

## The Value of Socially Accountable Care:

Investing in primary health care that supports pandemic recovery, promotes health equity, and improves health outcomes

Socially accountable care is health care that can anticipate and address the priority physical health, mental health, and social needs of a local community. Socially accountable care is therefore a powerful approach to supporting pandemic recovery, promoting health equity, and improving individual and population health outcomes. Increasingly, family physicians in leadership roles within their local health care institutions and medical schools are calling for greater emphasis on socially accountable care. Yet there is still a need for institutionalizing socially accountable care throughout the training of health professionals, the organization of clinical practices, and the various accreditation processes to strengthen primary care.

### Supporting pandemic recovery

Many patients from marginalized and underserved populations were already facing significant hardships, which have been aggravated by the COVID-19 pandemic. Socially accountable care addresses the social inequities that have been amplified by the pandemic and that underpin the health of marginalized people, such as unemployment, precarious housing, food insecurity, and exposure to violence.



### Promoting health equity

Health and social challenges disproportionately impact certain population sub-groups such as Indigenous communities, recent immigrants and asylum seekers, persons experiencing homelessness, single mothers and their children, persons living with disabilities, families from racialized communities, low-income neighbourhoods, and persons with mental health and substance use disorders. Helping address these challenges and providing outreach that improves access to care for marginalized, underserved, and harder to reach groups is central to reducing avoidable differences in health outcomes as compared to the general population.

### Improving individual and population health outcomes

Socially accountable care, provided through connection to a Patient's Medical Home and Patient's Medical Neighbourhood, enables integrated care that leads to improved access to services, greater patient adherence, fewer unmet care needs, improved clinical outcomes, reduced reliance on emergency room services and "revolving door" care, as well as a reduction in hospitalizations and other negative health and social outcomes.

## **Socially accountable care therefore has a host of benefits—it's time to act to strengthen the primary care system to provide socially accountable care for all in Canada**

While broader political and policy changes are needed to eliminate poverty and social exclusion at its source, emerging scientific evidence indicates that the organization and delivery of primary health care systems can enable more socially accountable care to better support the growing needs of marginalized and underserved populations during the pandemic recovery, address health inequity, and improve health outcomes. Advocacy by front-line health care providers in concert with patients can influence these needed policy changes.

### **How can we create systems that promote socially accountable care?**

#### **1. Socially accountable care is whole person care**

##### **Trauma-informed care to promote health equity: The cornerstone of socially accountable care**

Trauma-informed care provides a safe space to offer a range of support services in a coordinated and ongoing way. Studies have shown that this is an effective approach to care for new immigrants and asylum seekers, patients from religious minority or racialized communities, those with lived experience of violence or neglect, survivors of human trafficking, persons living with disabilities, persons experiencing homelessness, persons with mental health and substance use disorders, veterans, and others. In these times, with recent pandemic disruptions, it can also be used as a universal approach to better care for all patients, providing them with greater choice and control over their own care trajectory.

##### **Social history taking and prescribing: To meet physical health, mental health, and social needs**

Increasingly, social history taking, case finding, and screening for social determinants of health has been gaining traction in clinical care. This allows health

workers to identify key areas for social prescribing by focusing on patient assets and strengths and connecting them with further support resources. Particularly during the pandemic recovery, addressing patient social and economic needs is increasingly relevant in the context of care, and social prescribing is increasingly associated with high-quality, holistic patient care. Promoting joint advocacy with patients and civil society organizations can help address the upstream structural causes and prevent health inequities at the source.

##### **Action items to promote whole person care:**

- Integrate training including theory and practical applications of trauma-informed care, social history taking, and social prescribing into learning objectives in medical school and residency training
- Evaluate trauma-informed care, social history taking, and social prescribing skills in Objective Structured Clinical Examination (OSCE) exams and simulated office orals (SOOs)
- Incorporate tools for trauma-informed care, social history taking, and social prescribing into electronic medical records (e.g., include disability forms that help patients on social welfare receive additional financial support to help afford housing, food, and other necessities)
- Provide clinical training on how to complete and submit these forms to relevant authorities. Education in the realm of the CanMEDS competencies relating to the “physician as health advocate” can further complement these educational efforts.

#### **2. Socially accountable care is coordinated care**

##### **Patient navigators: Help patients navigate complex health and social care systems**

Studies have demonstrated that a new cadre of health care workers can help patients navigate existing support resources that are often difficult to learn about and access. Health care organizations aiming to provide more socially accountable care



are increasingly hiring a range of non-clinical staff to provide needed social support. These newer members of interprofessional primary care teams can include patient navigators, cultural brokers, health service brokers, and community care navigators. There is some promising experience with medical-legal partnerships (MLPs), as well as supporting informal caregivers who often undertake navigational roles for family members with little or no guidance to assist them in doing so. These navigator roles are key to helping patients access a range of support interventions within health and social care systems as well as community supports.

### **Specialized link workers: Help patients find employment, housing, and fulfill other basic needs**

Evidence shows that interprofessional primary care teams that take a holistic view of health and social needs are adequately trained to do social history taking and social prescribing, work alongside designated link workers (e.g., housing specialist, employment specialist, social workers, peer support workers, etc.), are better able to help patients connect with employment opportunities, reduce food insecurity, access permanent supportive housing, obtain financial support and government benefits, and reduce exposure to family violence and maltreatment.

### **Action items to promote coordinated care:**

- Increase funding for allied health workers to be hired as part of interprofessional teams in

Patient's Medical Homes to take on the important roles of patient navigators, cultural brokers, and liaisons to local community resources

- Increase funding to hire specialized link workers to work within Patient's Medical Homes to connect patients experiencing or at risk of homelessness with housing; persons in precarious work situations with stable, well-paying jobs; persons experiencing food insecurity with Meals on Wheels or other food support services; persons experiencing poverty with financial assistance; and persons experiencing violence with psychosocial supports so that people's basic needs are being met, in addition to addressing the health consequences of this precarity

## **3. Socially accountable care is timely and accessible care**

### **Increased support during transitions: Making difficult transitions easier to overcome**

Providing wraparound support is particularly important during transitions. These include persons with a new diagnosis, adolescents aging out of pediatric care, youth in foster care transitioning to independent living, persons leaving correctional services, young people living with disabilities embarking on post-secondary educational or work opportunities, or hospitalized patients being discharged to community-based care. For instance, having access to a family doctor reduces the risk of elderly persons entering long-term care by 25 per cent. Seamless support provided by primary care improves health and social outcomes, making sure that no patient falls through the cracks.

### **Outreach beyond the clinic: Reaching out to people in the local community**

Providing outreach and reorienting health services is a key tenet of the *Ottawa Charter for Health Promotion* to meet the needs of all patients, particularly those who may feel excluded and unsafe accessing care. Outreach can take many forms including mobile clinics, specialty clinics within primary care, out-

reach workers going to community organizations or providing services on the street, virtual and in-person care to rural and remote communities, or community engagement. Socially accountable care is inclusive care that reduces barriers, ensuring that marginalized and underserved populations can engage with and access the supports and care they need where they need them, in ways that are accessible to them.

### Action items to promote timely and accessible care:

- Working across systems to provide clear pathways for patients to enter into Patient Medical Homes, with particular focus on people transitioning between care systems or during life transitions
- Increased funding for specialized family doctors who are trained to work with specific groups to be integrated into interprofessional teams serving group homes or transition programs such as those for persons exiting correctional services, or working as part of Assertive Community Treatment teams
- Increased funding to hire community outreach workers who adopt a population health approach and can make links with other local community organizations to ensure that people living far from care but within the catchment area of the Patient's Medical Home are able to access health care

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## Resources

1. Abdel-Aleem H, El-Gibaly OM, EL-Gazzar AF-S, Al-Attar GS. Mobile clinics for women's and children's health. *Cochrane Database Syst Rev*. 2016;(8):CD009677. Accessed July 29, 2022. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009677.pub2/full>
2. Andermann A, Bloch G, Goel R, Brcic V, Salvalaggio G, Twan S, et al. Caring for patients with lived experience of homelessness. *Can Fam Physician*. 2020;66(8):563-570.
3. Aubry T, Bloch G, Brcic V, Saad A, Magwood O, Abdalla T, et al. Effectiveness of permanent supportive housing and income assistance interventions for homeless individuals in high-income countries: a systematic review. *Lancet Public Health*. 2020;5(6):e342-360.
4. Behforouz HL, Drain PK, Rhatigan JJ. Rethinking the Social History. *NEngl J Med*. 2014;371(14):1277-1279.
5. Berk-Clark C, Doucette E, Rottnek F, Manard W, Prada MA, Hughes R, et al. Do Patient-Centered Medical Homes Improve Health Behaviors, Outcomes, and Experiences of Low-Income Patients? A Systematic Review and Meta-Analysis. *Health Serv Res*. 2018;53(3):1777-1798.
6. College of Family Physicians of Canada. Best Advice guide: *Patient's Medical Neighbourhood*. Mississauga, ON: College of Family Physicians of Canada; 2020. Accessed July 29, 2022. <https://patientsmedicalhome.ca/resources/best-advice-guides/the-patients-medical-neighbourhood/>
7. Boles JR, Martinez O. Bridging Health Disparity Gaps through the Use of Medical Legal Partnerships in Patient Care: A Systematic Review. *J Law Med Ethics*. 2017;45(2):260-273. Accessed July 29, 2022. <https://papers.ssrn.com/abstract=3518752>
8. Buchman S, Woollard R, Meili R, Goel R. Practising social accountability: From theory to action. *Can Fam Physician*. 2016;62(1):15-18.
9. Chng NR, Hawkins K, Fitzpatrick B, O'Donnell CA, Mackenzie M, Wyke S, et al. Implementing social prescribing in primary care in areas of high socioeconomic deprivation: process evaluation of the 'Deep End' community Links Worker Programme. *Br J Gen Pract*. 2021;71(713):e912-920.



10. Dam AEH, de Vugt ME, Klinkenberg IPM, Verhey FRJ, van Boxtel MPJ. A systematic review of social support interventions for caregivers of people with dementia: Are they doing what they promise? *Maturitas*. 2016;85:117-130.
11. De Marchis EH, Torres JM, Benesch T, Fichtenberg C, Allen IE, Whitaker EM, et al. Interventions Addressing Food Insecurity in Health Care Settings: A Systematic Review. *Ann Fam Med*. 2019;17(5):436-447.
12. Embrett MG, Randall GE, Longo CJ, Nguyen T, Mulvale G. Effectiveness of Health System Services and Programs for Youth to Adult Transitions in Mental Health Care: A Systematic Review of Academic Literature. *Adm Policy Ment Health*. 2016;43(2):259-269.
13. Gregorevic KJ, Lim WK, Peel NM, Martin RS, Hubbard RE. Are health assets associated with improved outcomes for hospitalised older adults? A systematic review. *Arch Gerontol Geriatr*. 2016;67:14-20.
14. Gruen RL, Weeramanthri TS, Knight SSE, Bailie RS. Specialist outreach clinics in primary care and rural hospital settings. *Cochrane Database Syst Rev*. 2004;2003(1):CD003798. Accessed July 29, 2022. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003798.pub2/full>
15. Gunawardena N, Stich C. Interventions for young people aging out of the child welfare system: A systematic literature review. *Child Youth Serv Rev*. 2021;127:106076.
16. Hemmings S, Jakobowitz S, Abas M, Bick D, Howard LM, Stanley N, et al. Responding to the health needs of survivors of human trafficking: a systematic review. *BMC Health Serv Res*. 2016;16:320.
17. Hopkin G, Evans-Lacko S, Forrester A, Shaw J, Thornicroft G. Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review. *Adm Policy Ment Health*. 2018;45(4):623-634.
18. Lalji R, Francis A, Khalid R, Guha C, Johnson DW, Wong G. Patient navigator programmes for children and adolescents with chronic diseases. *Cochrane Database Syst Rev*. 2021:CD014688. Accessed July 29, 2022. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD014688/full>
19. Lindsay S, Lamptey D-L, Cagliostro E, Srikanthan D, Mortaji N, Karon L. A systematic review of post-secondary transition interventions for youth with disabilities. *Disabil Rehabil*. 2019;41(21):2492-2505.
20. Lucas P, McIntosh K, Petticrew M, Roberts HM, Shiell A. Financial benefits for child health and well-being in low income or socially disadvantaged families in developed world countries. *Cochrane Database Syst Rev*. 2008;2008(2):CD006358 Accessed July 29, 2022. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006358.pub2/full>
21. Magwood O, Leki VY, Kpade V, Saad A, Alkhateeb Q, Gebremeskel A, et al. Common trust and personal safety issues: A systematic review on the acceptability of health and social interventions for persons with lived experience of homelessness. *PLoS One*. 2019;14(12):e0226306.
22. Matin BK, Williamson HJ, Karyani AK, Rezaei S, Soofi M, Soltani S. Barriers in access to healthcare for women with disabilities: a systematic review in qualitative studies. *BMC Womens Health*. 2021;21(1):44.
23. Norman C, Wildman JM, Sowden S. COVID-19 at the Deep End: A Qualitative Interview Study of Primary Care Staff Working in the Most Deprived Areas of England during the COVID-19 Pandemic. *Int J Environ Res Public Health*. 2021;18(16):8689.
24. Nowak DA, Mulligan K. Social prescribing: A call to action. *Can Fam Physician*. 2021;67(2):88-91.

25. Pinto AD, Hassen N, Craig-Neil A. Employment Interventions in Health Settings: A Systematic Review and Synthesis. *Ann Fam Med*. 2018;16(5):447-460.
26. Purkey E, Patel R, Phillips SP. Trauma-informed care: Better care for everyone. *Can Fam Physician*. 2018;64(3):170-172.
27. Roland M, Everington S, Marshall M. Social Prescribing - Transforming the Relationship between Physicians and Their Patients. *N Engl J Med*. 2020;383(2):97-99.
28. Shommu NS, Ahmed S, Rumana N, Barron GRS, McBrien KA, Turin TC. What is the scope of improving immigrant and ethnic minority healthcare using community navigators: A systematic scoping review. *Int J Equity Health*. 2016;15(1):6.
29. Thomas L, Parker S, Song H, Gunatillaka N, Russell G, Harris M, et al. Health service brokerage to improve primary care access for populations experiencing vulnerability or disadvantage: a systematic review and realist synthesis. *BMC Health Serv Res*. 2019;19(1):269.
30. Turner W, Hester M, Broad J, Szilassy E, Feder G, Drinkwater J, et al. Interventions to Improve the Response of Professionals to Children Exposed to Domestic Violence and Abuse: A Systematic Review. *Child Abuse Rev*. 2017;26(1):19-39.
31. Employment and Social Development Canada. *Understanding Systems: The 2021 report of the National Advisory Council on Poverty*. Ottawa, ON: Government of Canada; 2021.
32. Wood E, Ohlsen S, Fenton S-J, Connell J, Weich S. Social prescribing for people with complex needs: a realist evaluation. *BMC Fam Pract*. 2021;22(1):53.
33. World Health Organization. *The Ottawa Charter for Health Promotion*. Geneva, CH: World Health Organization, 1986.

For additional readings on Socially Accountable Care please visit the CFPC Social Accountability Working Group – Resources web page at <https://www.cfpc.ca/en/member-services/committees/social-accountability-working-group#resources>.

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