Integrating health and social care for children in Canada

Andrew D. Pinto MD CCFP FRCPC MSc Kamna M. Gandhi BSc Ayu Hapsari MSc
Alia Sunderji MD FRCPC MPH Justine Cohen-Silver MSc MD FRCPC MPH

Evidence shows an ongoing close relationship between poverty and health.[1] Children living in poverty are at increased risk of mortality and poor health, including increased rates of unintentional injury, homicide, poor vision, and iron deficiency anemia.[2] One in 5 children in Canada lived in poverty before the COVID-19 pandemic and this number is projected to rise over at least the next 5 years.[1] Between February and August 2020, the unemployment rate rose from 5.6% to 10.2%, with the lowest income groups the most severely impacted.[3] In the early stages of the pandemic, the rate of food insecurity among families with children was 19.2%, almost double the rate in 2018.[4] Closing schools to in-person learning is expected to have widened pre-existing disparities in education and to have disproportionately impacted children and families who were already experiencing inequities in access to Internet and computers and who have abusive or unstable home environments.[5]

Practitioners and policy makers must anticipate that the COVID-19 pandemic will likely have long-term implications for health and well-being. The disproportionate burden of the pandemic on children experiencing unmet social needs warrants a call to action to imagine new models of care integration. In this commentary, we will outline the problem of disparate health and social care systems, review 3 main models of health and social care integration, and propose 4 key components to better integrate health and social care for children in Canada.

Disparate health and social care systems

Clinicians and health organizations often witness the impact of unmet social needs on health; however, the complex interplay between health and social services complicates resource delivery. In Canada, health care systems have generally evolved apart from social care systems. Health care, for our purposes, includes services provided by physicians, nurses, and other regulated health professionals within and through health organizations including hospitals, clinics, and long-term care facilities. Similarly, we define *social care* as services that aid and support individuals and their families with basic necessities of life, including coping with personal and contextual circumstances, provided by a range of regulated providers (eg, social workers) and unregulated providers (eg, unlicensed child care). Social care is delivered through community-based organizations such as schools and child welfare organizations, among others.

While universal access to health services is a key component of the Canadian social identity and a fundamental right, social care is not universally available or funded fully through tax dollars. Patients and families with social needs that impact health, such as poverty, inadequate housing, and food insecurity, are faced with a patchwork system of services that do not directly connect with the health system. The social pediatrics movement recognizes that children develop within a dynamic network of caregivers and systems that are accountable for their well-being.[6] Health organizations might refer patients and families to community services; however, records of the outcome of the referral are not typically shared. Funding for child health and social care follows a fee-for-service model that is reactive rather than proactive and focuses on individuals. This causes a flourish of support during crises rather than focusing on preventive opportunities.

Health and social care integration in North America

We identify 3 main models aiming to integrate health and social care for children in North America: "screen-intervene," co-localization of health services with community agencies, and community-based partnerships across different sectors.

Screen-intervene. The Canadian Paediatric Society encourages pediatricians to regularly take a social history of families, in addition to a medical history, to identify social determinants of health and resources they require.[7] Screening has been useful in identifying the social needs of patients; however, many health care sites struggle to gain seamless access to necessary interventions and to coordinate social care provision efficiently. Care navigators with training in social work and extensive knowledge of existing resources are ideal personnel to facilitate social care coordination. Unfortunately, many health clinics still have inadequate access to care navigators. The K!DConnect program at St Michael's Hospital in Toronto, Ont, is a successful hospital clinic–based care navigator program that supports children with developmental and mental health conditions and has been shown to have a positive impact on family social context.[8] The Integrated Care Program at Boston Children's Hospital in Massachusetts is another effective program that uses care coordinators, who routinely follow up with patients, and ongoing surveys to

ensure high quality of service delivery.[9] A drawback of the screen-intervene model is its reliance on access to local resources and clinicians' judgment to refer patients to a navigator.

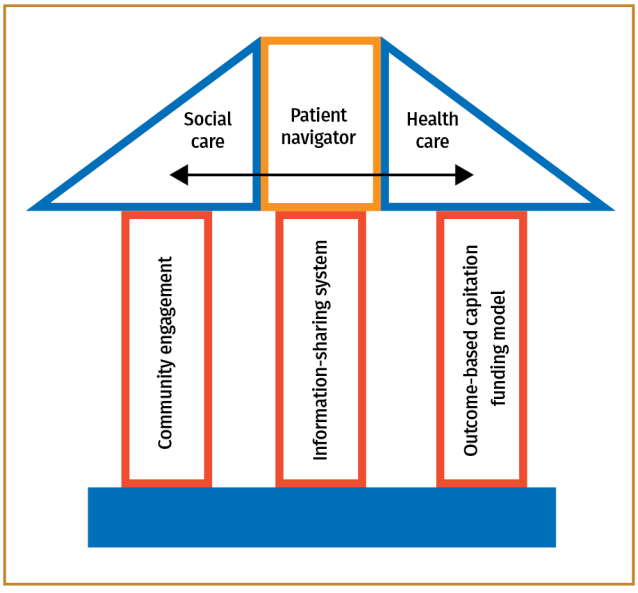
Co-localization. Delivering health care in local schools is a key example of co-localization that improves access to health services for disadvantaged populations. In the United States, more than 2000 school-based health centres (SBHCs) have been established and shown to be effective.[10] In Canada, at Unity Health Toronto, SBHCs have also been established in partnerships with local school boards through the Research Equity Advocacy in Child Health School Network and have provided care to more than 2000 children in the greater Toronto area.[11] Using schools to deliver health care and address health barriers affecting learning, these SBHCs support families experiencing language barriers, single-parent homes, parents who are unemployed, and newcomers to Canada. The outcomes of this initiative in Toronto show there is promise in addressing inequities in health care access elsewhere by implementing health clinics directly within sectors that serve disadvantaged subgroups. School-based health centres are often limited in the number of services they can provide and in their capacity to continuously share information with various health and social care providers.

Community-based partnerships. Partnerships with local professionals are opportunities to mobilize community-based resources and advance policies for entire communities.[12] In 2009, the Cincinnati Child Health-Law Partnership in Ohio brought together clinicians, attorneys, and local housing departments to identify substandard housing conditions and improve them for marginalized families.[12] The underuse of medical-legal partnerships in Canada at the community level means opportunities are often missed to use legal expertise to address social determinants of health for entire neighbourhoods. The Health Justice Program at St Michael's Hospital in Toronto seeks to protect families from eviction and to improve household income by addressing tenant, disability, and employment rights.[13] Other examples of intersectoral partnerships are those between hospitals and food banks in the United States that distribute medically tailored meals to patients with diabetes experiencing food insecurity[14] and StreetCred in Boston that helps families complete tax forms in the medical clinic waiting room.[15] Despite their potential, community partnerships are often limited to small-scale programs. Learning from them, one can consider how to scale up this type of collaborative partnership.

Effective integrated care

The following 4 components are key to effectively integrating care (**Figure 1**).

Figure 1. Key components of an effective integrated care model



Integration of health care and social care through patient navigators. We believe health services for children and their families must be directly integrated with social care. To facilitate this integration, system navigators who are able to access all services can act as a link and a support for children and families. Continuous engagement between system navigators and family health care providers is also crucial.

Information-sharing systems. Cross-sectoral work will require information technology systems that allow data sharing between organizations. A common, shared health and social care "passport" that covers patients from birth to 18 years of age and beyond into young adulthood, is interoperable among systems, and upholds patients' autonomy over data access permission is key. Although data will continue to be stored locally, a benefit of the passport is that data also move with the patient and family, thus easing communications between relevant health and social care providers. Organizations must also allot funding and outline their expectations for timely communication across resource sectors.

Capitation funding model for outpatients. Funding needs to flow with patients and families and be related in part to delivering a package of care over a period of time, rather than on a fee-for-service basis. New integrated care models in Alberta and Ontario support this change by moving organizations toward capitation and population health approaches to care, where clinics are compensated based on the number of patients served over a year, to allow physicians to spend adequate time with patients based on their needs.[16] Data that track outcomes and performance and integrate patient- and family-reported experience measures are crucial. As with

other bundled-care financing schemes, it will be important to capture the overall performance of the organizations and ensure that universal access is maintained.

Community engagement. We need to engage communities in both developing guidelines that will assist in creating cross-sectoral programs and in implementing these programs. It is necessary to work with multiple stakeholders using a social determinants of health lens, including public health organizations, schools, the justice system, child protective agencies, and housing authorities as well as community members. The providers who work within these sectors also deserve a seat at the table to inform high-level decisions.

Conclusion

The COVID-19 pandemic has revealed widening disparities in society and weaknesses in the system that is supposed to support care for families. We should emerge from the pandemic with a renewed vision of integrated health and social care to improve outcomes and reduce inequities. We have identified 3 models of health and social care intervention (screen-intervene, co-localization of services, and community-based partnerships) and 4 key components of effective integrated care (integration through patient navigators, information-sharing systems, a capitation funding model, and community engagement). These fit well with other efforts to integrate care for youth and young adults, such as those around mental health services.[17] Such initiatives could help us recover from the current crisis and plot a trajectory toward improved health and reduced health inequities for children in Canada.

Dr Andrew D. Pinto is Founder and Director of the Upstream Lab at the MAP Centre for Urban Health Solutions in the Li Ka Shing Knowledge Institute at Unity Health Toronto in Ontario, Associate Professor in the Department of Family and Community Medicine at the University of Toronto, a family physician and public health and preventive medicine specialist in the Department of Family and Community Medicine at St Michael's Hospital, and Associate Professor in the Dalla Lana School of Public Health at the University of Toronto. **Kamna M. Gandhi** is a master's degree student in counseling psychology at Yorkville University in Toronto, Ont. **Ayu Hapsari** is Research Coordinator in the Upstream Lab at the MAP Centre for Urban Health Solutions. **Dr Alia Sunderji** is Academic Clinician in the Department of Paediatrics at the University of Toronto and a pediatric emergency physician in the Department of Emergency Medicine at the Hospital for Sick Children. **Dr Justine Cohen-Silver** is Investigator in the Li Ka Shing Knowledge Institute at Unity Health Toronto, Assistant Professor in the Department of Paediatrics at the University of Toronto, and a staff pediatrician in the Department of Emergency Medicine at the Hospital for Sick Children and in the Women and Children's Health Program at St Joseph's Health Centre and St Michael's Hospital.

Competing interests
None declared

Correspondence
Dr Andrew D. Pinto; e-mail **andrew.pinto@utoronto.ca**

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