Social Prescribing Guidebook

for team-based primary care providers in Ontario

Key considerations and recommendations from the
Rx: Community experience in Community Health Centres

Alliance for Healthier Communities
Alliance pour des communautés en santé

Contents

HOW TO USE THIS GUIDEBOOK

Social prescribing, very simply, integrates social and community supports ("social") with medical care ("prescribing"). It looks different in different community settings. It must be adaptive to the unique strengths, assets, needs, and interests of each team, organization and community. This guidebook is not meant to be a step-by-step manual, nor is it an exact recipe to follow. Rather, it contains the overall approach, principles and recommendations to help guide the design of your own social prescribing initiatives. The key considerations and examples outlined here will help you evaluate your team's readiness, assemble your resources, design and plan your project, and develop a strategy for iterative measurement, improvement, and knowledge-sharing.

This guidebook emerged from practices and lessons learned through the Alliance for Healthier Communities' _Rx: Community – Social Prescribing in Ontario_ pilot. It reflects the combined experience of a very diverse group of Community Health Centres (CHCs), with a shared focus on health equity, health promotion, and community development, while situated in unique contexts and different implementation approaches.

Though based on the experience of CHCs, the principles we describe are generally transferrable, and we have tried to envision how they might apply in a variety of primary health care settings. As you localize social prescribing for your own community, you will likely experience challenges and considerations not addressed here, and thus it is important to be part of a Community of Practice where knowledge and learnings can continuously be shared, and to collaborate towards a more integrated, wellbeing-focused health system.

This guidebook was developed with interprofessional teams in mind. It assumes the presence of internal or partnered human and organizational resources that can be allocated to social prescribing, such as filling the role of a social prescribing navigator and supporting the development of "social prescriptions."

If you are a practitioner who does not work in an interprofessional team, consider connecting to one through TeamCare. TeamCare allows practitioners who do not work in team-based settings to connect their clients to integrated clinical and social care through participating community health centres and community-led family health teams.

Companion document:

- Rx: Community – Social Prescribing in Ontario, Final Report

Additional resources:

- Closing the Distance, a quick reference guide for ramping up social support in comprehensive primary care setting during the COVID-19 pandemic.
- Rx: Community – Social Prescribing in Ontario webpage, with introductory video, webinar recordings, resources, and media articles.

OVERARCHING PRINCIPLES

Social prescribing is not a one-size-fits-all technique. It is an approach to integrating clinical and social care that is:

- **Person-centred.** The social prescribing client is viewed as a whole person. They are characterized not only by their complex needs but by their unique goals, passions, and gifts.
- **Strength-based.** Clients are encouraged and supported to share their gifts through participation in peer support groups, volunteering with community partners, and even leading groups. Social prescribing empowers clients to take a more active role in managing their own health.
- **Co-created.** Clients work in partnership with their providers and social prescribing navigators to design a social care plan that meets their needs and utilizes their gifts, and they are supported in implementing their plan.
- **Community-led.** Social prescribing is about building individual and community resilience by supporting clients to become more connected to their communities and peers.

Adopting this approach may require some effort, especially if you are used to seeing clients as "patients" and focusing on their needs. Successfully implementing a social prescribing program requires openness to organizational culture change and supporting both staff and clients to collaborate together in new ways.

Commitment to *health equity* and an understanding of the *social determinants of health* are also essential to success in social prescribing. Effective social prescribing includes working with clients to remove the barriers they face to health and wellbeing. Some of these barriers may be structural, such as food insecurity, inadequate transportation, housing insufficiency, or low income. These exist alongside – and intersect with – other barriers, such as social isolation, marginalization, and a lack of community belonging. As you consider social prescribing options, ensure that they address these barriers. Consider, also, what barriers might make it difficult for clients to participate. Do the programs include and centre marginalized people? Are they cost-free? Accessible to people with disabilities? What supports can you provide to make it easier for clients to take part?

Social prescribing requires a *structured pathway* to connect social care to clinical care. Social prescriptions begin with a conversation between a client and a health provider. Once the prescription has been issued, the client works with a social prescribing navigator who co-creates a social care plan and maintains regular communication with both the client and the provider. This allows social care, when appropriate, to become part of that client's treatment plan. It allows the team to record and track social interventions alongside clinical interventions. The provider is kept informed of the client's progress, monitors the impact of the social prescription, and can recommend changes if necessary.

IMPLEMENTATION PROCESS

Necessary starting conditions

Before you implement a social prescribing program, ensure that the necessary foundation is in place. What's needed for a social prescribing program to be successful?

- Strong **organizational leadership** and committed management support.
- A culture of creative, **strength-based problem-solving** and innovation.
- The willingness and capacity to **reallocate staff and organizational resources towards** the social prescribing initiative.
- A **commitment to working collaboratively** with interdisciplinary teams, community organizations, and clients.
- A **commitment to continuous learning** and measurement of processes and outcomes related to social indicators.

Keeping in mind what social prescribing is and isn't

Social prescribing is:	Social prescribing is not:
A tool that complements, supports, and advances good medical care, investment in community, and public policy to address social determinants.	A replacement for medical care, for investment in community, or for public policy to address social determinants of health.
Viewing individuals holistically, as people with challenges and gifts.	Viewing individuals as solely patients with needs.
Integration of healthcare and social supports.	Only navigating the formal healthcare system; or social connecting between friends and community groups.
Supporting people to overcome challenges and barriers to access social supports and community interventions.	Medicalizing the social determinants of health.
Asking "What matters to you?"	Asking "What's the matter with you?"
Co-creating solutions with clients, staff, and community.	A prescription pad.
A structured, supported pathway with intentional data collection.	Ad-hoc conversations.
A culture change that provides a new way to think about and delivery healthcare.	An add-on to traditional models of care.

Implementation steps

There is no single, ordered way to build a social prescribing program. It is a non-linear, iterative process. The following sections are organized into loosely consecutive steps, but may be reordered and repeated, depending on need and capacity.

Step 1: Initiate planning and resourcing

Organizational commitment and strong management support is a precondition for launching social prescribing. Key considerations in the initial planning stage include....

Assemble Resources

Core implementation team: Identify one or two key staff members to be the "point people" who will move the initiative forward. Ideally, they are existing staff with good knowledge of the organization's processes and team dynamics. They should be innovative and passionate about this work. Their existing roles and responsibilities may be reallocated to give them explicit accountability and dedicated time to support the implementation of social prescribing processes.

Staff circle: Form a small group who will support the implementation of social prescribing processes. In a small organization, this may be the entire staff team. In a larger organization, this circle consists of staff who are representative of the interdisciplinary staff complement. This staff circle advises and supports the implementation team in testing, modeling and championing social prescribing. They should ideally be self-selected staff members, motivated by existing interest.

Other resources: Consider what resources are available for social prescribing, and what additional resources may be desired. Can existing staff roles be reallocated to provide some dedicated time for social prescribing navigation? Are there existing supports and programming that can be prescribed? Are there reserve funds, or local funding opportunities, that can enable navigators to support client access to social prescriptions, such as transportation or art supplies?

Resourcing examples in Rx: Community pilot sites

Guelph CHC allocated existing resources to form a new part-time Community Connector position for dedicated social prescribing navigation.

South Georgian Bay CHC applied for and received a small grant from the local hospital to fund materials and supplies for volunteer-run programming.

Country Roads CHC appealed to the community to collect a "flex fund" to help remove immediate barriers for clients to participate in social prescriptions, such as supporting transportation for low-income clients.

Gather Knowledge

Compile information that will inform implementation. This may include reviewing client data and consulting staff to identify the target population; identifying existing strengths and gaps in the organization in addressing social determinants of health; understanding the existing client journey between clinical and social care; performing rapid asset mapping of the community to understand existing resources and gaps and identify potential partners; and understanding existing data measures and collection processes.

Step 2: Develop the social prescribing pathway

The key elements of every social prescribing program are the clients, provider, social prescribing navigator, social prescriptions, and a structured data pathway. Please see the Rx: Community Final Report for detailed description of each of these elements and how they all fit together. As you assemble these elements, be sure to consider:

Objectives & priority population

What are the main objectives for your organizations, and how will you know that you are moving towards success? For example, your goals may be to improve collaboration between interdisciplinary teams, develop specific local partnerships, and increase client engagement in social activities.

Consider also if you will choose a particular population to focus on as the first stages of your social prescribing program. It may be isolated seniors, newcomer families, youth, or simply anyone who could benefit from increased social connections in their life.

Roles and responsibilities

Help staff understand how each of their roles fit into the social prescribing pathway. Who will refer clients? Who will track referrals? Who will support navigation? Who will support volunteers co-creating programs? How will information be fed back to the team?

> ### Examples of different pathways within comprehensive primary care teams
>
> Organizations need to create a pathway that is best suited to their unique context, needs and capacity.
>
> West Elgin CHC has an existing Systems Navigator staff, whose role was expanded to include functioning as a social prescribing navigator as a single point of contact to receive clinical referrals and follow up with referred clients.
>
> Centretown CHC assembled an interprofessional staff team where each team member is responsible for referring their clients directly to non-clinical resources and following up with them.
>
> Carea CHC has developed a pod model, where each pod is composed of a primary care provider, health promotion / community development staff, and a therapist. Each pod supports the clinical and social needs of their clients together.

The scope

Be clear about what your social prescribing initiative is and is not offering. This will depend on your organization's priorities and capacity. A smaller centre may be able to offer 'light' support, connecting clients to social groups in the community with a warm handoff. A larger organization with many partners may be able to offer a wider range of supports such as legal advice, tax clinics, and home visits. Having a clear sense of this and communicating it clearly to

your staff will help them understand what social prescriptions are available and who will best benefit from them.

Closing the loop

It's important to clarify who will follow up, and how, with clients, staff and other stakeholders, report progress, and document lessons learned.

Iterative improvement

If you wait until you have the perfect pathway before implementing, you will never start! Commit to rapid prototyping or the Plan-Do-Check-Act cycle to iteratively improve the pathway based on testing initiatives and collecting feedback.

Data tracking

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

Client	Prescriber	Social prescribing navigator	Social prescription
Individual with social and medical needs, interests, and gifts	Healthcare provider identifies non-medical issues and makes a social prescription - a referral	Connects individual to appropriate resources based on self-identified interests and needs, and supports their journey to wellbeing	Individual connected to social and community supports, with invitation to engage, co-create, and give back

Key components of a social prescribing pathway

Step 3: Staff consultation and engagement

Implementing a social prescribing program will require a culture shift. Organizations that have mainly focused on clinical care may have minimal experience in addressing the social determinants of health. Some may have robust social programs but lack experience with integrating clinical and social care, while others are not in the habit of rigorously measuring processes and outcomes. Some staff may be anxious that social prescribing will increase their workload or distract providers from clinical work. To enable a culture shift, it is important to continuously communicate the goals and processes for social prescribing and to be clear about how these will further the goals of the organization and improve the health of their clients. Having some social prescribing "champions" in your centre can help generate and maintain enthusiasm among those who are initially hesitant to accept change.

Below, we expand specifically on engaging healthcare providers and social prescribing navigators in the implementation of social prescribing.

Healthcare Providers

Health care providers are an important "door" for identifying when individuals have social needs and connecting them to non-medical supports where appropriate.

Clinical champions

Identify key clinical and interprofessional staff who are already keen to be involved. They can act as informants – helping to provide insights into what barriers exist and what would help facilitate participation. They can also be valuable advocates to their colleagues and help to increase engagement.

Client data

Client data are useful tools to help understand trends and client needs. Client appointment data over the previous 6 to 12 months can reveal the frequency of repeat visits. Focusing on the most frequent clients, the reasons for their visits, and their sociodemographic data (if available), health providers can help identify those who may benefit from non-clinical social and community supports in addition to, or instead of, clinical appointments.

Screening for Social Determinants of Health

Social Determinants of health (SDOH) are the "broad range of personal, social, economic, and environmental factors that determine individual and population health." They include

socioeconomic characteristics like income and education; experiences of discrimination or trauma; physical environment; and social supports.[1]

The list below contains some of the major social determinants of health for people living in Ontario. There may be others of particular relevance to people in your community.

1. **Social and Community Context** – e.g., social inclusion or isolation, experience with stigma, relationships with family and non-family members.

2. **Economic Stability** – e.g., food security, access to safe and secure housing, employment conditions, unemployment, and job security.

3. **Education** – e.g., education and literacy level, language competency.

4. **Neighborhood and Built Environment** – e.g., housing quality, neighbourhood safety, transportation, susceptibility extreme weather events, availability of safe public spaces.

> **Read more about Social Determinants of Health**
> - [What are social determinants of health?](), Canadian Public Health Association
> - [About social determinants of health](), World Health Organization

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,[2] Benefits Screening Tool,[3] Loneliness Screening Tool,[4] and Fall Prevention Screening.[5] 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. Our interviews with clinical providers in UK and in Ontario suggests that SDOH can be surfaced naturally during clinical appointments.

Steps for health providers

Recognize the clients' non-medical needs.

> *"Your well-being matters. In addition to treating the medical aspects of your health, I would like to provide whatever non-medical support I can to achieve a greater overall health outcome."*

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[1] 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

[2] Centre for Effective Practice (November 2016). Poverty: A Clinical Tool For Primary Care Providers. Toronto: Centre for Effective Practice.

[3] http://prospercanada.org/Our-Work/Taxes-and-Access-to-Benefits/Benefit-Screening-Tool.aspx

[4] 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

[5] North East LHIN. Stay On Your Feet (2017). Retrieved from http://www.nelhin.on.ca/stayonyourfeet.aspx

The following questions can help guide conversations to surface SDOH:

1. "How do you spend your time?"

2. "Can you tell me a little bit about your current living situation?"

3. "Have there been times where you've felt lonely or isolated? Can you tell me about it?"

4. "When you are going through difficult times, who are some of the people you rely on for support?"

5. "Any there any places in your community/neighbourhood where you feel like you belong?"

Acknowledge that health and well-being are complex. Sometimes it takes a team of caring professionals and a community of resources to support your patients' needs. Introduce and discuss with your patient the idea of social prescribing and its ability to help address the non-medical concerns that may be impacting their health and well-being.

> *"There are many things that affect our health – I am one supportive resource that can help you address your medical concerns, but there are other people in our community who may also be able help you with other aspects of your health."*

Determine the next steps on how to proceed with social prescribing. These steps may differ depending on the needs of your client and the capacity of your organization.

Next steps may include:

1. If the client is **hesitant or facing barriers**, connect them with a social prescribing navigator who can have additional conversations and provide follow-up support and encouragement.

2. If the client is **self-motivated** and able to attend programs and access resources independently, provide sufficient information for the client to explore further by themselves. Also consider suggesting the client become a volunteer to contribute their gifts and passions to the community.

3. **Document** conversations and referrals in the patient's Electronic Medical Record (EMR).

Examples of screening questions	
West Elgin CHC developed social prescription reminder card to help prompt providers during clinical appointments. These inform the "reasons for social prescribing referral" (below) that are entered into the Electronic Medical Record and passed to the Navigator. **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 / Alliance pour des communautés en santé	Carea CHC's Client Navigation & Support Program includes the following script to help guide providers (questions are to be chosen as appropriate, not that all will be asked within one encounter): A. Do you feel you are coping with the current COVID-19 situation? B. Are you feeling lonely or isolated? C. Are you struggling with your mental health? D. Are you struggling to access services? E. Do you need help with any of the following: • Accommodation / Housing • Food Security / Nutrition • Social Supports • Parenting Supports • Quitting Smoking • Employment Insecurity • Individual or Family Counseling Support • Parenting Supports • Maintaining Healthy Relationships F. Would you like me to connect you with a Health Promotion staff who can call you and see if we can provide some support?
See also this prescription form used by Alvanley Family Practice in Stockport, England	

Social prescribing navigators / link workers

Social prescribing navigators, sometimes called link workers, help social prescribing clients to connect with the most appropriate social-care resources or co-create new ones. They understand what barriers might prevent a client from accessing their social prescription and work with that client to remove them.

Having a staff member who is explicitly responsible for navigation increases capacity for follow-up with clients, feedback of results to the prescriber, and proper data-tracking and record-keeping. The more time a navigator is able to commit to this role, the better they will understand the client and the social resources available.

Who can be social prescribing navigators?

Within the CHC sector and the wider healthcare system, there are many existing positions that may include, or can be expanded to include, aspects of supporting social needs. These include system navigators, community connectors, link workers, health coaches, and outreach workers.

Navigators can be people from different professional backgrounds. These include nurses, occupational therapists, and social workers. There are also existing roles that can be easily adapted to become a social prescribing navigator, such as community outreach workers and health promoters.

A social prescribing navigator may be employed by a health organization or by a community or voluntary agency. Experience gained in the *Rx: Community* pilot suggested that irrespective of employer, it was important for the navigator to be co-located with the prescriber at least some of the time. This co-location fostered stronger integration with the prescribing team, and it reduced barriers to participation for clients who were already familiar with the health setting.

What does a social prescribing navigator do?

Different initiatives may utilize a spectrum of support, depending on client needs and available resources.[6] While the exact work of the navigator can vary, they generally:

- Focus on "what matters to you" instead of "what's the matter with you".
- Provide intentional support for clients to access non-medical services that may include goal-setting, referral, accompaniment, follow up, and close-out conditions.
- Help establish a long-term relationship between client and formal/informal resources.
- Listens deeply and is guided by the client to co-produce local solutions.
- Recognizes people's abilities and works from an empowerment perspective.
- Understands the SDOH and has deep knowledge of non-medical resources.

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 a specific need or achieve a specific goal. There is usually no formal follow-up.

- **Medium**: Referrals are made to address various needs. This may involve light assessments and formal feedback to the referrer.

- **Holistic**: A comprehensive approach where referrals are made in a formalized way. The social prescribing navigator co-designs solutions with clients and provides fulsome support to access resources, and follows up with the client and the referrer.

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[6] Kimberlee, R. (2016). Gloucestershire clinical commissioning group's social prescribing service: Evaluation report.

A full understanding of the knowledge, skills, and competencies required for this emerging role is still developing. Some key skills identified so far are listening deeply, showing empathy, and building strong relationships.[7]

Key considerations in developing the navigation process

The role of the navigator differs depending on organizational and community capacity and the needs of the client. The following are questions to consider as you define the processes that are suitable to your context:

- What spectrum of navigation support will you provide, and how will you communicate this to staff and clients?

- How will you receive and document referrals?

- Where will you meet clients? What will be documented in your meetings?

- How will you follow up, and how often? How long will support continue? This will vary depending on client needs and the level of support your model provides.

- What are the conditions for 'closing' the referral? That is, how will you know when client's goals have been reached? Or, how will you determine if the client's goals are beyond the scope of your role and organizational capacity?

- How does the navigator role interface with other interprofessional team members, organizational resources, and external partnerships?

Additional resources for social prescribing navigators

NHS England is beginning to develop formal accreditation and guidelines for the navigator/link worker role, with the understanding that there is significant variance in practice across contexts. See:

- Social prescribing and community-based supports: Summary guide, NHS England
  See especially, Appendix A: Link worker job description

- Social prescribing link worker welcome pack, NHS England
  See especially, Annex 1: Personalised care and support plan – template

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[7] National Association of Link Workers. (2019). Getting to know the link worker workforce – Understanding link workers knowledge, skills, experiences, and support needs. Retrieved 02 05 2020, from https://www.connectlink.org/wp-content/uploads/2019/04/Released_NALW_link-worker-report_March-2019.pdf

Step 4: Engage community partners in social prescriptions

Leverage the strength of cross-sectoral partners in the local community to provide social prescriptions for clients. This may include material support, such as navigating housing applications, legal advice, tax clinics, and healthy food; healthy living programs, such as walking groups, exercise classes, and cooking classes; and social activities and support groups, such as coffee clubs, knitting groups, and bereavement support. Many programs offer a mixture and can meet multiple interests and goals.

Asset mapping: get to know your community

Work with your clients and members of the broader community to identify the existing strengths of the community through tools like an asset map. What organizations already exist that provide health and/or social care for members of your community? What facilities and structures exist that might be helpful? What community resources might you draw on to make social prescriptions more accessible?

Information and referral organizations like Ontario 211 and thehealthline.ca can be a helpful resource in getting a scan of the community, and they can function as an ongoing virtual asset map for the community.

> **Read more:** There are many resources and tools for asset mapping. For example, see Asset Mapping Tools by DePaul University Asset-based Community Development Institute.

Build and co-create partnerships

Identify and connect with potential partners in other disciplines and sectors who may undertake this project with you. If you are a partnership broker or part of an agency that does a lot of inter-sectoral work, introduce your health care, social, and cultural partners to one another. If you are already participating in other care-integration/coordination strategies, such as TeamCare, consider incorporating Social Prescribing into that program.

For examples of innovative partnerships across municipal, food, environment, arts and other sectors in various communities, see *Rx: Community Final Report, Appendix C: Spotlights on Social Prescribing Sites*.

Considerations when forming partnerships

When connecting clinical clients with social prescriptions at external agencies, some key considerations emerged common across *Rx: Community* sites.

Transportation. Where public transportation is available, a client may struggle with the cost of transit. In suburban and rural areas where there is no public transportation, clients may be

unable to get to activities. Some clients may also experience discomfort in navigating to an unfamiliar location.

Activity cost. The clients who stand to benefit most from social prescribing are already in socially and medically precarious situations, and many are on low or fixed incomes. Activity cost can be a significant barrier to participation. Look for activities that are low-cost or free, or look for ways to have the costs waived for social prescribing clients.

Data-sharing and follow up. There is often a communication gap between the client's medical home and community partners. While this is somewhat mitigated by having a navigator operating in the more holistic end of the spectrum, further discussions around data-sharing and interoperable digital solutions are needed.

Risk. Not all organizations are suitable partners for socially and medically complex individuals. Their programs may be delivered in ways that are not safe, culturally appropriate, anti-oppressive, or trauma-informed, and this presents a potential for harm. It is important to vet partner organizations and partner-led activities.

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

Step 5: Engage volunteers in co-creation

This component of social prescribing is transformative in empowering clients and creating a sense of community and belonging, but it is dependent upon organizational capacity to support this work. If there is organizational capacity and when there is organizational readiness, invite clients and community members to become co-creative volunteers (called Health Champions within the Rx: Community pilot) who come alongside organizational staff to identify needs and create solutions. In some organizational contexts, this step may be more appropriate via external partnerships.

Principles of co-creation

The Rx: Community pilot adapted this approach with guidance from Altogether Better, which has developed a strong framework around Collaborative Practice and working with co-creative volunteers called Health Champions. This approach is a shift from a traditional view of volunteering. Instead of designating pre-determined roles, Health Champions work alongside staff to identify needs within their communities and how they would like to address them based on their interests, passions and skills. Rx: Community embedded a health equity lens in which clients of all capacities are invited and supported to participate. This may require thinking outside of the realm of what has been done at your organization and may challenge existing volunteer processes. For example, re-assessing which processes are absolutely necessary (e.g., police checks) and which ones can be streamlined, as well as reversing traditional power dynamics to support clients to guide and lead activities and programs.

Process of working co-creatively with clients

The below are general recommendations on how to get started, based on the experience of Rx: Community pilot centres and guidance from Altogether Better:

1. Invite clients to become volunteer health champions.

Send out general invitations to all clients in addition to prescribing clients to volunteer. Try to use minimal screening while also being mindful in inviting anyone that would be a risk to themselves or others.

2. Host a welcome workshop.

Hold a welcome workshop for clients who responded to your invitation. This workshop contains two portions. The first portion is dedicated to allowing clients to meet each other and discussing how this work is based on co-creating solutions for their communities, not being delegated pre-determined tasks. In the latter portion of the workshop, invite staff to come meet with the champions, as this will demonstrate the organization's support for this work.

3. Meet again 2-3 weeks later.

Hold a meeting no more than 2-3 weeks after the welcome workshop to keep the momentum of interested clients high. In this meeting, clients should further discuss their ideas. Staff should

use this as an opportunity to discern which of these ideas your organization can support while also being open to taking risks and trying something different.

4. Meet frequently at first.

Using a health equity lens (i.e., inviting clients with varying abilities) will require meeting with champions on a monthly basis until they feel ready to be on their own. The time required for champions to be ready will vary depending on the amount of support required and your organization's capacity.

5. Provide ongoing support.

Once champions have been running their programs, we recommend meeting on a quarterly basis to discuss what's working and identify changes that need to be made. Staff should also provide ongoing feedback for their contributions, as this will motivate champions to continue volunteering.

Additional reading on engaging clients co-creatively

- Read Altogether Better's evaluation report, <u>Working Together to Create Healthier People and Communities</u>, for a deeper look at how they worked with health champions.

- For examples of volunteer-initiated programs that were formed in Ontario, from bereavement support groups to weekly crafts drop in, see <u>Rx: Community Final Report, Appendix C: Spotlights on Social Prescribing Sites</u>.

Step 6: Data collection and evaluation

Social prescribing is a driver for integrated healthcare delivery. While numerous studies about its efficacy have been conducted in the UK, there is much more to learn and understand about its efficacy and how to get the most value from a social prescribing initiative. This makes it important to formally capture the process of social prescribing and its impacts on clients, providers, and the health system.

Understanding clients' healthcare journey

To follow clients' journey holistically, and provide understanding on who is being referred, why, for which activities and any impacts as a result of the intervention, we suggest the following to be tracked:

- A client identifier.
- The reason for the referral – for example, social isolation, depression, or food insecurity.
- The type of referral – for example, coffee and colouring group or physical activity such as a walking group.
- Referral uptake. Did the client follow through with the social prescription?
- Clients' sociodemographic - specifically, their age, sex, income, education, and ethnicity/race.
- Outcome measures at the client, provider, and health-system level. These could include clinical measures of health, patient-reported outcome measures (PROMs), client and provider satisfaction, or health system utilization.

Measuring outcomes

Outcomes can be measured around the quadruple aim: improving client experience, improving client outcomes, improving provider experience, and lower cost of care.

To measure the impact of social prescribing activities at the individual level, we recommend using a validated survey tool designed to detect changes over time, as well as conducting focus groups or interviews.

There are numerous tools available as outlined in the document mentioned above; however, we advise you to limit the number of tools you use in order to minimize the burden of measurement. While it may be tempting to measure all possible outcomes in fear of missing findings, overburdening clients and staff with numerous surveys and questionnaires should be avoided as it is a barrier to data completeness. We suggest using one or two tools that would be reflective of possible outcomes for your context. For example, you might use the loneliness measurement tool if loneliness is a known issue in your respective population.

Additional surveys can be utilized to capture client and provider experiences. Focus groups and interviews are also effective supplements for tools for capturing outcomes that surveys miss. They can also help you understand the client's social prescribing journey as a whole, from their

first clinical appointment to participating in their prescribed activity. This will help you identify barriers or challenges your clients experience along the social prescribing pathway.

We further suggest collecting information at the health-system level to assess if there are any changes in healthcare utilization, including tracking frequency of appointments, hospital admissions, and visits to Emergency.

Collecting this data will help you assess the efficacy of your social prescribing initiative, identify gaps, and improve quality of service delivery. It will also allow you to contribute to the growing body of evidence around social prescribing.

Additional reading on engaging clients co-creatively

- NHS England's Common Outcomes Framework identified a list of outputs that should be measured.
- The University of Westminster developed A Guide to Selecting Patient Reported Outcome Measures (PROMs) to support decision making when selecting appropriate outcome measures for research, evaluation and monitoring of social prescribing.

How best to collect data?

It is vital that you consult with all staff (clinical, interprofessional, health promotion, etc.) to identify how data will be tracked, by whom, and when. Ensure that all staff participating in the intervention are aware of what data they are responsible for tracking and that they are adequately trained to do so. If possible, remind staff at meetings about tracking. This will not only prompt staff to continue to make and track referrals, but it can address any challenges or gaps that emerge. Regarding client outcomes, consider when to follow up with clients. We suggest collecting a baseline at the start, and in six months post referral.

Develop a Data & Evaluation Strategy

Work with your partners to develop or adapt systems for sharing data about social prescriptions at the individual and community level. The more interoperable your systems are, the easier it will be to track social prescriptions and evaluate their effectiveness.

Develop shared data standards and evaluation metrics. Develop processes for measuring both clinical and patient-reported health outcomes. If possible, have shared or interoperable systems for recording and accessing this data.

Finally, don't forget to develop shared policies and procedures for keeping your data safe and protecting client privacy and anonymity as required.

Step 7: Communicate and share learning

Successfully embedding new innovations and practices requires continuous communication with staff, partners, clients, and the public. Rx: Community pilot centres also found value in sharing challenges and lessons learned with other practitioners in a community of practice. They identified this as a key way to support implementers in overcoming challenges and a catalyst for new ideas.

Continuous learning and iterative improvements

As your social prescribing initiative develops, continuously evaluate your processes, the experience of participants and stakeholders, and the outcomes. Establishing a regular schedule for communicating the results and lessons learned back to the team and to stakeholders is important to help maintain engagement and momentum for your initiative, and enables you to use these learnings to make iterative improvements.

Share best practices and contribute to evidence base

Social prescribing can provide a common framework for how to collaborate across teams and sectors to provide integrated health and social care to clients. Form or join a community of practice where you can draw on the expertise of others, contribute your own insights, and solve problems collaboratively with your peers. Finding opportunities to share your experiences and evaluation results broadly will help to strengthen the evidence base and improve the delivery of integrated care that is personalized and holistic.

Foster a supportive policy environment

Social prescribing works best in a context of strong primary health care, adequate investment in the community supports and services offered as social prescriptions, and robust social policy aimed at addressing the broader social determinants of health. The success of social prescribing in the CHC context is largely due to the presence of enabling infrastructure: a focus on the social determinants of health, robust community programming, and a digital tracking system.

For social prescribing to spread and continue to be successful, this context needs to be available across health and social care sectors. Policymakers, funders, and Ontario Health Teams have important roles to play in creating this context. They must recognize that social needs and social determinants are vital to the healthcare system of the future, and they must demonstrate it through supportive policies, stable funding, and active collaboration with the health and social care sectors.

FOR ADDITIONAL READING

Building partnerships for integrated care

- [Complex Construction: A Framework for Building Clinical-Community Partnerships to Address Social Determinants of Health](#), United Hospital Fund

Role of healthcare in addressing loneliness and social isolation

- [Connected Communities: Healthier Together](#), 2017 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario
- [Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System](#), Consensus Study Report led by the National Academies of Sciences, Engineering, and Medicine
- [A Portrait of social isolation and loneliness in Canada today](#), survey by the Angus Reid Institute

Scientific Articles

- Fancourt, DE and U. Tymoszuk (2019). [Cultural engagement and incident depression in older adults: evidence from the English Longitudinal Study of Ageing](#). *The British Journal of Psychiatry*.
- Polley, M., M. Berotti., R. Kimberlee, and K. Pilkington (2017). [Review of evidence assessing impact of social prescribing on healthcare demand and cost implications. Report](#). University of Westminster.
- Mamtis, M., S. Sanford, D. Ansara, and B. Roche (2019). [Promoting Health and Well-Being through Social Inclusion in Toronto: Synthesis of international and local evidence and implications for future action](#). Report. Toronto: Wellesley Institute.
- Fancourt, D; Steptoe, A; (2018). [Community group membership and multidimensional subjective well-being in older age](#). *Journal of Epidemiology and Community Health*, 72 (5): 376-382.
- Wildman, J. M., N. Valtorta, S. Moffatt, and B. Hanratty (2019). ['What works here doesn't work there': The significance of local context for a sustainable and replicable asset-based community intervention aimed at promoting social interaction in later life](#). *Health and Social Care in the Community*. 27: 1102– 1110.
- Payne, K., E. Walton, and C. Burton (2020). [Steps to benefit from social prescription: a qualitative interview study](#). *British Journal of General Practice* 70(690): e36-e44.
- Pescheny, J., G. Randhawa, and Y. Pappas. [Patient uptake and adherence to social prescribing: a qualitative study](#). *BJGP Open* 2(3).
- Husk, K., K. Blockley, R. Lovell, A. Bethel, I. Lang, R. Byng, and R. Garside (2019). [What approaches to social prescribing work, for whom, and in what circumstances? A realist review](#). *Health & social care in the community*. 28:309-24.