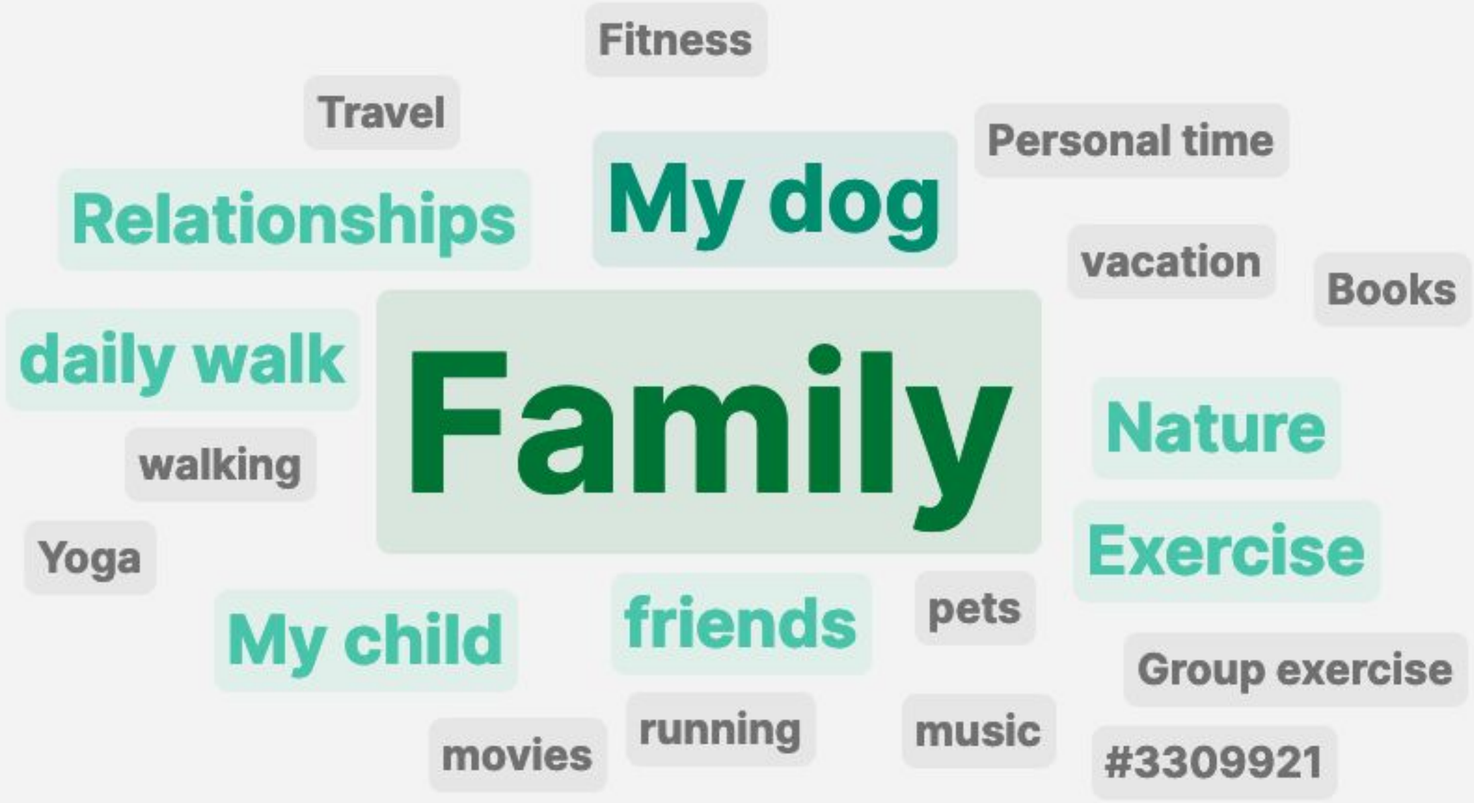
What is something (or someone) that brings you health, meaning, or connection?



Social Prescribing

Alliance for Healthier Communities

Alliance for Healthier Communities
Alliance pour des communautés en santé

Our guests

Natasha Beaudin
Social Prescribing Lead
Alliance for Healthier Communities

Margo Reilly
Executive Director
Windsor FHT

Dr. Dominik Nowak
Family Physician
Women’s College Hospital

WHAT IS SOCIAL PRESCRIBING

Guelph CHC Soup & Symphony event

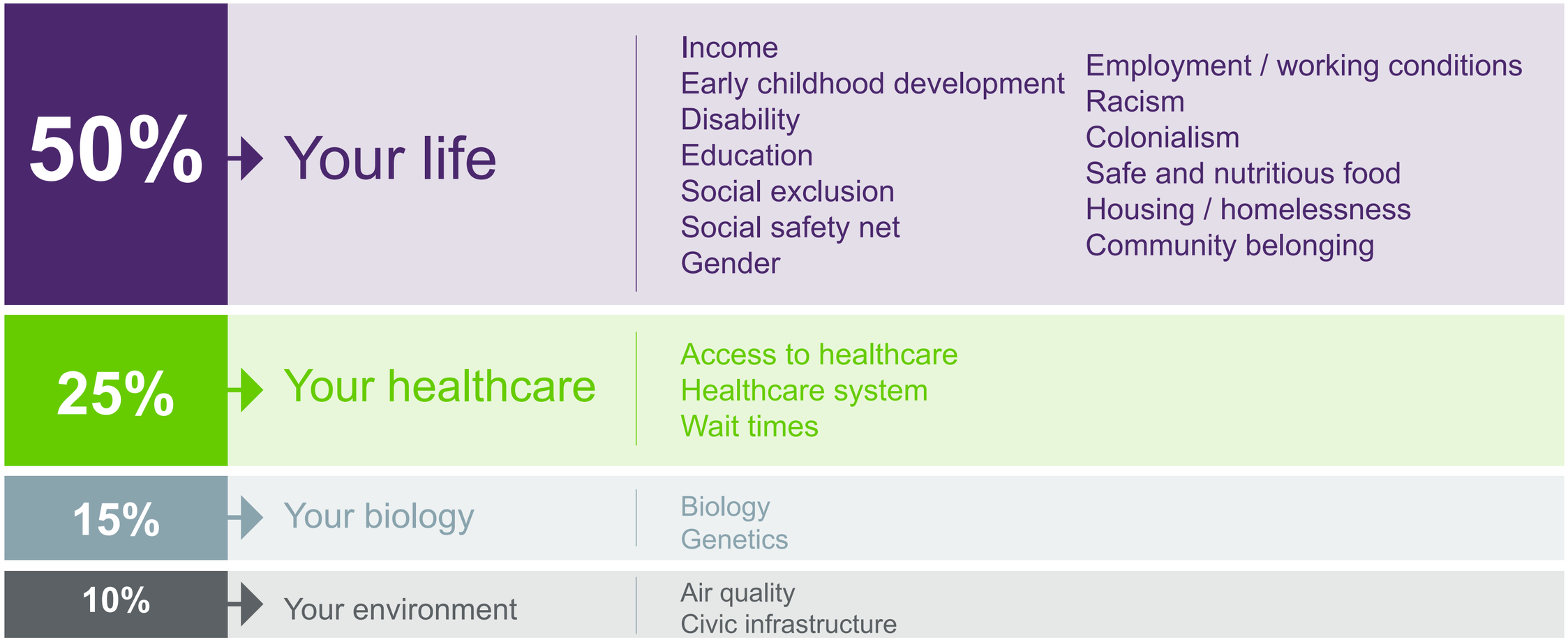
- An intentional, structured way of connecting people with a range of local, non-clinical services, to address the determinants of health and wellbeing for people accessing primary care.

- Social prescribing can look different for each community depending on resources and supports.

- Health equity is a cornerstone of effective social prescribing. Successfully implementing a social prescribing program means removing the barriers clients experience.

Instead of asking "What is the matter with you?" let's start asking "What matters to you?"

What makes Canadians sick?



These are Canada's determinants of health.

What are example social prescriptions you've introduced?

Anonymous
Thehealthline.ca

Anonymous
Adult Lifestyle Centre; If finances is a struggle for membership- connect with the manager to be able to wave the fee

Anonymous
Walking groups

Anonymous
Recipe of the month

Anonymous
Transportation services/grocery bus

Anonymous
Community exercise programs

Anonymous

Physical activity

Housing support

Social support

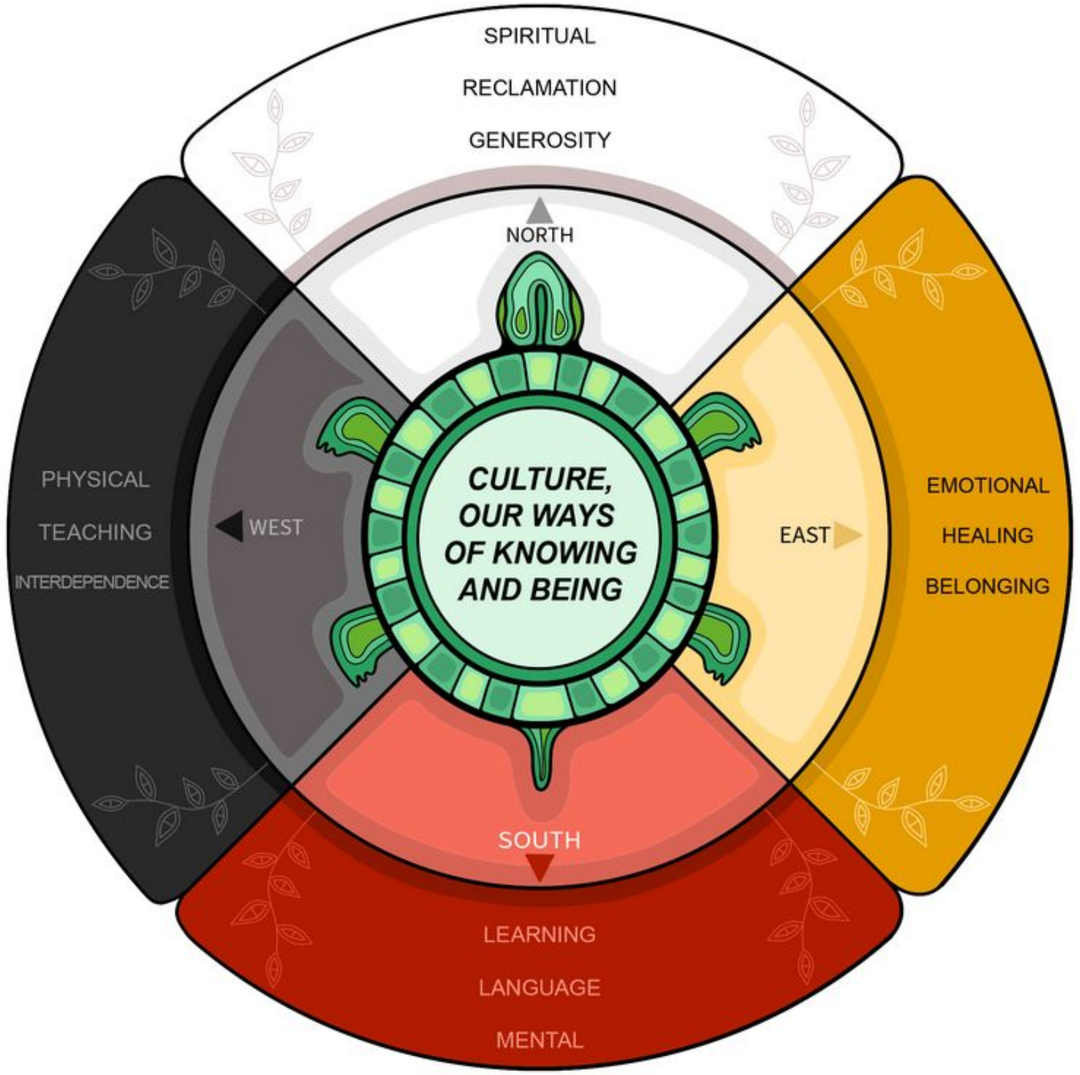
Self-expression

Creative

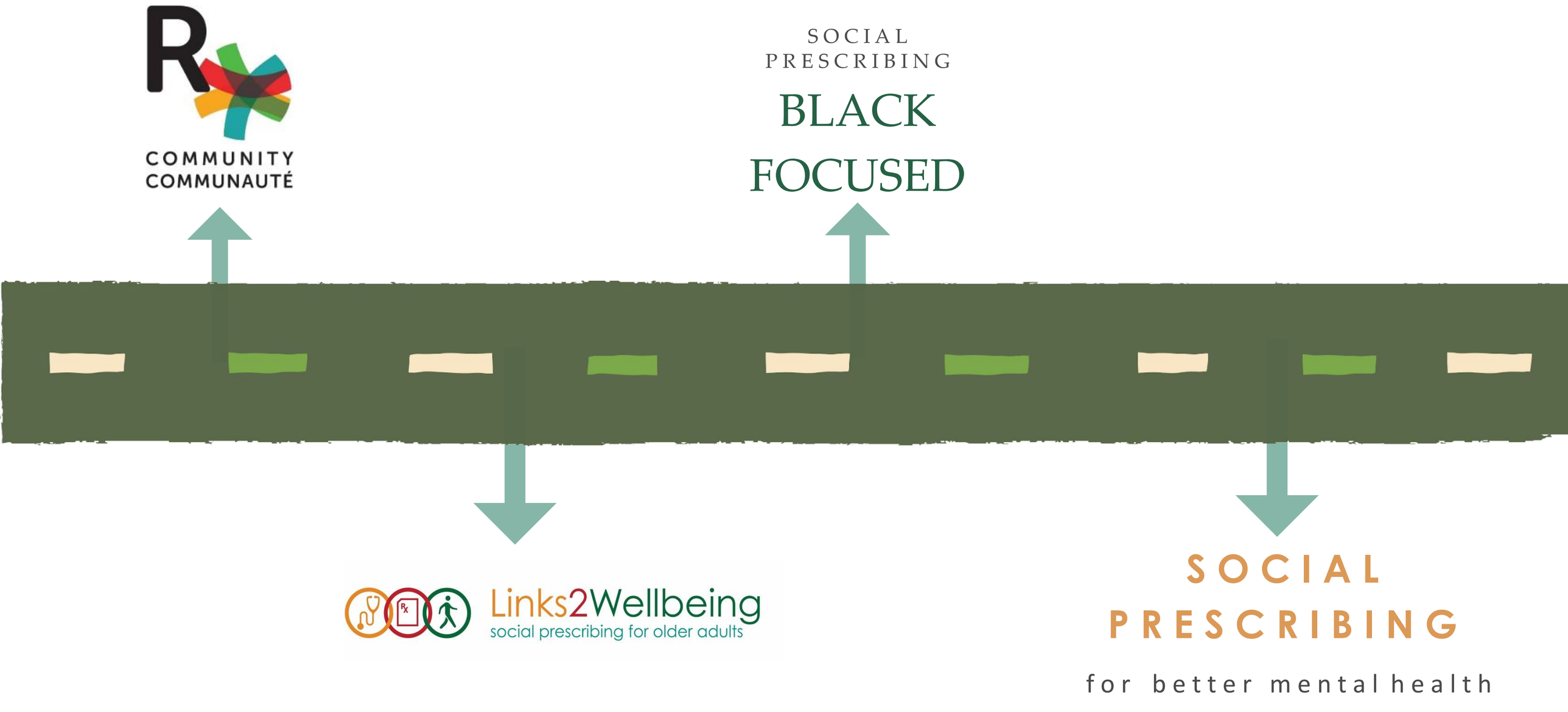
Financial support

Mental growth

SOCIAL PRESCRIBING AND THE MODEL OF HEALTH & WELLBEING



THE SOCIAL PRESCRIBING JOURNEY AT THE ALLIANCE



PAST RESULTS ALLIANCE PROJECTS

Participants in the Alliance for Healthier Communities' research pilot Rx: Community – Social Prescribing reported:

49% decrease in perceived loneliness

12% increase in perceived mental health

19% increase in social activities

Partnering with the Older Adult Centres' Association of Ontario, the Links2Wellbeing project offers social prescribing for older adults.

Here are some highlights from year 2 of the program:

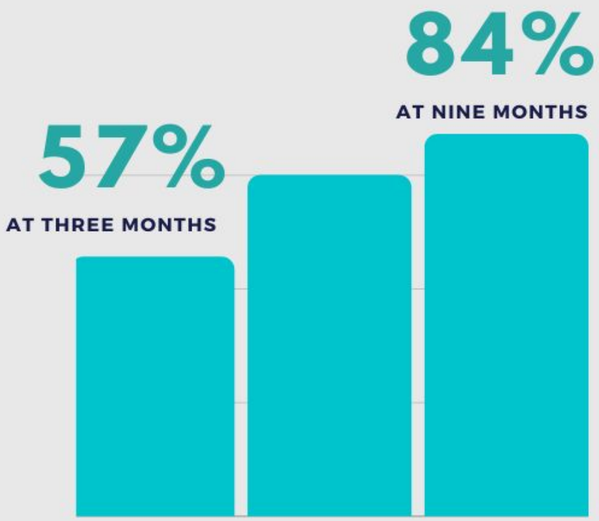
1200+ older adults referred to program to date

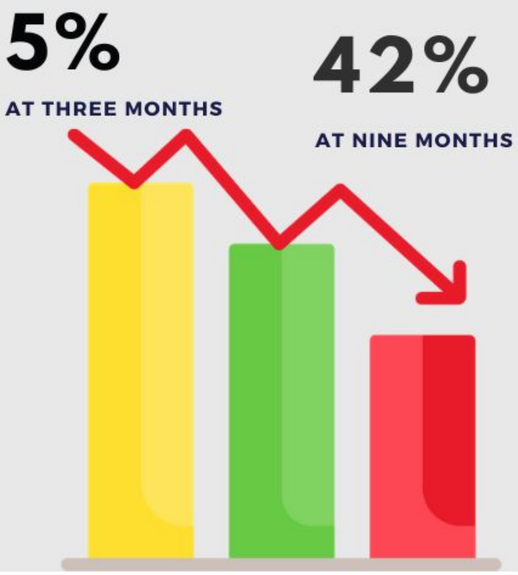
33% reported greater connections to community and improved physical and mental health

50% decrease in perceived loneliness over 6 months

Result: Positive impact clients and healthcare providers

HEALTH PROVIDERS REPORTED SOCIAL PRESCRIBING IMPROVED THE CLIENT'S HEALTH AND WELLBEING





HEALTH PROVIDERS REPORTED SOCIAL PRESCRIBING DECREASED NUMBER OF REPEAT VISITS BY CLIENTS

For more details, read Rx Community Final Report: allianceon.org/Social-Prescribing

Potential Partners

211

Older Adult Centres' Association of Ontario
Association des centres pour aînés de l'Ontario

OACAO

The Voice of Older Adult Centres
La voix des centres pour aînés

celebrating 50 1973 – 2023

Find an Older Adult Centre

THE ONTARIO caregiver ORGANIZATION

Potential (non traditional) Partners

NATIONAL GALLERY OF CANADA

WRITERS COLLECTIVE OF CANADA

OAG GAO

Ottawa Symphony Orchestra

canadian museum of nature
nature
musée canadien de la nature

WALK OR RUN TO QUIT

5 KEY COMPONENTS OF THE PATHWAY

Client

Individual with social and medical needs, interests, and gifts.

Data tracking

Track client journey, follow-up, and improve through a Learning Health System.

Prescriber

Healthcare provider identifies non-medical issues and makes a social prescription referral

Navigator/Connector

Connects individual to appropriate resources based on self-identified interests and needs, and supports their journey to wellbeing.

Social Prescription

Individual connected to social and community supports with invitation to engage, co-create and give back.

cep.health/social-prescribing

Social Prescribing: a Resource for Health Professionals

Last Updated: October 11, 2023

Search Content

Developed by:

CEP Centre for Effective Practice | cisp Canadian Institute for Social Prescribing, Anchored by the Canadian Red Cross | Alliance for Healthier Communities, Advancing Health Equity in Ontario | ST. MICHAEL'S UNITY HEALTH TORONTO, Academic Family Health Team

This resource is designed to support health professionals working in primary care to implement social prescribing in their practice. This resource brings together the best available evidence and expert opinion to provide guidance on social prescribing.

Expand All

- Introduction to social prescribing
- Assess and understand the social factors impacting health
- Initiate social prescribing
- After social prescribing: follow-up and follow through

Further resources and to get involved

Canadian Social Prescribing Community of Practice

Quarterly meetings are held 12:30 p.m. EST on the second Tuesday of the month in January, April, July and October.

Ontario Social Prescribing Community of Practice

bi-monthly meetings held from 1:00-2:30 p.m. EST, every third Thursday of the month.

https://www.allianceon.org/Social-Prescribing#cop

Coming soon: Online Learning Modules on Health Equity focussed Social Prescribing

Questions

Natasha.Beaudin@AllianceON.org

Merci / Thank you/ Meegwetch

Social Prescribing

FOR BETTER MENTAL HEALTH

by the Windsor Family Health Team

WINDSOR
Family | Health | Team

Are there any benefits *to health professionals* from social prescribing?

Anonymous
Allows better integration of physical,mental and social health

Anonymous
Greater insights into the person for person centered care

Anonymous
Becoming more aware of what is happening in the community

Anonymous
Less burden because things are delegated

Anonymous
Social prescribing helps the client to get connected, and can help in their treatment so it can reduce their need for re-occuring referrals

Anonymous
patient feels supported and cared about

Anonymous

At the Windsor Family Health Team the goals of the Social Prescribing Program is to:

1. Address the social determinants of health by connecting patients to social services in community (direct community referrals);
2. Reduce burden on our primary care team and decrease emergency department visits;
3. Empower patients to take control of their health and well-being;
4. Provide care to vulnerable populations and provide an advocate that they can lean on throughout their journey;
5. Decrease overall stress on our healthcare system;
6. Create a sustainable model of care within our team.

Determine who is Eligible

Example of inclusion and accessibility statement:

Social Prescribing is available to all enrolled patients of the Windsor Family Health Team and patients of affiliated primary care providers with the Team Care Centre.

Patients can access the program through self-referral, referral by a primary care provider or IHP, or by checking the box for a referral through our Socio-Demographic and Race Based Data collection form.

The Social Prescribing Program is designed to benefit patients of all ages.

Social Prescribing in Primary Care

Implementation Approach

01 Assess community needs and determine what services are currently available and which are not.

02 Build and leverage community partnerships. Partners play a key role in identifying who would benefit from what program. It’s important to understand who is providing which resources and supports.

03 Identify a team member to be responsible for the work and train them.

04 Develop a referral process that is clear and streamlined and that can be embedded into existing workflows. When referring, ensure individuals are able to access the program in a timely and efficient manner.

05 Establish a system for monitoring and evaluating the success of the program. Evaluate if the needs of the individuals connected are being met and if these connections are having a positive impact on their lives.

06 Have a communication and outreach approach. Raise awareness about the social prescribing program within your practice and with partners.

Assess community needs and determine what services are currently available and which are not.

1. Prioritizing the collection of Socio-Demographic and Race-Based data is a key mechanism to assessing and understanding the patient population you serve, enrolled and unenrolled;
2. Patient and Family Advisory Council or Focus Groups;
3. Patient and/or stakeholder surveys;
4. Employee feedback (by survey or include staff in Strategic Planning);
5. Connect with partners and established community resources (i.e., 211 Southwest Ontario) to leverage existing community referral inventories.

Community Partnerships

Partners play a key role in identifying who would benefit from what program.

Start a local community of practice and encourage sharing of resources.

Refer to existing programs in the community instead of creating duplicative programs.

Meet with partners that may have capacity to address patient service gaps in the community.

What are some challenges you could see in engaging with social prescribing?

Anonymous
Needs to be accepted or have a deeper understanding by the entire team or FHT. Strategic planning does not always happen within all FHTs, and therefore there are some gaps between docs, NPs, and other health professionals

Anonymous
awareness of resources that often change

Anonymous
Awareness of community resources / opportunities to connect patients with. So much benefit of team based care to support

Anonymous
Finding partners, gettinga dn staying up to date with avilable programs, asking sensitive questions to collect data

Anonymous
Limit of finances

Team Work

Identify a team member to be responsible for the work and train them.

1.Best Practice:

Hire a “Link Worker” and having dedicated person focus on the evolution of the program for your patients and community and provide them with opportunities to be involved with provincial and national SP groups;

2.If you can't hire a dedicated person*:

- Add the Social Prescribing Program portfolio to an employee’s job description (i.e., Health Promoter, Social Worker);
- Create a referral system in the EMR that facilitates the process of connecting patients with community programs (via e-fax, Ocean, etc.) allowing any clinician the ability to refer directly.

**Training for this second option does require management involvement so information sharing and opportunities are available to all team members consistently and equitably.*

Develop a Patient Visit Framework that Aligns with your Goals

Example of a Program Framework

01

Patient with specific non-medical needs

02

Provider identifies need during appointment or patient self refers into the program

03

Nurse/Health Promoter is sent and/or receives referral and contacts patient

04

Nurse/Health Promoter identifies appropriate supports for patient

05

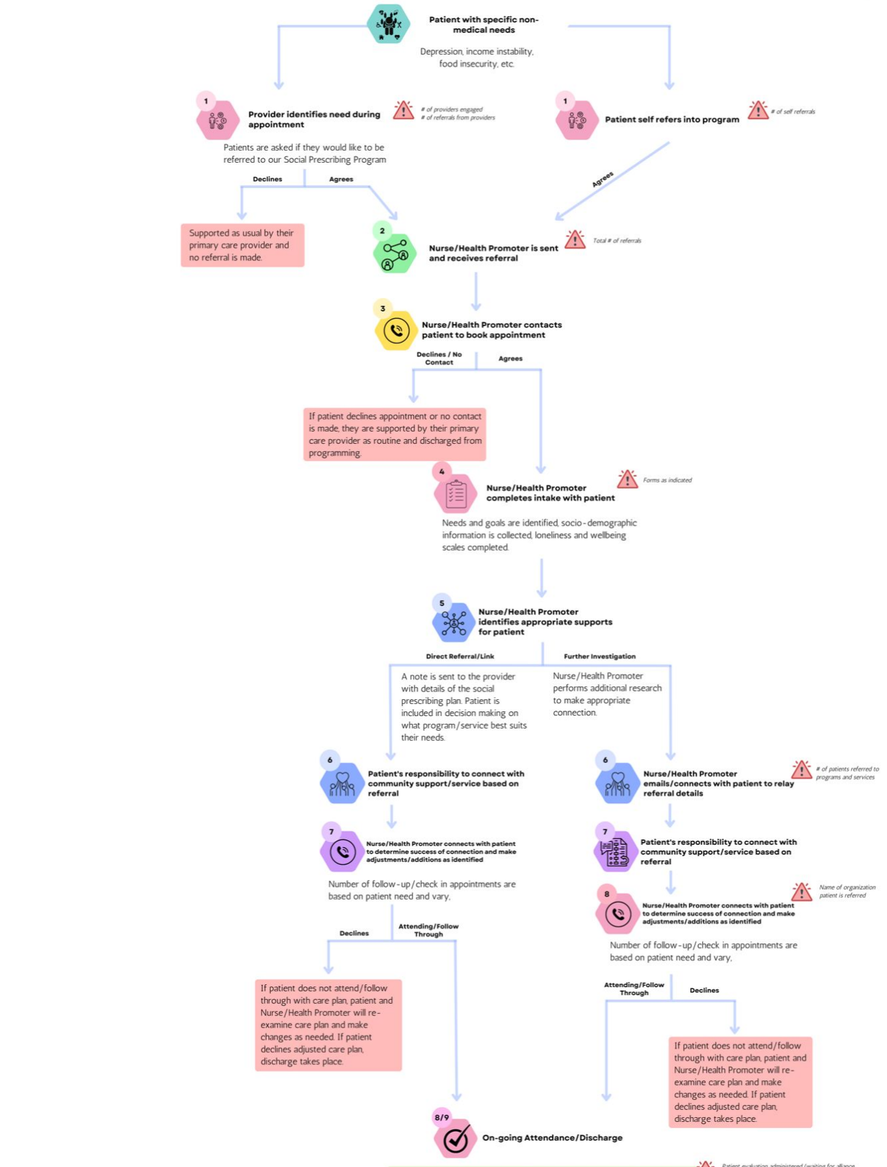
Nurse/Health Promoter connects with patient to determine success of referral

06

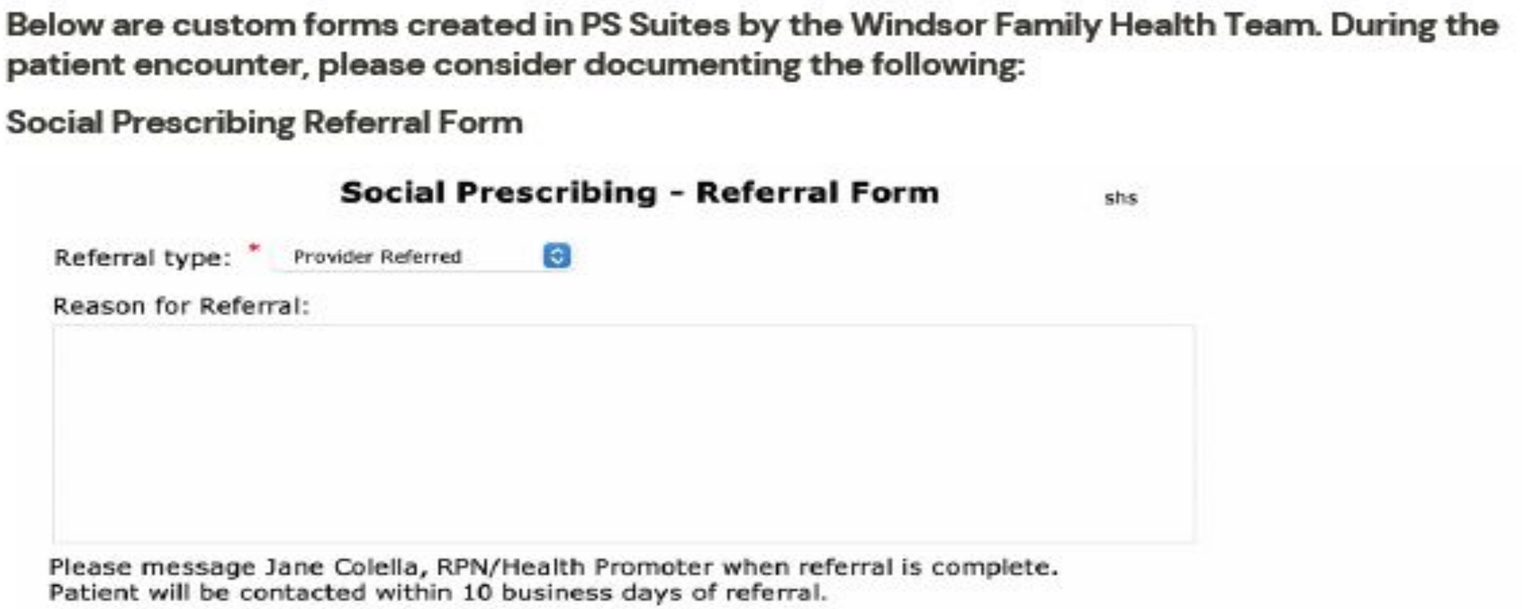
On-going attendance or discharge

Social Prescribing Process Map

Windsor Family Health Team



Develop a referral process that is clear and streamlined & that can be embedded into existing provider workflows. When referring, ensure individuals are able to access the program in a timely and efficient manner.



Below are custom forms created in PS Suites by the Windsor Family Health Team. During the patient encounter, please consider documenting the following:

Social Prescribing Referral Form

Social Prescribing - Referral Form shs

Referral type: * Provider Referred

Reason for Referral:

Please message Jane Colella, RPN/Health Promoter when referral is complete.
Patient will be contacted within 10 business days of referral.

The Nurse Health Promoter plays an essential role in helping patients access local services and support.

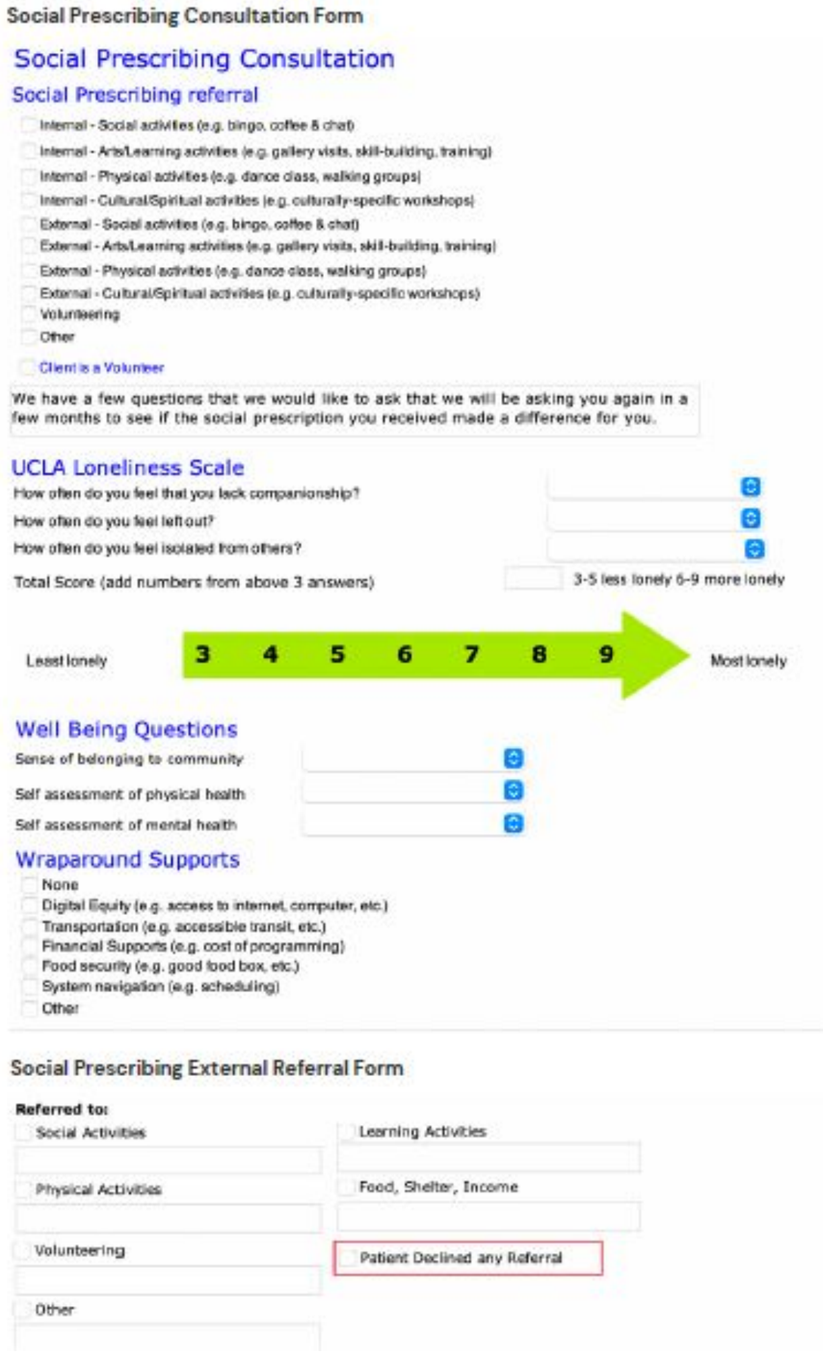
Patients are provided information about local programming and resources which may include referrals to local food banks, activities, and other resources that can provide an intervention.

Creating custom forms is one way of collecting data from the EMR; however, some may choose to use shadow billing to collect data and monitor number of encounters.

Physicians may refer to the Centre for Effective Practice and the Canadian Institute for Social Prescribing for Billing recommendations. There are no OHIP Billing Code for SP specifically.
https://www.socialprescribing.ca/resources

Examples:

- K005 – Primary mental health care
- K013, K033 – Counselling



Social Prescribing Consultation Form

Social Prescribing Consultation

Social Prescribing referral

- Internal - Social activities (e.g. bingo, coffee & chat)
- Internal - Arts/Learning activities (e.g. gallery visits, skill-building, training)
- Internal - Physical activities (e.g. dance class, walking groups)
- Internal - Cultural/Spiritual activities (e.g. culturally-specific workshops)
- External - Social activities (e.g. bingo, coffee & chat)
- External - Arts/Learning activities (e.g. gallery visits, skill-building, training)
- External - Physical activities (e.g. dance class, walking groups)
- External - Cultural/Spiritual activities (e.g. culturally-specific workshops)
- Volunteering
- Other
- Client is a Volunteer

We have a few questions that we would like to ask that we will be asking you again in a few months to see if the social prescription you received made a difference for you.

UCLA Loneliness Scale

How often do you feel that you lack companionship?

How often do you feel left out?

How often do you feel isolated from others?

Total Score (add numbers from above 3 answers) — 3-5 less lonely 6-9 more lonely

Least lonely 3 4 5 6 7 8 9 Most lonely

Well Being Questions

Sense of belonging to community

Self assessment of physical health

Self assessment of mental health

Wraparound Supports

- None
- Digital Equity (e.g. access to internet, computer, etc.)
- Transportation (e.g. accessible transit, etc.)
- Financial Supports (e.g. cost of programming)
- Food security (e.g. good food box, etc.)
- System navigation (e.g. scheduling)
- Other

Social Prescribing External Referral Form

Referred to:

- Social Activities
- Learning Activities
- Physical Activities
- Food, Shelter, Income
- Volunteering
- Patient Declined any Referral
- Other

211 South West Ontario

Health Care Professionals Referral Form

Fax to: 519-969-3811

What to expect: 211's Community Navigators help people understand community/government programs & services, assist with problem solving/decision making& connection to the most appropriate available services. Community Navigators may advocate for people at risk, conduct follow up to ensure continuity of care, and identify unmet needs/service gaps.

Patient/Client Name:
Address:
Postal Code: N8X 3N9
No Fixed Address [
Phone #: (H) **(C)**
Email: hbarker@windsorfht.ca

Health Card:
DOB (Y/M/D):
Age: 27
Identifies as: [Male [Female [Other:
Preferred Pronouns: [He [She [They
Other:
[**Home & Community Care (LHIN) Client**

Other Patient Demographics:
[Indigenous [First Nation [Metis [Inuit
[Francophone [New Immigrant
Other:

Anticipated Discharge Date:

Language:
[English [French [Other:

Poverty Screening Information:
[Has difficulty making ends meet
[Has not filed taxes

Indicate primary reason for this social prescription:
From the drop-down, select the primary reason for the referral, please enter the details in the Notes section below.

Indicate secondary reason for this social prescription:

Notes:

[**Patient has provided express consent to fax this referral form to 211 and expressly consents to being contacted by telephone by a 211 Community Navigator.**
Primary Contact: [Patient [Third Party – Name & Phone #:
Permission to leave a message: [Yes [No Language:
Preferred time of contact: Weekdays [Morning [Afternoon
Name/Alternate Contact &Phone:

Referral Source: Windsor Family Health Team
Telephone: **Fax:**
Referral Date: Mar 8, 2024
Form Completed By:
Name of Family Physician:

Links2Wellbeing

social prescribing for older adults

Client Referral Form

Date:
Name of client:
Client phone number:
Client email address (if applicable).

Reason for referral. Please check all that apply.

- [ ] Social isolation
- [ ] Loneliness
- [ ] Mild[1] depression and/or anxiety
- [ ] Other. Please specify.

Referral source:

- [ ] Community Health Centre (CHC). Please specify role of referring individual (e.g. physician, nurse).
- [x] Family Health Team (FHT). Please specify role of referring individual (e.g. physician, nurse)
- [ ] Community Paramedic
- [ ] Solo physician
- [ ] Nurse Practitioner-Led Clinic (NPLC)
- [ ] Hospital. Please specify department. E.g. discharge planning
- [ ] Other. Please specify.

Signature: Date: Mar 8, 2024

Please send this referral form to:

[1] Please note that the social and recreational programs are not able to serve clients requiring clinical interventions or those individuals who are living with significant cognitive impairments.

Establish a system for monitoring and evaluating the success of the program. Evaluate it the needs of the individuals connected were met and if these connections are having a positive impact on their lives.

During the planning phase, ensure that the outcomes are measurable. There should be established metrics/outputs that effectively monitor the programs progression.

1. Referrals Received
2. Number of referring providers
3. Number of referrals from each provider
4. Number of self-referrals
5. Referrals sent by Nurse Health Promoter
6. List of places referred to
7. Number of initial, follow-up, discharge without being seen, discharge after single appointment, and no shows.
8. Time spent with patient
9. Loneliness score
10. Well-being scale
11. Socio-demographic data collection

Collect patient feedback to support program evolution

- Surveys
- Patient and Family Advisory Councils or Focus Group

Communication & Outreach

Raise awareness of the Social Prescribing Program and ensure individuals are aware of the services available

- Create materials that can be distributed to patients and translate them as needed;
- Add information to your organizational website;
- Actively use social media accounts to share information and encourage self-referrals by promoting community programming;
- Follow or subscribe to receive information from the Canadian Institute for Social Prescribing, National Academy for Social Prescribing (NHS), Alliance for Healthier Communities;
- Educate staff about Social Prescribing, encourage the sharing of success stories at team meetings, and add SP as a metric on your **Schedule A or QIP** to keep the initiative top of mind;
- Include SP related updates in your newsletters, as ads on your waiting room TVs or on monitors in the waiting rooms, posters in exam rooms.

Funding and Sustainability

New funding specifically for Social Prescribing or for a dedicated Link Worker is only available (to my knowledge) through grant funding.

Social Prescribing in principle is not a new concept. Social Workers have been trained to make effective community referrals and in agencies like CHCs this is built into their Health Promoter role. Program responsibility could be added to an existing role.

Refer to existing services in the community to create a sustainable system and focus on creating new programs only when there is a need that can't be served elsewhere.

By collecting Socio-Demographic and Race-Based data, organizations will have a better understanding of the patients being served. You can use this data to gauge what programs and services are missing in your communities and if you want to invest in creating new programs and services to meet growing patient needs.

Make regular requests for funding for a dedicated position through the AOP process and use collected data to demonstrate need and the success of your program.

Creating New Programs to Meet Patient Needs

Creating a new program program can be tricky. With limited health human resources, Leaders will need to evaluate the ROI for the patient and the clinic by offering the new program.

Why create a new program?

- Your SD data has demonstrated a great need in your patient population and there are no other existing programs in your community that can support this need.

Patient/client independence & resilience:

- SP programming should **include the goal to encourage self-advocacy and follow-through that support meeting health and wellness goal.**
- When making community referrals and creating new programs, keeping this goal in mind will **empower patients** but will also build capacity in your SP programs.

Before creating a new program, consider this:

- Does a similar program exist and would my community partner consider adjusting their program?
- If the program is too far for the patients, will your community partner come to you?
- How many participants would be required to ensure the investment is impactful?
- Does your employee have capacity to facilitate?
- What outcomes are we measuring?
- Does this new program align with organizational goals for the SP program?
- Is this program sustainable?

Social Prescribing

FOR BETTER MENTAL HEALTH

by the Windsor Family Health Team

WINDSOR
Family | Health | Team

Margo Reilly, Executive Director
mreilly@windsorfht.ca