June 28th, 2022

Current State of Social Prescribing in Canada

Summary Report

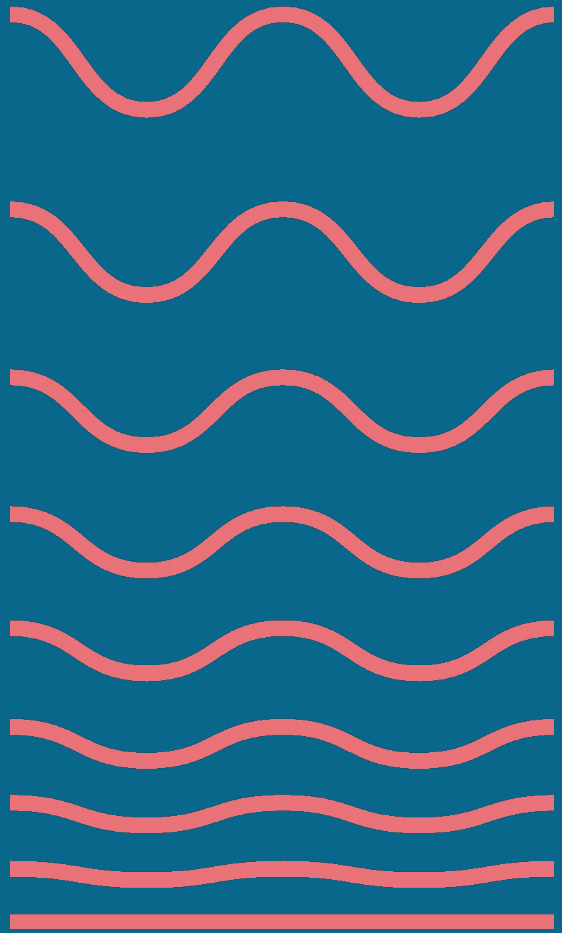

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Table of Contents

Project Overview

Project Overview

This report is the first output of a project being delivered in partnership with the **Canadian Institute for Social Prescribing (CISP)** and the **Canadian Social Prescribing Community of Practice (CoP)**. The objective of the project is to better understand the current state of social prescribing (SP) in Canada. The research in this report will help support the development of a national model of SP in Canada. The project is being delivered in three phases, outlined below:

Phase 1:
Understand & Define the current state of SP in Canada through a multi-faceted research approach

Phase 2:
Co-create and validate Identify ideal building blocks for a national SP framework through collaborative co-design strategies with SP experts and knowledge keepers

Phase 3:
Formalize and Deliver project learnings into a final tool that will accelerate CISP's development of a national model for SP

Our Phase 1 research approach

Desk Research	Public Perception	Key Opinion Leaders
Document review and web-based environmental scan from 18 sources exploring the current state of SP globally and in Canada.	**25 intercept interviews** with members of the public at 3 strategically-chosen locations in the Greater Toronto Area: Jane & Wilson, Bloor & Bathurst and Scarborough Town Centre.	**10 interviews** with SP experts and members of the CoP from a variety of settings and geographies in Canada.

Executive Summary

The landscape and delivery of SP in Canada is diverse. There are many programs, services and initiatives that are focused on connecting individuals to non-clinical supports that provide a person-centred approach to improving their health and well-being. Currently, only some of these initiatives are formally referring to their work as a SP approach and are paving the way for continued buy-in and support.

Current SP efforts are grounded in:

Fostering Collaboration

- Building partnerships and leveraging existing resources across both primary care and community organizations
- Fostering shared decision-making and aligning on a shared vision

Providing Agility & Flexibility

- Connecting individuals with the supports they need at the moment they need it
- Offering programs and services that are flexible, low barrier and respond to the changing needs of the communities served

Measuring Impact

★ Many of these initiatives are capturing quantitative data to measure impact at a local level. However, measuring SP benefits at a population health level and gathering qualitative data on the less tangible benefits of SP remains a challenge.

These initiatives also share a common thread…

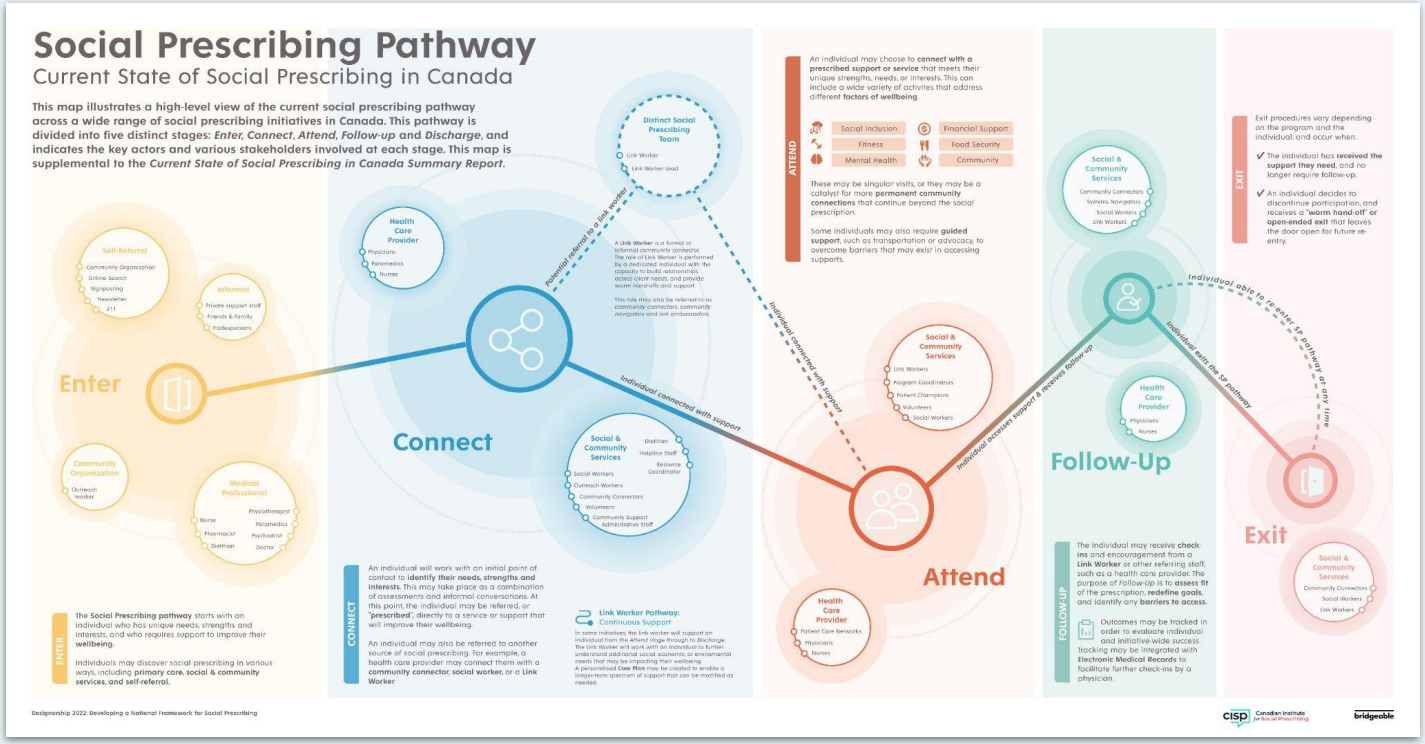
The "Link Worker"

The "link worker" role takes on many shapes but is ultimately a formal or informal community connector. Having a dedicated individual with the **capacity to build relationships**, **assess client needs** and **provide warm hand-offs** and support is at the core of these initiatives!

Note: Other than a link worker, these roles might also be referred to as *community connectors*, *community navigators* and *link ambassadors*.

Executive Summary

The pathway for SP varies across provincial, regional and local initiatives. Based on our research, the SP pathway consists of five stages: **entry** into the referral pathway, **connection** to a referral source, **attendance** at a social prescription program or service, **follow-up** from a dedicated individual and a warm or open-ended **exit** from the program or service. Refer to the full-scale map provided for a more detailed view.



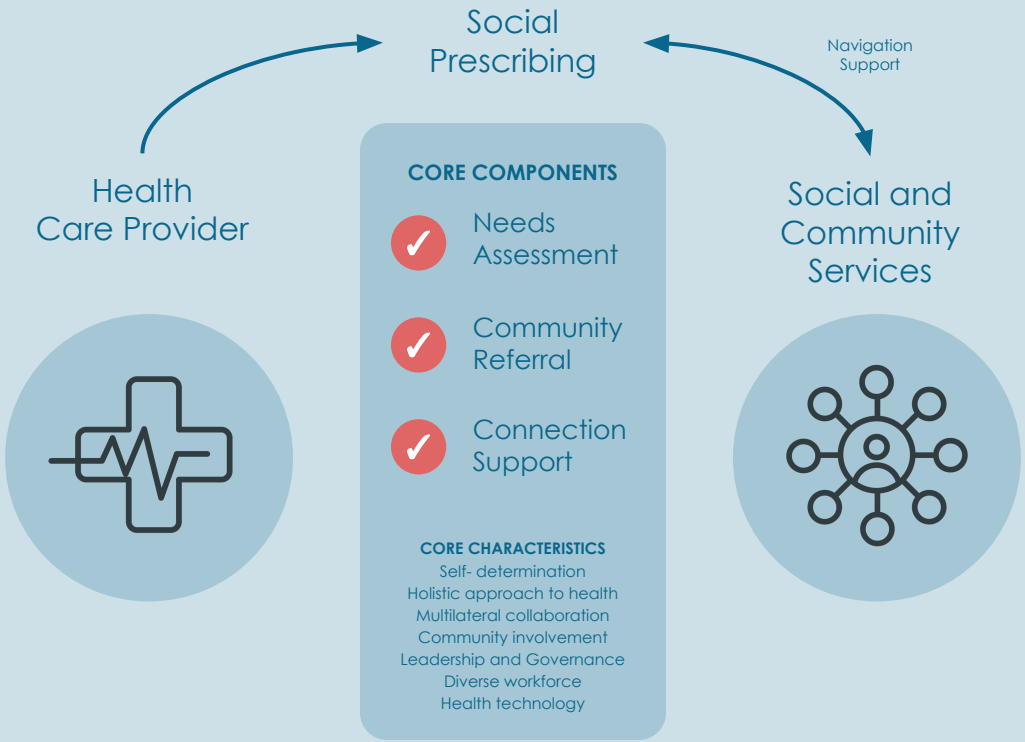
What is Social Prescribing?

What is Social Prescribing?

Social prescribing is a means for health-care providers to connect patients to a range of non clinical services in the community, in order to improve their health and well-being.

As opposed to simply treating symptoms, social prescribing can help to address the underlying causes of patients' health and well-being challenges. Social prescribing is a more holistic approach to health care, which promotes community-based integrated care, and helps to demedicalize health service provision.

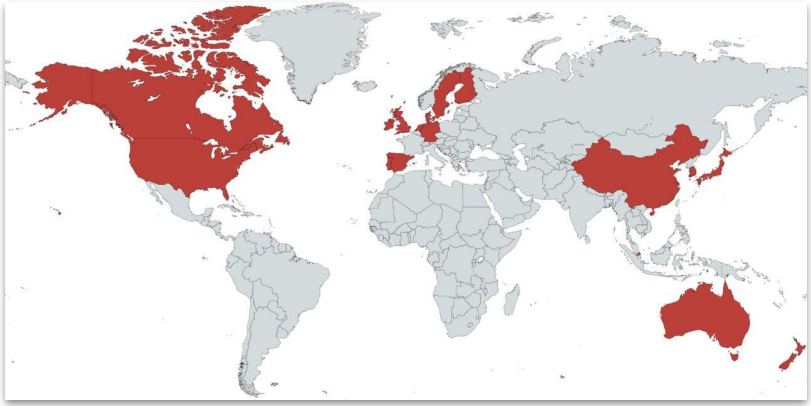
Reference Link:
World Health Organization: A Toolkit on how to Implement Social Prescribing.



Social Prescribing Around the World

SP as we know it today was first developed in the United Kingdom (UK) as early as the 1990s through small pockets of practice. By 2016, the number of UK SP pilot initiatives was growing significantly and prompted the development of the **International Social Prescribing Network and conference**. Today, the National Health Services (NHS) has incorporated SP into its national model of personalized care.

Currently, SP programs are being developed and implemented by approximately **17 countries around the world**. Similar models of connecting people to non-medical care have existed though not united under the term “social prescribing”



Examples of 17 countries which have developed and/or implemented social prescribing programmes: China, South Korea, Germany, Denmark, Finland, Sweden, Spain, Singapore, Ireland, The Netherlands, Portugal, New Zealand, USA, Japan, UK, Canada, Australia

Reference: Morse, D. F., Sandhu, S., Mulligan, K., Tierney, S., Polley, M., Giurca, B. C., ... & Husk, K. (2022). Global developments in social prescribing. BMJ Global Health, 7(5), e008524.

Social Prescribing in Canada

Spotlight on Social Prescribing in Canada

There are many diverse SP initiatives happening across Canada that vary in size, approach and target audiences and are tailored to meet the specific needs of their communities. We've captured SP initiatives at 5 different levels, ranging from national to hyper-local. This list is not exhaustive and is based on what we learned from our interviews with SP experts and some desk research (see Appendix B & C). An overview of these initiatives can be found in Appendix D.

National	Provincial	Regional	Local	Hyper-local
✓ Initiative, resource or service available across Canada	✓ Initiative, resource or service at a Provincial level	✓ Initiative, resource or service that covers one region	✓ Initiative, resource or service that serves a city or town	✓ Initiative, resource or service that serves a community or neighbourhood
• Parks Prescriptions (PaRx)*	• Alliance for Healthier Communities + Links2Wellbeing Project (ON) • United Way British Columbia's Social Prescribing Program (BC)	• **Fraser Health Authority & BC United Way: Seniors Community Connectors (BC)**** • 211 Community Connection in Collingwood (ON)	• **Seniors Community Services Partnership and Community Connect (Lethbridge, AB)** • Whistler 360 Health Collaborative (Whistler, BC) • Country Roads CHC (Portland, ON) • Legacy Project (Markham, ON)	• **Askennonia Senior Centre - Links2Wellbeing + Reach Out and Touch Someone (Midland, ON)** • People for a Healthy Community (Gabriola Island, BC) • Centretown Community Health Centre (Ottawa, ON) • Temiskaming CSC (Temiskaming, ON)

**Identified through desk research only*
***This is a province-wide health initiative, administered at a regional level*

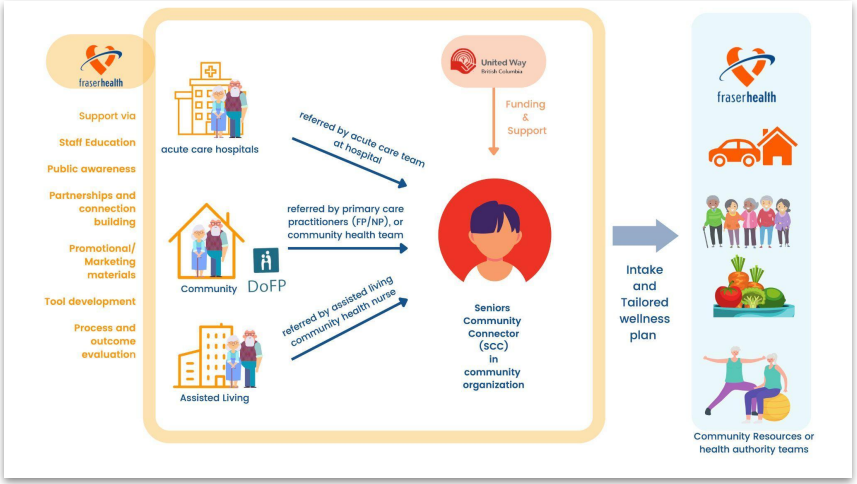
*We'll spotlight **3 initiatives** from these levels to capture novel approaches in SP implementation.*

Level: Regional

Setting: Urban / Rural | **Population:** 1.9 M

Seniors Community Connectors, Fraser Health Authority, BC

Fraser Health has 10 divisions of Family Practice, each working with a community-based seniors-serving organization. In this model each partner organization appoints a Seniors Community Connector (SCC), funded by the BC Ministry of Health, and managed by United Way British Columbia. The SCC does client intake, assessment and social care plan co-creation, and referrals to community services and supports. With an aging population, an emphasis on preventative care to avoid overburdening acute care services was required.



Reference Link: Fraser Health Seniors Community Connector Role Description

"When they are not connected in the community, [seniors] end up using the acute care system more [...] the health authority realized there needs to be more upstream focus on prevention and health promotion."

Dr. Grace Park, Family Physician and Regional Medical Director for Community Health Services, Fraser Health Authority, BC

What's working well:

- ✓ Using EMRs for data tracking and impact assessment
- ✓ Pilot project showed that after 6 months frailty was reduced
- ✓ Strong outcome measurement
- ✓ Partnership with United Way for funding and administration
- ✓ Health Authority leadership and staff embracing benefits of social prescribing

Opportunities:

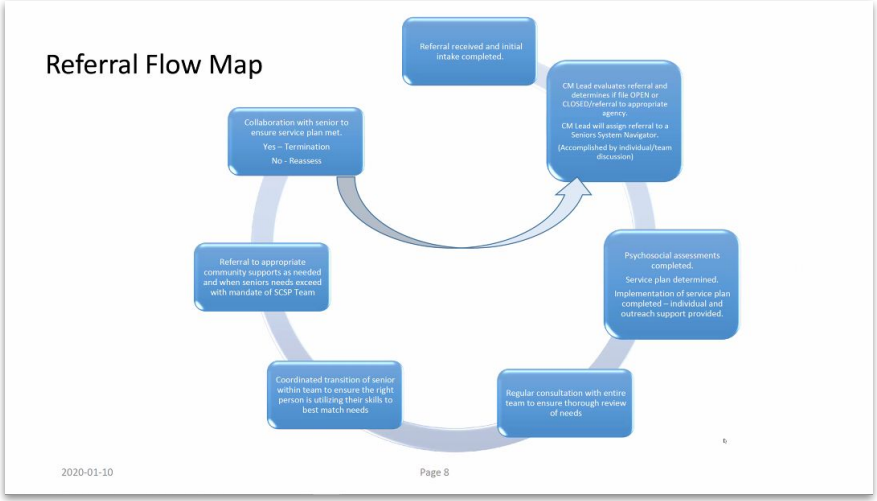
- ❑ Sharing information between organizations to create proactive care plans for vulnerable individuals ahead of climate emergencies (e.g., heat dome)
- ❑ Consistent funding across the province so every community has a "link worker" role
- ❑ Finding more Physician Champions to spread the word about SP
- ❑ Further inclusion of Indigenous communities

Seniors Community Services Partnership (SCSP) + Community Connect, LSCO Lethbridge, Alberta

SCSP is a partnership between six service organizations that support seniors in navigating health care and social resources, access financial benefits and housing, and provide emotional support and care for those with complex psychosocial needs.

Clients are referred to a lead intake worker, and are then assigned to a Senior System Navigator (SSN) to create a care plan and link them to a community partner or to services at the Lethbridge Senior Citizens Organization (LSCO). This SSN then provides ongoing one-on-one support up until discharge.

Community Connect is an outreach program that runs in parallel with the SCSP. The goal of this program is to conduct outreach to seniors who are experiencing isolation and loneliness, and provide them with social infrastructure and mental health resources.



Source: SCSP Proposed Delivery System, January 2020, LSCO

"The big advantage to having people based in multiple organizations is it doesn't look like one agency owns it. It forces us to work with the other organizations on an equal footing."

Rob Miyashiro, Executive Director, Lethbridge Senior Citizens Organization, Lethbridge, AB

What's working well:

- ✓ Positive relationships between the community and local government, and equal partnerships within the care community
- ✓ Partnerships between organizations has helped weather funding cuts from the provincial government

Opportunities:

- ❑ City and LSCO use different outcome tracking and case management software; alignment might allow for ease of data sharing and impact analysis

Level: Hyper-local

Setting: Town | **Population:** 16,850

Links2 Wellbeing + Reach Out and Touch Someone, Midland, Ontario

The Askennonia Senior Centre is a participating partner in the *Links2Wellbeing* SP project led by the Alliance for Healthier Communities. *Links2Wellbeing* enables health providers to link socially isolated older adults with community programs and services offered by Seniors Active Living Centres. Through a Simcoe County grant in 2021, Askennonia was able to add a second program, *Reach Out and Touch Someone*, to serve individuals 55+ facing complex social, financial or health challenges. In the program's first year, Mary was able to connect with 236 seniors requesting help with programs, services or financial support.

These programs are managed by a single volunteer with a social work background, Mary Moreau, and supported by the centre's Executive Director. Mary connects with each program participant to create an individualized care plan - ranging from fitness groups to using discretionary funds to repair a member's broken refrigerator.

Mary Moreau (right) volunteering at an Askennonia community picnic

Reference Link: Askennonia Centre's Weekly E-Blast Newsletter (community news and events listings)

"Seniors are so hesitant to ask for help, but once the door opens and they are comfortable with you, they will tell you more honestly [how they are]."

Mary Moreau,
Volunteer with *Links2Wellbeing / Reach Out and Touch Someone*
Askennonia Senior Centre,
Midland, ON

What's working well:

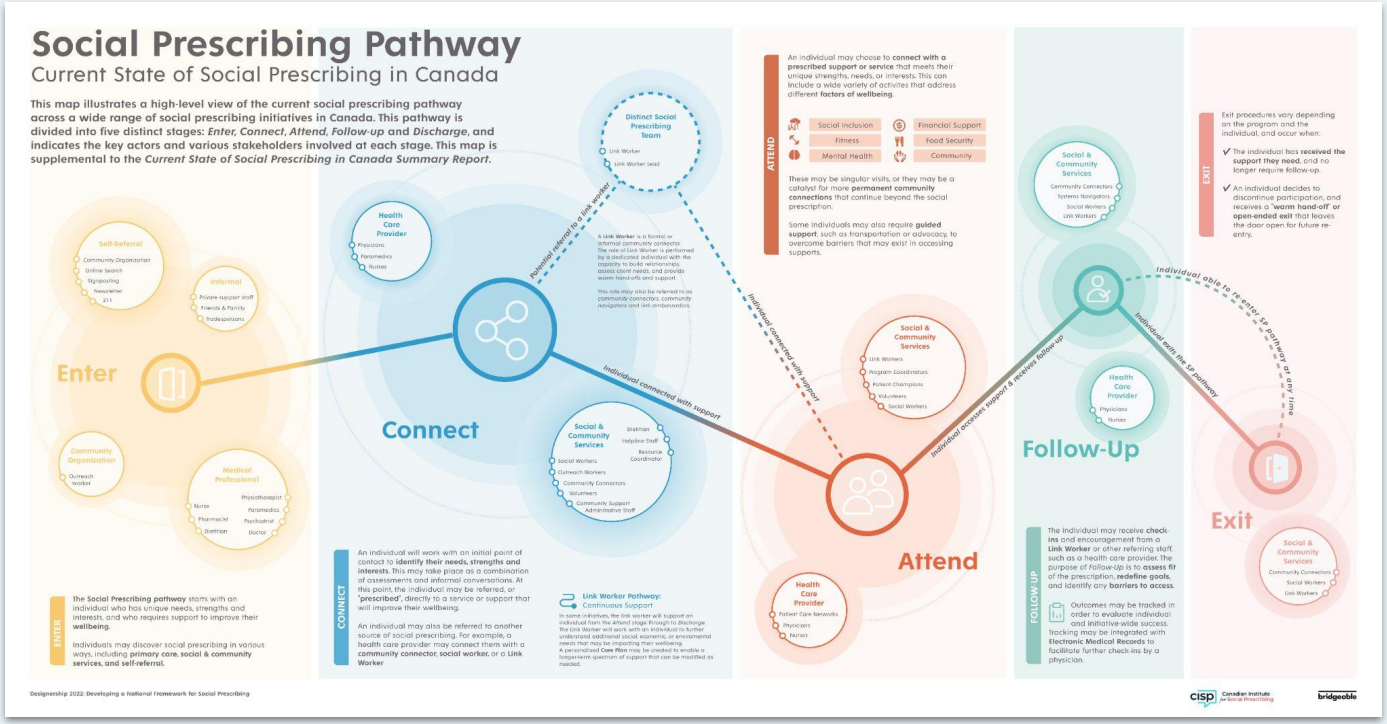
- ✓ People are often afraid to share details about their social challenges with their doctor. Mary's role as an intake worker has allowed her to build trust and personal connections with those accessing these services

Opportunities:

- ❑ Increasing referrals from health care providers (only 18 in the past year)
- ❑ Ensuring referrals are client-led so clients are ready to participate
- ❑ Improving measures to maintain client confidentiality for potential scaling

The Social Prescribing Pathway

The Social Prescribing Pathway



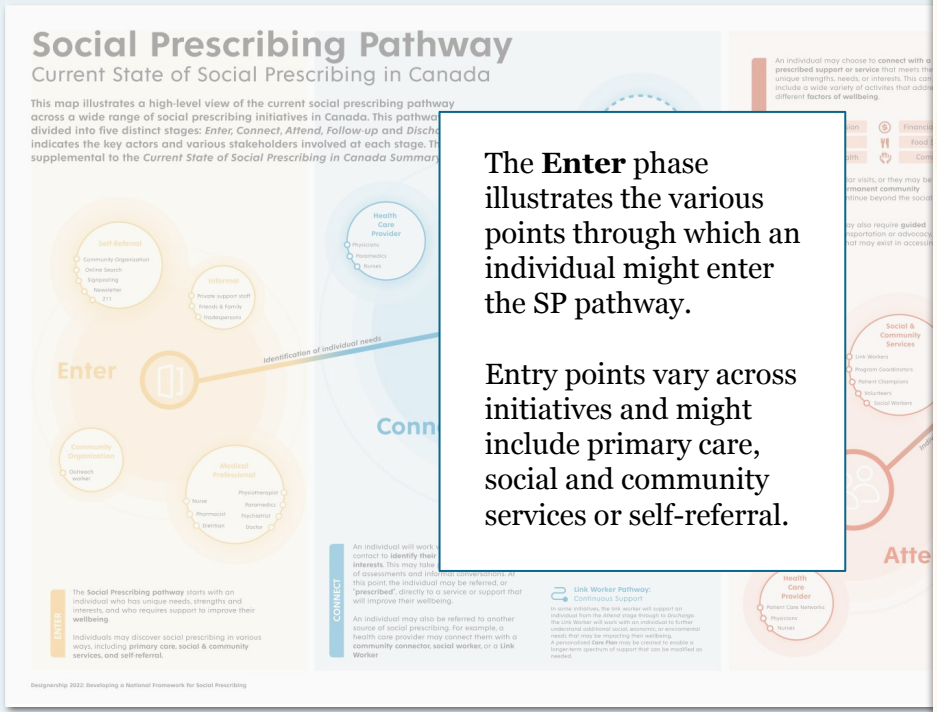
The *Social Prescribing Pathway* illustrates the **current state of social prescribing in Canada**, based on primary research and conversations with social prescribing experts.

It includes a high-level view of the **five stages** of an individual's experience through a social prescribing program or service, as well as the key stakeholders involved at each stage.

The following slides illustrate the content of the map in detail.

For a higher resolution view, see the full PDF version.

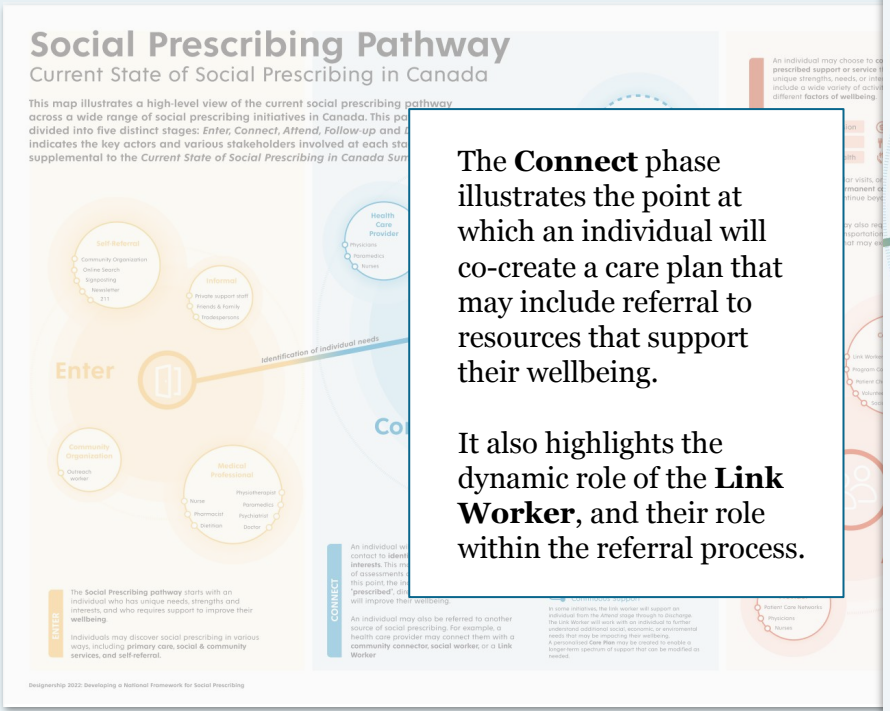
The Social Prescribing Pathway
Enter



The **Enter** phase illustrates the various points through which an individual might enter the SP pathway.

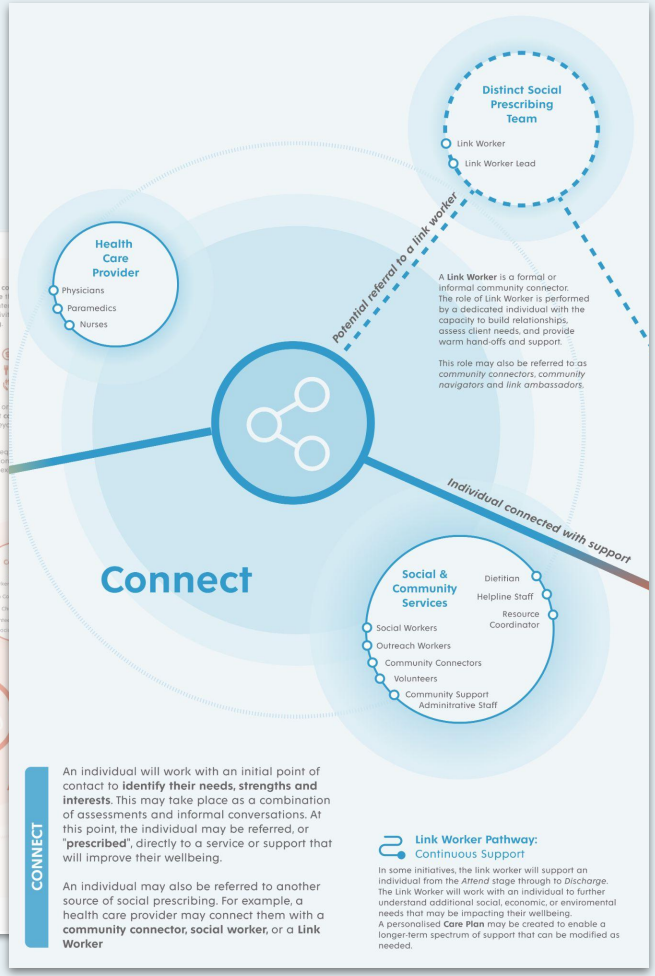
Entry points vary across initiatives and might include primary care, social and community services or self-referral.

The Social Prescribing Pathway
Connect

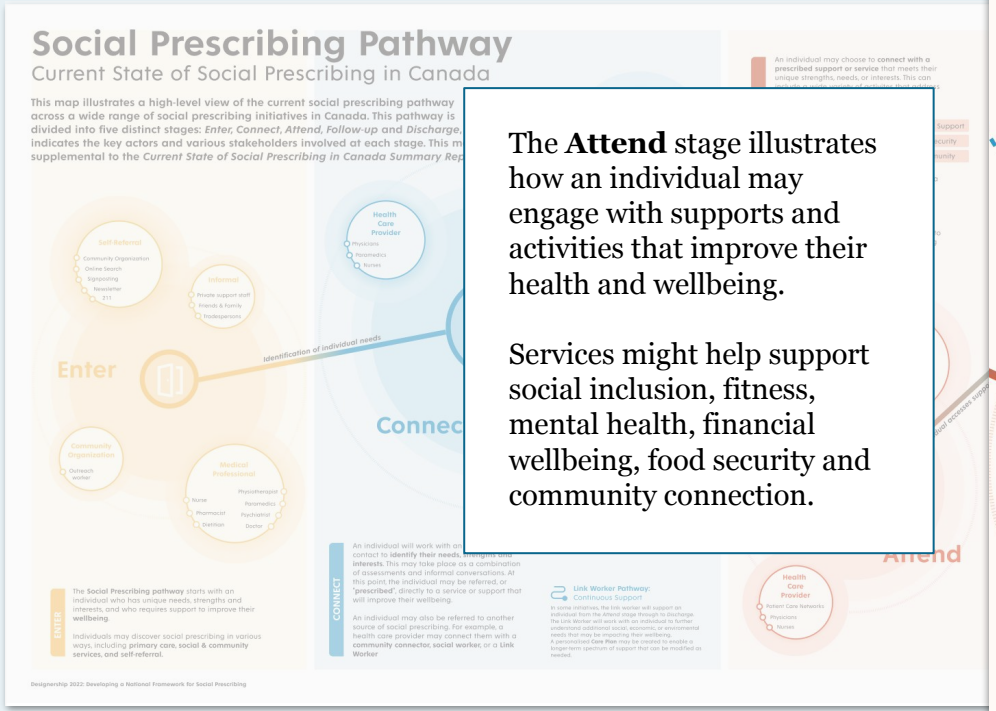


The **Connect** phase illustrates the point at which an individual will co-create a care plan that may include referral to resources that support their wellbeing.

It also highlights the dynamic role of the **Link Worker**, and their role within the referral process.

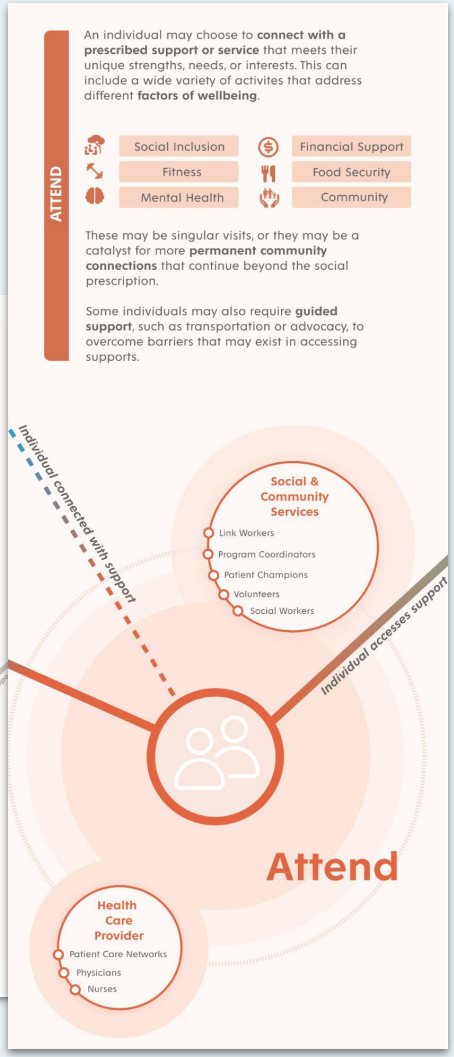


The Social Prescribing Pathway
Attend

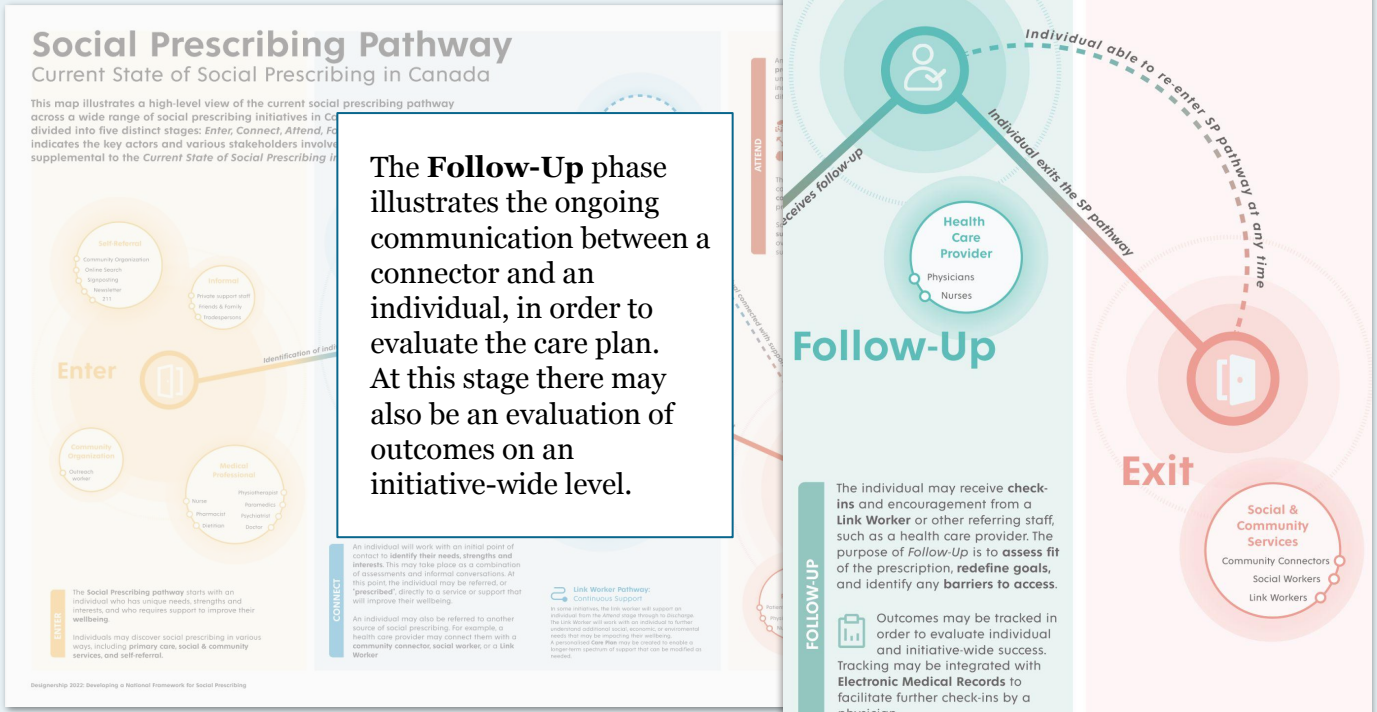


The **Attend** stage illustrates how an individual may engage with supports and activities that improve their health and wellbeing.

Services might help support social inclusion, fitness, mental health, financial wellbeing, food security and community connection.



The Social Prescribing Pathway
Follow-Up & Exit



The **Follow-Up** phase illustrates the ongoing communication between a connector and an individual, in order to evaluate the care plan. At this stage there may also be an evaluation of outcomes on an initiative-wide level.

The **Exit** phase illustrates the various points at which an individual may choose to exit the SP pathway.

It also depicts a *Closed Loop Exit*, which represents the potential for future re-entry into the SP pathway.

Insights Deep Dive

Insights Deep Dive

Our research condenses into 6 emerging themes. These themes answered two questions about the current state landscape of SP in Canada: *"What is being done well?"* and *"What are we working towards?"*.

What we're working towards…

What is being done well…

This symbol represents novel insights gathered from intercept interviews with the public

Communicating the value of SP

SP has been shown to have a positive impact on the healthcare system by increasing efficiency, focusing on preventative care measures and reducing the burden on primary care and acute and emergency services. **Communicating this systems level value to key stakeholders (e.g., physicians, policy-makers, etc.) has been shown to increase buy-in and advance SP initiatives.**

What we learned:

- By connecting individuals to preventive and socially- and materially-supportive care, SP is able to lighten the workload for Family Physicians and HCPs. These demonstrated benefits have led to buy-in from the healthcare system and a re-imagining of community-involved primary care.
- In Whistler, the organically generated SP initiative has led to the formation of the *Whistler 360 Health Collaborative* which offers full-service primary care that is community-led and governed and works with social and community organizations to address the social determinants of health at the individual and family levels.

Members of the public perceived SP as beneficial to individual, family and community health. Framing SP through the lens of public good and supporting community wellness will increase buy-in.

"It has really made us reimagine how we provide primary care in our community- that is community-led and governed, and really tightly tied to community services"

Dr. Karin Kausky, Family Physician,
Sea to Sky Division of Family Practice and Whistler 360 Health Collaborative
Whistler, BC

"The way I address it with the city of Lethbridge is that we are giving them a gift. They actually have increased funding to this system for us in the last couple of years because literally they don't have to do any work."

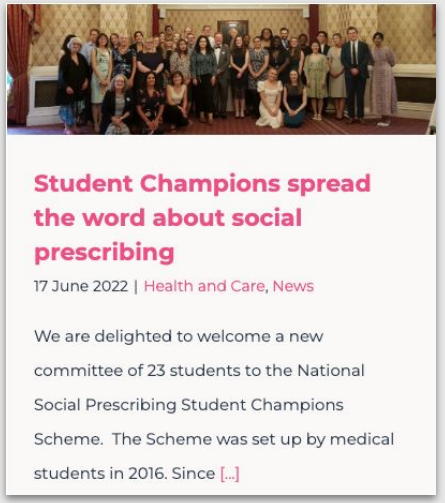
Rob Miyashiro, Executive Director,
Lethbridge Senior Citizens Organization,
Lethbridge, AB

Advancing SP in the UK: The National Academy for Social Prescribing

The **National Academy for Social Prescribing** is an organisation developed by the NHS that works to advance SP through **promotion, collaboration and innovation.**

Key components of this initiative:

- Prioritizing buy-in from the healthcare system and primary care providers by:
  - promoting the benefits of SP to the healthcare system,
  - providing learning opportunities for other health and care professionals,
  - and by working with social prescribing link workers to develop solutions to emerging problems across community, primary, and secondary care in a locality
- The **Social Prescribing Champions Programme** (SPCP) in partnership with the NHS builds a yearly multidisciplinary cohort of team members across England to promote the delivery of SP.



Student Champions spread the word about social prescribing

17 June 2022 | Health and Care, News

We are delighted to welcome a new committee of 23 students to the National Social Prescribing Student Champions Scheme. The Scheme was set up by medical students in 2016. Since [...]

Reference Link: National Academy for Social Prescribing: Social Prescribing Champions Programme

Collaborating to increase buy-in

Equitable and adaptive collaboration between health care providers and community organizations through patient care networks and integrated teams **contributes to increased efficiency of service provision and adds to service provider job satisfaction.** Showcasing this type of successful collaboration and its impacts is an effective way to foster buy-in.

What we learned:

- The healthcare sector is facing a human resource crisis, and there is importance in building partnerships with local governments as well as community service providers. Exemplifying 'equal footing' creates stronger relationships amongst the different stakeholders.
- Involving community organizations in health initiatives helps to increase accountability and attain buy-in of local health authorities.
- Teams, such as *People for a Healthy Community* on Gabriola Island, are in the process of conducting their own outreach to fill service gaps. Innovative outreach methods include: social media, newsletters, posters and holding informational sessions.

"The positives were not only better patient outcomes, but better provider satisfaction because collectively we were able to accomplish things that at times would be crushing work loads. People were almost weirdly energetic and happy to be at work."

Dr. Karin Kausky, Family Physician,
Sea to Sky Division of Family Practice and Whistler 360 Health Collaborative,
Whistler, BC

Addressing public mistrust of healthcare institutions and professionals will be crucial for participation and public buy-in of SP.

A multinational approach: WHO's Open Course on Social Prescribing

The World Health Organization (WHO) recently published an online training module and toolkit for how individuals, groups and organizations can implement SP. This resource provides concrete steps for introducing SP initiatives and includes case studies, interview and regional practices that can be adapted to learners.

Highlights of this resource include:

- The creation of this course was possible due to collaboration amongst a number of community organizations, as well as physicians who connected with a bigger overarching health organization.
- This is a concrete example of how an innovative outreach method can be used with a large scale organization.

Reference Link: OpenWHO Social Prescribing Course Link

Expanding the way we collect data and measure impact

Data collection and assessment strategies that focus on specific vulnerabilities and strengths related to social and environmental factors in a community can unearth unexpected opportunities for support. **It is important for this data to be collected and shared between primary care and SP teams in order to improve quality and proactiveness of care.**

What we learned:

- Assessments that deeply explore social and environmental context have led to innovative and collaborative solutions to address complex community needs.
- In Whistler, detailed histories of community members accessing COVID-related services revealed income loss due to exposure-related isolation. A collaborative and community-involved approach led to the acquisition of self-isolation housing for social reasons.
- On Gabriola Island, there is a call to raise awareness and share information among primary care providers about the realities of healthcare access for rural communities in order to provide more tailored care.

"We work to build awareness around what the realities are for patients from this community [...] so there is a more thoughtful approach on the healthcare side [...]for example not discharging someone after 11 pm if they are from G.I.. Older adults have left the hospital and spent the night outside because they cannot get home or afford a hotel"

Chloe Straw, Community Navigator, People for a Healthy Community, Gabriola Island, BC

Members of the public may not associate non-medical support (such as housing, mental health or income) as playing a role in their overall health. This leads to reluctance in discussing non-medical needs with their healthcare provider. Increasing public awareness of SDoH and how these can be addressed through primary care supports will be important for the success of a national SP model.

Expanding the way we collect data and measure impact

There are positive impacts and outcomes of the SP process for individuals and for the health system at large that are difficult to measure. **Creative impact measurement and especially formalized qualitative data collection will be key to capturing a complete picture of program success**

What we learned:

- Services attended and community connections derived from SP initiatives have been found to benefit individuals and the health system in unquantifiable ways.
- For individuals, SP offers a source of informal emotional support, environmental and material support, confidence building and facilitated community connections.
- There are calls to capture the emotional impacts of the assessment conversation. Other downstream benefits manifest over time.
- For the health sector, these supports have led to less reliance on acute and primary care.
- In Portland, Ontario, a referral to social prescribing helped a reclusive and isolated community member explore their art skills and build their confidence to eventually lead an arts-based program

"I can give you the number of attendances and referrals, but how do we convey that a life was saved or that a person received ODSP after having their back taxes paid for by community supports and the time spent by the team to assist them from beginning to end. There's no comparison between the meaning behind the work that was done and the quantitative data"

Marci Bruyere,
Manager of Health Promotion and Community Development,
Country Roads Community Health Centre, Portland, ON

Sharing patient information: The San Diego Community Information Exchange (CIE)

The San Diego Community Information Exchange (CIE) is **an ecosystem of multidisciplinary partners that work to share patient information**, connect individuals to services, and create collective impact.

Key components:

- **Shared language**: The CIE presents a holistic view of a person's needs through screenings and assessments which feed into a **Risk Rating Scale** measuring a person's immediacy of need across 14 categories within SDoH.
- **Resource database**: Enables partners to connect individuals with appropriate supports by leveraging and connecting existing resource databases.
- **Integrated technology platform**: Enables the integration of multiple partner data systems to populate a longitudinal, person-centred record of an individual's interaction with resources and significant life events. This platform also facilitates follow-up through alerts and notifications to care providers.

The risk rating scale scores on a scale from *crisis* to *thriving* in each SDoH domain.

Reference Link: San Diego Community Information Exchange- What is CIE

Building capacity & leverage existing resources

The role of the link worker and other informal community connectors can be an impactful way to address the limited capacity of GPs. **It is important to thoroughly understand the diverse functions of link workers and how informal community connectors may be leveraged to support SP.**

What we learned:

- Link workers in various forms provide a myriad of support including community referrals, bureaucratic and social sector navigation support, patient advocacy, and emotional support throughout the SP process.
- Informal community connectors can be leveraged in lower resource setting to support SP.
- On Gabriola Island where there are only 4 physicians, paramedics offer in home follow-up support. Paramedics, as well as trades-persons are sources of referral into SP as they can observe patient needs within their environments.
- In Whistler, social workers offer mild to moderate mental health support while offering SP services. This is important in the context of long wait times for mental health services.

"Simply referring people to social activities in the community isn't enough to address systemic issues like a breakdown of social cohesion. To reweave the social fabric, we need a back-end for social prescribing that creates genuine pathways toward enriching life experiences in meaningful community. Our intergenerational approach changes the way we do health, and education, and social supports, and more across silos"

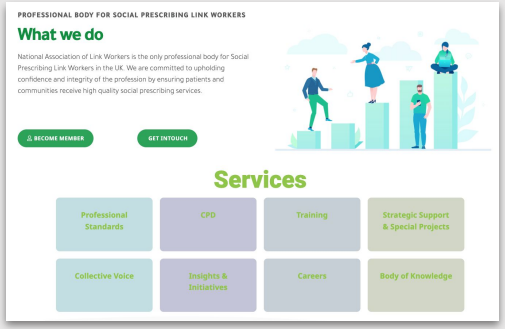
Brian Puppa, Executive Director, Legacy Project, Markham, ON

Members of the public voiced concerns about primary care as the single entry point to SP due to their perception of capacity and time limitations of physicians. Leveraging community-based practitioners and considering other non-HCP sources of referral could address some barriers to access.

Building SP infrastructure: National Association of Link Workers (NALW)

The NHS England works to build the infrastructure of SP in primary care by integrating Link Workers in the primary care network. They recently made a commitment to have 1000 link workers in place by 2020/2021

- The NALW is the professional body for SP Link Workers in the UK. They work to uphold the integrity of the profession and promote SP by **establishing standards of practice, offering training and career opportunities and contributing to the body of evidence that demonstrates the benefits of SP**.
- The NALW worked with the Black Country and West Birmingham Training Hub (BCWB) to bring to life their vision of an **SP Link Workers program**.
- The NALW provided strategic support and access to professional supervision, continuing professional development, peer support, best practice sharing and support to clarify and recognize the Link Worker role.
- The NALW also supported the establishment of the **SP Link Worker Ambassador role** to support continued training and development of SP Link Workers and to provide guidance for SP projects across BCWB Primary Care Networks



Reference Link: NALW SP Link Worker Workforce Strategy and Development

Adapting to community needs

Community collaboration can create greater agility and adaptability when addressing the needs of the public. **To meet the diversity of community needs, an individualized and client-led approach is required.**

What we learned:

- Conversations with clients tend to be organic, and are most successful when a participant-led approach is used.
- Every participant is different, and they may need a different approach, level of support and follow-up routine.
- Co-creation within community organizations and volunteers was used as a way to create and modify programs in order to answer local needs.
- Examples such as 'ad-hoc' coffee chats showcased the flexibility used for responding to individual participant needs. Volunteers were also available to meet on an as-needed informal basis.

"What I love about social prescribing is that it is really flexible. Within our organization it allows us to provide a much more robust personalization of services. […] The ability to sit down with a person and explore what wellness means to them. This is what is guiding the work."

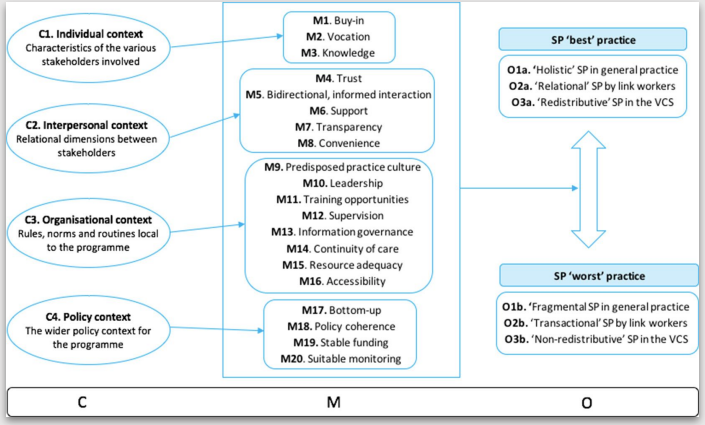
Chloe Straw, Community Navigator,
People for a Healthy Community
Gabriola Island, BC

Information should be disseminated through multiple channels that account for varying degrees of access to resources (eg. digital divide, language) to ensure equality and accessibility. Members of the public also expressed a need for a health advocate, or trusted confidante, and identified mental health professionals as a natural starting point for SP. This should be taken into consideration when developing the initial touchpoint for referral and when assessing link worker competencies.

Facilitators of SP Implementation: A Realist Review

This realist review of 140 SP studies explored the mechanisms and contexts that enable or hinder social prescribing practices and sought to define what comprises 'good' practice in SP within relevant settings and levels of implementation. **It was found that 'relational' and 'holistic' archetypes of SP were more adaptable and effective.**

- **Holistic SP models** work to thoroughly understand and integrate patients' social needs and **conduct community referrals through collaboration with other stakeholders**.
  - In contrast, 'fragmented' SP models involve triage and allocation of patients to appointed stakeholders, leaving a dearth of understanding among clinicians of social circumstances.
- **Relational SP models** involve **ongoing and open-ended interactions** which **allow link workers to adapt and respond iteratively to patients' needs as they change**.
  - In contrast, 'transactional' SP models involve pre-established limitations (e.g. on number of sessions) which may hinder customization of care.



Context (C), mechanism (M), outcomes (O) identified in the literature reviewed. SP = social prescribing. VCS = voluntary and community sector.

Reference: Calderón-Larrañaga, S., Milner, Y., Clinch, M., Greenhalgh, T., & Finer, S. (2021). Tensions and opportunities in social prescribing. Developing a framework to facilitate its implementation and evaluation in primary care: a realist review. BJGP open, 5(3), BJGPO.2021.0017. https://doi.org/10.3399/BJGPO.2021.0017

Formalizing partnerships to advance policy & funding

Formalized integrated care networks that involve primary care, community and social services and the community **can promote program efficiency and sustainability and help to secure funding and have the potential to influence policy.**

What we learned:

- Several networks and care collectives have formed through the origins of SP initiatives:
  - Whistler, ON - *Patient Care Network*, *Whistler 360 Healthcare Collaborative*
  - Lethbridge, ON - *Seniors Community Services Partnership*
  - Portland, ON - *Country Roads CHC* and associated locations serve as a hub for local community services
  - Gabriola Island, BC - *Integrated Community Care Management* team
- These networks allow for increased efficiency through formalized information sharing strategies, mutual promotion of services, rapid and creative mobilization of resources when needed.
- The *Whistler 360 Health Collaborative* was able to leverage built relationships to mobilize firefighters in a rapid COVID response during the most recent surge.

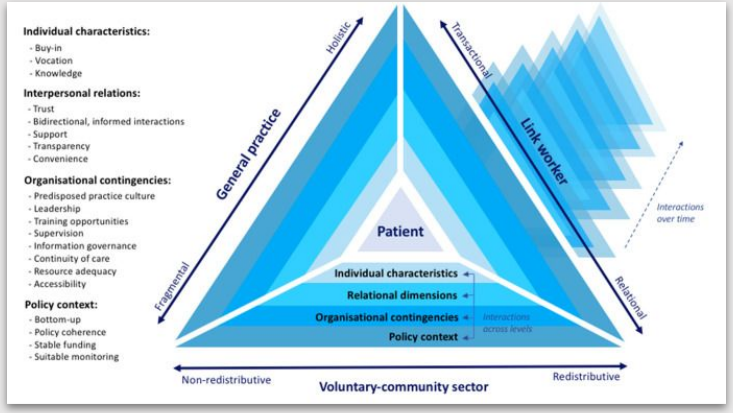
"It is critical to have these relationships established. We can contact decision makers to leverage other practitioners to participate in social and medical initiatives"

Dr. Karin Kausky, Family Physician,
Sea to Sky Division of Family Practice, Whistler 360 Health Collaborative
Whistler, BC

Facilitators of SP Implementation: A Realist Review

This realist review of 140 SP studies explored the mechanisms and contexts that enable or hinder social prescribing practices and sought to define what comprises 'good' practice in SP within relevant settings and levels of implementation. **It was found that interpersonal and organizational relations that emphasized trust, endorsement and collaboration were best able to address diverse community priorities.**

- ➔ Within 'good' SP initiatives, stakeholders had significant buy-in and knowledge of SP and **emphasized trust-building and collaboration among practitioners** and with patients.
- ➔ Interpersonal and organizational contingencies that promoted effective SP practices included:
  - Sustainable local community networks
  - Endorsement by primary care to give credibility
  - Regular feedback to referring primary care practitioners to encourage future referrals and ensure appropriateness of care
  - Integrated information governance and sharing strategies to ensure connected and coherent SP services



A Framework for Theorising and Evaluating Social Prescribing in Primary Care.

Reference: Calderón-Larrañaga, S., Milner, Y., Clinch, M., Greenhalgh, T., & Finer, S. (2021). Tensions and opportunities in social prescribing. Developing a framework to facilitate its implementation and evaluation in primary care: a realist review. BJGP open, 5(3), BJGPO.2021.0017. https://doi.org/10.3399/BJGPO.2021.0017

Key Uncertainties

Key uncertainties for further exploration

Through our research we identified several key uncertainties that require further exploration. Exploring these key uncertainties will be critical to developing a national framework that is inclusive and representative of the diverse needs of individuals, communities and regions across the country. These key uncertainties will be used to guide Phase 2: Co-creation & Validation of this project work.

1. What are the key characteristics and functions of a link worker? Where do they already exist? How do we leverage existing roles, resources, tools and relationships?
2. How are we and how might we communicate the value of SP to practitioners?
3. What are some of the characteristics of ideal settings for implementation of SP? What resources and supports are involved?
4. What might the steps for formalized partnerships between primary care, community organizations and the community-at-large look like?

Thank You!

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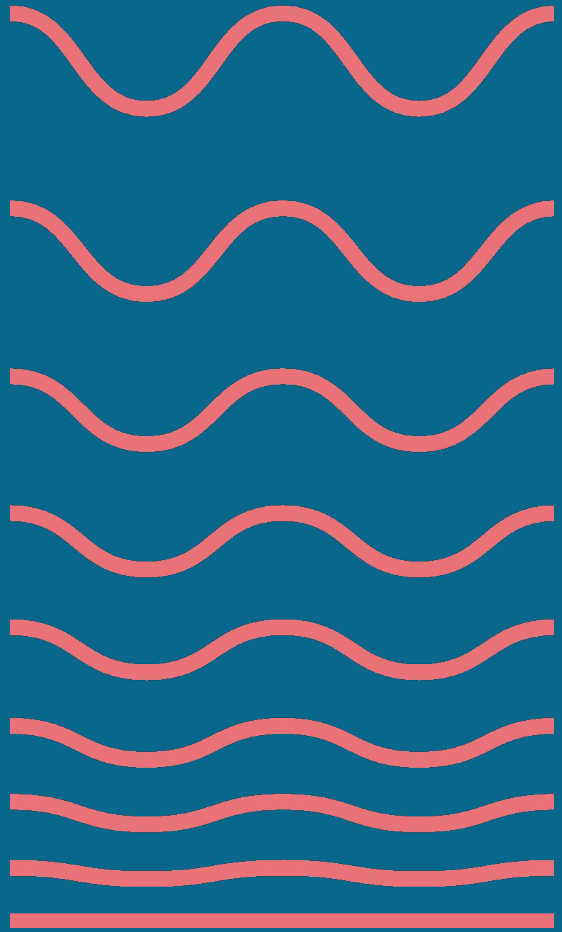

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- Alliance for Healthier Communities- What is Social Prescribing?
- Fraser Health Seniors Community Connector Role Description
- SCSP Proposed Delivery System, January 2020, LSCO - Provided by by Rob Miyashiro
- Toronto Star- Midland's Askennonia Senior Centre a 'lifeline' for area residents
- National Academy for Social Prescribing: Social Prescribing Champions Programme
- OpenWHO Social Prescribing Course Link
- San Diego Community Information Exchange- What is CIE
- NALW SP Link Worker Workforce Strategy and Development
- Calderón-Larrañaga, S., Milner, Y., Clinch, M., Greenhalgh, T., & Finer, S. (2021). Tensions and opportunities in social prescribing. Developing a framework to facilitate its implementation and evaluation in primary care: a realist review. BJGP open, 5(3), BJGPO.2021.0017. https://doi.org/10.3399/BJGPO.2021.0017
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- Toronto Strong Neighbourhoods Strategy 2020: Neighbourhood Equity Index Methodological Documentation

Appendix

Appendix A: KOL interview methodology

Objectives	Methods	Limitations
• To understand the current state of SP in specific regions across Canada. • To understand the different service delivery models across regions. • To understand how SP is being implemented, evaluated and scaled in a specific region	• Semi-structured interview guide • 10 interviews conducted with key actors in SP from the community of practice in Canada (see Appendix B)	• Limited sample size • Missing demographics • Selection Bias

Reference: Toronto Strong Neighbourhoods Strategy 2020: Neighbourhood Equity Index Methodological Documentation

Appendix B: Desk research sources

- The Kings Fund: What is social prescribing?
- United Way Healthy Aging: Social Prescribing - Enhancing wellness and social connectedness for older adults
- NHS England >> Social Prescribing
- Social Prescribing | Alliance for Healthier Communities
- Rx Community Social Prescribing in Ontario
- Social Prescribing - a highly practical way to address the social determinants of health, Larter Australia
- Social Prescribing Guidebook for team-based primary care providers in Ontario
- Social Prescribing Roundtable (RACGP, Consumers Health Forum of Australia, NHMRC Partnership Centre for Health System Sustainably) Report
- NHS England - Social prescribing and community-based support: Summary Guide
- Global developments in social prescribing
- Using self-determination theory to understand the social prescribing process: a qualitative study
- Social prescribing: A rapid literature review to inform primary care policy in Australia
- A controlled evaluation of the effect of social prescribing programs on loneliness for adults in Queensland, Australia (protocol)

Appendix B: Desk research sources

- Global Social Prescribing Alliance: International Playbook
- PaRx: A Prescription for Nature - About
- OpenWHO Social Prescribing Course Link
- National Academy for Social Prescribing: Social Prescribing Champions Programme
- NALW SP Link Worker Workforce Strategy and Development

Appendix C: KOL interview participants

Name	Role	Organization	Location
Dr. Karin Kausky	Family Physician Co-chair	Whistler 360 Health Collaborative Sea to Sky Division of Family Practice	Whistler BC
Rob Miyashiro	Executive Director	Lethbridge Senior Citizens Organization	Lethbridge, AB
Dr. Grace Park	Family Physician and Regional Medical Director for Community Health Services	Fraser Health Authority	Fraser Health Region, BC
Chloe Straw	Community Navigator	People for a Healthy Community	Gabriola Island, BC
Rebekah Vaughan	Health Initiatives Lead	211 Community Connection	Collingwood, ON
Angele Belanger	Registered Nurse	Centre de santé communautaire du Témiskaming	Kirkland Lake, ON
Mary Moreau	Volunteer Link Ambassador	Links2Wellbeing/Reach out and Touch Someone, Askennonia Senior Centre	Midland, ON
Natasha Beaudin	Social Prescribing Project Lead	Alliance for Healthier Communities	Ottawa, ON
Marci Bruyere	Manager of Health Promotion and Community Development	Country Roads Community Health Centre	Portland, ON
Brian Puppa	Executive Director	Legacy Project	Toronto, ON

Appendix D: Overview of initiatives

Initiative	Description	Location	Level (National, Provincial, Regional, Local, Hyper-local)
Alliance for Healthier Communities (Links2Wellbeing Lead)	A network of over 100 community-governed, team-based primary healthcare organizations across Ontario. Alliance member centres are committed to supporting those who face the highest barriers to health and well-being, including marginalized seniors. Links2Wellbeing is a partnership between Alliance and the Older Adults Centres' Association of Ontario.	Ontario	Provincial
Fraser Health Authority, Senior Community Connectors	A health authority in British Columbia with 10 divisions of family practice. Each division is each working with a community-based seniors-serving organization. Within each organization there is a Senior Community Connector (funded by the BC Ministry of Health and managed by United Way British Columbia), who does intake from referrals and creates individual social care plans for clients.	White Rock, Chilliwack, Langley, Abbotsford, Mission, New Westminster, Coquitlam, Delta, Surrey, Maple Ridge, Burnaby, BC	Regional
211 Community Connection	211 Community Connection receives referrals from primary care and places outbound calls to community members in need of social support. Information and resources are provided based on individual needs. 'Empowerment conversations' and hands-on support are offered to facilitate connection to services.	Collingwood, ON	Regional
Whistler 360 Health Collaborative	A health collaborative based in Whistler, created to support patients in accessing a widespread, interconnected network. This team is comprised of primary healthcare providers and community organizations that promote well-being through collaboration.	Whistler BC	Local
Seniors Community Services Partnership (SCSP)	A SP program specifically supporting seniors in Lethbridge. Embedded within the Lethbridge Senior Citizens Organization, this program has a team of Link Workers that work in partnership with 6 organizations and has a well-developed procedure for data tracking and impact evaluation.	Lethbridge, AB	Local
Country Roads Community Health Centre	A multidisciplinary SP team operating through the Country Roads CHC, receiving referrals from primary care and community services for individuals with identified social needs. The team creates individual care plans and accurate referrals to social supports through a in-depth needs assessment.	Portland, ON	Local

Overview of initiatives continued

Initiative	Description	Location	Level (National, Provincial, Regional, Local, Hyper-local)
7-Generation Markham	The Legacy Project is leading a whole-community Collective Impact initiative in collaboration with the City of Markham, Markham Public Library, Social Services Network, York University, and other partners locally and internationally. SP is part of the social change ecosystem, with local healthcare providers referring people to specially trained 7-Generation Guides who help explore what matters to individuals while simultaneously connecting them into a variety of meaningful intergenerational community opportunities. The goal is to reweave the social fabric, and SP is a key "front-end" leading into the 7-Generation community-building "back-end."	Markham, ON	Local
Links2Wellbeing + Reach Out and Touch Someone	The Askennonia Seniors Centre has an SP program through which individuals can access a wide variety of social or fitness programs and activities. The intake process enables the client to discuss which activities or services best suit their needs. The Reach Out and Touch Someone program is an outreach program to engage with individuals with more complex needs; and the centre uses a discretionary fund to address barriers to access (eg. membership fees, home repairs, personal items, transportation).	Midland, ON	Hyper-local
People for a Healthy Community	Smallest SP program in BC offering social support connection and navigation services via one Link Worker/Navigator hybrid role. Through the multidisciplinary Integrated Community Care Management Team, information regarding community and individual health is shared to optimize support services.	Gabriola Island, BC	Hyper-local
Centretown Community Health Centre	SP program embedded within the Centretown CHC, provides in-house referrals for social supports to specific vulnerable populations in downtown Ottawa: newcomers, parents, seniors, 2SLGBTQIA+ individuals, BIPOC individuals, and those with complex mental health and addiction challenges.	Ottawa, ON	Hyper-local
Temiskaming CSC	The Centre de Sante is a not-for-profit organization with an SP program operating in Temiskaming. At this centre there is no specified link worker, and personalized client care is provided by staff members (doctors, nurses, social workers), who might increase the client's social exposure.	Temiskaming Shores, ON	Hyper-local

Appendix E: Intercept interview methodology

Objectives	Methods	Limitations

To gauge public knowledge and perception of social prescribing. Survey questions explored perceptions of wellness, any services they access to support their holistic wellness and their experience with social prescribing and its perceived benefits.	• Semi-structured interview guide
	• 25 interviews conducted
	• Locations :
	  ○ Jane & Wilson
	  ○ Bloor & Bathurst
	  ○ Scarborough Town Centre
	
	Locations were chosen using the TSNS Neighbourhood Equity Index
		• Limited sample size
		• Missing demographics
		• Selection Bias

Reference: Toronto Strong Neighbourhoods Strategy 2020: Neighbourhood Equity Index Methodological Documentation

Appendix F: Intercept interview participant demographics