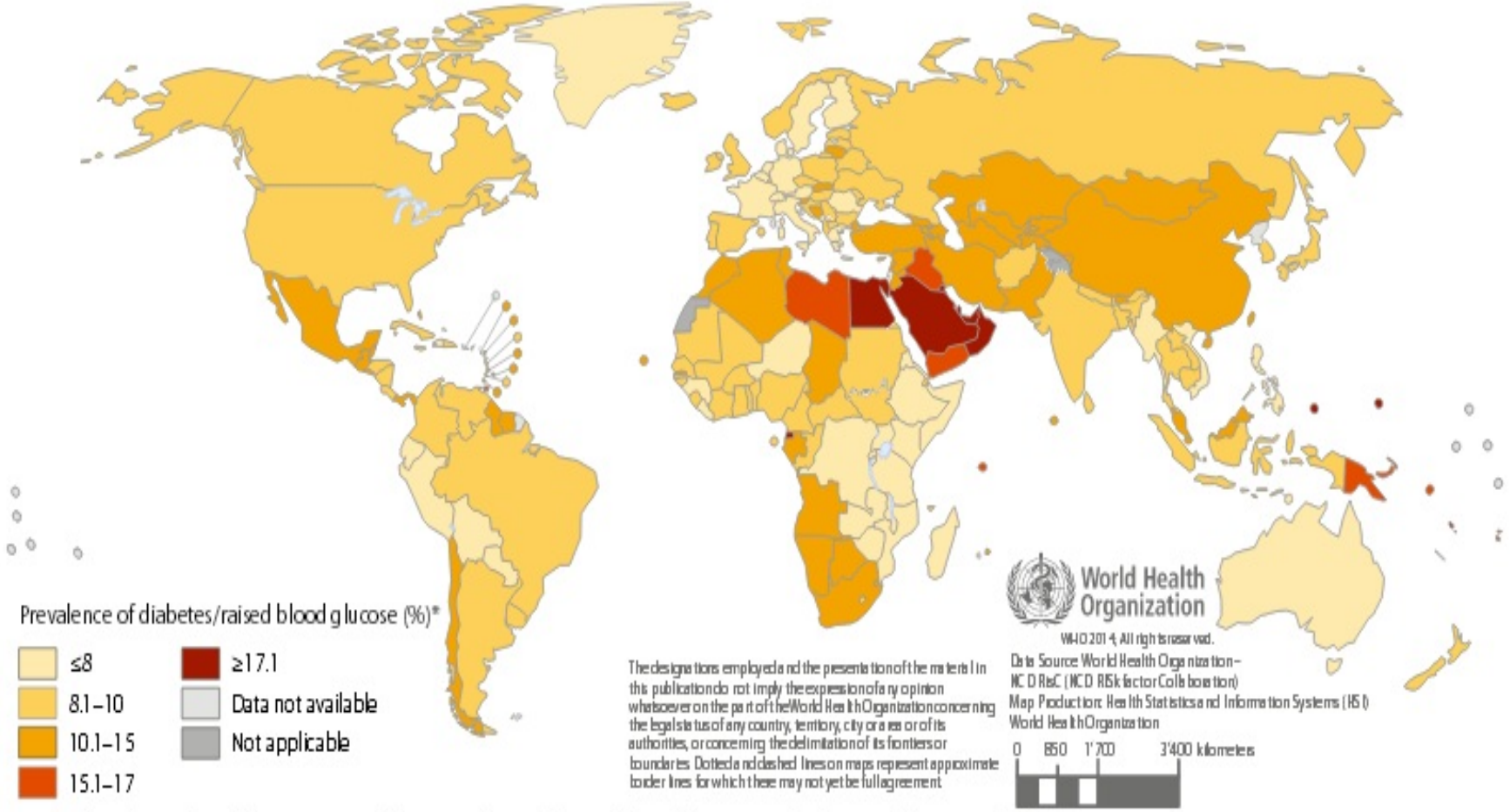


Fig. 7.7 Age-standardized prevalence of diabetes, (Fasting glucose ≥ 7.0 mmol/L, or on medication for raised blood glucose or with a history of diagnosis of diabetes), in men aged 18 years and over, comparable estimates, 2014



* Defined as fasting blood glucose ≥ 7 mmol/l or on medication for raised blood glucose or with a history of diagnosis of diabetes.

Prevalence in the literature

Kinzie et al., 2008- Higher Prevalence of Diabetes and Hypertension Among Refugee Psychiatric Patients

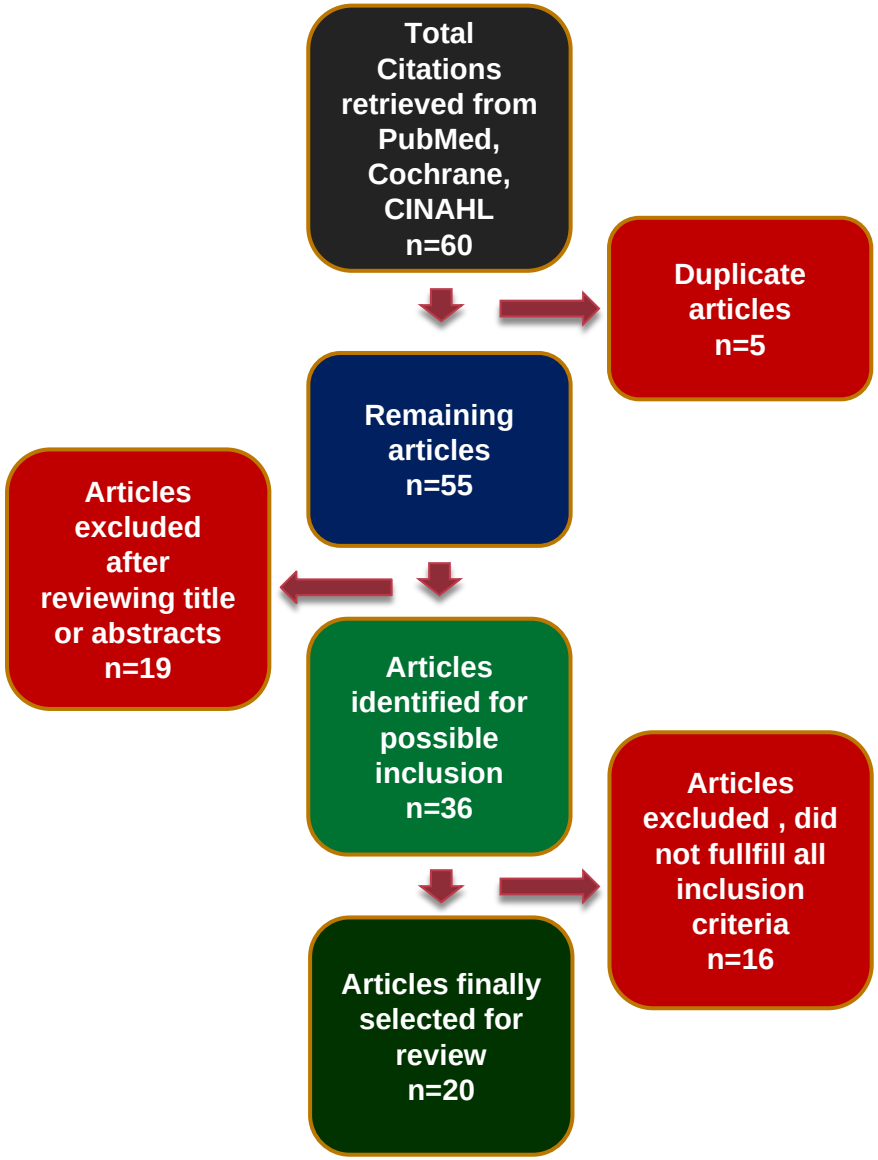
Yun et al 2012- Chronic Disease and Insurance Coverage Among Refugees in the United States

Newbold 2008- The short-term health of Canada's new immigrant arrivals: evidence from LSIC

Dookeran et al 2010- Chronic Diseases and Its Risk Factors Among Refugees and Asylees in Massachusetts, 2001-2005

What we did:

- **Literature review**
  - Conducted systematic lit review
  - Adopted PRISMA model for sorting articles
  - Keywords: refugee, chronic disease, hypertension, diabetes, chronic care model
  - Searched databases
  - Generated non-directional hypothesis



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Search Design

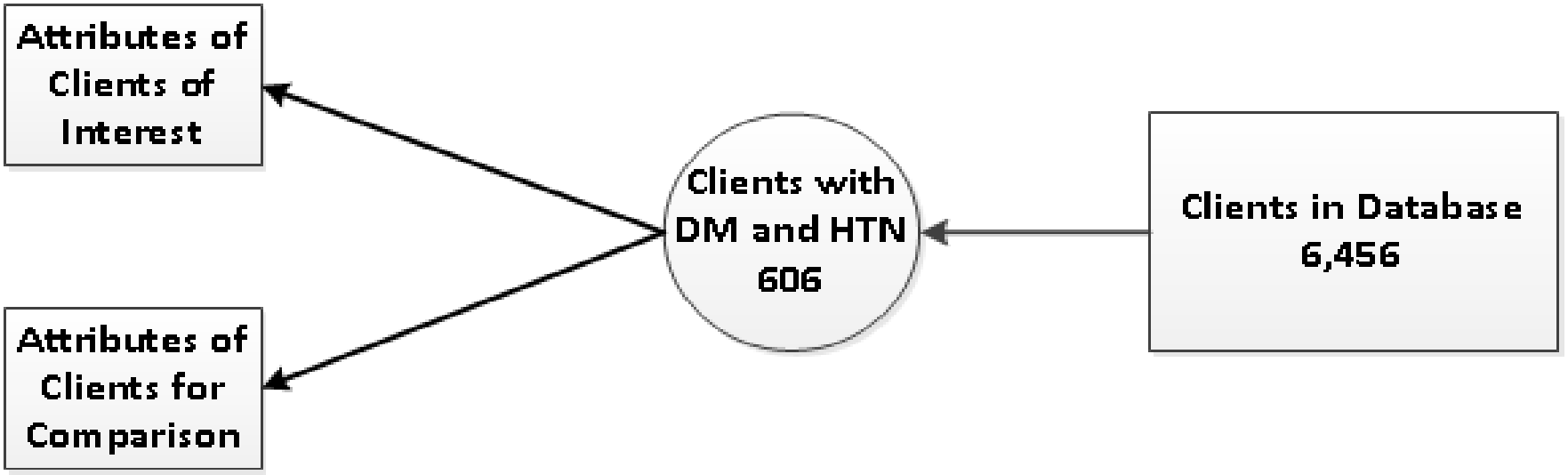

Chart review from NOD

- Retrospective (from Apr 2012-Mar 2014) comparative study with clients from the NOD database

- Limitations-
  - Transition of NOD versions and demographic indicators
  - Trichotomous cleavage of the DV (DM, HTN, and Both)

Clients with DM or HTN

	Clients of interest (Refugees)	Comparison group (Citizens & Permanent Residents)
Clients with DM and HTN [All Clients in database]	40.3% [33.9%]	48.3% [54.8%]
Mean Age	53.6 ± 12.2 years	60.5 ±13.7 years

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Attributes of Refugee Clients with Hypertension & Diabetes

	Hypertension	Diabetes
Mean age	55.4 ± 13.1 years	59.08 ± 13.8 years
Racial/Ethnic group White- Europeans Asian- South Latin American	 22.6% 17.9% 12.8%	 18.9% 18% 14.1%
Strength of relationship with Racial/Ethnic group	χ^2=40.7, df=15, p=0.000	χ^2=35.1, df=15, p=0.003
Clients did not reach guideline recommended targets	61.9%	60.9 %

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Identified factors for compliance with the chronic disease management recommendations

Drivers for Clients with Hypertension	Statistic
Not having a second care provider	F= 47.3; p=0.000
Age in years	F= 5.7; p=0.018
Lipid profile	F= 5.1; p=0.025

Drivers for Clients with Diabetes	Statistic
Not having a second care provider	F=10.8; p=0.001
Age in years	F=9.9; p=0.002
Insurance status	F= 6.2; p=0.013

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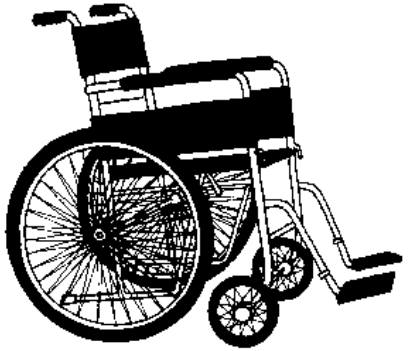
People:

65 yo woman, refugee claimant from Hungary

- IFH- not renewed after 1 year, waiting for reinstatement
- Insulin dependent type 2 DM, HTN, spinal stenosis
- Little interest in improving her glucose control
- Husband's issues dominated visits
- Insulin injections and time change
- Slow to build trust

50 yo woman from middle east with Parkinson's disease

- Refugee claimant with IFH coverage
- Wheelchair bound and dependent on daughter for most ADLs
- Significant delays in accessing specialty care, equipment and support
- Her mental health deteriorated as did her physical abilities



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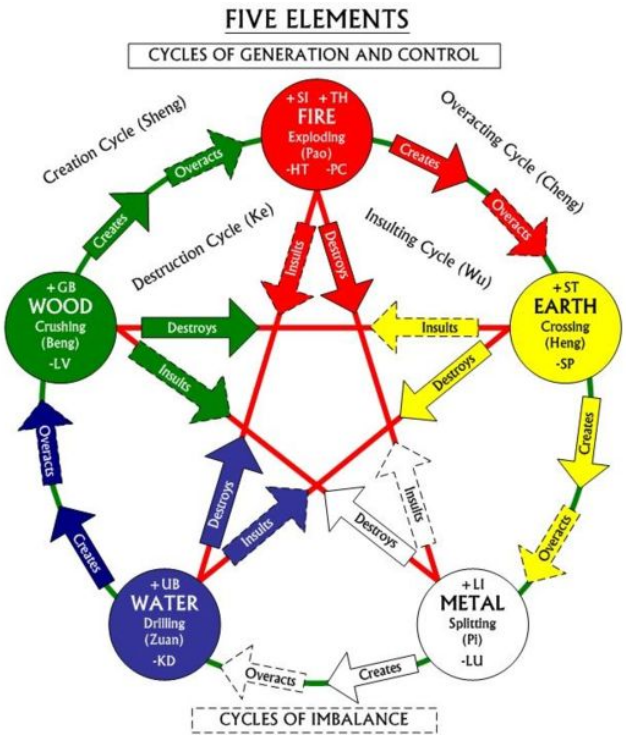
Access to care and everything else

- Access to care pre arrival
- Precarious insurance on arrival
  - *Canadian IFH changes and confusion*
- Lack of chronic disease supports and teams
- Cultural and linguistic barriers
- Income insecurity, low socio-economic status
- Experiences of discrimination in the health care system

Cultural impact on health literacy

- Concept of chronicity
- Paradigms of health and illness
- Self efficacy - Belief in the ability to change outcome



Glycemic control and knowledge scores improve significantly over 3 and 6 months with culturally competent diabetes education

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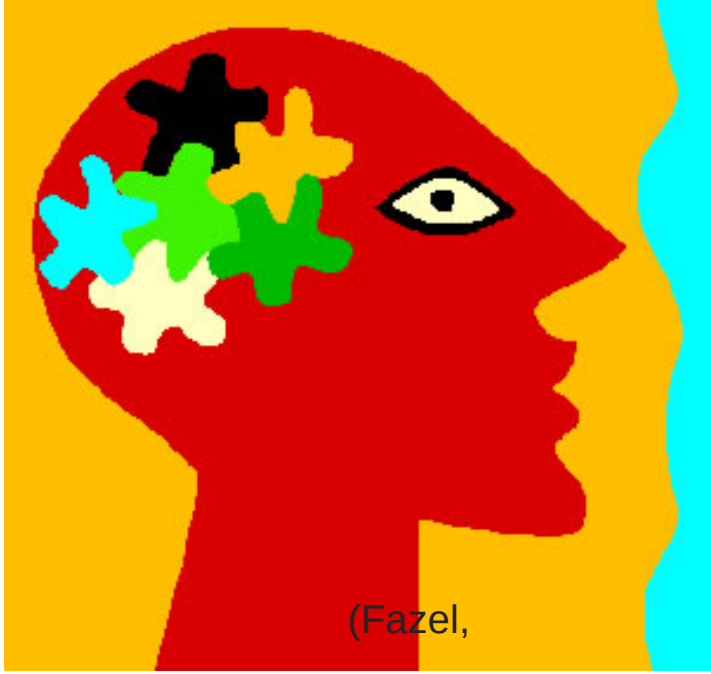
Mental health and experience of trauma



(Fazel,

- In a sample study of adult refugees Wheeler, & Danesh, 2005):
  - **64%** of adult refugees had PTSD
  - **17%** had major depression
- Depression, anxiety and PTSD are risk factors for diabetes
- Linked to prognosis
- Impact of discrimination, social isolation

People

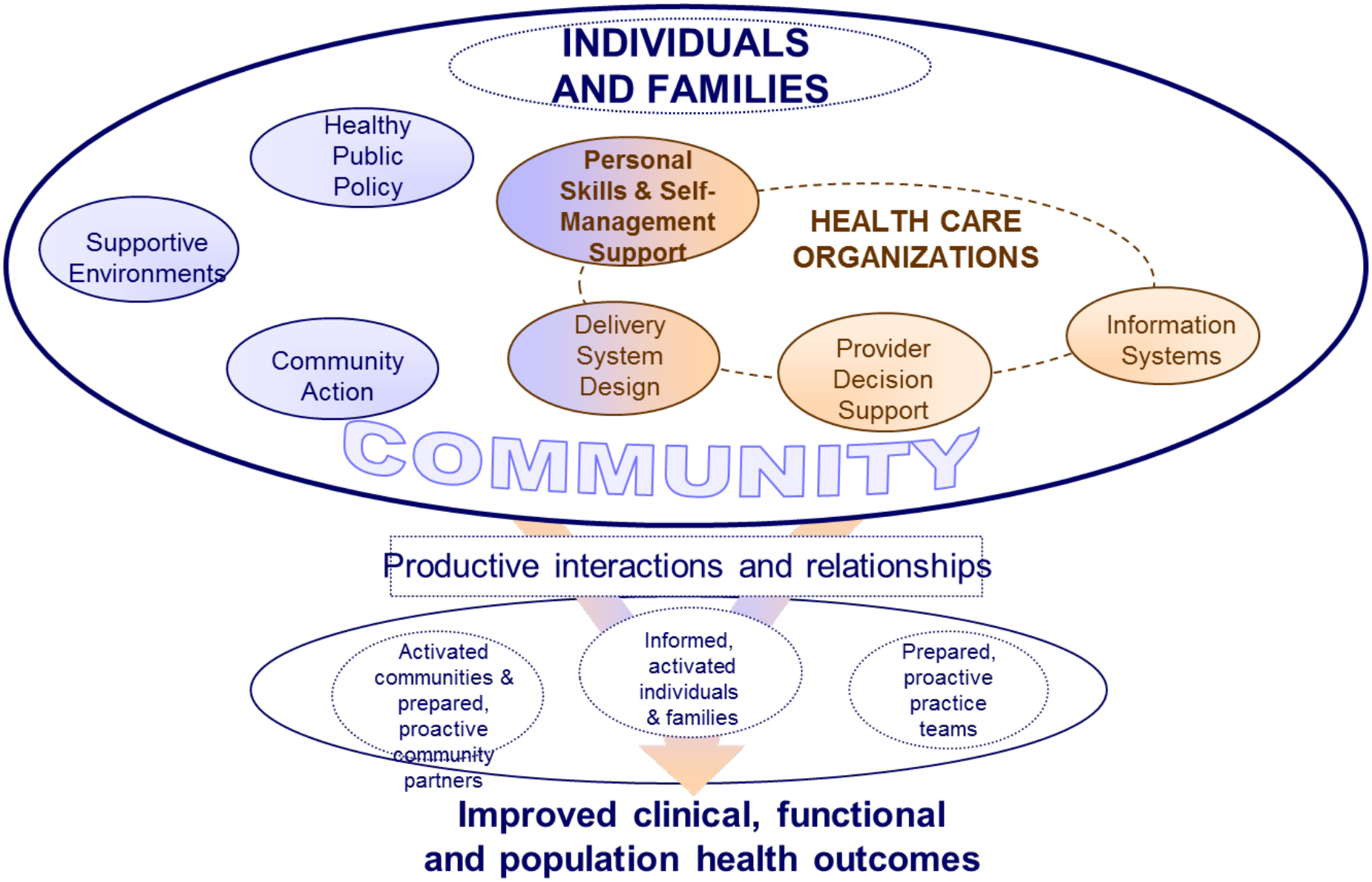
45 yo man from North Africa with PTSD

- Diagnosed with hypertension early 40s, smoker
- Socially isolated- left wife and son in home country- unsure of whereabouts
- Attempts of healthy lifestyle change interrupted by mental health complaints
- Weight gain, continues to smoke, now diagnosed with diabetes
- More disengaged then ever

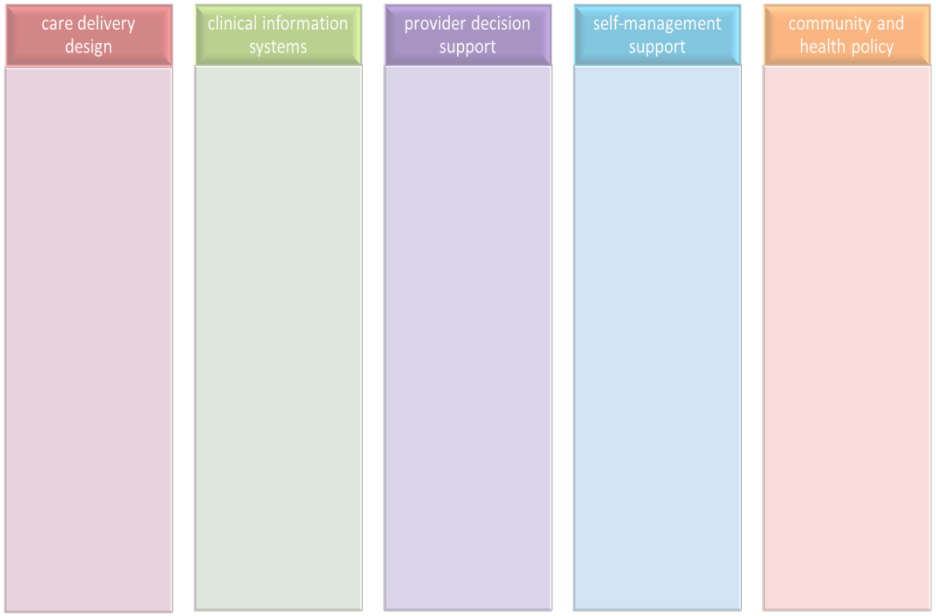
55 yo woman from the Caribbean with poorly controlled diabetes

- Non insured (through NIWIC) no medication coverage
- Started on insulin due to severe hyperglycemia
- Slow to titrate, little sense of urgency
- Competing priorities-work outside of the city
- Warnings of consequences of hyperglycemia – *"God won't let that happen*"

Ontario's CDPM Framework



Translating concept to practice

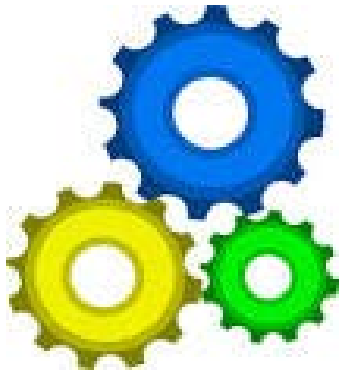


Worksheet

Where you are sitting:

- Discuss and share experiences in each of the domains
- Document your brilliant thoughts and ideas
- Each group highlights their favorite to the rest of the group
- Fill in contact information in order for us to send you a report of our findings

Health System Redesign



Logistics of how we organize our interactions with the clients and team members

The structure of medical practice must be altered, creating practice teams with a clear division of labor and separating acute care from the planned management of chronic conditions.

Improving Primary care for Patients with Chronic illness, Bodenheimer, Wagner, Grumbach- JAMA 2002;288:1775-1779

Clinical Information Systems

1. Reminder systems that help primary care teams comply with practice guidelines;

2. Feedback to physicians, showing how each is performing on chronic illness measures such as HbA1c and lipid levels

3. Registries for planning individual patient care and conducting population-based care.

Improving Primary care for Patients with Chronic illness, Bodenheimer, Wagner, Grumbach- JAMA 2002;288:1775-1779

Decision Support:

Beyond guidelines

Real-time evidence-based information to support treatment decisions embedded into daily practice

- Medication interaction alerts
- Guideline-informed templates
- Timely and informative access to internal and external experts
- Case conferencing

Improving Primary care for Patients with Chronic illness, Bodenheimer, Wagner, Grumbach- JAMA 2002;288:1775-1779

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Self-Management

Self-management support involves collaboratively helping patients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools (eg, blood pressure cuffs, glucometers, diets, and referrals to community resources), and routinely assessing problems and accomplishments.

- ***What are unique self-management considerations in the refugee populations?***

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Table 2. Comparison of Traditional Patient Education and Self-management Education

	Traditional Patient Education	Self-management Education
What is taught?	Information and technical skills about the disease	Skills on *how* to act on problems
How are problems formulated?	Problems reflect inadequate control of the disease	The patient identifies problems he/she experiences that may or may not be related to the disease
Relation of education to the disease	Education is disease-specific and teaches information and technical skills related to the disease	Education provides problem-solving skills that are relevant to the consequences of chronic conditions in general
What is the theory underlying the education?	Disease-specific knowledge creates behavior change, which in turn produces better clinical outcomes	Greater patient confidence in his/her capacity to make life-improving changes (self-efficacy) yields better clinical outcomes
What is the goal?	Compliance with the behavior changes taught to the patient to improve clinical outcomes	Increased self-efficacy to improve clinical outcomes
Who is the educator?	A health professional	A health professional, peer leader, or other patients, often in group settings

Community and Health Policy

- Support for optimal CDM needs more than a strong health care system
- Need to collaborate with other government sectors and community organizations
- ***Advocacy***

Questions?

Thank You

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