

**SOCIAL WORK, PRIMARY  
CARE AND FAMILY HEALTH  
TEAMS IN ONTARIO:  
DELIVERING COMPREHENSIVE,  
FAMILY-CENTERED CARE**

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J. Kasperski, RN, MHSc, CHE  
Executive Director and CEO  
Ontario College of Family Physicians



Kate Power, MSW, RSW  
OASW HealthCare Committee  
Ontario Association of Social Work



Susan D. VanderBent, BA, BSW, MSW, MHSc, CHE  
Executive Director  
Ontario Home Care Association

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# EXECUTIVE SUMMARY

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Family physicians are seen by patients as major providers of health care and as the entry point to the rest of the system. Patients have easy access to care when it is offered within the familiar surroundings of their doctor's office; therefore, the physician's office provides an ideal opportunity to link patients to professional social work supports. Reassured by the knowledge of the close working relationship between the family physician and the social worker, patients will be more likely to engage in care and social workers will have increased opportunities to deliver comprehensive and cost-efficient care to individuals, couples and families (Smith: 2004).

This paper examines the key role that social work can play in the realization of a successful Family Health Team (FHT). Social workers specialize in working with people, families and communities whose needs are high and whose resources to meet those needs are compromised or depleted (Antle: 2004). Over fifty per cent (50%) of all persons seen in a family doctors office are experiencing a psychosocial overlay to their physical problems or have a mental health problem (OCFP: June 2002; Stewart, M: 1997). Issues range from managing depression, dealing with marriage problems or family breakdown, living with chronic or debilitating health conditions, recovering from trauma, or facing end-of-life issues.

Most family doctors confirm that assistance is needed in assessment and on-going management and support of psychosocial issues. In order to ensure that problems are dealt with proactively, thus preventing more costly use of the health care system, one of the key criteria for the new FHTs should be the inclusion of social work within the primary care practice (Wilson: 2004).

Social work intervention contributes to the stabilization of individuals and families thus saving system resources. Research has proven that overall health care costs are much lower for people who are stable in their type and level of care than those who are in transition and are using multiple resources (Hollander: 2002).

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# WHAT IS PRIMARY CARE PRACTICE?

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International research demonstrates that countries with strong primary care systems have better population health outcomes for people, improved health and social equity for their citizens and spend less of their GDP.

The important areas of primary care practice are defined as:

- accessibility and first contact when needs arise;
- more person-focused interactions as distinguished from disease-focused interactions;
- greater comprehensiveness of care;
- better referral networks;
- coordination of care when referrals are necessary;
- family orientation
- community orientation
- cultural competence (Starfield: 2004)

The two factors that correlate best with a strong primary care system are family-centred care and comprehensiveness. Family-centred care supports family unity by acknowledging that the illness/injury of one family member affects the well-being of all family members. Comprehensiveness of service means that all services should be provided within primary care except those services that are done so rarely that primary care providers would not be able to maintain their skills (Starfield: 2004).

In Ontario, the creation of Family Health Teams (FHTs) is well underway. The goals of FHTs are to provide: comprehensive primary health care; patient and family centred care; expanded access; system navigation and care coordination to link patients to other parts of the health care system; emphasize health promotion; chronic disease management; and links to the community.

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- Social work services are often invisible threads in the fabric of a healthy community - Antle, 2004

Social work is uniquely equipped to meet these needs as an adjunct to the physician, assisting in developing comprehensive networks, care coordination for both health and social issues, and links to other providers and sectors within a family and community oriented practice model (Levin, Herbert: 2001). Social work education and competencies are based on a belief that people live in the context of their families and communities and that private troubles are often a reflection of public issues that should be addressed by

the larger system (Mills: 1959). It is within this broad, systemic and comprehensive view of health care that the social worker and the family doctor can create a strong team focus within which to deliver excellence and efficiency in primary care in Ontario.

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# WHAT DO FAMILY DOCTORS NEED TO SUPPORT THE HEALTH AND SOCIAL CARE NEEDS OF PATIENTS?

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Canada's health care system is anchored in a strong family-medicine oriented primary care system with an emphasis on comprehensiveness and family-centred care. However, the system supports needed to support a comprehensive approach in primary care have eroded, making it difficult for family doctors to provide the full range of services that patients and their families need (OCFP: 2004). This is coupled with the fact that thousands of people in Ontario do not have a family doctor and rely upon walk-in-clinics, emergency departments and specialty services for their primary care. The critical shortage of family doctors has left the remaining physicians with innumerable challenges as they try to deliver care to an increasingly complex patient population within a fragmented and unconnected system. With too few coordinating resources available in the broader primary care sector, patients who could be managed effectively by their family doctors are often unnecessarily referred to secondary/tertiary services and enter what is often referred to as the "black box of specialty services".

- Mental stress can trigger a lack of blood flow to the heart and increase risk of death in people with coronary disease. Patients who had ischemia in response to mental stress had a 3-fold increase in the risk of death compared to people without mental stress. Mental stress increases oxygen demand because blood pressure and heart rate are elevated (Dr. D. Sheps, American Heart Association (2002).

Regardless of the problem's origin (physical, mental, emotional, social or educational), patients see their family doctors as their main provider of care and as the co-ordinators of care delivered by others. As the

providers who open the gates to the rest of the health and social care system, they play key roles throughout the system. "Ask your family doctor; she/he will know" is one of the most common statements made in health care. Family doctors provide "cradle to grave" care. Problems are wide ranging in nature: Family doctors deal with issues related to preconception, pregnancy, child-rearing and parenting, learning difficulties, adolescent problems, drug and alcohol addictions, marital discord, job loss, death in a family, marriage or family breakdown, chronic or debilitating health conditions, traumatic illness, depression or psychiatric problems and end-of-life care. The family doctor is expected to know what to do to fix the all these problems or at the very least, open the doors to the right system supports in a timely manner.

From the perspective of the family physician in Ontario, access to the community-based system has improved for those that are deemed eligible for publicly-funded home care or long term care placement due to the coordinating role played by the Community Care Access Centres. However, access to other supports for the continuum of patients' problems remains difficult and time-consuming (National Physicians Survey: 2004).

Often, other broader social issues such as child welfare, substitute decision-making, elder abuse, homelessness, lack of finances come within the constellation of issues with which the family practice must cope. To address these issues family doctors overwhelmingly identify a social worker/ mental health worker as the first priority to supporting, delivering and advocating for improved care for their patients (Badger et al: 1997).

- Dr. Lynanne McGuire, of John Hopkins School of Medicine, suggests the effect of mild depression on the immune system is linked to the increased risk and severity of infections and cancer found in older adults. The older the person, the poorer the immune response was found to be. "Failure to address chronic, mild, depressive symptoms in older adults has important negative physiological consequences." (2002)

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# HOW CAN SOCIAL WORK CONTRIBUTE TO THE HEALTH AND SOCIAL CARE NEEDS OF PATIENTS?

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I am drowning in mental health problems. Just give me a social worker and my biggest headaches will be over. Dr. C

The profession of social work has historically stressed the importance of supporting the family system (Pardeck: 1999). Social workers specialize in working with individuals, families and communities whose needs are high and whose resources to meet those are compromised or depleted (Antle: 2004). In helping people to navigate complex systems, live productively with chronic or debilitating health conditions, recover from trauma or deal with life's stressors more effectively, social work services strengthen people, families and communities.

Comprehensive care for patients is based on coordinated communication and care planning. Health care and social services are inextricably linked. Health and social supports are crucial to enable clients to age in place, sustain family configurations, reduce client transitions resulting from caregiver fatigue and minimize transition points for clients through the health care continuum (Canadian Home Care Association: 2003). Helping people to access supports in the community is a critical social work function and making the connections with various supports systems in health, social services, education, judicial or municipal sectors is a system navigation role that social workers in all FHTs are able to provide.

Studies have validated the effectiveness of social work practice with primary care patients showing decreased depression, anxiety, adjustment reactions, fewer physician visits, less somatization and improved compliance with medical and diet/nutrition regimes (Rock: 2000). Older people often have difficulty accessing social services and suffer delays when waiting for assessments. Having social workers available in the primary care practice has been shown to reduce the anxiety some clients feel in being referred to a social worker (Banyard et al: 2002).

"Caregivers who cannot identify any positive aspects of caring may be at particular risk for depression and poor health outcomes. They also may be more at risk of institutional their care recipient than others" (Cr. Carole Cohen, University of Toronto, Department of Psychiatry, 2002)

Social workers deliver comprehensive primary care to families by:

- ♦ providing counselling for depression and a broad spectrum of mental health needs
- ♦ supporting individuals, families and caregivers to cope with episodic and long term illness of family members
- ♦ addressing end-of-life issues and grief counselling
- ♦ interfacing with community agencies to coordinate patient movement through the health care system and to advocate for additional resources when required
- ♦ making referrals for additional health and social care supports outside the practice (Ontario Association of Social Workers: 2004).

In a health climate punctuated by persistent change requiring adaptations and transitions, social workers are expert in coordinating transition points in complex health care and social service systems. Hospitalization, placement, re-location, hospice care or respite care, can be a disruptive and costly for clients, families and the health system. These transitions may present risk to the client, the caregiver system, impact stability and the course of recovery or end-of-life-care. Coordination and early intervention, rather than crisis intervention provides an opportunity to foster sustainable solution finding versus stabilizing the client through crisis management.

The HSO mental health program in Hamilton provides a good example of the effective use of the core competencies of social work in a well-functioning family practice (Smith, 2004). In this practice setting, social workers deliver five (5) types of service that support the patient within the primary care practice:

- ♦ Assessment of psychosocial problems
- ♦ Advocacy for home and community care services
- ♦ Provision of counseling and psychotherapy to individuals, couples and families
- ♦ referrals for other types community health and social care services
- ♦ Consultation with other health care providers on the psychosocial aspects and impacts of illness on behaviour and overall patient compliance with treatment regimes (Salvatore: 1988)

In the Hamilton HSO setting, upon diagnosis of a psychosocial or mental health problem, the family physician will either consult indirectly with the social worker to obtain advice regarding case management or make a direct referral for assessment. As the communication between the doctor and the social worker is seamless, patients are seen in a timely fashion. Patients' anxiety is reduced by the close working relationship between

"Having a psychiatrist come to our office to help establish the game plan and then leaving me and the social worker to execute the plan has improved our ability to deal with very complex problems tremendously."

Dr. C.

the doctor and the social worker (Rock: 2000). Once the patient is assessed by the social worker, the specific issues can be identified and addressed. Treatment can be arranged to suit the patient and can be of a short term or episodic nature depending on the assessed needs of the patient. Progress in any area can be communicated to the

physician and referrals for additional services outside the practice can be expedited. Cases may be referred to a consulting psychiatrist in instances where a medical review of psychiatric problems is required. This model demonstrates the comprehensiveness of a strong primary health care system and the interconnectedness of good physical, mental and social functioning in the overall health of an individual (Smith: 2004).

There are many ways in which new Family Health Teams can access or utilize the expertise of a professional social worker. From a human resource perspective, the social worker can be contracted to the practice through a number of organizations that employ social workers; can operate as an independent professional or as an employee of the FHT.

By strengthening the services provided in a primary care setting and being able to make referrals to the greater home and community care sector, social workers support a seamless continuum of care and contribute to overall health system cost reduction related to hospital re-admissions, emergency department presentations, frequency of physician visits, and crisis placements in long term care (Glendinning: 2002). All new FHTs should have social work supports within the practice to ensure excellence in integrated care.

"I'm expected to be all things to all people. With a social worker at my side, maybe I could be."

Dr. R.

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# CONCLUSION

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"Imagine a system in which the Emergency-based Social Worker connects with the primary care social worker who connects with the family doctor, public health, CCAC case manager and all the other community-based service providers. Now that's an integrated health care system that could really work."

Dr. R.

True system transformation in Ontario will depend on the success of the Family Health Teams and the adoption of a strong and central role for primary care. Primary care delivered within a community setting must become the hub of integrated service in order to reduce overdependence on the costly acute care system. Family Health Teams provide an ideal opportunity to support this foundation for patients who require access to comprehensive, family-oriented primary care. The creation of a strong working partnership between the family physician and the social worker in the practice will integrate care at the critical point of first contact and address the breadth of health and social issues that affect people living in the community.

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# CONTACT INFORMATION

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**The Ontario College of Family Physicians (OCFP)** is a provincial, voluntary, not-for-profit organization whose mandate includes undergraduate, post-graduate education, the continuing professional development of family physicians and the maintenance of high standards of medical care and education in family practice. The OCFP is the voice of family medicine in Ontario and represents more than 6,800 family physicians who provide patient care for remote, rural, suburban, urban and inner city communities throughout Ontario. For more information please contact:

Jan Kasperski, Executive Director and CEO  
Ontario College of Family Physicians  
3457 Bay Street, Mezzanine Level  
Toronto, Ontario M5H 2T7

Phone: 416-867-9646  
Fax: 416-867-9990

Email: [jk\\_ocfp@cfpc.ca](mailto:jk_ocfp@cfpc.ca)  
Web Site: [www.cfpc.ca](http://www.cfpc.ca)

**The Ontario Association of Social Workers (OASW)** is a bilingual voluntary membership organization that represents social workers in Ontario. OASW represents all sectors of the profession, including a significant number of the profession who practice as clinicians within the field of health care. For more information, please contact:

J. MacKenzie Davies, Executive Director  
Kate Power, OASW HealthCare Committee/Community Rehab  
Ontario Association of Social Workers  
410 Jarvis Street  
Toronto, Ontario M4Y 2G6

Phone: 416-923-4848  
Fax: 416-923-5279

Email: Joan MacKenzie Davies – [jmd@oasw.org](mailto:jmd@oasw.org)  
Kate Power – [kpower@commrehab.com](mailto:kpower@commrehab.com)  
Web Site: [www.oasw.org](http://www.oasw.org)

**The Ontario Home Care Association (OHCA)** is an organization of home health and social care service providers. Association members deliver nursing care, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, speech language therapy and medical equipment in the home. For more information, please contact:

Susan D. VanderBent, Executive Director  
Ontario Home Care Association  
19 Melrose Avenue South  
Hamilton, Ontario L8M 2Y4

Phone: 905-543-9474  
Fax: 905-545-1568

Email: [suevan@homecareontario.ca](mailto:suevan@homecareontario.ca)  
Web Site: [www.homecareontario.ca](http://www.homecareontario.ca)