COMMUNITY
COMMUNAUTÉ

SOCIAL PRESCRIBING IN ONTARIO

FINAL REPORT

MARCH 2020

Alliance for Healthier Communities
Alliance pour des communautés en santé

Alliance for Healthier Communities (2020). *Rx: Community – Social Prescribing in Ontario, Final Report*.

This report has been prepared by the Alliance for Healthier Communities. We represent community-governed primary healthcare organizations offering health and social services under one roof. Our membership includes Ontario's Community Health Centres, Aboriginal Health Access Centres, Community Family Health Teams and Nurse Practitioner-Led Clinics.

We share a strong commitment to advance health equity. And we recognize that access to the highest attainable standards of health is a fundamental human right. Our vision is the best possible health and wellbeing for everyone living in Ontario.

We recognize that the work of the Alliance and our members takes place on traditional territories of the Indigenous people who have lived here and cared for these lands since time immemorial. The land we call Ontario is covered by 46 treaties, agreements and land purchases, as well as unceded territories. We are grateful to have the opportunity to live, meet and work on this territory.

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Ontario

*All client names in the report have been changed to protect anonymity

EXECUTIVE SUMMARY

Social prescribing in context

For over 50 years, Community Health Centres and other community-led primary healthcare organizations in Ontario have been united in their commitment to community development, health equity, and social justice. We know that as much as 80-90% of our health outcomes are driven by the social determinants of health.[1, 2] For a person to thrive in health and wellbeing, they must have access not only to appropriate clinical care and material supports, but also to meaningful social support and a community where they feel they belong. Social prescribing is a healthcare tool that can help ensure that clients are supported to connect with appropriate social and material supports. The Alliance for Healthier Communities embarked on Canada's first social prescribing initiative because it offered an opportunity to demonstrate and deepen members' work.

Developing the *Rx: Community* pilot

Eleven community health centres (CHCs) across the province participated in *Rx: Community*. Using client- and community-centred design thinking, they identified non-clinical interventions, built a structured referral pathway, and tracked the impact of their work.

Social prescribing may look different in different communities, depending on local needs and capacity. However, these five essential components have emerged as the foundation of an impactful model of social prescribing:

1. A *person or client* who is experiencing social and health barriers and challenges, and who has unique goals, interests, and skills;
2. A *prescriber* who recognizes the impact of social determinants on a client's health and refers them using social prescribing;
3. A *navigator* who receives the referrals and works collaboratively with the client to connect them to appropriate non-clinical, community-based supports;
4. *Social prescriptions*, non-medical and co-created supports in the community;
5. A *data pathway* that enables continuous incorporation of meaningful data and lessons learned to ensure quality of delivery and monitor outcomes.

Rx: Community began with a health and wellbeing grant in May 2018 and was launched at our pilot sites in late 2018. Data were collected throughout. This report was prepared in March 2020 to share findings and make recommendations for scaling up social prescribing across Ontario and beyond.

Evaluation findings

We used a mixed-methods implementation evaluation that combined qualitative and quantitative research approaches to examine how social prescribing was implemented; clients' and providers' perceptions of the initiative; its effects on clients' health; and its impact on systems within healthcare organizations.

During the year-long pilot, over 1,100 clients across 11 CHCs were provided a total of nearly 3,300 social prescriptions. Seventy-one of the clients who received social prescriptions were supported to become volunteer Health Champions who co-created and delivered social activities and programs.

Finding #1: Clients reported overall improvements to their mental health and a greater capacity to self-manage their

health, as well as decreased loneliness and an increased sense of connectedness and belonging.

Finding #2: Healthcare providers find social prescribing useful for improving client wellbeing and decreasing repeat visits. They recognized the value of the navigator role, and, where it was not in place, they felt a need for more support.

Finding #3: Social prescribing enabled deeper integration between clinical care, interprofessional teams, and social support; and it enhanced the capacity of the community through co-creation.

The project team, local social prescribing implementers, health providers, and clients provided insights into the challenges, lessons learned, and key enabling factors of implementing social prescribing with a health equity lens.

Participating centres identified the following as significant, common challenges:

- Lack of dedicated staff capacity;
- Stretched organizational capacity;
- Barriers in data tracking;
- Lack of community infrastructure to support social prescriptions;
- Early lack of clarity in defining the social prescribing model in Ontario.

We learned that the following are essential to a successful social prescribing program:

- Organizational culture change toward innovative, person-centred ways of working;
- Dedicated staff and organizational commitment to support practice change;
- A Learning Health System approach to data collection and utilization;
- Clarity in social prescribing terminology and model;
- Supportive social prescribing navigators;
- Inviting clients to define their own goals;
- Enabling volunteers of all abilities to contribute.

Participating centres observed and reported the following as enabling factors:

- Implementation within the context of a team-based, community development oriented healthcare setting;
- The spirit of innovation and persistence at pilot centres;
- Provincial coordination support.

Recommendations for scaling

Social prescribing is gaining momentum in Canada among healthcare providers, community partners, researchers, funders, and policymakers. This report concludes with a series of recommendations as to how each of these groups can contribute:

Policymakers, funders, and Ontario Health Teams can create fertile ground for social prescribing by investing in primary health care and social supports. They can further advance social prescribing initiatives with direct financial, material, and/or policy support.

Health care, cross-sectoral, and social support organizations can build and strengthen local partnerships, adapt social prescribing to the needs and assets of their communities, embrace culture change, and develop strategies for data collection and use.

Researchers and academic institutions can contribute screening and evaluation tools, conduct data analysis, and provide research support to health care and social support organizations.

CONTENTS

Graphic recording at Gateway Community Health Centre Social Prescribing Fair (ThinkLink Graphics/Kathryn Maxfield)

INTRODUCTION

What does it take for the healthcare system to truly integrate clinical and social care and to fully support the physical, mental, and social health and wellbeing of each person? What if, along with medication, doctors and nurse practitioners prescribed art and dance classes, volunteer roles, caregiver supports, and supportive peer networks?

Rx: Community – Social Prescribing in Ontario is a pilot that is enabling just this. It's demonstrating that this approach can empower clients to take control of their own health and wellbeing and co-create solutions. And it's showing that when primary care centres are places of belonging, they can be especially effective places of healing.

Social prescribing is gaining recognition across the United Kingdom and around the world. Here in Ontario, it is built on a foundation of integrated health and social services that has been at the heart of Alliance members' work since the 1960s and 1970s. As Ontario's health system undergoes transformation, social prescribing can help the whole system become one that supports community development, health promotion and prevention, and multi-sector integration. It can help us move from a "sickness" system which provides care after people get sick to a health system where every point of contact is a gateway to better overall wellbeing.

At its heart, social prescribing is a tool to better connect social care ('social') and clinical care ('prescribing') – with an emphasis on the delivery of care and the power of people to direct their own care. It broadens the definition of clinical care to encompass the social, environmental, and economic factors that affect people's health and wellbeing, and supports clients and clinicians to take action on what they know is important. Taking action on these social needs is an important dimension of the work of health equity, which seeks to reduce population health gaps and individual and community barriers to good health and wellbeing.

Social prescribing is enabled by the use of electronic medical records (EMRs) to track interventions and monitor their impacts, as well as by the engagement of social prescribing navigators or link workers. These navigators "fill" social prescriptions in partnership with the client, helping them access the most appropriate social care programs to support their health. At the same time, social prescribing entails a culture shift toward de-formalizing care and supporting deeply integrated partnerships with people and communities.

Social prescribing does not replace the vital work of medical care, investment in community, or interprofessional support for health. It does not replace sound policy or funding to address the upstream determinants of health. What it can do is help recognize social care as essential to health care and support people and communities – no matter what their formal or informal roles are – to integrate health and social services.

For social prescribing to work well, it requires a context of strong primary health care, adequate investments in the community supports and services offered as social prescriptions, and robust social policy aimed at addressing the broader social determinants of health. Social prescribing was successful in the CHC context largely because much of the enabling infrastructure was already in place.

The Alliance for Healthier Communities has piloted *Rx: Community* to adapt this model and measure its impacts in our context of comprehensive, community-led primary health care. Our member centres are already leaders in providing social and community supports. The pilot formalized and

strengthened the existing work by creating more intentional pathways between clinical care and social supports, and by tracking this process and its impacts on clients, providers and the wider community.

Early results corroborated what we know intuitively: people are healthier when they are connected to social and community supports and when they are empowered to play meaningful roles in both their own health and the health of their wider community, Adaptive community supports provide net benefits to our systems and communities.

This final report for *Rx: Community* shares our experience of implementing the first-in-Canada social prescribing initiative across diverse contexts in Ontario. It begins by reviewing the reasons why social services and care are necessary and the context that motivates social prescribing as a new twist on social care. It then describes the development and implementation of *Rx: Community* in the 11 participating centres. This is followed by discussion of what our evaluation of the project revealed, implementation challenges, lessons learned, and key enabling factors. We spotlight some of the unique ways member centres have adapted social prescribing for their contexts, and we conclude with some ideas about the future of social prescribing – the role it can play in an integrated health system and what's needed for social prescribing to be scaled and spread across the province, throughout the primary care sector, and beyond.

Volunteers and staff at Belleville and Quinte West Community Health Centre co-design a volunteer framework that would enable everyone to contribute their gifts and passions.

SOCIAL DETERMINANTS AND THE HEALTHCARE SYSTEM

Health and wellbeing are not merely the absence of disease or infirmity. Rather, they refer to physical, mental and social wellbeing, including the ability to adapt and self-manage in the face of challenges.[3] This is not a state that exists in a vacuum. It is a relational, dynamic process that reflects individual, social and ecological capacities and interactions. This means health care is more than medical care: factors such as education, income, housing, nutrition, relationships, and self-confidence all play essential roles.

Research suggests that as much as 80-90% of our health outcomes are driven by these factors, collectively known as **social determinants of health** (SDOH).[4, 5] For a person to reach their optimal state of health and wellbeing, they must have access not only to appropriate clinical care and material supports, but also to meaningful social support and a connected community where they feel a sense of belonging.

The importance of social connectedness for both physical and mental health has become increasingly clear over the last few years. Loneliness, exclusion, and stigma cause serious harm – a sobering fact in our increasingly fragmented society. Ontario's Chief Medical Officer of Health has identified loneliness and social isolation as major health threats, noting that "people with a weak sense of community belonging are more likely to be in the top five percent of users of healthcare services; this five percent accounts for more than 50 percent of total healthcare spending [...] costs that could be reduced if these individuals were part of connected communities."[6] Conversely, individuals with strong social relationships have a 50% lower risk of premature death than those with poor relationships.[7]

While we are becoming more aware of the risks associated with being socially disconnected, we are also becoming more aware of how disconnected many of us are. A 2019 Angus Reid Institute report[8] found that a third of people living in Canada are lonely, and about two thirds of those (23% of the population, or nearly nine million people) are also socially isolated. Among those who are both lonely and isolated, fewer than half feel a sense of belonging in their communities, and only about one in ten feel "very satisfied" with their lives.

Even among those who are moderately connected, there is a sense of longing for more. According to the same Angus Reid survey, nearly two thirds of Canadians wish they could spend more time with friends and family, and only a third are "very satisfied" with their lives. Perhaps unsurprisingly, loneliness and isolation are also correlated with marginalization and other social determinants of health. Those who are both lonely and isolated are more likely than others to be Indigenous; to be lesbian, gay, bisexual, transgender, queer, or two-spirit; to have a physical disability; to live alone; or to have a low income.[9,10, 11]

For individuals experiencing social challenges that affect their health, **primary care providers** and the health system can be their most trusted connection in their community. In many cases, they turn to the healthcare system – making frequent appointments for **primary care**, or visiting the hospital emergency room – for material and social support. Studies in the UK show that 20% of primary care visits are for non-medical needs,[12] and that loneliness and associated mental health concerns are linked to increased contact with primary care, especially among older adults.[13] This is similarly

reported by primary care physicians in Ontario.[14]

Over the past twenty years, there has been a dramatic increase in both the interest and evidence base for the social determinants of health.[15] Yet while most healthcare providers understand the importance of social care, they don't always know how to help their clients access it. A recent Commonwealth Fund survey of physicians shows that although 60% of family doctors in Canada screen their patients for social needs, only 43% frequently coordinate care with social services, and 36% don't know about what social services are available in their community.[16]

Visiting a primary care provider or emergency department to address non-medical health needs often provides little benefit for a person's wellbeing. It also creates stresses for medical staff who want to help but do not necessarily have the tools or training to do so,[17, 18] and it can be costly to the public. Yet without adequate supports, people who are marginalized or do not feel a sense of belonging will continue to experience poor health and to use elements of medical care that are costly but provide limited benefit to them.

With an increasingly fragmented population, we need to find sustainable and effective ways of addressing social isolation and loneliness, as well as immediate social needs like support with housing, income or food. Social prescribing is a tool healthcare providers can use to ensure that clients are connected to appropriate social supports. It reduces stress on the provider and cost to the health system while improving the health and wellbeing of clients and communities.

Marginalization, exclusion, stigma, isolation and loneliness: mounting recognition of social connectedness as a key determinant of health

In 2017, Ontario's Chief Medical Officer of Health released a report on Connected Communities as part of a series on health equity and the determinants of health.[19]

In 2018, the UK government launched a loneliness strategy,[20] based on the work that had been started by the late MP Jo Cox. As part of that strategy, they began to expand social prescribing, an initiative which had first emerged in the UK in the 1990s.

In 2019, Canada's Chief Public Health Officer spent a year studying the health effects of stigma and exclusion.[21]

GROWING FROM OUR ROOTS: INTEGRATING HEALTH & SOCIAL CARE

For nearly 100 years in Canada, and more than 50 in Ontario, **Community Health Centres** (CHCs) have offered both health and social services under one roof, in a **health promotion** model that supports individuals and communities to take control over the conditions for their own health and wellbeing. These multi-funded, community-centred and community-led organizations focus on **health equity** through a comprehensive approach to primary health care.

Today, this model of person- and community-centred **comprehensive primary health care** extends beyond CHCs. More than 100 organizations in Ontario follow the evidence-driven, WHO-supported **Model of Health and Wellbeing** (Figure 1) which describes a shared commitment to holistic care.[22] They include CHCs, Community-Governed Family Health Teams, Nurse Practitioner-Led Clinics, and Aboriginal Health Access Centres (AHACs).

In addition to anti-oppressive, team-based clinical care, these centres offer community kitchens and gardens in partnership with community programs such as FoodFit, supported by Community Food Centres Canada;[23] education supports through our flagship Pathways to Education[24] program; financial literacy training for newcomers[25] and Income Tax Clinics[26] for people on low or fixed incomes; peer-involved harm reduction services;[27] embedded Seniors' Housing;[28] and much more.

AHACs along with Aboriginal CHCs and Indigenous Interprofessional Primary Care Teams, as part of the Indigenous Primary Healthcare Council, offer Indigenous-governed, culturally centred services similar to social prescribing – for example, sweat lodge ceremonies, cultural teachings, Indigenous language classes, beading, singing and

Figure 1: Model of Health and Wellbeing (MHWB)

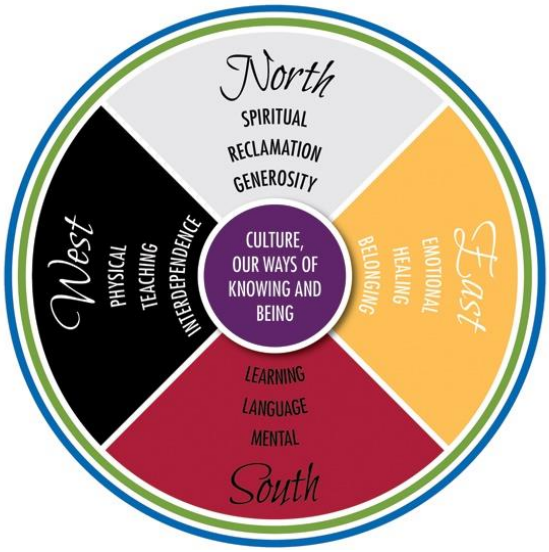


Figure 2: Model of Wholistic Health and Wellbeing (MWHWB)

dancing. They use the Indigenous-created **Model of Wholistic Health and Wellbeing** (Figure 2) to represent their approach to care.

Drawing on these years of expertise in addressing social needs and taking action on social determinants, Alliance member organizations deployed the **Canadian Index of Wellbeing** in their communities in 2014.[29] A key finding that emerged from this work is that CHCs feel like "home" to many people, and that a sense of belonging in the centre and in the community is a key determinant of health and wellbeing.

We started *Rx: Community* because we knew it was time to take action on community belonging. We knew Alliance members were already doing a lot of this work. We also knew social prescribing offered an opportunity to deepen this work: better integration between the health and social services we offer; an increased emphasis on **co-design** and **community development**; and a holistic way to meaningfully follow the client journey.

The roots of integrating health and social care in Canadian Community Health Centres

The social approach to health was formally recognized in 1948 with the creation of the World Health Organization, whose founders "shared a vision of health as pre-eminently shaped by social conditions."[30] That same year, Canada's first CHC – the Mount Carmel Clinic in Winnipeg – broadened its scope from clinical care alone to one that includes community outreach and support for material needs.[31]

In Ontario, CHCs emerged in the late 1960s and early 1970s in response to new social challenges to health.[32] In 2014, the member organizations of the Association of Ontario Health Centres (now the Alliance for Healthier Communities) adopted the Model of Health and Wellbeing (MHWB).

Since their inception, Alliance members have addressed community connectedness and the social determinants of health through personal development programs and community initiatives. *Rx: Community* builds on and supports this work by enhancing the integration of health and social care within the participating centres.

DEVELOPING *RX: COMMUNITY – SOCIAL PRESCRIBING IN ONTARIO*

With an 18-month Health and Wellbeing Grant from Ontario's Ministry of Health, the Alliance for Healthier Communities implemented *Rx: Community*, a social prescribing pilot research project.

Interested Alliance members were invited to an initial training workshop to learn from two groups of mentors from the UK – Herts Valleys Clinical Commissioning Group, with experience in social prescribing navigation, and Altogether Better, an organization with expertise in a model of deep co-creation between primary care staff and clients termed **Collaborative Practice**.

Following initial training, 11 CHCs across Ontario saw potential benefits in developing this initiative at their centres and self-selected to become participants in the research pilot. Self-selection was important to the success of the project, as centres had built-in readiness to take on this new initiative.

These CHCs represent a diverse mix of urban, rural, Northern, and Francophone communities. Using client- and community-centred design thinking, participating teams identified non-clinical interventions, built a structured referral pathway, and tracked the impact of this work on health outcomes and healthcare provision.

Core to the project was studying the implementation of social prescribing in the Ontario CHC context and measuring its impacts on clients, health providers, and the wider community. Informed by the literature and lessons learned from the UK experience, enabled by a common EMR and a shared evaluation framework, and guided by an Advisory Council of external researchers and experts interested in social prescribing, we built ongoing evaluation into the *Rx: Community* pilot.

The following table provides a general overview of the *Rx: Community* implementation process from the provincial coordination perspective, including major milestones completed. The implementation process was intentionally open to localized adaptation and innovation. This would ensure that social prescribing was implemented in ways that reflected diverse local contexts and recognized the unique challenges and strengths of each community.

Rx: Community Implementation Milestones

(See glossary for terms and abbreviations)

Preparation	May 2018	Health and Wellbeing Grant received.
	June 2018	Social prescribing experts from UK presented at the Alliance annual conference and provided train-the-trainer workshops.
	August 2018	CHCs self-selected to participate in the pilot; Memorandum of Understanding with participating sites signed.
	September 2018	Advisory Committee formed. Research ethics approved. Evaluation framework and EMR templates developed. Organizational context survey completed by all centres. Communications materials developed, including webpage, resource portal, and introductory video.
Implementation	September to November 2018	UK experts returned to provide on-site training. Pilot sites launched social prescribing. Implementation included staff circle, rapid asset mapping, local stakeholder communication, referral pathway, EMR templates, and invitation to clients to volunteer co-creatively. Clients were identified, referred, and pre- and post-referral outcomes collected on a rolling basis.
	January 2019	First round of data collection completed.
	March 2019	Social prescribing webinar held on International Social Prescribing Day. In-person Community of Practice with pilot sites held.
	May 2019	Second round of data collection completed.
	June 2019	Interim Progress Report produced. Social prescribing session held at the Alliance conference.
	July 2019	Presented at International Social Prescribing Conference in London, UK, where *Rx: Community* received inaugural International Social Prescribing Award.
	November 2019	Final round of data collection completed.

	December 2019	Social prescribing webinar for cross-sectoral stakeholders, "Collaborating for Systems Change," was held.
	January to March 2020	Data analysis completed. Pilot centres developed plans for ongoing sustainability.
	March 2020	Social prescribing final report launched.
Strengthening capacity	Ongoing	Advisory committee met monthly to provide guidance and insight; research advisory met at regular intervals coinciding with each round of data collection to inform methodology and analysis. Pilot centres participated in biweekly status check-in calls with Project Team, as well as monthly Community of Practice group teleconference calls. Non-pilot CHCs began to develop plans to implement social prescribing and participate in their own Community of Practice teleconference calls. Provincial conversations with stakeholders and partners across diverse sectors continued to form and deepen. Supported sustained media interest in social prescribing on local, provincial, and national levels. Provided guidance to province-wide national and international conversations on social prescribing. Project staff attended conferences and tables by invitation to share about social prescribing principles, practices, and ongoing evaluation results.

ESSENTIAL COMPONENTS OF SOCIAL PRESCRIBING

The five essential components of a standardized yet adaptable social prescribing pathway are:

1. A *person or client* who is experiencing social and health barriers and challenges, and who has unique goals, interests, and skills;

2. A *prescriber*, who recognizes the impact of social determinants on a client's health and refers them using social prescribing;

3. A *navigator* who receives the referrals and works collaboratively with the client to connect them to appropriate non-clinical, community-based supports;

4. *Social prescriptions*, non-medical and co-created supports in the community;

5. A *data pathway,* which enables continuous incorporation of meaningful data and lessons learned to ensure quality of delivery and monitor outcomes.

Social prescribing may look different in different communities, depending on local needs and capacity. The diversity of the *Rx: Community* pilot sites makes it clear that there is no single "right" way to do social prescribing. Many implementation approaches and focuses can be incorporated.

Nevertheless, these five essential components – client, prescriber, navigator, social prescriptions, and data pathway – have emerged through iterative refinements of *Rx: Community* as the foundation of an impactful and evidence-informed model of social prescribing. In the rest of this section, we will explore each of these elements and their contributions to the model.

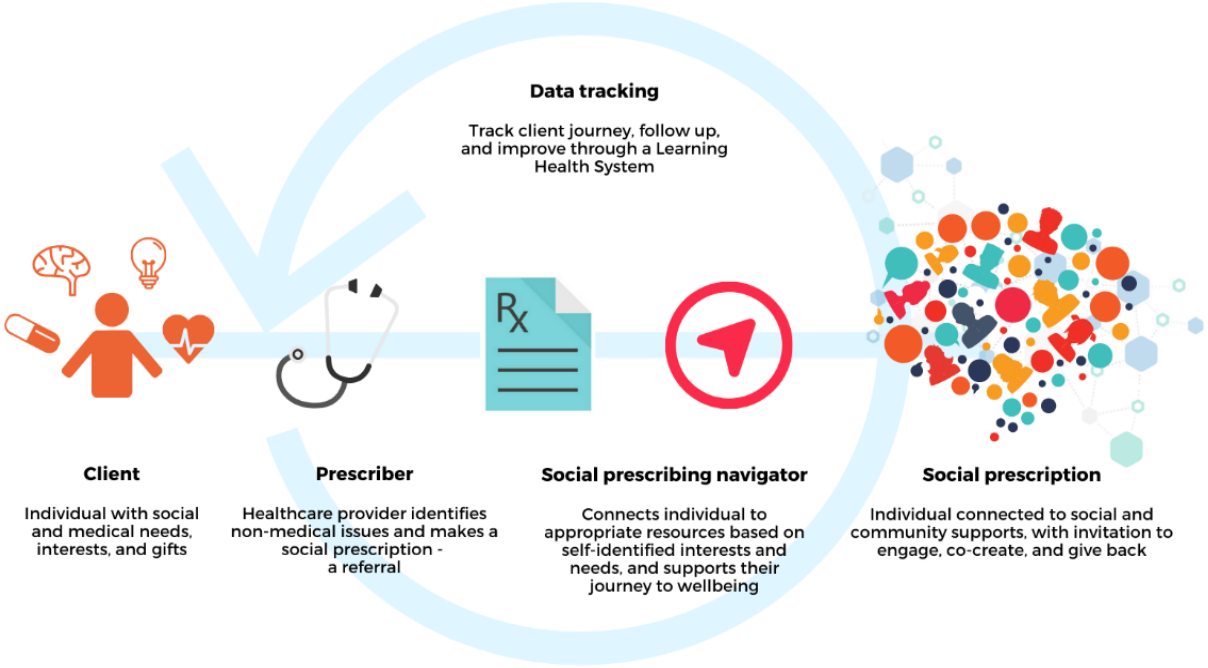


Figure 3: Social prescribing model/pathway implemented in Rx: Community

Client

Social prescribing focuses on individual clients who are accessing medical care and whose health and wellbeing would be enhanced by additional non-medical supports to address the important social determinants of health mentioned earlier.

Relative to other models of health care in Ontario, CHCs serve a higher proportion of clients with social and medical complexities. This includes people living on low income or social assistance, newcomers, and individuals living with chronic conditions, mental health issues, or comorbidities (the presence of two or more conditions).[33] It also includes people from the population groups facing the highest health disparities in Ontario – Black and racialized people, Indigenous people, those from 2S and LGBTQ+ populations, and Francophones.

Within this context, each *Rx: Community* site defined its own social prescription criteria. Broadly, sites focused on clients the prescribers felt could benefit from additional social support and connections, in addition to those who require structural supports like housing and food.

Social prescribing was particularly appropriate for clients who faced low- to medium-complexity challenges and required some encouragement and support to access non-medical care and services. Some centres chose to further focus on specific populations, such as isolated seniors or newcomer families.

Screening for social prescribing

There are no agreed-upon standardized screening tools, as of yet, in the UK or in Canada, for social prescribing. Individual tools have been developed and piloted in various settings that deal with specific areas of a person's SDOH, such as the Poverty Tool,[34] Benefits Screening Tool,[35] Loneliness Screening Tool,[36] and Fall Prevention Screening.[37] Standard intake forms at all CHCs include collection of socio-demographic and race-based data, which gives a sense of a person's social situation. CHCs also collect responses to three questions associated with self-reported physical and mental health and sense of belonging, adapted from the **Canadian Index of Well-Being (CIW) initiative** (see Appendix B). In a related project, **TeamCare**, which connects clients of solo-physicians to interprofessional teams, questions on material and social aspects of an individual's life are included in the intake.

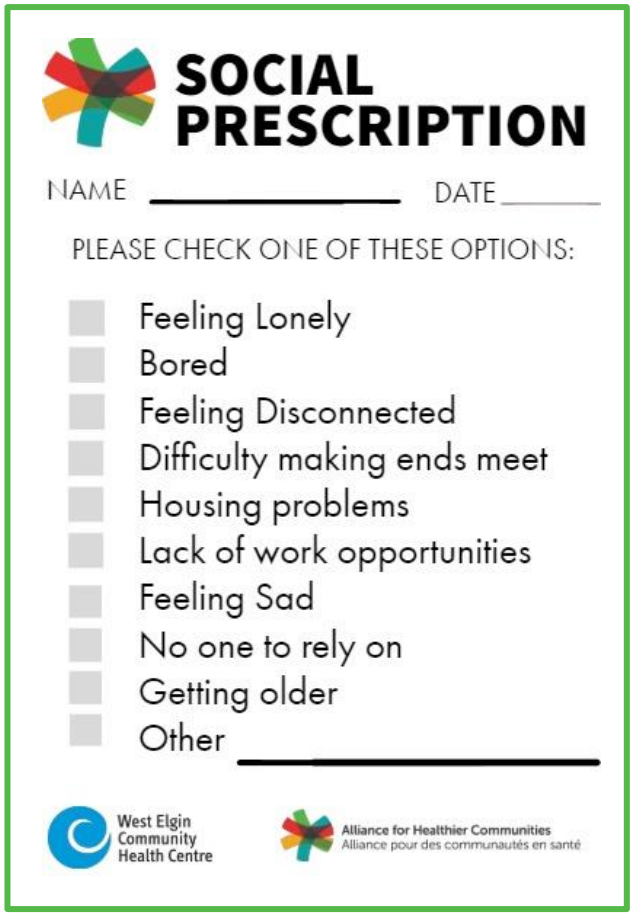
Prescriber

When a socially vulnerable or marginalized person is experiencing poor health, their relationship with their healthcare provider (a 'prescriber') may be a significant – or perhaps the only – trusted relationship they have. Social prescribing leverages this relationship to ensure that within the healthcare system, both clinicians and clients are supported to recognize and address social needs.

With social prescribing, healthcare providers work collaboratively with other team members to connect clients with appropriate non-medical resources and supports for their needs, allowing them to focus their energy on treating medical issues.

In *Rx: Community*, which was based in CHCs, the prescribers were primary care providers (physicians and nurse practitioners) and interprofessional team members (such as nurses, dieticians, social workers, community support workers, and occupational therapists). When they met with a client and identified that there were underlying issues, they could refer the client directly to activities and programming where they felt the client would be capable of independently taking up the referral. They could also refer the client to a navigator, who could provide more intensive support to help the client connect with non-medical interventions.

Sometimes the referrals were written down on prescription pads, similar to a medical prescription. Individuals found this novel and there was anecdotal evidence of higher interest in taking up the prescription when presented this way.[38] Prescribers could also make an immediate face-to-face direct introduction between the client and navigator. In all cases, prescribers recorded the social prescription referral and reason for referral in the EMR, which also flagged the navigator to follow up.


SOCIAL PRESCRIPTION

NAME _____ DATE _____

PLEASE CHECK ONE OF THESE OPTIONS:

- ☐ Feeling Lonely
- ☐ Bored
- ☐ Feeling Disconnected
- ☐ Difficulty making ends meet
- ☐ Housing problems
- ☐ Lack of work opportunities
- ☐ Feeling Sad
- ☐ No one to rely on
- ☐ Getting older
- ☐ Other _____

West Elgin Community Health Centre

Alliance for Healthier Communities
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West Elgin CHC used this Social Prescription pad to prompt clinical providers in their client appointments

Throughout the pilot, social prescribing implementers at each location consulted with and engaged clinical providers to co-create referral and data-tracking pathways that were easy to understand and did not unduly increase the appointment and record-keeping burden. Interprofessional staff teams or "circles" were created that included clinical, interprofessional, and health promotion staff, creating an internal forum to share ideas, discuss pathways, and provide feedback.

Beyond the CHC model, we envision the prescriber may be any individual who has professional responsibility related to an individual's health, including primary care providers in Family Health Teams, hospital clinicians, specialists, public health nurses, hospice and home care workers, and so on.

Social prescribing focuses on the integration between clinical care and community supports. It emphasizes that clinical providers have a vital role in referring clients to non-medical supports. At the same time, it recognizes that many interprofessional team members are already habitually connecting clients with community resources, though these connections are often not tracked in the client's clinical record.

"I think [social prescribing] is a type of care that puts the patient at the centre of the healthcare plan and focuses on the determinants of health, and it's something that the whole team can use as a common language about how to create a management plan that respects the wellbeing of the patient and makes sure that the overall aspects of the social health of the patient are considered."

Physician, Centretown CHC

"The biggest point of validity is recognizing that individuals need to look at their health in a more holistic way and that it's a good thing for them, and sometimes having the primary care provider suggest or mention something else that will help instead of a prescription, such as counseling or engaging in other activities – I think that validity from a primary care provider has been the biggest reason that people will come and take it more seriously, with the sense that 'participating in this group will help me get out of the house or become more healthy.'"

Health Promoter, NorWest CHC

Social prescribing navigator

In general, a dedicated **social prescribing navigator** (also known as a **link worker**) provides a supported connection that helps clients access the prescribed supports. After receiving a social prescription referral, the navigator co-creates a personalized solution with the client by listening deeply to their self-identified need and interests. They then match the client with appropriate community assets. The navigator thus serves as the connection between clinical providers and community resources.

The navigator helps the healthcare team move beyond asking participants "what's the matter with you?" to asking – and supporting – "what matters to you?" A social prescribing navigator is different from a **system navigator**, who is typically focused on helping clients navigate the health system.

UK studies identify the navigator role to be essential to the success and impact of social prescribing,[39] though different initiatives may utilize a spectrum of support, depending on client needs and available resources (see box).[40] National Health Service England have invested funding and training for 1000 social prescribing navigators by 2020/2021, with the aim of enabling social prescription service in every primary care network by 2023.[41]

Social prescribing navigators understand the assets of the community, and they support individuals in addressing the SDOH through formal and informal community-based services. This role is complementary to, yet distinct from, traditional health navigators or care coordinators who are focused on supporting an individual's navigation of the formal healthcare system, such as long-term care placement and specialist appointments.

"We would go to a program, such as congregate dining, with clients to introduce that program to them, because there is a fear of the unknown. They would meet me here at the health centre and then we would walk over, just until we got them connected and introduced them to someone. It's getting them into the room to understand what it was like and to see what a vast range of people were there, and that they did fit in."

System Navigator, West Elgin CHC

Spectrum of Support

Signposting: Advertise the resources available. Trust clients to self-refer or access the supports on their own.
Light: Referrals are made to address an identified need. No follow up.
Medium: Referrals involve light assessment, co-design and follow up.
Holistic: Referrals include formalized assessment, co-designs, and dedicated support to access resources.

Rx: Community pilot sites did not receive funding for a dedicated navigator role. Some sites began with direct referrals from prescriber to prescription, without a navigator. In doing this, they landed on the "signposting" to "light support" end of the spectrum. Some sites trained volunteers to help provide information and encouragement to connect clients with services. Others reallocated a portion of an existing staff member's time to function as a navigator, which enabled "medium" to "holistic" support. In these cases, the role was filled by staff with diverse professional backgrounds and job titles, including nurse, social worker, outreach worker, health promoter, and community support worker.

Despite the varied initial approaches, there was clear consensus among practitioners that dedicated staff time was necessary to provide intentional support in connecting clients with prescriptions. This was especially true with socially and medically complex clients who would most benefit from these social prescriptions yet faced higher barriers to navigating and accessing supports on their own. Having dedicated staff time and explicitly allocated responsibility also increased centres' capacity for follow up with clients, feedback of results to the prescriber, and proper data-tracking and record-keeping.

Read more in Appendix C: Spotlights
Stonegate CHC focuses on "warm handoffs"; and Guelph CHC creates new Community Connector role to support social navigation.

Social prescribing navigators in integrated care models

There is strong integration between the role of a social prescribing navigator and other concurrent initiatives, such as *TeamCare* and *WrapAround*.

TeamCare is an initiative that connects clients of solo-practice physicians to interprofessional teams such as social worker, system navigation, dietician, mental health worker, housing and other social supports. Within 1.5 years, TeamCare has expanded access to 2258 physicians and over 26,000 people who did not have access to these supports before. At full scope, the team complement will include a social prescribing navigator.

WrapAround is a well-defined model that blends formal and informal community supports into one care team chosen by the client. The WrapAround facilitator, who may be a professional or a volunteer, functions as a holistic navigator who provides comprehensive support for the SDOH. WrapAround is an option that can provide the intensity, rigour and consistent practice sometimes needed at the "holistic" end of the social prescribing spectrum of support. Sites such as Country Roads CHC and CHCs of Northumberland (with an emergent, non-pilot social prescribing initiative) are exploring an approach that integrates social prescribing and WrapAround to better support clients at the interface of health and social care.

Read more in Appendix C: Spotlights
NorWest CHC integrates TeamCare and Social Prescribing processes; and Gateway CHC integrates wellbeing and social supports into care plans.

Social prescription

Non-medical prescriptions that enhance health and wellbeing can include a wide range of activities and supports. These include help with navigating social services and housing application forms, accessing poverty and food security services, or connecting to various social groups and activities. There is an existing strong evidence base for the positive impact of many non-medical interventions on health and wellbeing, such as exercise,[42] time in nature,[43] social activities,[44] and arts and culture participation.[45]

In *Rx: Community*, the social prescriptions given vary based on individual self-identified interests and needs as well as community capacity. They were drawn from three sources:

- Internal capacity of CHCs,
- Supports that were co-created with client volunteers, and
- Partnerships with external organizations from diverse sectors.

Internal resources

Operating within the Model of Health and Wellbeing (MHWB), CHCs already provide community supports and programming within clinical spaces that are open to both clinical clients and the broader community. These supports and programs are facilitated by staff, peer volunteers, or community partners. They include support for structural determinants of health, such as navigating housing and employment services, as well as activities such as communal dining, exercise groups, coffee clubs, and community gardens.

Focus group participants stated that internally-run and cost-free groups had fewer barriers to participation. As they occurred in clinical spaces that were already familiar, it was easy for staff to accompany their clients to the first session. Many clients expressed comfort in being in social and group settings with others who have similar health challenges. Internal groups were also easy to familiarize to health providers, who could be certain of when and where the groups would take place, as well as the quality of program delivery.

Monthly Baking Group at West Elgin CHC

Volunteer co-creation

Co-creating activities and programs with volunteers and peer leaders from the community offers another source of social prescriptions. Six pilot centres focused on implementing a model of Collaborative Practice with the support of UK mentors from Altogether Better. In this model, clients of all abilities are invited and supported to work alongside clinical staff to identify needs and co-create solutions out of their passions and gifts.[46]

These volunteers were sometimes called "**Health Champions**" to distinguish this kind of informal, co-creative, **asset-based** and community-informed approach from traditional volunteering programs, which generally utilize a more fixed approach where needs have been pre-identified by the formal health organization and people with specific technical skills are asked to fulfilled the predetermined roles.

This work is strongly supported by the long history of health promotion, which focuses on empowering people and communities to take control over their health and wellbeing.[47]

Pilot centres sent out broad invitations to their client roster, with a minimal screening process to ensure a client's participation would not be a risk to themselves or others. Some social prescribing clients were also prescribed and screened to begin volunteering as Health Champions. All interested clients were invited to a Welcome Workshop, where they met together with an interprofessional group of centre staff to begin a co-creative conversation of the social and health needs, challenges, passions, and gifts that each brings. Subsequently, these volunteer Health Champions continued to meet with staff and one another regularly and were supported in developing and implementing activities and programs for which there was a felt need and shared enthusiasm.

"The whole idea of eliminating the pressure on the professional team, and say, 'what are the needs of society and how can we address it?' was what spoke to me as a volunteer. This program said, 'In fact, you identify the different needs in your local community, and then create the solutions they need.' There's no prescribed solution, it was a philosophy that we are creating the solution for each other. That really spoke to me. It's given back to me so much."

Health Champion, South Georgian Bay CHC

A creative diversity of activities and groups has emerged in *Rx: Community*, including bereavement support groups, sing-alongs, knitting classes, card game groups, addiction support groups, music in the waiting room, a community kitchen, pole walking, friendly visiting, and many others.

For regions that had less existing capacity within the community, such as in rural areas and for Francophone clients, Health Champions added significantly to the capacity of the pilot centre, and the community at large, to provide non-medical supports. See **Appendix C: Spotlights** to read more about the creative activities and supports that have been uniquely developed at each location.

Volunteers initiated and led a Nordic Pole Walking Group at South Georgian Bay CHC

> *"Before, I would be running more programs. Now there's such a good variety and diversity of programs because of our Health Champions, I can focus more on one-to-one supports for the clients."*
>
> *Community Health Worker, NorWest CHC*

Use of the Term "Health Champions"

The term "Health Champion" resonated at some centres as a way to distinguish individuals who gift their time more co-creatively with the centre, and the Champions expressed pride and embraced a collective identity under this term. Elsewhere, individuals found the term confusing, and preferred to self-identify as volunteers, while recognizing the difference between their roles and traditional volunteering. It may be that the distinction is most relevant and helpful for enabling health providers to understand and relate with volunteers in more co-creative ways.

Cross-sectoral partnerships

At the start of the initiative, *Rx: Community* sites created or updated an **asset map** of community resources and partnerships to better understand the available external social prescriptions.

Essentially, an asset map is a listing of what already exists in a community that can be highlighted and encouraged in order to advance community development. These things include community members and their stories as well as physical assets (land, buildings, transit networks, parks, etc.), economic assets (local businesses, bartering and trading relationships), and local associations and institutions. In *Rx: Community*, asset mapping was particularly useful for smaller and rurally situated centres.

After the asset map was completed, sites strengthened existing relationships and fostered new ones with a wide range of sectors that impacted health. These included arts and culture organizations, nature groups, senior services, good food organizations, and other community and social service agencies.

By connecting with and leveraging existing community assets, the social prescriptions were adaptive and responsive to local needs and strengths, and they created a broad network of support for clients that reduced silos and encouraged innovative cross-sectoral partnerships.

Prescriptions for Good Food

At the intersection of nutrition, education, and social connectedness, three centres have developed food prescriptions as an extension of social prescribing.

Farmacy Rx @ Rexdale CHC
Partnering with FoodShare, socially isolated clients living with chronic disease on low incomes are prescribed bi-monthly Good Food Boxes with locally grown fresh produce, and supported by an in-house dietitian and food literacy programs.

Food Rx @ Guelph CHC
A new initiative with SEED, an in-house coalition program that addresses food insecurity, enabled health providers to prescribe food interventions to food insecure households with supporting programming for food education, communal cooking, and social connections.

Veggie Rx @ NorWest CHC
In partnership with Roots to Harvest's Punks Growing Food, a local food education and employment project for youth, health providers prescribed clients living with diabetes free fresh-grown vegetables, nutrition education, and communal cooking components.

Read more in **Appendix C: Spotlights**

Arts and culture partnerships were a particular strength. Two strong arts and culture networks in support of health and wellbeing emerged in Toronto and Ottawa, with the Royal Ontario Museum, the Art Gallery of Ontario, the Toronto Symphony Orchestra, the Hamilton Philharmonic Orchestra, and the Museum of Nature in Ottawa all providing admission passes. These passes were prescribed by health providers and led to emergent discussion about moving beyond the provision of passes to co-created, facilitated programming.

Food, education, and recreation partnerships were also strengthened. A staff member from the Toronto Public Library is now co-located at Rexdale CHC to provide support and animate programming around digital literacy. The Belleville and Quinte West CHC has partnered with their local library on a Reading Well program to curate education on mental health and nutrition. Three centres have begun food prescriptions with various good food organizations (see box). Others have connected with the community band, local businesses, older adult centres, park authorities, and creative writing collectives, among many others.

Read more in Appendix C: Spotlights
West Elgin CHC's asset mapping initiative; CSC du Temiskaming's cross-sector advisory committee; Country Roads CHC's rural partnerships; and South Georgian Bay CHC's closed-loop referral partnership with 211 Central East Ontario.

Soup and Symphony at Guelph CHC, in partnership with Guelph Symphony Orchestra, combines nutritious food, social interaction, and music toward better health and wellbeing.

Data-tracking and evaluation

From the beginning of the *Rx: Community* pilot, we recognized the importance of defining strong data-tracking mechanisms in order to capture as much of the social prescribing pathway as possible. We knew it would be important for us to follow the client's journey between the prescriber, navigator, and social prescriptions. This would allow us to properly evaluate the intervention, and it would allow for an accurate reflection of the client as a whole person whose health and wellbeing is shaped by a variety of medical and social influences.

All CHCs that participated in *Rx: Community* shared an **electronic medical record** (EMR) system. The system is supported by local Data Management Coordinators under the oversight of a common provincial Information Management Strategy coordinated by the Alliance. This structure enabled us to rapidly standardize data collection processes and allowed each centre to adapt them to their preferred client flow processes.

As mentioned previously, standard intake forms at all CHCs include socio-demographic questions, as well as three questions associated with self-reported physical health, mental health, and sense of belonging.

In addition, *Rx: Community* sites recorded data on who received social prescribing referrals, for what medical and/or social reasons, which activities or programs those clients were referred or prescribed to, and the degree of prescription uptake and follow-through. Data was also collected on changes in self-reported health outcomes through pre- and post-intervention surveys and focus group interviews. It was also important to capture the experiences of clients, volunteer Health Champions, navigators and health providers.

The data-tracking and evaluation component of social prescribing supports the goals of a **Learning Health System** (LHS) – to learn from the data we collect and make real-time improvements. In *Rx: Community*, the data collected supported staff engagement, informed iterative improvements to the pathway, and helped assess the quantitative and qualitative impact that intentional social prescriptions have on individuals, health providers, and the wider community.

The next section, Evaluation Findings, provides more details about how *Rx: Community* was evaluated and what we learned.

> *"The pilot has helped us standardize the way we do our referrals and track the work that we're actually doing. Before, we may have an informal conversation or send a message, and information could get lost. Now it's a process and it doesn't really take away from having a conversation about a client, but it's more consistent. When you don't have a process in place there's nothing to look back on or to reflect on how you're doing."*
>
> *Staff, South Georgian Bay CHC*

EVALUATION

We used a **mixed-methods** implementation evaluation to understand the practical lessons that emerged from implementing social prescribing in Ontario CHCs. A mixed-methods evaluation draws on both qualitative (descriptive and experiential) and quantitative (numeric) data. Our goal was to evaluate the implementation of *Rx: Community*, in order to understand how social prescribing impacts clients and clinicians and to identify key factors that enable successful implementation.

A common evaluation framework and a shared EMR empowered us to conduct a relatively straightforward analysis of the impact of *Rx: Community* without unduly increasing the administrative burden on providers or clients.

Broadly, the outcomes of social prescribing should align with the Quadruple Aim of health care: healthy populations, good care experiences for clients, a sustainable health system, and joy in work for providers. Over-surveying clients or overburdening staff who are already working at stretched capacity could negatively impact client experiences, reduce joy in work, and add to costs.

We used a limited set of survey tools to detect changes in clients' health outcomes related to loneliness, social connections, and self-reported wellbeing at baseline and at 6 months after engaging in social prescriptions. The survey questions can be found in Appendix B. At three points throughout the 18-month pilot, we also assessed our progress through organizational and provider surveys, EMR data extraction, and a series of focus groups.

Iterative improvements were made throughout the intervention based on this evaluation data as well as from information gained through informal feedback, check-ins, meetings, and communities of practice.

Evaluation methods

Qualitative: Focus groups were conducted with clients, community champions, and providers to understand the contextual factors, facilitators, barriers, and impact of social prescribing. A semi-structured interview format was used and thematic analysis undertaken.

Quantitative: Aggregate-level data extracted from the CHC EMR was reported at three points in time. Common templates and data queries were used to promote consistency among the different CHCs.

Key findings

We present a descriptive summary of our main outputs and outcome findings here. In-depth analysis will be shared in future journal publications. In general, we found that:

1. Clients reported overall improvements to their mental health and a greater capacity to self-manage their health, as well as decreased loneliness and an increased sense of connectedness and belonging.

2. Healthcare providers found social prescribing useful for improving client wellbeing and decreasing repeat visits. They recognized the value of the navigator role, and, where it was not in place, they felt a need for more support.

3. Social prescribing enabled deeper integration between clinical care, interprofessional teams, and social support. It enhanced the capacity of the community through co-creation.

Client profile

All Alliance member centres are committed to collecting socio-demographic and raced-based data for purposes of performance evaluation and research.

In equity-oriented healthcare settings, this data collection is an important step towards understanding how our clients are impacted by the social determinants of health, identifying populations who experience structural barriers to wellbeing, and measuring whether – and how much – our interventions advance health equity. For example, we may identify a population of clients who live alone on a low income, and we may notice that their health outcomes are poor compared to their wealthier, and more-connected peers. We can then tailor interventions that meet their needs for structural support and social connection, and we can look for improvements in their overall health and wellbeing and a levelling of those health disparities.

Among *Rx: Community* clients whose socio-demographic data was collected, nearly half were aged between 61-80 years, most were female, and over a third were non-white. Additionally, nearly half of them lived on a low income, even though close to a third had at least some post-secondary education. This is illustrated in the figures below (Figures 4-8).

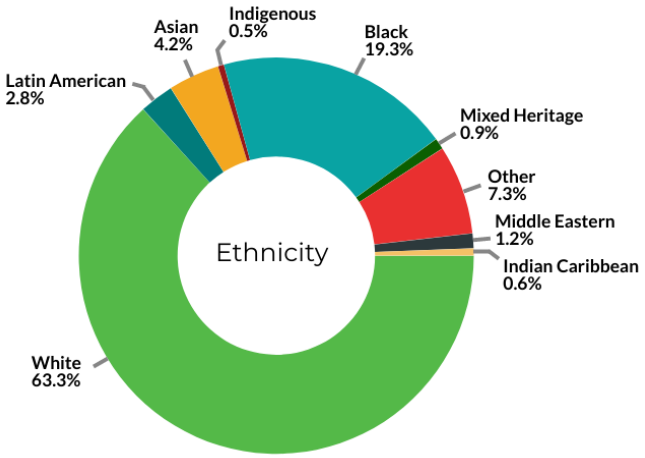


Figure 4: Client's self-identified ethnicity

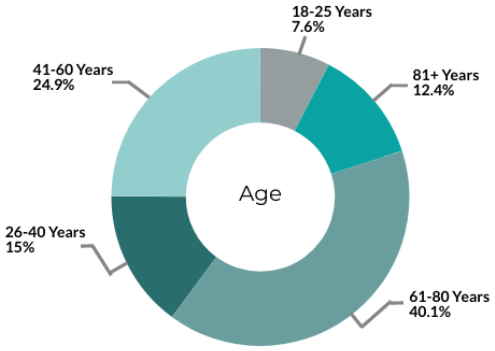


Figure 5: Clients' age

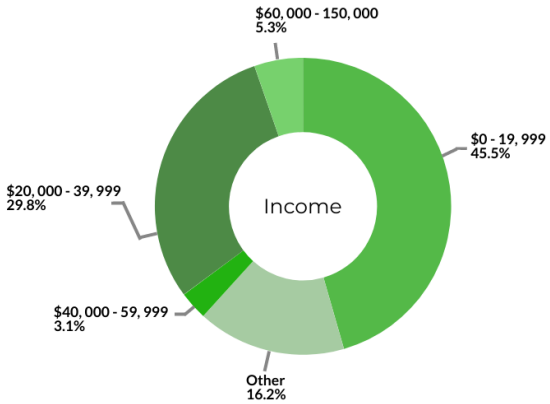


Figure 6: Clients' income

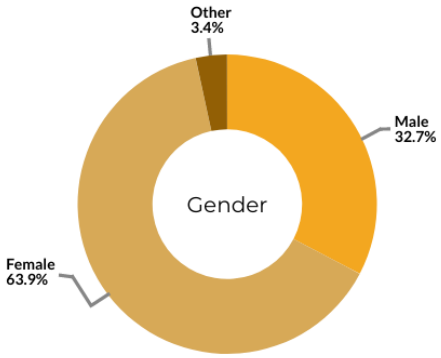


Figure 7: Clients' gender

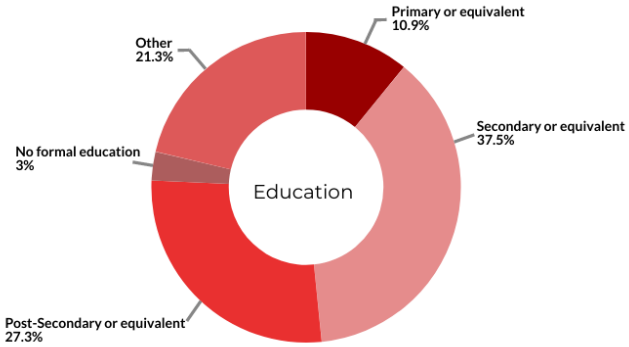


Figure 8: Client's highest level of education

Social prescriptions

During the year-long *Rx: Community* pilot, 147 providers referred 1,101 clients to 3,295 social prescriptions. Many referrals were made to internal or co-created resources offered within CHCs, with external (partner-provided) referrals focused mainly on food security and housing supports (Figure 9).

Mental health was a key health driver of social prescriptions, with anxiety and depression being the most frequent conditions addressed (Figures 10).

The average referral uptake was 57%, according to available data. This is a conservative measure; uptake was not captured for all social prescriptions, including single-occurrence events, activities not requiring registration, and activities with external partners, due to a combination of technical limitations, the nature of social programming, and limited staff capacity to follow up.

Among *Rx: Community* clients, 71 became volunteer Health Champions, meaning they not only participated in social prescriptions but also co-designed and led activities and programs for peers at their centres. Operating with a grounding in health equity, pilot centres encouraged and supported clients of all capacity, regardless of health and social complexities experienced, to participate in co-creation. Altogether, Health Champions developed a total of 58 new programs across participating CHCs, and new activities are continually being created.

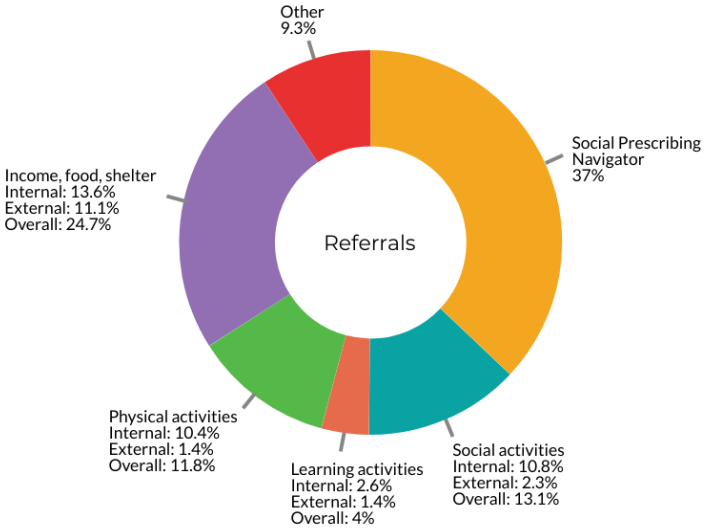


Figure 9: Breakdown of social prescribing referrals

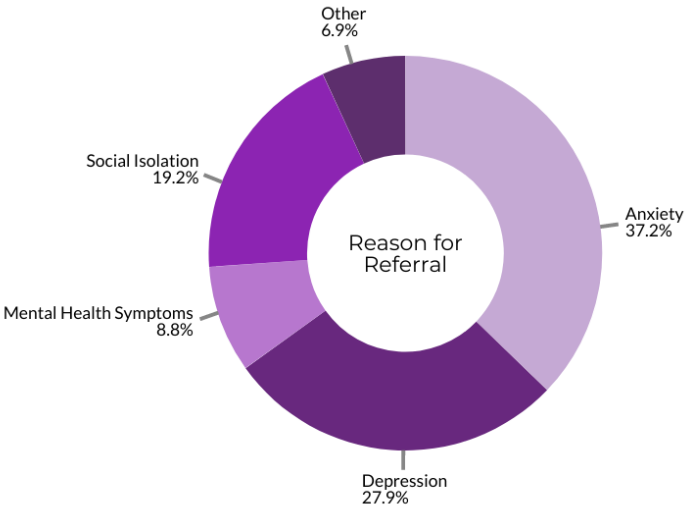


Figure 10: Recorded reasons for referring clients to social prescriptions

Figure 11: Key outputs of Rx: Community

KEY FINDINGS

Finding #1: Clients report improvement in mental wellbeing and self-management of health, decreased loneliness, and increased sense of connectedness and belonging.

Improved mental wellbeing

Client outcome (# of respondents = 108)	% Change
Self-reported mental health	↑ 12.1%

Table 1: Change in clients' self-reported mental health.

Social activities like the ones prescribed in *Rx: Community* can provide an opportunity to relax with friends and a welcome respite from stress and anxiety. Consistent with this, there was an average improvement of 12.1% in self-reported mental health among *Rx: Community* participants (Table 1).

Many participants told us that participating in social prescriptions elevated their mood because they knew they were going to see their friends. They felt that attending a program provided stress relief, distraction from anxiety, and a chance to take time for themselves. They enjoyed knowing that for an hour a week they could focus on things they enjoy and not think about other issues in their personal lives.

> *When I have social things to do, it helps with the other stuff. Sometimes when you're just so focused on your issue, you don't have time to recuperate, you don't have time to refocus, you don't have time to do anything else, and this break just gives you an opportunity to just let go and unwind. It's just good overall to escape for a minute and kind of give you clarity on what's going on, even if it's just temporary escape of what is going on in your time or your circumstance. It's a welcomed break.*
>
> *Participant, Rexdale CHC*

Jordan* was prescribed a free visit to the Art Gallery of Ontario in Toronto by their mental health counsellor after it was discovered that they used to study art. Taking public transportation was a barrier, but the free transit tickets provided by the CHC gave extra confidence and motivation to take on the challenge of travelling to the gallery. They shared, "Going there had positive effects for my mental health, and that was after I first thought I might not be able to go because of anxiety. I spend a lot of time at home. When I'm somewhere that I enjoy -- and especially a place with art, that gives me good emotions."

Greater capacity to self-manage health

Clients who received social prescriptions reported improvements in their ability to manage different aspects of their health. These included managing a new disability or chronic condition, managing or coping with anxiety and depression, and becoming more physically active. The programs helped clients understand what they were going through and equipped them with the appropriate knowledge and tools to make them feel more competent in taking care of their health.

Participants appreciated that programs were facilitated in a compassionate way that made skills attainable and manageable. These skills were further developed through peer learning. Clients with similar lived experiences – whether medical or social in nature – connected with one another through participation in the same programs. This created safe spaces where they were able to share their burdens and experiences. As they discovered that there were others who faced similar situations to their own, they came to feel less alone and more confident.

The National Gallery of Canada partnered with Centretown CHC to offer an indoor walking group at the Gallery. Since meeting at this group, Lisa and Alison have gotten together several times per week to walk outside of group times.

"I'll say that before I took the programs here, I wasn't very good at accepting myself and looking after myself, and what I was taught here helped me realize that I could do something to look after myself, to improve my health, that there was something I could do."

Client, Centretown CHC

John* was socially isolated and living with uncontrolled type 2 diabetes for many years. He wanted to be more physically active but was afraid to ask friends in fear of walking too slow and creating tension in those relationships. John's health provider suggested attending a walking group, but John was apprehensive. He was afraid he would slow down the group, and he was anxious about not knowing anyone. John's provider spent several appointments helping John feel comfortable. They emphasized the welcoming nature of the group, that facilitators are non-judgemental, and that everyone is there to have fun.

The provider then introduced John to the walking group facilitator so that he would know someone before attending. John has now been attending the walking group for six months. His blood sugar is more controlled; he feels happier; and he has made a new friend who walks at the same pace he does.

Decreased loneliness, increased sense of connectedness & belonging

The most significant quantitative improvements in self-reported health outcomes were in clients' reported sense of loneliness, social support, and community belonging (see Table 2). The improvement in client-reported loneliness was particularly dramatic, showing a 48.5% decrease in overall score as measured by the Campaign to End Loneliness Tool.[48] Social support was measured in terms of clients' self-reported involvement in social activities (a 19.3% increase) and community belonging (a 15.9% increase).

Client outcome (# of respondents = 118)	% Change
Sense of loneliness (Campaign to End Loneliness Tool)	↓ 48.5%
Social Support: Having someone to count on	↑ 4.5%
Social support: Involvement in social activities	↑ 19.3%
Self-reported sense of community belonging	↑ 15.9%

Table 2: Change in clients' self-reported wellbeing

The qualitative elements of our evaluation provide context for these numbers. Many clients reported experiencing feelings of loneliness due to the loss of long-term spouses and close friends, children leaving home, newly acquired disability (e.g., traumatic brain injury), or being a newcomer to Canada without a local network of social supports. For them, attending support groups was an opportunity to connect with others. They deeply valued this, especially when connecting with individuals who shared similar experiences. For some, participation in the group lifted their spirits so that they no longer felt they were "struggling from day to day."

Other clients have friends and family but lack opportunities for meaningful engagement with them. When these clients were prescribed tickets to arts and cultural activities, they commented on how this facilitated quality time with their loved ones.

Participants emphasized how important they felt such social support was to their health. One person mentioned that a lack of social connectedness had led them to suffer with depression and experience unwanted weight loss; they reported feeling significantly better since attending programs and building a network of supports.

In addition to facilitating social connections, clients mentioned that social prescribing had helped them develop a richer sense of community belonging. Many of them described the centre itself as a locus of community.

> *"When my wife passed away, I was lonely for about a year and I had to do something. This is what brought me back to reality, doing stuff like this."*
>
> *Client, West Elgin CHC*

Participants prepare fresh food and share a meal together at Tasty Tables at Guelph CHC

Exercising together at Rexdale CHC

Jane*, an older client at Country Roads CHC, was referred to the Social Prescribing Team after she shared that she felt lonely and had been housebound for some time. Managing her mental health issues had become a daily struggle. She had previously attended a mental health art group that brought her joy, but that group took place 45 minutes away, and transportation was a barrier. She felt it was impossible to attend.

Staff helped Jane find a local space where she could facilitate her own art group. Interest spread to other clients who received social prescriptions. These included a client who uses an oxygen tank and whose ODSP worker was able to find support for accessible transportation; another is a young man with developmental disabilities who is supported to live in the community.

Jane now facilitates the weekly group on her own with very little staff support. It has made such a difference in her life that recently she has spearheaded a weekly knitting and crocheting group with another local partner organization. Recently, with the help of a Resource Coordinator, Jane applied for the Ontario Seniors Dental Care program. Because she experiences anxiety when filling in forms, she was grateful for the help, and she is now helping to spread the word about this new application process to the other seniors in her housing unit.

The connections this client found through *Rx: Community* brought a house-bound, socially isolated individual into a supportive, purposeful, skill-building role in her community, based on her interests and passions. In this new role, she has had a direct, positive impact on other people's lives and their sense of connectedness.

Finding #2: Healthcare providers find social prescribing useful for improving wellbeing and decreasing repeat visits, but dedicated navigator support is needed.

Improvement in client wellbeing

Providers participating in the pilot overwhelmingly believed that social prescribing had improved their clients' health and wellbeing. Our surveys showed a significant increase in the number of providers expressing this belief from the third month to the ninth month of the pilot (Table 3).

During focus groups and interviews, providers named several observed benefits of social prescribing for their clients: An increase in the number and quality of social connections, a strengthened sense of community, an improvement in general mental wellbeing, and better overall health. Clients who once seemed to be quite isolated were now coming to programs on a weekly basis to connect with others, and those who had initially believed they were not good at making friends were finding new connections and, consequently, exhibited improvements in their mood.

Providers noticed that that clients were coming more frequently to the centres – not for clinical appointments, but to attend programs and meet other clients. They felt that this had brought about a greater overall sense of community at the centre.

Additionally, providers recognized the positive impact on clients of gifting their time and helping others. They have seen champions develop a sense of accomplishment regarding their work and, in some cases, improved self-confidence.

> *"The pilot has helped me provide better care for my clients. It gives us a better understanding of how important social connections are in somebody's health, and it's not just their physical health. We all say this, but it really shows us the power of social connections, those clients that have been connected and are not waiting to book an appointment twice a month just to be heard. It also helps us explain to our clients, and really looking at the client as a whole and exploring their interests. It's not about saying, oh, you have diabetes, you should be going to a diabetic group. It's not that at all. I find that's the beauty of this approach."*
>
> *Nurse, CSC du Temiskaming*

Health provider survey	At 3 months (# of respondents = 21)	At 9 months (# of respondents = 31)
SP has improved client's health and wellbeing	57.1%	83.9%
SP has decreased number of repeat visits by clients	4.8%	41.9%

Table 3: Response to provider experience surveys

Fewer repeat visits

Providers overwhelmingly felt that social prescribing had decreased repeat client visits to primary care. By the ninth month of the pilot, 41.9% of providers reported that they were seeing fewer repeat visits – a significant increase from the first three months (Table 3). However, encounter data recorded in the EMR showed negligible impact on the number of encounters. There are several possible explanations for this inconsistency. For example, some clients may be better managing their own health and seeing clinical providers for medical rather than social needs. Other clients may have been referred to social prescriptions verbally and thus not identified in the EMR.

Need for dedicated navigator support

Although providers reported that social prescribing had improved their clients' health and wellbeing, there was a decrease in the percentage of providers who felt supported in referring clients – from over 90.5% to just over 77.4% (Table 4). Over a third of participating providers felt that there were not sufficient resources available to support social prescribing at their centre (Table 4). These results were supported by our qualitative findings, in which providers discussed the need for a dedicated social prescribing navigator and a lack of follow-up after making a referral.

Providers identified that it is beneficial to have a dedicated navigator who is equipped to have deeper conversations with the client on what is important to them and who can provide extra support if necessary to help the client attend their prescribed activity. They also noted that it was beneficial to have a "warm hand-off" between primary care provider, navigator and the prescribed activity (e.g. program facilitator or space where activity is taking place). With this additional support, follow up on referrals can also be conducted more frequently. Due to their own time constraints, providers emphasized the importance of having a dedicated, full-time navigator at the centre who can provide this extra support and make social prescribing more efficient.

> *"Sometimes it's quite clear in the visit what exactly the patient needs, and then you can do it directly. And sometimes it's very unclear what they need, what they want, what they'd be capable of, and then it's better if they have a follow-up conversation with someone who has a really good knowledge of community resources and can put the plan together better."*
>
> *Physician, Centretown CHC*

Health provider survey	At 3 months (# of respondents = 21)	At 9 months (# of respondents = 31)
Supported in referring clients	90.5%	77.4%
Sufficient resources are available to support SP	47.6%	61.3%

Table 4: Response to provider experience surveys

Finding #3: There is deeper integration between clinical care, interprofessional teams, and social supports; and community capacity has increased through co-creation.

Deeper integration between clinical care, interprofessional teams, and social supports

While CHCs co-house social and health programs and teams, these programs are not always deeply integrated. Providers at larger centres have many community support programs to choose from, and they may not fully understand the purpose or health benefits of each one. Social prescribing can help correct this. Nine months after the pilot began, nearly three quarters of participating prescribers felt that collaboration and integration within their centres had increased (Table 5).

By improving communication across teams, the *Rx: Community* pilot made room for discussions about how to improve processes and inter-team collaboration within each participating centre. Program calendars, documentation of referrals, and other processes were formalized and standardized to meet the needs of providers and other staff. This allowed more consistent linkage between medical and community supports. Improved communication has made it easier for link workers to determine which programs are best suited for each client or issue.

"The excitement of saying, we can actually translate this into health outcomes, into data! We already do this, but do we do it the best way possible? I don't know, because we're losing out on the linking and follow-up. This has allowed us to explore the efficiency, how we do it, how we present it to clients. We've explored a bit more on breaking down barriers, and it's promoted that communication between teams. We have the health promotion team, the primary care team, the diabetes team, and so sometimes we're in our own bubbles. This helped to open up a little bit those doors for communication."

Dietitian, Centretown CHC

Health provider survey	At 3 months (# of respondents = 21)	At 9 months (# of respondents = 31)
Increase in collaboration and integration between inter-professional health providers	66.70%	74.20%
SP is a legitimate part of my role	85.70%	93.50%

Table 5: Response to provider experience surveys

"There's definitely more opportunities to think about and incorporate the social aspects of health in client care now. Those things have always been there, but there wasn't a formal or structured way to address them properly."

Community Resource Worker/System Navigator, Belleville and Quinte West CHC BQW

I attended some of the clinical meetings, and there were times the clinical team were attending our meetings to talk about social needs and the internal referral of the clients. This has improved integration of our services and having a comprehensive response to the need of the clients.

Health Promotor, Rexdale CHC

A provider from an interprofessional Social Prescribing team at Centretown CHC highlighted that, while team managers often meet and talk regularly, direct service providers did not necessarily have the same opportunity before implementing social prescribing. Other providers emphasized that although teams and team members do different work, they need to be more aware of each other's work in order to avoid becoming siloed.

The *Rx: Community* pilot has given more momentum to integrated and interprofessional teamwork within organizations. Having a standardized process of making referrals not only allowed staff to track the non-medical aspect of care they provide, but it generated greater awareness of what resources are available to clients. That, in turn, generated a greater number of referrals.

Staff also felt that the social prescribing pathway had reinforced the importance of and need to address the social wellbeing of clients along with their medical needs. One centre realized that simply offering programs on site was not enough; there needed to be more emphasis on actively referring and engaging clients to attend them. Clients were often unaware that the centre offered such programs or that they could attend at no cost. Overall, staff felt that there was greater intentionality towards making these types of referrals. By the end of the ninth month of the pilot, 29 of 31 surveyed providers agreed that social prescribing was a legitimate part of their role (Table 5).

Read more in Appendix C: Spotlights
Centretown CHC improves interprofessional collaboration through the Social Prescribing Horizontal Team (SoHoT).

Increased co-creative capacity within the community

A core component of social prescribing is to invite clients, as members of the community, to co-create solutions based on their passions and interests. Pilot centres reported that this has deepened their approach to community development. There is more focus on listening to what volunteers think is needed, rather than what staff may assume the centre needs. This shift has required centres to create spaces and supports that empower clients of all abilities to take the lead. It is a new twist on existing community development and health promotion work in CHCs that has increased their capacity.

Volunteer Health Champions have created diverse programs, from pet visiting to pole walking, increasing the offerings available to clients. Further, because champions are identifying needs of the community and leading programs, staff are able to devote more time to one-on-one appointments.

This process highlights how much clients, when given the space and flexibility to be creative, are willing and able to give. It also demonstrates the impact they have made at the centre level. In some cases, staff have come to think of champions as a part of their team.

Centres have begun to think more frequently about what assets are already present in their communities and how they can be utilized. Some have moved away from relying on clients coming forward to volunteer to reaching out during appointments and inviting them to start programs or get otherwise involved in the centre's work.

> *The Health Champions are key informants with the ideas that they have about changes that could be made here or recommendations that they have. That empowerment is helping us to provide a higher level of service.*
>
> *Community Health Worker, Norwest CHC*

> *As a leader of a program, [client and Health Champion] gained so much. It helps her health, it helps her mental health, it helps her to give back and feel like she's part of the community and part of the world. People still don't get how important this is. I think this is just an amazing idea.*
>
> *Nurse, Guelph CHC*

> *It's really like an extension of the team [...], they have talents and expertise that we don't have, and they also see things in a way that we as staff don't see. I don't know if it's because we get tunnel vision or we're just used to working in a certain way, but they point out things that are really refreshing and sometimes obvious, but we would never have seen them. So by bringing them on to be a part of our team, it's just all this extra knowledge and passion. It's amazing.*
>
> *Social Worker, Belleville and Quinte West CHC*

By giving of my time, I have felt much more integrated into the community. I moved from Toronto to retire here, and I think I'm a very extroverted person, but even as an extroverted person it was difficult to make this my home. So by going out and doing things, I feel like I'm getting back to being myself, to establishing what I used to be at work, and this is feeling like home.

Client and volunteer, South Georgian Bay CHC

The only thing I have is the family I take care of. I had no way of contributing in a positive way to the world I live in, until the health centre invited me to do so.

Client and volunteer, Stonegate CHC

This gives me a feeling of, "you know what, you're not useless." That's really important to me because it's been many years for me now since I've really felt like aside from my part-time evening job, there's something else that I can do.

Client and peer leader, Guelph CHC

Co-creative volunteers gain purpose & belonging

Clients who were invited to become Health Champions reported that volunteering brought them joy because it allowed them to meet new people with shared passions. They also valued the co-design process with staff: Coming together as a group to brainstorm ideas, then working together to realize their plans separated this work from traditional volunteering.

These co-creative volunteers often formed strong relationships with each other, as they would meet regularly to discuss and design activities. One client who had moved to a smaller town after retiring found herself quite isolated. Through volunteering, she finally began to feel like a part of the community. Volunteers also gained a sense of belonging within the community and enjoyed being a part of a cohesive group.

Volunteers described feeling more confident after leading a program at the centre and having gained a sense of accomplishment from seeing others enjoy their programs. They appreciated having the opportunity to draw on their own lived experiences to help support others. Some champions, especially those who were retired and who for most of their lives had been defined by their jobs or who were full time caregivers in need of an outlet, valued having an opportunity to keep busy and feel useful. Being able to contribute to their community in a way that was aligned with their passions gave them a renewed sense of purpose.

"I began this part of my journey with an end: the end of cancer treatments. I felt alone, disconnected, lonely, misunderstood, and needing the companionship of others who could deeply relate on my level. The CHC didn't have an existing support group, but they supported me to form my own. I wasn't sure I wanted to facilitate a group. I just wanted to be part of one. But I now realize that starting this group has given me a sense of purpose again. The ladies are fantastic. Each brings something to the table: an artist, a gardener, a knitter, the quiet one, the talkative one, the contemplative one. All of us are much more than the label we wear as a result of cancer.

Now, I am not only dealing with my own emotional aftermath from diagnosis and treatments and how my world has changed, but I must be present and energetic enough to be a good active listener and leader so that I can support others. It is hard. But it is also worth it. We have come together and I see and feel how as individuals we support the whole.

We share intimate knowledge of our experiences with treatments and a brush with mortality. We trust in each other to be able to share openly. We cry a little. We laugh a little. We hug. We boost each other when it all seems so overwhelming and daunting. We paint, drink coffee, share recipes and meet under the shade of trees. We are warriors. We are a group. And we celebrate that."

Client and volunteer Health Champion, Belleville and Quinte West CHC

Left:
Volunteer Health Champions at South Georgian Bay CHC identified visiting isolated seniors in the region as a priority. An enthusiastic Friendly Visiting group was quickly formed. Friendly Visitors and their visitees got together for a holiday party at the health centre. It was so successful, a spring event is now being planned.

Right:
Grandma Penny frequently donated knitted hats or baked goods to a local organization but wanted more social connection. Now, as a Health Champion, she shares her life and her gifts at the popular Soup and Crochet with Grandma Penny at Guelph CHC.

IMPLEMENTATION CHALLENGES

A number of challenges emerged during the implementation of the research pilot, particularly relating to *staff capacity, organizational capacity, data tracking, environmental factors, and defining the social prescribing mode*l. This was partly to be expected in implementing any new processes, and some were due to the unique context and practice of Community Health Centres.

Staff capacity

All pilot centres utilized existing staff members to implement social prescribing. Existing staff were reallocated to social prescribing, and in the majority of instances, staff took this on in addition to their existing responsibilities.

Staff capacity was the most commonly identified challenge. Staffing issues identified included capacity to engage the wider organization in implementing new processes; staff turnover resulting in loss of continuity; and limited staff time to provide more supported navigation for clients and follow up, especially for those individuals who faced the highest barriers to participation but would benefit most from doing so.

Organizational capacity

Implementation of the social prescribing pilot coincided with a number of other activities that had organization-wide impact. This stretched both management and staff capacity. These activities included migration to a new EMR system as part of a sector-wide changeover, work on capital projects already in progress, and accreditation processes already in progress.

Data tracking

A number of challenges arose in collecting data. These included an initial lack of standardized processes across sites, the ongoing migration to a new EMR, and unfamiliarity with the EMR interface for tracking non-clinical interventions. Centres also reported challenges in engaging health providers, as well as stretched administrative capacity. They noted that they were unable to follow external referrals in part due to the lack of interoperable digital solutions across sectors. Finally, there were cases in which data collection had to be compromised to protect the confidentiality of clients who did not wish to be identified as participating in certain programs.

Environmental factors

Structural and environmental factors largely outside the control of individual pilot sites were barriers in enabling client uptake of social prescriptions. These included a lack of transportation; a lack of low-barrier, cost-free programming appropriate to client needs and interests; and poor winter weather.

Defining the model

Social prescribing in Ontario began with loose guiding principles. The expectation was that each pilot centre would adapt it to their particular context – rural, urban, Northern, or Francophone – depending on organizational capacity, priority population, and community resources. While necessary, this approach also created early challenges in defining what a high-impact social prescribing pathway looks like in Ontario.

This challenge was especially felt when early media attention sparked public interest in the term and various external organizations began to use it to denote a much wider range of approaches.

LESSONS LEARNED

Learnings related to implementing an intentional social prescribing pathway with a health equity lens were gleaned from the experiences of the project team, local implementers, health providers and clients. These learnings were categorized into *culture change, organizational support and capacity, data collection practices and utilization, social prescribing terminology and model, and social prescribing processes.* While they are specific to the CHC contexts in which the social prescribing initiative took place, it is expected that many of these learnings are also applicable to other healthcare settings.

Culture Change

Social prescribing is more than just overlaying a structure over existing processes, providing a set of new guidelines, or collecting more information. It is about fundamentally shifting the culture of the healthcare system. Social prescribing requires us to view healthcare from a strengths-based instead of illness-based perspective, to shift our perception of individuals from "patient with needs" to "person with gifts," and to make collaboration and co-creation between clinical and social care the norm rather than the exception.

Successful implementation of social prescribing rested on the willingness and ability of organizations to explore new ways of working, internally and externally, and to adapt an innovative plan-do-check-act spirit for continuous improvement.

Read more in Appendix C: Spotlights Changing the culture at Belleville and Quinte West CHC.

Organizational support and capacity

Successfully launching social prescribing required investments of staff time and organizational energy. Dedicated staff, with the support of an interprofessional staff circle and strong management champions, were crucial for implementation of essential components, adoption of new practices, and fostering culture change. Communities of Practice supported continuous engagement with opportunities for peer-learning and resource-sharing among participating centres.

Pilot centres' experiences suggested that time-investment and support needs decrease over time. Challenges were overcome, processes were put in place, and volunteers and staff became more and more engaged as new practices and ways of working became familiar and routine.

Data collection practices and utilization

Intentional data collection and evaluation in the project enabled us to observe several key gaps. A disconnect exists between the perception of what is being done and what is actually occurring. For example, although socio-demographic and wellbeing questions are asked in the standard intake process, data completeness varies.

There were also fewer social prescription referrals tracked in the EMR relative to staff's sense of how many referrals were being made, even after adjusting for technical challenges. It may be that many referrals are occurring through verbal conversations only, but it may also be that health providers are making fewer referrals to address the social determinants of health than assumed.

This experience highlights the need for a Learning Health System approach to ensure that the appropriate data is collected, accessible, and regularly reviewed. It must then be used to support decision making and service delivery, particularly relating to the SDOH.

Social prescribing terminology and model

Social prescribing is an imported term from the UK, and concerns have been raised with its use in Ontario. One such concern has to do with the implied power dynamics of "prescribing;" another a sense that the term "social" is unrelated to health and does not adequately capture the structural supports provided. However, the term has captured the concept of an integrated health and social care pathway in a way that resonates widely across sectors, with the general public, and with the media, more so than any terminology that has been used in Ontario to date.

Public embrace of the term also had an unexpected effect, whereby the term began to be adopted by widely diverse initiatives and models. It was quickly apparent that clarity around the Alliance's model was needed. This model captures the health equity, co-creation, and asset-based community development principles that are at the foundation of our work. The interim progress report and this final report have attempted to capture the core essence of what we understand, and have learned from evidence, to be an effective and equity-oriented social prescribing model.

Social prescribing processes

Through the *Rx: Community* pilot, we gained a rich understanding of social prescribing and its impact on clients, including the need to provide supported navigation, to enable clients to define success, and to co-create solutions with volunteers of all capacities.

Across all pilot sites, providers and clients report that a higher level of navigator support is valuable and often instrumental for uptake of social prescriptions. Clients who may most benefit are often those who require repeated invitation, material support and accompaniment before taking on social prescriptions.

We have also learned how important it is that clients be invited to define their own needs and indicators for wellbeing, and being open to the potential that this may not align with health provider's traditional expectations or reporting matrix.

Finally, volunteers of all abilities can contribute their gifts and passions. Healthy, retired professionals are a default demographic for volunteering. However, when people with medical and social complexities are invited and supported to contribute, there is a positive impact on their sense of purpose, self-confidence, and belonging to community that can lead to better health outcomes and more positive interactions with the healthcare system.

KEY ENABLING FACTORS OF IMPLEMENTATION

Several factors emerged by consensus among the project team and local staff as instrumental in the rapid implementation of social prescribing across pilot sites, especially a *team-based community development model, spirit of innovation and persistence,* and *provincial coordination*. While the *Rx: Community* pilot benefited uniquely from the in-house presence of these enablers, these conditions can also be cultivated in cross-sector collaborations such as Ontario Health Teams.

Team-based, community development model

The existing team-based care model and community development capacity at pilot CHCs enabled very rapid implementation, despite having no influx of staff or programming resources. In particular, the existing health equity lens, understanding of SDOH, and principles of MHWB formed a strong common approach. Co-located interprofessional teams, along with a strong grounding in asset mapping, social programming, community development and partnership building provided capacity to navigate referrals and support context-specific social prescriptions.

Spirit of innovation and persistence

Social prescribing is a shift in the way good health care is thought about, delivered and measured. Pilot centres approached social prescribing with a spirit of innovation and willingness to change the status quo. They let go of existing processes and adopted new ones, persisting through challenges.

Sites adopted a plan-do-check-act approach that iteratively tested ways of working to develop best practices and pathways that were tailored to their contexts and strengths. Sites were also open and creative in exploring new activities, peer-run programs, and partnership possibilities, which resulted in creative programs like friendly pet-visiting, and non-traditional partnerships with arts and culture sector.

Implementation staff were persistent in their efforts to raise awareness, both internally and externally, which was vitally important. They provided continuous reminders and training on social prescribing processes, reported on its impact and successes, and created forums for ongoing interprofessional conversations. All of these were key to sustaining the momentum of social prescribing, engaging staff and clients, and enabling new practices and ways of working to become more normative.

Provincial coordination

Centralized coordination and alignment support was identified by implementation staff as a key enabling factor of success. Accountability and support need to be maintained through regular check-ins, common data-tracking processes, and a shared evaluation framework with provincial technical support. Resource-development, training, and peer learning and training must be supported through documentation, webinars, and communities of practice. Communication must also be coordinated to enable internal and external knowledge-sharing. Finally, there needs to be coordination of provincial cross-sector partnerships.

GROWING MOMENTUM IN CANADA

Social prescribing is increasingly recognized as the next step in improving and better integrating health system in Canada and around the world. From early in the pilot, *Rx: Community* generated significant positive attention from the general public and across diverse spheres for the concept alone, aided by positive front-page and prime-time coverage of *Rx: Community* in the *Toronto Star*,[49, 50, 51] the *Globe & Mail*,[52] the Canadian Press,[53] and the CBC,[54, 55, 56] along with coverage in local papers on the work of the pilot sites in their communities.

Rx: Community saw social prescribing resonate widely with existing and new partners at local and provincial levels. Many organizations aligned with the vision of holistic health and wellbeing for the community, and the structured pathway enabled a clear connection for clients to be referred between clinical interventions and non-clinical supports in the community.

From the health sector, professional associations, home care organizations, public health units, family health teams, solo-practice physicians, hospitals, researchers, students, and universities have connected directly to learn more about this practice and early results. This is in addition to inter-sectoral interest from arts and culture institutions, environment agencies, good food organizations, older adult groups, community organizations and municipal councils.

Throughout the pilot, Alliance staff supported conversations from diverse organizations across Canada to increase understanding of social prescribing and to share implementation learnings and in-progress findings. Staff presented on social prescribing and its implications for heath, connectedness, and belonging at a variety of conference plenaries and workshops, including the Canadian Public Health Association, Orchestra Canada, the Ontario Museum Association, Ryerson University, McMaster University, the Ontario Public Health Association, the Dalla Lana School of Public Health at the University of Toronto, the North American Primary Care Research Group conference, and the Older Adults Centres' Association of Ontario.

LOOKING AHEAD

As healthcare systems around the world grapple with the limits of their return on investment in acute care, community health and social prescribing offer a path forward. Through social prescribing, participants from across a range of sectors and locations take action to address people's most pressing social needs with dignity, support, and an informational feedback loop that helps iterate and improve over time. That's because social prescribing is part health and social referral pathway, part patient co-design, part community development approach, and part tracking and quality improvement tool.

In many countries, the integration of health and social services is a key component of integrated care. In many U.S. states, for example, digital technologies are empowering statewide integration of health and social service databases for easier referral and tracking. In the United Kingdom, an emphasis on personalised care has seen social prescribing rolled out in primary care networks right across the country.[57] In Singapore, community rehabilitation hospitals are engaged in social prescribing,[58] while in Australia, the Royal College of Physicians and Surgeons has teamed up with the country's leading Consumer Health Forum to see social prescribing foregrounded in the country's first 10-year health plan.[59]

Here in Ontario, both the transformation of the healthcare system into collaborative Ontario Health Teams and the parallel modernization of public health (which emphasizes the interface between public health and primary care) offer new opportunities for social prescribing to put social determinants and social needs at the forefront of a transformed healthcare system.

One of the most hopeful signs about social prescribing is the explosion of interest from a wide range of stakeholders. We are pleased that the Association of Family Health Teams of Ontario is poised to take on social prescribing as it enters its next year, and we note with interest that many Ontario Health Teams have committed to doing the work of social prescribing collectively in their areas. We have met with interested people from home care, hospitals, public health, arts and culture, parks and recreation, social services, and many other sectors who are eager to support the growth and development of this work across Canada.

RECOMMENDATIONS

The end of the *Rx: Community* pilot phase marks a new beginning for social prescribing in Canada. Healthcare systems across the country are looking for innovative approaches that will enable care to be more integrated, more holistic, and more focused on upstream solutions. Social prescribing is a promising response to this need. Providers and community partners now have an opportunity to enable its spread in this country by adapting it to their own situations, while drawing insight from the 11 teams who were early adopters in Ontario.

Whether you are a healthcare provider, a community partner, a policy maker, a researcher, or a community member, and you want to advance social prescribing in your area, here are a few steps you can take.

Recommendations for policymakers, funders and Ontario Health Teams

- Build a context in which social prescribing can thrive: Strong team-based primary health care, adequate investment in community supports and services, and social policy that addresses the broader social determinants of health.
- Implement policies that promote collaborative, cross-sectoral action on social connectedness and the social and structural determinants of health, as vital components of an integrated, modernized health system.
- Identify and invest in community-development and social support agencies that can contribute to social prescribing initiatives across Ontario, including in rural, Francophone, and Indigenous communities.
- Provide direct financial, material, and policy support for new and expanded social prescribing initiatives, including funding for the navigator role.

Recommendations for healthcare organizations

- If you are already participating in other care-integration and coordination strategies, such as TeamCare or WrapAround, consider expanding it to incorporate social prescribing.
- Shift your organizational culture to embrace health equity, social connectedness, and the social and structural determinants of health as foundational to primary health care.
- Get to know your community. Build partnerships and support community members to be leaders and co-creators.
- Develop a strategy for effective data-collection and sharing so you can track social prescribing processes and outcomes.

Recommendations for cross-sectoral and social support organizations

- Reach out to new and existing partners, especially health providers, to build stronger multidisciplinary and multi-sectoral collaborations.
- Support shared data collection and feedback to follow an individual's journey between health care and community support.

Recommendations for researchers and academic institutions

- Partner with organizations to help them conduct asset-mapping, community engagement, social prescribing design, and evaluation.
- Conduct data analysis to help assess the efficacy of social prescribing and find opportunities for quality improvement.
- Assess the existing evidence base for social activities in improving health.
- Develop evidence-based tools for clinical screening, assessment and tracking of health and healthcare outcomes.

Graphic recording at Gateway Community Health Centre Social Prescribing Fair (ThinkLink Graphics/Erica Bota)

APPENDIX A: GLOSSARY OF TERMS

Asset Based Community Development (ABCD): This is an approach to community development "based on the capacities, skills, and assets" of the neighbourhood and the people who live there. It involves community members at every level and is based on developing existing assets rather than looking to outside sources which may not come through. It is an alternative to needs-oriented solutions, which "teach people the nature of their problems and the value of services as the answer."[60]

Asset Mapping: A strengths-focused process of identifying existing assets within a community, and documenting, categorizing and organizing these assets for easy reference. Examples of assets include community groups, businesses, public spaces, institutions, and physical structures.

Canadian Index of Wellbeing (CIW): The CIW is an internationally recognized tool developed at the University of Waterloo to measure the wellbeing of Canadians. It consists of 64 indicators grouped into eight interconnected domains: healthy populations, democratic engagement, community vitality, environment, leisure & culture, time use, education, and living standards. Alliance members use the CIW in a variety of ways, including incorporating the Be Well Survey into their work. This survey is a minimum set of eight meaningful standardized questions. These questions cover all eight CIW domains with a particular focus on community vitality. The survey was designed for adaptable use in community-governed primary healthcare settings and is comparable with provincial and national CIW measures that show trends over time.

Client: A person who is accessing the healthcare system for any kind of clinical or social care. The term *client* is preferred to *patient* because it acknowledges the whole person and their autonomy. A client is not just a person with clinical or social needs who undergoes treatment. They are an active partner who comes to the client-provider relationship with their own health goals and unique assets, and they work with their provider towards those goals.

Co-design and co-creation: Co-creation is an approach to planning, implementing, testing, and communicating about programs and services that involves clients as partners at all stages. Co-design is the first part of this process, where clients and providers work together to identify a problem and define a solution.

Collaborative Practice: A model from Altogether Better[61] that engages clients and members of the community to become volunteer Health Champions and work alongside staff to co-create non-medical, community-based solutions. This model supports a new way of working that fosters interconnectedness between formal, professionalized health care, and informal, community-led supports.

Comprehensive Primary Health Care: A "whole-of-society approach to health and wellbeing."[62] Rooted in a commitment to justice and equity, it is care for the physical, mental, and social health and wellbeing needs of the whole person throughout their lifespan. Comprehensive primary health care addresses the broader determinants of health and empowers people and communities to optimize their health. The Model of Health and Wellbeing (MHWB) draws from and expands this definition.

Community Development: An approach that builds on a community's assets and strengths to contribute to the health and wellbeing of its members. An organization works with a community to determine what programs and

services it needs for optimal health and wellbeing. Where resources are absent or inadequate, they work together to create or improve them. One of the attributes of the MHWB is that health care is grounded in community development.

Community Health Centre (CHC): A non-profit, multi-service centre that provides primary health care, social and community outreach services with an emphasis on health promotion and health equity. CHCs are particularly positioned to serve vulnerable populations, including seniors, the LGBTQ community, those living with mental illness and addictions, people experiencing homelessness, and newcomers to Canada.

Electronic Medical Record (EMR): An EMR is a computer-based system for record-keeping in primary care. The EMR is specific to each provider or their practice and contains each client's medical charts as well as relevant personal and sociodemographic information. It is used to track a client's interactions with the primary care provider (or team), treatments provided, and health outcomes.

Health Champions: Someone who gifts their time and skills to co-create social prescribing solutions alongside CHCs. They may lead activities, form groups, produce resources, or provide other social and community supports to socially prescribed clients.

Health Equity: An approach to health care that includes policies and interventions which address discrimination and oppression. The goal of a health equity approach is to eradicate social inequality and disadvantage for the purpose of reducing differences in health outcomes.

Health Promotion: The principle and process of enabling people to increase control over, and to improve, their health. Key elements of health promotion include improving health literacy, advocating for healthier city-building, and mobilizing groups of people to work together to advocate for health care, deliver resources and services, prevent illness, and cultivate community involvement.[63]

Implementation Evaluation: An evaluation method used to study whether new and emerging projects and programs are implemented as intended. This approach is focused on understanding what works for whom and in what circumstances and contexts.

Learning Health System (LHS): A system in which organizations or networks continuously self-study and adapt. A LHS uses data and analytics to generate knowledge, engage stakeholders, and implement behavior change that transforms practice. In a learning health system, best practice knowledge is immediately available to support decisions, and improvement is continuous through ongoing learning. This happens routinely, economically, and almost invisibly, because it is part of the culture.

Model of Health and Wellbeing (MHWB): This model describes the overall vision of CHCs and guides the delivery of primary care. The MHWB is the foundation of our model of social prescribing. It consists of three guiding principles and eight attributes. The principles are *Highest Quality, People- and Community-Centred*; *Health Equity and Social Justice*; and *Community Vitality and Belonging*. The attributes are *Accessible*; *Anti-Oppressive and Culturally Safe*; *Community-Governed*; *Grounded in Community Development*; *Based on the Determinants of Health*; *Population Needs-Based; Interprofessional, Integrated, and Coordinated*; and *Accountable and Efficient*.[64]

Model of Wholistic Health and Wellbeing: Adopted by Aboriginal Health Access Centres (AHACs) in Ontario, this model frames the work toward healthy communities. It conceives of the person and community as an integrated whole. At the centre are culture and Indigenous ways of knowing and being. Built around this centre are the physical, emotional,

spiritual, and mental aspects of health, each with its own attributes.

Mixed Methods Evaluation: Evaluation that draws on both qualitative (descriptive and experiential) and quantitative (numeric) data.

Primary Care: Day-to-day health care a person receives from a doctor, nurse practitioner, or interprofessional primary care provider. It is generally the main point of entry into the healthcare system and may include care coordination. Primary care is an element of comprehensive primary health care; the difference is that comprehensive primary health care looks beyond individual medical needs to address the broader determinants of health at both the individual and community level.

Primary Care Provider: A physician or nurse practitioner who provides day-to-day clinical health care. Usually serves as the main point of contact for individuals in the health system.

Social Determinants of Health (SDOH): Determinants of health (DOH) are the "broad range of personal, social, economic, and environmental factors that determine individual and population health." Social and economic factors within the DOH are collectively called the Social Determinants of Health (SDOH). They include socioeconomic characteristics like income and education; experiences of discrimination or trauma; physical environment; and social supports.[65] The Model of Health and Wellbeing recognizes that health and wellbeing are grounded in the DOH.

Social prescribing navigator: This role has a variety of names, such as link worker, system navigator or community connector. In this report, the social prescribing link worker specifically refers to a person who works with a socially prescribed client in a co-creative way to identify strengths and needs and connect them to appropriate, non-medical community resources or supports. This role can be held by people with diverse backgrounds and training, both clinical and non-clinical.

Social prescribing pathway: While CHCs and others have long recognized the importance of social and community support for improving well-being, social prescribing refers to a deliberate and structured way of referring clients from clinical practice to non-clinical supports when appropriate, with the goals of improving their overall health and wellbeing and decreasing the use of the healthcare system for non-clinical needs.

System Navigator: In CHCs, a system navigator is typically focused on supporting clients to navigate the health system. They may connect clients with more structural SDOH, such as housing, employment support, or transportation. System Navigators working to the fullest scope of their roles also help clients connect with community, social, and informal supports, in which case this role is equivalent to the role of a Link Worker.

TeamCare (Advancing Access to Team-based Care): TeamCare is a solution that allows family practice physicians and their clients to access interprofessional health teams, even if they don't work in an interprofessional setting. This program, co-created with Alliance member centres, allows the physician to connect a patient with a system navigator embedded at CHC. Collaboration continues throughout the cilent's journey among the client, provider, system navigator, and interprofessional staff at the CHC.

WrapAround: WrapAround is a model that blends formal and informal community supports into one care team chosen by the client. The WrapAround facilitator, who may be a professional or a volunteer, functions as a holistic navigator who provides comprehensive support for the SDOH.

APPENDIX B: CLIENT HEALTH AND WELLBEING SURVEY

Campaign to End Loneliness Tool

1. I am content with my friendships and relationships
   Scale: Strongly disagree / Disagree / Neutral / Agree / Strongly Agree / Do not know

2. I have enough people I feel comfortable asking for help at any time
   Scale: Strongly disagree / Disagree / Neutral / Agree / Strongly Agree / Do not know

3. My relationships are as satisfying as I would want them to be
   Scale: Strongly disagree / Disagree / Neutral / Agree / Strongly Agree / Do not know

Social Support Questions

1. Do you have someone you can count on when you don't feel well (such as a neighbour or other person who is there for you when you need them)?
   Scale: Yes / No / Sometimes / Not as often as I would like

2. Are you involved in any social activities (such as hobbies you enjoy, visiting with friends and other recreational activities)?
   Scale: Yes / No / Sometimes / Not as often as I would like

Self-reported Wellbeing Indicators

1. In general, would you say your overall physical health is?
   Scale: Excellent / Very good / Good / Fair / Poor

2. In general, would you say your overall mental health is?
   Scale: Excellent / Very good / Good / Fair / Poor

3. How would you describe your sense of belonging to your community?
   Scale: Very Strong / Somewhat Strong / Somewhat weak / Very Weak

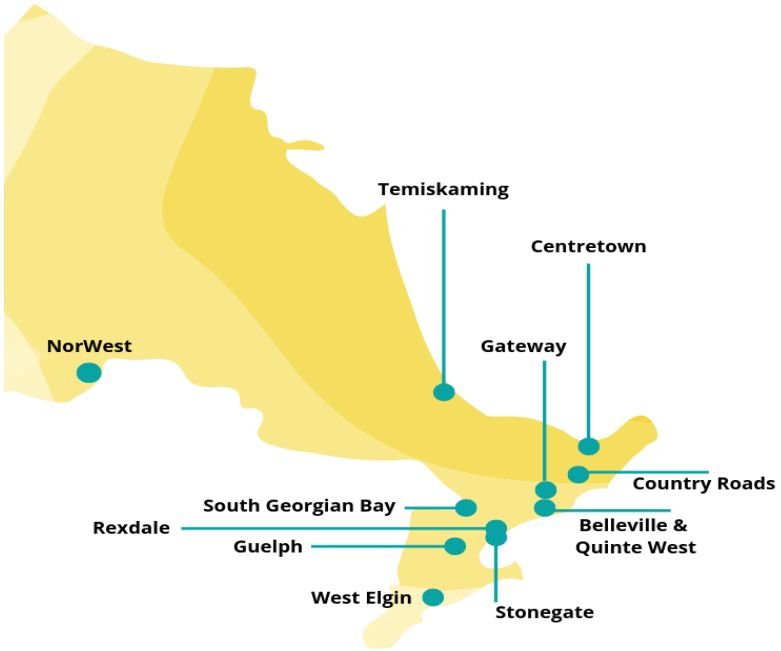
APPENDIX C: SPOTLIGHTS ON SOCIAL PRESCRIBING SITES

Eleven Community Health Centres self-selected to participate in the *Rx: Community – Social Prescribing in Ontario research pilot*. They represent a diverse mix of urban, rural, Northern, and Francophone communities, with differing geographies and priority populations. These include seniors, youth, newcomers, young families, people living on low incomes, and people facing multiple barriers to connecting with health and social supports.

While each pilot site built the five essential components into their social prescribing practice, each also brought unique innovations and approaches to developing their initiative. These were based on their existing strengths, their community's capacity, and the needs of the people they serve.

One of the social prescribing model's biggest strengths is that it can be adapted to local health and social needs. The model's flexibility allows front-line providers, clients, and volunteer health champions to truly co-create unique program offerings and solutions based on interests and strengths.

These spotlights provide detail of each pilot's setting and the local interventions they made with staff, community and partners. They also showcase the results each centre is looking to build on and what's ahead when it comes to the possibilities for scaling social prescribing across entire regions with other healthcare and cross-sectoral partners.



BELLEVILLE AND QUINTE WEST COMMUNITY HEALTH CENTRE

The Setting

Belleville and Quinte West Community Health Centre (BQWCHC) has sites in both Belleville and Trenton. Social prescriptions are offered at both locations. Like many CHCs, the centre focuses on individuals who have complex health and/or social needs and face multiple barriers to accessing care. The clients they generally serve are people who face employment issues, addiction issues, and/or multiple chronic conditions; live on low incomes; and are part of the region's aging population.

The Local Intervention

BQWCHC invited clients to gift their time and passions to co-create the social prescribing initiative alongside staff. Many new informal activities and formal programs emerged from this approach. This includes volunteer greeters, live music in the waiting room, a peer-run support group for people widowed from their spouses in a nursing home called "Life After Grief: Learning to Live Again," and a peer-run cancer group for women called "The Purple Lotus Sisters."

Physicians and nurse practitioners identify clients who could potentially benefit from becoming more socially involved and refer them directly to the social worker, who acts as a social prescribing navigator, guiding clients between clinical care and other social supports. The social worker manages referrals that come in, follows up with a friendly phone call, assesses the client's situation with them, and identifies groups or programs that the client might find of interest or benefit from.

The Results to Build On

At BQWCHC, there has always been a high level of collaboration between the primary care and community health teams. The social prescribing pilot has helped staff to better track and measure work that was happening at the centre, with an intentional pathway and feedback loop that made it easier for the primary care team to make and manage social prescriptions.

The centre re-oriented its staff culture and practices to prioritize deeper listening and co-creation with clients from a strengths-based perspective. They changed their traditional volunteer processes and policies with the aim of reducing barriers for clients to engage in co-designing groups and programs offered at the Centre. These mindset shifts enabled staff to think of and work with volunteers in more community-driven ways, and they encouraged more initiative and ownership at the centre. This also increased the capacity of the organization to meet non-clinical needs identified by the community.

Volunteers playing music in the waiting area at BQWCHC

Looking Ahead

The shift towards a culture of deeply client-driven, strengths-based co-creation that was initiated through the pilot will continue. Staff are further embedding social prescribing into existing structures, so more care clients can be connected with social supports. Clinical and non-clinical staff will continue to invite clients to gift their time and passions. This enables clients to take control of their own wellbeing while working to support others and creating an environment of connectedness and belonging at the CHC.

In the Media

Ontario Morning from CBC Radio
CBC Radio, November 20, 2019

Client and volunteer health champion, John Paton, shares his experience and why he believes social prescribing will allow health care to go beyond the traditional medical model to build social connection and address social isolation and loneliness.
https://www.cbc.ca/listen/live-radio/1-112-ontario-morning-from-cbc-radio/clip/15747423-ontario-morning-wednesday-november-20-2019-part-2

A prescription for happiness
The Intelligencer, January 3, 2019

Registered social worker, Meghan Shanahan Thain, and health promoter/team lead, Bianca Sclippa, describes the types of social prescriptions offered, and its impacts, in addressing health holistically at BQWCHC.
https://www.intelligencer.ca/news/local-news/a-prescription-for-happiness

Learning to Live Again: Life Beyond Grief support group at BQWCHC

CENTRE DE SANTÉ COMMUNAUTAIRE DU TÉMISKAMING

The Setting

Centre de santé communautaire du Témiskaming is unique in that it has five sites spread across its region, all situated in northeastern Ontario, and all designed with a mandate to serve the district's Francophone population. The social prescribing pilot was run at the Kirkland Lake site, the centre's northernmost location. The Kirkland Lake community is home to about 8,000 people, 14.5% of whom are Francophones.

Though the centre was created for Francophones, it is open to the whole community. There is an approximately 50-50 split between English and French-speaking clients. Additionally, the centre's priority populations include seniors and families with children under 12.

The Local Intervention

The primary care team at the centre includes physicians, nurse practitioners, registered nurses, mental health workers and a dietitian. Anyone in the primary care team can identify a client's needs and refer them to a specific activity or program either within the centre or to other supports in the community. The prescriber who makes a social referral is to follow up with their client directly.

The centre's community worker runs exercise programs, painting classes, and social groups and is part of the core team working with Health Champions. Their role has expanded to include tracking whether a client who has received a social prescription for a group/activity at the centre has followed through.

For the *Rx: Community* pilot, the centre focused on inviting clients to co-create solutions. A wide invitation to the centre's roster of French-speaking clients asked if they would be interested in working alongside staff and giving back to the community. Volunteer Health Champions have since joined to create innovative programming. The group also created a brochure to better inform other staff and clients about social prescribing and available supports.

An external advisory committee was formed to support and resource the initiative. It included representatives from local public health, the arts council, the Francophone Adult Learning Centre, home support, and francophone social clubs in the community. Partnerships, such as with a local band for concert admissions, have also been added to the social prescription offerings.

The Results to Build On

The Health Champions work with a core group of staff and have strong ownership in terms of programming or supporting the centre – implementing programs they feel would best support the community. The Health Champions have been integral in identifying priorities for the community that were surprising to staff. For example, the team discussed how some people in the community couldn't access care because they didn't have anyone to look after their pets. Now, there is a program where volunteers can look after someone's pet to enable clients who might need to leave home for a surgery or other services.

Looking Ahead

Thanks to the Health Champions and the willingness of the primary care team to do things differently, social prescribing has helped to increase the capacity of the centre to offer Francophone programming in this rural community. Staff at other locations expressed interest, and the centre is now planning to expand this social prescribing work to two of its other sites.

Painting class held by volunteer Health Champions at CSC du Temiskaming

Coffee and Knitting group led by volunteer Health Champions knitted a newborn blanket to donate to the community

"We are convinced that the effort to combat loneliness among the members of our community made us... CHAMPIONS! We want to help people as much as we want to help ourselves not to sink into the throes of loneliness.

The Champions met and, from one meeting to another, activity programs sprang up: physical exercise sessions, board games, dinner meetings, social outings, coffee and knitting, photography courses. And this is just the beginning.

One of our members said, 'After being laid off, I had lost my pride. By getting involved as a Health Champion, I was able to fight my isolation while helping people in my community fight their loneliness. I am now proud of myself, knowing that I offer others the chance to follow this good prescription, that of putting life into our lives!'

Getting involved in activities, as an organizer or participant, is a winning recipe that allows people to bounce back after a loss. To participate is to make a very decisive choice to live better. It's choosing to take your place in the sun.

To those who suffer from being alone, you may only be a hair's breadth away from happiness. Come on, we'll be happy to have you with us!"

Health Champions team, CSC Témiskaming

CENTRETOWN COMMUNITY HEALTH CENTRE

The Setting

Centretown Community Health Centre is one of the oldest CHCs in Canada, having opened its doors in 1969 in the heart of Ottawa, a few minutes' walk from Parliament Hill. Within its area, Centretown's priority populations include seniors, 2S&LGBTQ+ people, children and families, people who use drugs, people experiencing homelessness, and newcomers to Canada.

The Local Intervention

For social prescribing, Centretown put together a specialized, interprofessional team, affectionately named "SoHoT" (Social Prescribing Horizontal Team) to guide their implementation. This horizontal team consists of a registered dietitian, a physician, a nurse, the data management coordinator, a health analyst, and multiple health promoters. Though any provider at the centre can refer people to social prescribing, this team was tasked with piloting social prescribing with new and existing patients.

When any of the providers on the team met with a client, they used part of the time to have full conversations in order to surface underlying non-medical needs. They then referred clients to the supports needed directly, or to a health promoter who functions at a navigator for follow-ups and reminders. Additionally, every provider on the team documented the referral they made in the electronic medical record so that the client's history and progress would be tracked.

Staff were educated in the social prescribing pathway and its implications for their practices. This included regular meetings of the interprofessional team, all-staff presentations, an asset mapping project undertaken by practicum students, and continuous reminders and feedback on the impact of client referrals. The pilot was also an opportunity to engage the centre's existing volunteer base to become Health Champions. These individuals are now playing important roles in developing programming for the centre as well as helping to identify emerging community needs.

Centretown CHC can now offer indoor walking groups at the beautiful National Gallery of Canada thanks to a new partnership. Dina Groulx, Corporate Relations Officer, National Gallery of Canada (centre) poses with Centretown CHC staff Natasha Beaudin (left), Health Promoter and Alex Brown-Thériault (right), Kinesiologist, Diabetes Program.

The Results to Build On

Social prescribing increased communication between primary care and health promotion staff, and enabled closer collaboration when identifying and addressing clients' social needs. With the support of a clear data-collection pathway, the centre was able to better identify gaps and co-plan service for priority populations.

The pilot spurred the creation of easily accessible programs at the centre – such as coffee groups where people could grab a cup of coffee and draw – and several other groups to address social isolation. Centretown also forged new external partnerships for social prescription opportunities, such as with the National Gallery of Canada, where the centre's walking group holds indoor walking events. CHC staff have also partnered with a writing collective to co-create workshops.

Looking Ahead

Centretown, along with the Ottawa region's other five CHCs, was instrumental in making social prescribing a key component of the Ottawa Ontario Health Team application, to address integration among providers and the social determinants of health in the region. Building on their local success, Centretown CHC is already proceeding to embed the social prescribing pathway and roles into the three-year strategic plan and operational plan of the centre, to ensure that the work during the pilot becomes a permanent part of the centre's core practice.

In the Media

The cost of loneliness: Canadian are facing a solitary future- and it's affecting their health
Ottawa Citizen, December 22, 2019

Ken Roberts describes his experience participating in social prescribing activities such as the cooking club, walking group, and music jam to support his mental health challenges, social isolation, and medical diagnosis of Type II diabetes.
Link:
https://ottawacitizen.com/health/seniors/does-one-loneliness-kill

Why doctors are prescribing bingo, not pills, to keep patients healthy
CBC News, September 30, 2018

Health promoter Natasha Beaudin explains how social prescriptions, like joining a walking group, can be used as a preventative measure to address health issues associated with high levels of stress.
https://www.cbc.ca/news/canada/ottawa/social-prescribing-loneliness-health-problems-1.4833088

Coffee Connections at Centretown CHC

COUNTRY ROADS COMMUNITY HEALTH CENTRE

The Setting

Since 1988, Country Roads Community Health Centre (CRCHC) has served people in Portland, Westport and surrounding Rideau Lakes communities in southeastern Ontario. CRCHC specializes in engaging isolated residents, including seniors and young families, and at addressing transportation and other low-income barriers to access.

Recognizing the value of engaging rural community members in healthcare delivery, CRCHC integrated high fidelity WrapAround into its services model in 2011. The CHC also received training from the U.K.'s Altogether Better in 2014 on Health Champions and engaging rural clients in health care.

The Local Intervention

Building on a strong history of WrapAround and working with Health Champions, continued education of staff and the formation of a Social Prescribing (SP) Team were the keys to success for the CRCHC pilot. To leverage a strong history of community asset mapping, CRCHC created a SP Team, led by a half-time health promoter, also including a client navigator, community health worker/volunteer coordinator, resource coordinator, social worker and the coordinator of health promotion and community development.

Clinicians referred clients directly to the health-promoter-led SP Team, and clinical collaboration and ongoing learning about social prescribing were embedded into full staff meetings, individual team meetings, the electronic medical record, or through individual face-to-face collaborations with clinical advisors. The goal was to match the need(s) of SP clients with the right resources and people. The CHC's strong existing volunteer program helped support the development of Health Champion volunteers, who, in turn, helped to fill valuable roles in the social prescriptions for other clients.

The Results to Build On

Referrals have increased through the term of the project, and client satisfaction with social prescribing continues to be overwhelmingly positive. Teamwork, both within the centre, and also across sectors, was enhanced by the social prescribing pilot. Now that people understand others' roles better it has become easier to make connections.

The "No door is the wrong door" approach of CRCHC's pilot enabled more and deeper connections between CRCHC and other health and social service providers. Partnerships have blossomed and strengthened: both with the local five-branch library system to provide additional, closer-to-home programming, and with a local branch of Developmental Services of Leeds and Grenville, a new partner at CRCHC's Guthrie House hub.

On the individual level, closer collaboration among organizations has surfaced more opportunities for people to become involved, often closer to home, in volunteer work related to social prescribing, enhanced by CRCHC's Volunteer Coordinator.

Looking Ahead

CRCHC will look to continue the success of its social prescribing team led by a health promoter acting a social prescribing navigator. The hope is to expand the role to support more partnerships in the community and also more education, both of other organizations and also the public. Staff will continue to learn from practice and results, while tracking ED visits, clinical appointments, and other metrics for SP clients to help make the case. The social prescribing Team will continue to look for ways to connect clients to the resources they need and to each other.

"Social Prescribing has been able to strengthen the sense of connectedness that our clients have with their communities. People are happier, self-motivated, taking care of themselves better, more confident, connected, and less lonely. In some cases they've become their own advocates. It's those types of results that can be easily lost [in the quantitative results of a short study], but they're game-changers in people's lives and health. It's the difference between someone wanting to live their life, and just being here."

Marci Bruyere, Coordinator of Health Promotion and Community Development, Country Roads CHC

GATEWAY COMMUNITY HEALTH CENTRE

The Setting

Gateway Community Health Centre opened in 1991 and serves over 5,000 people in Tweed, plus a large catchment in the Rural Hastings area, including Bancroft, in southeastern/central Ontario. The CHC is focused on isolated populations and people facing poverty and transportation barriers, as well as complex chronic medical and social issues. The centre also recently expanded, adding more program space for its Early Years and other community programs.

The Local Intervention

Gateway CHC's pilot in social prescribing built on the role of its Health Link system navigators, who support the most medically and socially complex patients. The system navigator is the main point of contact between the patient and the family, primary care physician, inter-professional team members, and across health and social sectors. The system navigator looks beyond the patient's medical need to also support their social complexities. They go beyond the traditional referral system to ensure that the patient is connected with the appropriate resources, and they provide ongoing follow-up to ensure that the services are meeting the patient's needs.

Asset-mapping was done through two in-person engagement days conducted with partners, community members, and other providers in North and Central Hastings. This provided a complete picture of services and programs already offered in the community. These ranged from a knitting group at a local library branch to formal offerings from groups like the Alzheimer Society. Two social prescribing fairs were held in September and October 2019, which brought together over 100 potential partners and Health Champions. These fairs helped raise awareness of the impact social isolation and loneliness can have on mental and physical health, including chronic conditions.

Staff are developing a weekly social prescribing drop-in-and-mingle session that will feature activities demonstrations and where people can talk to staff, volunteer facilitators, and each other to get connected to programs they might be interested in. The CHC has set aside resources for refreshments and transportation to support wide participation. These weekly sessions will also serve as a venue for community engagement a co-design of programs that clients want to see at the CHC. Clinician training and education continues on what types of programs and connections are available to clients through social prescribing.

Local band plays at Social Prescribing Fair hosted by Gateway CHC

The Results to Build On

As the lead organization for the Rural Hastings Health Link (RHHL) and a member of the Rural Hastings Ontario Health Team, Gateway CHC is an established organizational hub for integration of providers to better serve the needs of clients across a wide rural catchment. Social prescribing has provided the impetus to become more deliberate about integrating wellbeing and social supports into care plans and primary care encounters. Interest is growing among partners in primary care, such as a local family health team and other family physicians in the area, as well as in acute care. As one hospital administrator says, "Wouldn't be great if we could give someone a social prescription where needed at discharge?"

Looking Ahead

Gateway CHC believes that social prescribing is a pillar of an integrated healthcare system, enabling better connections between health and social care providers to offer truly comprehensive primary health care to everyone living in their region. This is why social prescribing was a key component of the proposed Rural Hastings Ontario Health Team (OHT) application. Gateway's vision is to ensure that 100% of complex clients in the area have access to the connections made possible by social prescribing.

Local community and social service agencies connect at the Social Prescribing Fair

To fully tap into the possibility for health and social service integration in the area created by strong existing provider partnerships and pathways, more support is needed to link clinicians, clients and opportunities, when isolation and other social needs are surfaced during appointments.

A dedicated navigator working across providers to link clinically surfaced needs to community connections and resources would be invaluable, to help navigate challenges such as transportation. CHC staff will also continue to look to clients, local partners, and Health Champions during its weekly sessions for direction on how to continue developing its social prescribing work.

> *"By becoming more aware of everything that's happening in our communities, especially in a rural community across a large geography, we've come to realize that we don't have to offer every program ourselves, but that it's more about finding creative ways to connect people to what's already there."*
>
> *Julia Swedak, Director of Quality and Knowledge Management, Gateway CHC*

GUELPH COMMUNITY HEALTH CENTRE

The Setting

Since 1988, Guelph Community Health Centre has served people living in the southern Ontario city, with a particular focus on people who have a hard time accessing healthcare services elsewhere. This includes people experiencing homelessness and low incomes, newcomers and people with language barriers, people living with disabilities, people dealing with mental health and addiction issues, Indigenous communities, and LGBTQ+ populations. One hundred and forty staff work from many locations, including a satellite location in a hub for youth, parents, and children. Guelph CHC has a strong focus on advocacy and programs that address food insecurity, social isolation, and adverse childhood experiences.

The Local Intervention

A strong existing network of community-based peer leader volunteers provided a foundation and asset map on which to build social prescribing pathways, and a clear way to identify existing volunteer leaders.

Peer leaders are often clients who live in priority areas for the CHC, deliver neighbourhood programs and groups there, and who are also key partners for community engagement and new program co-design. Peer leaders promote and run approximately half of the estimated 40 programs per month (the other half is run by paid CHC staff), including Zumba, yoga, chronic pain peer support, cooking groups, drop-in exercise, English conversation circles, and a community garden.

Peer leaders are coordinated and supported by a Health Promoter, who provides logistical oversight and the creation of new groups. A CHC Nurse and Health Guide have also co-designed new offerings alongside peer leaders, creating programs such as Soup and Crochet with Grandma Penny and Creative Connections, a board games/art/karaoke drop-in group. Social prescribing has also created an opportunity to build on the CHC's 200-plus volunteer base, and its volunteer-run front desk support service. The front desk volunteers support Guelph CHC's social prescribing work by researching local programs and services, then sharing the information with people they interact with.

The pilot began by educating clients, peer leaders and staff members about the health impacts of social isolation. Efforts were taken to inform staff about social prescribing as an intervention for people not in crisis or in need of stabilization, but as a way of building resilience among people at-risk of health declines due to social isolation.

Keys to success included: sustained engagement with the leadership team, including clinical leaders, with the purpose and possibility of social prescribing for complex clients; support from a provincial team for tools like presentation resources, media relations and building a community of practice; and forging new interprofessional work, such as the collaboration between the SEED (in-house food security program) and the clinical team to launch the CHC's food prescription program that combine food insecurity interventions with opportunities for social connections, such as the Tasty Table cooking group.

East End Community Market at Guelph CHC

The Results to Build On

A new role was created in January 2020, the community connector, to work directly with clients receiving a social prescription. In keeping with the true assets-based nature of social prescribing, this role is a paid peer position, filled by a community member who has lived experience of navigating through Guelph's community programs and resources. The community connector will receive social prescriptions and act as a navigator for clients, helping to surface their needs, and following up after connections to Peer Leaders and programs have been made.

Clinician referrals to social prescribing are now being made through the electronic medical record. Proactive outreach is also being done to people who are deemed to have a high frequency of primary care appointments and unmet social needs. The community connector starts conversations that might lead to social prescriptions or volunteer opportunities and can surface barriers that people might face to getting connected. Throughout the project, the number of social prescriptions from staff has steadily increased, and tracking data to show the impact of health promotion work has been a key focus.

Looking Ahead

The newly created community connector role, which will function as a modified link worker role combined with some outreach and program co-design, will put the social prescribing initiative at Guelph CHC on sustainable ground moving forward. Guelph CHC leadership has supported the inclusion of social prescribing in the centre's OHT application, and local family health teams are interested in expanding the program to their clients. Continued backbone support on the provincial level, through the Alliance and the Ministry of Health, would help to formalize the progress Guelph CHC has made so far with social prescribing.

Yoga at Guelph CHC

In the Media

Guelph doctors, health providers treat loneliness by prescribing yoga and crochet lessons
CBC News, August 13, 2019

Learn about different programs happening at Guelph CHC to reduce isolation and loneliness.
https://www.cbc.ca/news/canada/kitchener-waterloo/guelph-doctors-treat-loneliness-by-prescribing-yoga-and-crochet-lessons-1.5240124

Social prescribing proving to be a success in Guelph
Guelph Today, July 26, 2019

Client and volunteer, Izabela Lukomska, describes how social prescribing has led to positive changes and more connectedness among individuals who attend different social programs offered at the CHC.
https://www.guelphtoday.com/local-news/social-prescribing-proving-to-be-a-success-in-guelph-1609105

NORWEST COMMUNITY HEALTH CENTRE

The Setting

Serving people in urban Thunder Bay and also in surrounding rural communities at sites in Longlac and Armstrong, NorWest Community Health Centres served almost 17,000 clients in 2018/19, and saw nearly 7,000 visits to its walk-in clinic services (provided to clients and the general public) during the same period.

Populations targeted for NorWest's comprehensive primary health care services include socially isolated people, especially seniors, Indigenous clients, people living on low incomes, and people living with Fetal Alcohol Spectrum Disorder.

NorWest's Thunder Bay site was the setting for the pilot, in an area relatively isolated from other community assets, such as libraries, schools, and parks, which posed unique challenges.

The Local Intervention

The navigator role assumed by the health promoter was a key initial enabler of both supported referrals and a strong group of Health Champions. The group of Champions was built in a number of ways: staff advertised via posters in the CHC, seeking clients who were interested in starting their own programs; and clinicians recommended and prescribed clients to volunteer.

Staff worked together to identify clients who were socially isolated and would benefit from social prescriptions. In some cases, people were referred to groups directly, and in others the navigator would visit the clinical team and guide someone towards a group that was a good fit for them. Health Champions were encouraged to co-design programs and groups with support from the navigator to lower barriers by providing snacks, secure spaces, and connections to people referred through primary care.

An important step at the outset of the pilot was developing trust and systems for Health Champions to run their own programs and handle logistics – such as opening up locked doors, setting up a room, letting people into the CHC after hours, or serving food – due to the lack of other community spaces to hold programming nearby.

It took staff time and energy to grow the Health Champions group initially. But now many weekly groups are self-sustaining, including an LGBTQ and Two-Spirit support group, a knitting and quitting smoking group, a walking program, a craft group, a Wellbriety group for addictions support, and others. The navigator encouraged the cultivation of other groups by Champions, with strong support from CHC leadership to allow volunteers to experiment. Staff were educated about social prescribing at all staff meetings and encouraged to make referrals for social prescribing either directly to group facilitators, or if more guidance or conversation was needed, through the social prescribing navigator.

The Results to Build On

Better integration of clinical encounters with health promotion opportunities was a key piece of progress, with staff feeling more empowered to refer clients when a social issue surfaced during appointments. Better general awareness was established among staff of the programs, volunteer opportunities, and groups available for socially isolated clients.

Though NorWest CHC's standard intake form asked clients what their interests were, the information was generally unused. Now staff are able to actively use this information to

support clients' social needs in meaningful ways.

Self-sustaining groups run by volunteer Health Champions and an environment in which community co-designed programs were encouraged were also important results of the pilot. Engagement of external facilitators of groups to help fill gaps not met by CHC programming was an important step.

Looking Ahead

NorWest CHC also participates in TeamCare, where solo-practice physicians are able to refer clients to interprofessional team members at the CHC. This support now includes the social prescribing navigator and Health Champion programs. As a result, there is now a pathway to support the social needs of clients of solo physicians.

Dedicated staff resources for navigator functions, and to help coordinate new volunteers Health Champions and the creation of new groups and programming, will be the keys to sustaining the work begun during the pilot.

Extending the reach of Social Prescribing to external partnerships with other providers and municipal programs is a stretch goal that will require more resources and creative thinking, due to transportation and other logistical barriers involved.

In the Media

Ontario health-care providers explore social prescriptions to help patients heal without drugs
The Globe and Mail, December 17, 2018

Myra Rzepa shares how being supported to co-create and lead activities have helped with her mental health and struggles with addiction.
https://www.theglobeandmail.com/canada/article-ontario-health-care-providers-explore-social-prescriptions-to-help/

> *"Social prescribing really brings back our community health centre to its original vision and mission, which is to meet the needs of the community by making sure we're tapping into what our clients have to offer each other. That helps make our programming much more robust and rewarding for participants."*
>
> *Michelle Kolobutin, Health Promoter, NorWest CHC*

REXDALE COMMUNITY HEALTH CENTRE

The Setting

Located in northwest Toronto, Rexdale CHC serves a diverse population, including women, children, youth, seniors, low income individuals, newcomers, pregnant mothers, and racialized people from South Asia, Caribbean, Latin America, African and emerging Arabic and French-speaking communities. Barriers in the area include language, social isolation, income levels, food insecurity and transportation.

To address these barriers, Rexdale CHC provides services in many languages, including French, Arabic, Italian, Polish, Spanish, Somali, Twi, Hindi and Punjabi via staff members or translation services, as well as transportation and food.

The Local Intervention

Before this pilot, Rexdale had trialled social prescribing focused on engaging newcomer families. Building on their experience, Rexdale CHC engaged both their primary care team and health promotion team to create two main pathways for clients to be part of social prescribing. First, physicians or nurse practitioners can identify a client's needs and directly prescribe them to a program. Along with this prescription, the social prescribing navigator is notified and included to ensure that the client has everything they need to follow through.

Secondly, if the client is new to the centre, they are automatically set up to meet with the client support worker – in this case, this person also acts as the social prescribing navigator. During their first meeting, the navigator is also able to identify clients' needs and both prescribe and follow up.

A health promoter coordinates the program and connects health promotion and primary care teams, while also building external partnerships to enhance social prescribing offerings for clients and staff. Social prescriptions include mood walks, knitting club, drumming/music classes, exercise groups, grieving/healing circle, meditation groups, and gentle chair yoga. Staff have worked to train peer leaders, who have successfully implemented programs such as the mood walk group.

Farmacy, a food prescription initiative, enables clients facing food insecurity, who are socially isolated, living with chronic diseases and relying on social assistance to receive Good Food Boxes twice per month and access nutritional consultations with the community dietitian as needed. All clinicians and health promotion team members were educated about this program and encouraged to identify clients who'd benefit from it .

"Social Prescribing has strengthened the integration of our services, it has improved the relationship between clients and providers. Clients become more active, engaged and inspired – and that's led us to co-design more social recreational activities like choir groups, mindfulness, dance and other ways for people to have more fun and be social."

Fadumo Abshir, Health Promoter, Rexdale CHC

Key successes include strong engagement and awareness on social determinants of health from the primary care team; increased social prescribing referrals; and strong support and interest from the leadership team. Social prescribing also became part of morning huddles where staff share highlights, remind about resources available to clients and work to identify clients in need of social connections. The organization is now fully onboard to sustain social prescribing services and build new partnerships.

Results to Build On

Social prescribing has helped to build on the already strong connections between the clinical and health promotion teams. The pilot has had a positive impact on the social wellbeing of clients and has allowed the centre to expand programming like Farmacy to reach more people.

The CHC has secured external partnerships with organizations including Royal Ontario Museum, Art Gallery of Ontario, Ripley's Aquarium, Toronto Symphony Orchestra, CAMH and FoodShare, to create many new opportunities for clients. Clients who received prescriptions to groups, classes, and events have widely given positive feedback. Focus group discussions indicated that clients felt a stronger connection with their provider and that they were being cared for beyond the scope of the medical appointment.

Looking Ahead

Rexdale CHC plans to continue its social prescribing program beyond the pilot and has embedded training for social prescribing into the orientation process for all new staff. In addition to this, the centre is in the process of pursuing more external partnerships with places like the Toronto Science Centre and the Toronto Zoo, and has started talks with other organizations who want to collaborate in implementing more social prescribing offerings.

In the Media

Doctors can now prescribe a visit to the ROM through a new initiative to combat anxiety and loneliness
The Toronto Star, December 6, 2018

Nafisa Nezam Omar shares her experience with social prescriptions, including seniors' programs and a museum visit, and how they improved her sense of wellbeing during a difficult transition period.
https://www.thestar.com/news/gta/2018/12/06/doctors-can-now-prescribe-a-visit-to-the-rom.html

Doctors pen 'social prescriptions' aimed at easing depression, loneliness in patients
CTV News, January 1, 2019

Primary care physician Sonia Srivastava describes the impact of social connectedness on health and wellbeing, and volunteer health champion Tammy McEvoy shares her experience co-creating social programs.
https://www.ctvnews.ca/health/doctors-pen-social-prescriptions-aimed-at-easing-depression-loneliness-in-patients-1.4236834

Healthy Eating Cooking Class at Rexdale CHC

SOUTH GEORGIAN BAY COMMUNITY HEALTH CENTRE

The Setting

Open since 2011, South Georgian Bay CHC (SGBCHC) is a semi-rural centre serving people in Wasaga Beach, Clearview, Collingwood, Elmvale and the Blue Mountain. Priority populations for the centre include youth, isolated seniors, people living with disabilities, and people facing barriers due to poverty, housing challenges, food insecurity, and mental health and addictions issues.

The Local Intervention

SGBCHC invited clients and community members to become volunteer Health Champions to develop activities, groups and programs. A need and collective passion was identified early on for a visitation program for older adults and people facing complex health issues and social isolation. The centre partnered with a local community service organization to train Health Champions with a passion for visiting others, and a Friendly Visiting Program was formed.

From this initial work, other peer-led programs emerged: Coffee and Colour drop-in, card game socials, Indigenous storytelling workshops, hobby and craft group, pole-walking, among others.

SGBCHC is part of a regional innovative partnership with 211 Ontario Community Connection, which enables them to leverage 211 Ontario's informal telephone and internet-based referral services to refer clients to social and community services in the area. This existing strength was folded into SGBCHC's social prescribing initiative, and they complemented their existing screening for low income and material poverty with conversations on social needs. SGBCHC also applied for and received a small endowment fund from the local hospital to support programming cost for social prescriptions.

Results to Build On

Supporting clients of all abilities to contribute their gifts required a greater investment of staff time and energy. However, being invited to co-design and implement innovative solutions has ignited a new passion in the centre's community, with volunteers experiencing a strong sense of empowerment while taking pride in their contributions to the community.

The Friendly Visiting program has evolved beyond visiting and giving support to caregivers. It has become a valuable communication channel between health providers and isolated individuals. Visitors are able to learn about individuals' circumstances, and with permission, follow up with any information and concern to the isolated person's health provider. For example, Friendly Visiting volunteers support things like filling out forms and helping to write letters to landlords to help clients maintain housing. In one instance, a volunteer was able to help an individual research and access appropriate hearing aids, which changed their daily interactions significantly.

Hobbies and Crafts group led by Volunteer Health Champions knit blankets for the local animal shelter

Many clients have expressed that the social prescriptions they're involved in are making them feel more socially connected and less isolated and lonely.

Looking Ahead

As SGBCHC shares their approach with potential partners in the area, their work has been receiving keen interest from a local hospital, community hubs, and other organizations. Clients who've seen the Friendly Visitor program in action or heard about it from others have now expressed interest in becoming part of it.

SGBCHC is now developing partnerships with a local outdoor adventure company for guided nature activities for clients, as well as sharing programming and referrals with the Seniors Active Living Centre. They are also in discussion with local park and conversation authorities to develop additional nature-related social prescriptions.

SGBCHC will look to build on its internal capacity to train their own Friendly Visitors in the coming months, while continuing to support its Health Champions and peer-run programming development, and looking to enhance external partnerships to widen social prescribing offerings.

In the Media

Social prescriptions: Sense of belonging could be best medicine
Global News, June 19, 2019

Carroll Thompson describes her experience with loneliness, and how receiving a social prescription helped her build connections with others and find belonging in the community.
https://globalnews.ca/video/5410124/social-prescriptions-sense-of-belonging-could-be-best-medicine

Pilot project has health team prescribing hobbies, social activities to patients
Collingwood Today, July 18, 2019

SGBCHC Executive Director, Heather Klein Gebbinck, describes the social prescribing pilot and the local programs and activities that have been co-created with clients.
https://www.collingwoodtoday.ca/local-news/pilot-project-has-health-team-prescribing-hobbies-social-activities-to-patients-1591205

From "What's the matter with you?" to "What matters to you?"

Terry* has congenital deafness, which they felt stigmatized by, and was very socially isolated. They exhibited difficult behaviours in primary care that escalated over time. Terry was encouraged to become a Health Champion, and was supported by staff to host weekly card games at the centre. These new social connections led to calmer and shorter primary care appointments. Moreover, Terry used to be very resistant to participating in group activities, but since becoming a Health Champion, they have now become involved with other groups like Living Healthy Life with Chronic Conditions.

Being invited to become a Health Champion and supported to lead activities, Terry saw that they can be involved with other people in a trusting, accepting environment at the centre, which is having a transformative impact on their life.

STONEGATE COMMUNITY HEALTH CENTRE

The Setting

Serving people of all ages in the south Etobicoke neighbourhood of Toronto and surrounding areas, Stonegate CHC focuses on newcomers, youth, and low-income seniors. Seventy surrounding apartment buildings make up much of the centre's client roster, and a high child poverty rate in the community makes young families a focus, too. Barriers that the CHC regularly addresses include language, poverty and food insecurity.

The Local Intervention

Without a dedicated social prescribing navigator, Stonegate CHC staff focused on the development of a strong group of volunteer Health Champions. Champions were identified both by clinicians, but also health promoters, social workers and other staff, and prescribed to become Health Champions. The centre also made an effort to advertise the Health Champion role on bulletin boards around the centre, and in communications like newsletters. Word of mouth among clients themselves also played a key part in helping to identify candidates to become Health Champions.

Orientation and co-design sessions were held with this engaged volunteer base to identify the types of activities and groups people wanted to organize at the centre itself.

Volunteer Health Champion dresses up as Wonder Woman at community market to encourage connections

Individual encounters between clients and staff who were trained in social prescribing made a big difference in surfacing hidden gifts and skills that volunteers could then bring to the lineup of programming. A great example is the story of a baker struggling with anxiety, and how social prescribing helped to provide an opportunity to see themselves as someone with a gift. This wasn't about asking someone to help cut up apples in the kitchen for a community lunch. This was about finding the role where someone feels empowered, feels valued, and where they feel they can give back.

Partnerships with Toronto cultural institutions to prescribe museum, gallery, concert, and aquarium visits also helped to build "buzz" and provided novel social prescriptions.

The CHC is already strong on providing "warm handoffs" for social prescribing, with clinicians introducing their clients directly to a health promoter. Staff found that starting a referral to a program or group with a face-to-face encounter meant people were much more likely to show up. These initial encounters also created space and time for people to surface other things they're interested in, or challenges they might be facing, so that staff can better match them to the supports available.

Education of staff across clinical and health promotion about making these connections in a deliberate way – and allowing clients time to have these conversations about social needs with someone who can connect them to resources – was essential to social prescribing's success.

The Results to Build On

Staff leading the project are now looking at embedding a client support worker, as well as an Early Years Nurse, each trained in social prescribing, in an office close to the clinical

team during appointment times, in order to facilitate even more warm handoffs, and build on strong education of staff in social prescribing.

The idea is to increase interaction between these staff on a day-to-day basis, to create a comfortable place for collaboration, and to increase the surfacing of social issues and frequency of social prescriptions for clients who may benefit. The Health Champions group will continue to be a valuable way of identifying gaps in programs that clients want to see at their centre, and increasing their ownership over the offerings.

Looking Ahead

Quarterly orientations will be held for Health Champions in order to ensure that the group remains strong, growing, and engaged with staff in co-design. Health Champions will also be celebrated on a regular basis, including recognition alongside the CHC's donors as essential parts of the centre's work.

Some staff will be embedded into the Health Champions group to help sustain it, but a navigator role is desired to fully sustain and develop the social prescribing initiative, evolving it to meet client needs while exploring the possibility for more external partnerships with community and cultural groups. Having a dedicated staff member would also ensure that the momentum of the Health Champions group can be maintained long term, ensuring that client enthusiasm and ideas aren't lost along the way because of pressure on staff in other areas of their roles.

In the Media

'It changed my life': New pilot project tests health benefits of social prescribing
CBC News, December 24, 2019

Hayfa Mousa and Gina Caradonna describe their experience with social prescribing, the positive impact on medical conditions, as well as finding social connections, community, and a sense of belonging and purpose.
https://www.cbc.ca/news/canada/toronto/it-changed-my-life-new-pilot-project-tests-the-health-benefits-of-social-prescriptions-1.5390878

Discovering hidden gifts

Betty* felt socially isolated. She connected with a social worker for anxiety and other mental health issues and mentioned her love for baking. The social worker invited Betty to facilitate a baking workshop. After being a little hesitant initially, Betty worked with staff to host the workshop for other clients of the centre. It was well attended, and participant feedback was very positive.

When staff reconnected later to let Betty know how much the workshop had been appreciated, Betty said, "I've really struggled in the last while, but you know what? The day of the workshop was the best day I've had in five years."

Betty had thought, "Well, you know it's just baking." Staff engaged her in a conversation about how what seemed like a "natural" skill to her was actually a gift she was bestowing on other community members. Betty was very excited, and has since become a volunteer Health Champion to continue contributing her gifts to the community.

WEST ELGIN COMMUNITY HEALTH CENTRE

The Setting

Serving everyone in the Dutton Dunwich and West Elgin municipalities of rural southwestern Ontario, West Elgin CHC focuses on seniors, including frail elderly, as well as youth and families. The CHC regularly addresses barriers such as isolation, transportation, low incomes, and poverty.

The CHC truly functions as a support hub for the entire community, with a 100-plus strong volunteer program including a half-time volunteer coordinator, and many community support services, such as Meals on Wheels, operating out of the CHC and powered by its volunteers.

The Local Intervention

Turning a static spreadsheet of resources and potential partners into a dynamic, public-facing electronic booklet to be an active resource for staff and clients alike was a foundational piece for implementing social prescribing in this rural CHC setting.

The booklet is a core resource of programs, activities and opportunities within the CHC itself, but also with external groups, programs and organizations listed. All staff were given ready access to the e-booklet on their computer desktops, and all were encouraged to make social prescriptions.

Clinicians make referrals to in-house programming regularly, and a part-time system navigator also acts in a link worker role for clients. Clients are connected to social prescriptions through clinicians, allied health staff, health promotion staff, and volunteer group leaders.

Community service groups embedded in the CHC, such as Early Years and Seniors' programs, were able to navigate clients to social prescriptions independent of other centre staff. The supportive linking function of the system navigator remains vital for social prescriptions coming from primary care, and supporting complex clients.

A "Client Council", which advises the governing community board of the CHC, also contributed guidance and inspiration for the pilot, with many "movers and shakers" in the area helping to ensure a rich process of asset-mapping and the identification of program gaps and opportunities. Volunteers, through the volunteer coordinator and also through individual groups within the centre, have contributed greatly to social prescribing's offerings, such as a retired recreational therapist who is now running an art group once a week.

The Results to Build On

Staff's ability to track and record health promotion and community development interventions with individual clients at the CHC was enhanced by the framework of social prescribing. Education and training are still works in progress to ensure consistent and standard data collection, especially within the centre's electronic medical record. Rigorous asset-mapping revealed many more opportunities for connection and meaningful community roles beyond what centre staff were aware of.

Bike ride and exercise at West Elgin CHC

The centre believes that further support is needed for a full time navigator to assist and track clients on their social prescription journeys; help staff develop their capacity and understanding of opportunities available; work with potential community partners and driven community volunteers to further enhance the social prescription choices that clinicians and clients have available to them; and update and keep current the existing asset map and e-booklet and other core resources.

Looking Ahead

Social prescribing training will become part of the onboarding process for all new staff at the centre, to enhance organization-wide awareness and participation in building the program.

Strong interest in further developing social prescribing based on West Elgin's pilot is continuing to grow from the municipal government, local public health unit, home care service providers, other CHCs, family health teams, CMHA, the Frail Seniors Strategy Group for the area, and others. Interest was driven among these partners and the wider public by several successful local media interviews, including on CBC Radio, and in local publications.

Cooking together at West Elgin CHC

In the Media

CBC Afternoon Drive
CBC News, January 22, 2019

Health Promoter and System Navigator Stephanie Skelding shared about social prescribing at West Elgin CHC with CBC Radio. https://www.cbc.ca/listen/shows/afternoon-drive/segment/15664516

"Groups, volunteering and other opportunities afforded by social prescribing give people a purpose, and show them that we all have something to offer to each other. People make friends when they engage in these programs and groups. When they do that, they encourage each other, they're more likely to come to an exercise group or a cooking group. And it also means that they're taking better care of themselves and their own health when they do, too."

Stephanie Skelding, RN, System Navigator and Health Promoter, WECHC

REFERENCES

[1] Magnan, S. (2017). Social determinants of health 101 for healthcare: five plus five. *NAM Perspectives*. Discussion Paper, National Academy of Medicine. Accessed February 20, 2020. DOI: 0.31478/201710c.

[2] Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135. DOI: 10.1016/j.amepre.2015.08.02.

[3] World Health Organization. (n.d.). *Frequently Asked Questions*. Retrieved 04 15, 2019, from https://www.who.int/about/who-we-are/frequently-asked-questions

[4] Magnan, S. (2017). Social determinants of health 101 for healthcare: five plus five. *NAM Perspectives*. Discussion Paper, National Academy of Medicine. Accessed February 20, 2020. DOI: 0.31478/201710c.

[5] Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135. DOI: 10.1016/j.amepre.2015.08.02.

[6] Williams, D. C. (2017). *Connected Communities Healthier Together: 2017 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario*. Retrieved 04 16, 2019, from http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_19/cmoh_19.pdf

[7] Public Health Agency of Canada. (2013)). *What Makes Canadians Healthy or Unhealthy?* Retrieved 04 16, 2019, from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html

[8] Angus Reid Insitute (2019). *A Portrait of social isolation and loneliness in Canada today.* http://angusreid.org/social-isolation-loneliness-canada/

[9] Campaign to End Loneliness (n.d.). About Loneliness. Retrieved on February 20, 2020 from https://www.campaigntoendloneliness.org/about-loneliness/

[10] Williams, D. C. (2017). *Connected Communities Healthier Together.* 2017 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario. http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_19/cmoh_19.pdf

[11] Angus Reid Insitute (2019). *A Portrait of social isolation and loneliness in Canada today.* http://angusreid.org/social-isolation-loneliness-canada/

[12] Low Commission. (2015). The role of advice services in health outcomes: evidence review and mapping study.

[13] Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., ... & Halder, M. M. (2019). The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. *BMJ open*, *9*(11).

[14] Adhopia, Vik. (2019, March 20). *Canadian healthcare's 'one issuer per visit' problem.* Retrieved 05 1, 2019 from https://www.cbc.ca/news/health/second-opinion-one-problem-visit-1.5061506

[15] Mikkonen, J., & Raphael, D. (2010). Social Determinants of Health: The Canadian Facts. Toronto: York University School of Health Policy and Management.

[16] Canadian Institute for Health Information. (2019). *Commonwealth Fund Survey*, 2019. Retrieved from https://www.cihi.ca/en/commonwealth-fund-survey-2019

[17] Kung, A., Cheung, T., Knox, M., Willard-Grace, R., Halpern, J., Olayiwola, J. N., & Gottlieb, L. (2019). Capacity to address social needs affects primary care clinician burnout. The Annals of Family Medicine, 17(6), 487-494.

[18] De Marchis, E. D., Knox, M., Hessler, D., Willard-Grace, R., Olayiwola J. N., Peterson, L. E., Grumbach, K., & Gottlieb, L. (2019). Physician Burnout and Higher Clinica Capacity to Address Patients' Social Needs. *Journal of the American Board of Family Medicine* 32 (1) 669-78. DOI: 10.3122/jabfm.2019.01.180104. Retrieved February 20, 2020 from https://www.jabfm.org/content/32/1/69

[19] Williams, D. C. (2017). *Connected Communities Healthier Together.* 2017 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario.http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_19/cmoh_19.pdf
[20] H. M. Government (2018*). A connected society: A strategy for tackling loneliness – laying the foundations for change.* London, Department for Digital, Culture, Media, and Sport. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Loneliness_Strategy_web_Update.pdf
[21] Tam, T. (2019). *Addressing Stigma: Towards a More Inclusive Health System.* The Chief Public Health Officer's Report on the State of Public Health in Canada 2019. https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard.html
[22] Rayner J, Muldoon L, Bayoumi I, McMurchy D, Mulligan K, Tharao W. Delivering primary health care as envisioned: a model of health and well-being guiding community-governed primary care organizations. J Integr Care, 2018;26(3):231-241. Doi: 10.1108/JICA-02-2018-0014.
[23] See Community Food Centres Canada, https://cfccanada.ca/en/Our-Work/Programs/FoodFit
[24] See Pathways to Education, https://www.pathwaystoeducation.ca/
[25] See Access Alliance Financial Literacy Program, https://accessalliance.ca/programs-services/community-programs/financial-literacy/
[26] See LAMP Community Health Centre Income Tax Clinic, https://lampchc.org/programs-services/community-health-programs/ask-community-information/income-tax-clinic
[27] Penn, R. A. Strike, C., & Mukkath, S. (2016). Building recovery capital through peer harm reduction work. *Drugs and Alcohol Today, 16*(1): 84-94. doi: 10.1108/DAT-08-2015-0039
[28] See Carlington CHC and Ottawa Community Housing partnership, http://www.och-lco.ca/carlington-community/
[29] Association of Ontario Health Centres (2014). *Measuring What Matters: How the Canadian Index of Wellbeing can improve quality of life in Ontario.* https://www.allianceon.org/sites/default/files/measuring-what-matters-web.pdf
[30] Irwin, A. & Scali, E. (2007). Action on the social determinants of health: A historical perspective, *Global Public Health*, 2:3, 235-256. https://www.ncbi.nlm.nih.gov/pubmed/19283626
[31] Mount Carmel Clinic (n.d.). Our Story. https://www.mountcarmel.ca/about-us/our-story/
[32] Church, W. J. (1994): *Health Politics And Structural Interests: The Development Of Community Health Centres In Ontario.* PhD thesis, Western University. ir.lib.uwo.ca/digitizedtheses/2337/
[33] Glazier RH, Zagorski BM, Rayner J. Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012.
[34] Centre for Effective Practice (November 2016). Poverty: A Clinical Tool For Primary Care Providers. Toronto: Centre for Effective Practice.
[35] http://prospercanada.org/Our-Work/Taxes-and-Access-to-Benefits/Benefit-Screening-Tool.aspx
[36] Campaign to End Loneliness (n.d.). Measuring your impact on loneliness in later life. Retrieved from https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1-1.pdf
[37] North East LHIN. Stay On Your Feet (2017). Retrieved from http://www.nelhin.on.ca/stayonyourfeet.aspx
[38] Canadian Press. (2019, Jan 1). Social Prescriptions aim to ease patients' depression, loneliness. *CBC.* Retrieved 02 05, 2020 from, https://www.cbc.ca/news/health/social-prescriptions-depression-loneliness-1.4962817
[39] Pescheny, J. V., Pappas, Y., & Randhawa, G. (2018). Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. *BMC Health Services Research, 18*(86): 1-14. doi: 10.1186/s12913-018-2893-4
[40] Kimberlee, R. (2016). Gloucestershire clinical commissioning group's social prescribing service: Evaluation report.
[41] National Health Service. (2019). *The NHS long term plan.* Retrieved from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[42] Warburton, D. E. R. & Bredin, S. S. D. (2017). Health benefits of physical activity: a systematic review of current systematic reviews. *Current Opinion in Cardiology, 32*(5): 541-556. doi: 10.1097/HCO.0000000000000437

[43] White, M. P., Alcock, I., Grellier, J., Wheeler, B. W., Hartig, T., Warber, S. L., Bone, A., Depledge, M. H., & Fleming, L. E. (2019). Spending at least 120 minutes a week in nature is associated with good health and wellbeing. *Scientific Reports, 9*(1): 1-11. doi: 10.1038/s41598-019-44097-3
[44] Park, H. K., Chun, S. Y., Choi, Y, Lee, S. Y., Kim, S. J., & Park, E. (2015). Effects of social activity on health-related quality of life according to age and gender: an observational study. *Health and Quality of Life Outcomes, 13*(140): 1-9. doi: 10.1186/s12955-015-0331-4
[45] Fancourt, D. & Finn, S. *What is the evidence on the role of the arts in improving health and well-being? A scoping review.* Copenhagen: WHO Regional Office for Europe; 2019 (Health Evidence Network (HEN) synthesis report 67)
[46] Altogether Better, Working Together to Create Healthier People and Community
[47] World Health Organization. (1986). *Ottawa Charter for Health Promotion: First International Conference on Health Promotion Ottawa, 21 November 1986.* Retrieved from https://www.who.int/healthpromotion/conferences/previous/ottawa/en/
[48] Campaign to End Loneliness (n.d.). Measuring your impact on loneliness in later life. Retrieved from https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1-1.pdf
[49] Blake, C. (2019, January 28). Feeling Isolated? You can now be prescribed a trip to the museum. *The Star.* Retrieved 04 16, 2019, from https://www.thestar.com/life/health_wellness/2019/01/28/feeling-isolated-you-can-now-be-prescribed-a-trip-to-the-museum.html
[50] Miller, J. (2018, December 6). Doctors can now prescribe a visit to the ROM through a new initiative to combat WE. Retrieved 04 16, 2019, fromhttps://www.thestar.com/news/gta/2018/12/06/doctors-can-now-prescribe-a-visit-to-the-rom.html
[51] Mishori, R. (2018, March 18). Doctors are starting to give patients 'social prescriptions'. *The Star.* Retrieved 04 16, 2019, from https://www.thestar.com/life/health_wellness/opinion/2018/03/18/doctors-are-starting-to-give-patients-social-perscriptions.html
[52] Leung, W. (2018, December 17). Ontario health-care providers explore social prescriptions to help patients heal without drugs. *The Globe and Mail.* Retrieved 04 16, 2019, from https://www.theglobeandmail.com/canada/article-ontario-health-care-providers-explore-social-prescriptions-to-help/
[53] Ubelacker, Sheryl. (2019, January 1). Doctors pen 'social prescriptions' aimed at easing depression, loneliness in patients. *CTV News.* Retrieved 04 16, 2019 from https://www.ctvnews.ca/health/doctors-pen-social-prescriptions-aimed-at-easing-depression-loneliness-in-patients-1.4236834
[54] The Canadian Press. (2019, January 01). 'Social prescriptions' aim to ease patients' depression, loneliness. *CBC News.* Retrieved 04 16, 2019, from https://www.cbc.ca/news/health/social-prescriptions-depression-loneliness-1.4962817
[55] Lee-Shanok, P. (2018, December 09). Doctor's orders: 'Social prescriptions' have been shown to improve health. *CBC News.* Retrieved 04 16, 2019, from https://www.cbc.ca/news/canada/toronto/social-prescriptions-pilot-program-royal-ontario-museum-1.4937016
[56] CBC News. (2018, September 30). Why doctors are prescribing bingo, not pills, to keep patients healthy. *CBC News.* Retrieved 04 16, 2019, from https://www.cbc.ca/news/canada/ottawa/social-prescribing-loneliness-health-problems-1.4833088
[57] See NHS England, https://www.england.nhs.uk/personalisedcare/social-prescribing/
[58] See SingHealth, https://www.singhealth.com.sg/SCH/about-us/corporate-profile/Documents/BVH-Annual-Report-2018.pdf
[59] See Consumer Health Forum of Australia, https://chf.org.au/social-prescribing
[60] McKnight, J. L. & Kreitzman, J. P. (1990). *Mapping Community Capacity.* Report of the Neighbourhood Innovations Network funded by the Chicago Community Trust. Evanston, IL: Institute for Policy Research. https://web.archive.org/web/20161011224806/http:/www.abcdinstitute.org/docs/MappingCapacity.pdf
[61] Altogether Better. (2016). *Working together to create healthier people and communities: bringing citizens and services together in new conversations.* Retrieved 03 04, 2019 from https://www.altogetherbetter.org.uk/the-evidence-behind-our-work
[62] World Health Organization (n.d.). *Primary healthcare.* Retrieved 05 09, 2019 from. https://www.who.int/news-room/fact-sheets/detail/primary-health-care.
[63] World Health Organization (n.d.). *What is health promotion?* Retrieved 05 09, 2019 from

https://www.who.int/healthpromotion/fact-sheet/en/
[64] Alliance for Healthier Communities. (n.d.). *Model of Health and Wellbeing*. Retrieved 03 04, 2019, from https://www.allianceon.org/model-health-and-wellbeing
[65] Government of Canada. (2018). *Social determinants of health and health inequities*. Retrieved 04 15, 2019, from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

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