GPSC
General Practice Services Committee

A key component in evaluating the success and benefits of patient medical homes involves collecting stories of health care change from doctors, patients, and allied care providers. These stories take readers on a journey toward understanding how patient medical homes are improving care around the province.

Change Snapshot: How having a social worker in practice helps meet broader community needs.

Listen to an audio version of this story here.

Dynamic Support for Community Needs

I became employed as a social worker 37.5 hours per week by a health care cooperative 9 months ago. I work with 10 doctors and 1 NP, plus MOAs and nurses, spread across 5 clinics, covering a distance of 100 km. The model in the clinics where I work is focused on providing better care for patients through wrap-around support from team members. Because I have access to medical records, paperwork can be done to better reflect the patient's functioning. I see that doctors struggle with paperwork. They are required to fill out so many forms in order to try and help the patient, without having the training or time to fill them in properly. Some forms, including provincial and federal disability, disability tax credit, fuel tax credit, insurance forms, and end of life planning can be supported by a social worker.

I have the same group of tasks in each clinic, but the proportions vary depending on the area- in the west, where there is more extreme poverty, I do more paperwork. In general, I spend about 30-40% of my time doing counseling for; anxiety, depression, stress, coping skills, and grief and loss, 30-50% on forms, and 25-30% on referrals, including assessing clients for relevant programming and making referrals. Paperwork can often be done in 2-5 appointments, while counselling may take longer depending on the subject. The counseling is working with clients that are considered low to moderate acuity. Moderate to severe mental health clients are still referred to mental health and substance use through Interior Health.

Sometimes I get referrals from the doctors on the fly. These patients might include a woman whose husband committed suicide, a person whose kids are in care, someone who is struggling financially, or a patient who comes to an appointment intoxicated. They might not be moderate to severe, and they don't meet the criteria for support through Health Authority Mental Health and Substance Use but they need resources and perhaps some brief counseling. Doctors may know that a patient needs more financial support but aren't aware of the programs that are out there or the varied and complex eligibility criteria. Many patients don’t have computers or computer skills, and they need support to apply for programs that they are eligible for. I’ve worked with patients on CPP disability who didn’t realize they could qualify as a person with a disability- I was able to increase their income from $800 to $1,200 per month, an increase of 30%, in 2 appointments. That can make a huge difference to someone’s life and ability to function.

I moved to BC from Alberta, where I have a history of working with chronic pain patients, street clients, doing street outreach, harm reduction, and dealing with severe mental health and substance use issues. I worked within complex systems and assessing clients’ biopsychosocial and programming needs. While I’m very familiar with the federal system, the provincial welfare systems are completely different, and it has been a steep learning curve to catch up. BC does not trust clients to know what they need to apply for. If a person knows they have to apply for person with disability services, they have to apply to the Ministry for support and then be assessed. In Alberta, clients have case workers locally who they can sit down with and talk to face to face, build a relationship with. In BC they have to use a call centre with no set contact person; anytime they need to contact the ministry they have to call the call centre and sit on hold for an

hour before they talk to a random case worker who they have never had contact with before. It is definitely a different system and something to get used to.
The most significant change I've experienced since starting the role is that I've moved from the job description to developing an idea of how the role can meet community needs. When I first started, the cooperative knew that they wanted a social worker who could do counselling, but no doctors had worked directly with a social worker before, and there is limited access to social workers in the community without being a client of a particular agency (Mental health clients can see a social work at mental health, people who are inpatients of the hospital can see the hospital social worker, etc.). This role has been constantly evolving and will hopefully continue to evolve to support the health of the clients.

This change is significant to me because I really value the autonomy in my role. Because I'm not employed by the Health Authority, I can be incredibly dynamic in meeting the needs of the community I serve. For example, if one community is experiencing a crisis, I can provide support right away. It's a much more gratifying way to work, and the non-profit trusts my skills and judgement in providing the best benefits to the community. I really see the value in having a social worker available to the general public. The change that I have been able to effect in people's life and healthcare has been striking.