Social Prescribing in Practice
June 17, 2020

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Housekeeping

Click the orange arrow to open up your webinar control panel.

To minimize background noise, we will keep all attendees muted throughout the presentation.

Questions? Type them in the "Questions" box. We will address them during the Q&A period at the end of the webinar.
Overview

• Continuation to May 27, 2020 webinar: Meeting Social Needs in an Integrated Health System: Social Prescribing During COVID-19 and Beyond - Slides | Recording

• Deep dive on practical implementation in the context of Community Health Centres + examples

• Questions and discussion

• Followed by: Lunch & Learn: Social Prescribing in Research on Jun 24, 2020 @ 12:00 pm https://attendee.gotowebinar.com/register/374104840607315726
Social prescribing: A pathway to integrate health and social care
Key components: Identification and referral

Individual
- Have social and medical needs
- Have interests and gifts to contribute

Health Provider
- A trusted relationship with people facing higher barriers
- Can identify those who are in need of support
- A ‘door’ to supporting individual’s non-medical needs

Having the primary care provider suggest something else that will help instead of a prescription – 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
Example in practice | Identification and referral

Provider prompt card @ West Elgin CHC

Client Care Pandemic Support Check-in Call @ Guelph CHC

- Do you feel like you have the information you need about the coronavirus?
- How are you spending your time now?
- Do you have family, friends or neighbours that you are keeping contact with over the phone?
- Do you have any needs related to food access?
- Do you have secure income at this time?
- Do you have other health care needs or other practical needs that you are concerned about (eg, medication access, hygiene items, etc)?
Example in practice | Identification and referral

Provider script @ Carea CHC

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:
   1. Accommodation / Housing
   2. Food Security / Nutrition
   3. Social Supports
   4. Parenting Supports...
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?

Upstream Lab COVID-19 Social Care Guidance

1. Will you or your household find it hard to pay for basic expenses in the next 4 weeks?
2. Is there a risk you or your household won’t have food or be able to pay for food in the next 4 weeks?
3. Are you currently homeless or at risk of losing your housing in the next 4 weeks?
4. Are you alone, and do not have family/friends who can help you during this time?
5. Do you have concerns about your (or your children’s) physical safety?
Key components: Identification and referral

- ‘Super clients’ or ‘friendly faces’ list
- Each interdisciplinary team identify 1-5 person to start
- For clients who are not extremely complex but may be at risk

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Key components: Navigator / Link Worker

“What matters to you?” instead of “What’s the matter with you?”

- Provides intentional support for clients to access non-medical services that may include goal-setting, referral, accompaniment, follow up.
- Listens deeply and is guided by the client to co-produce local solutions.
- Recognizes people’s abilities and works from an empowering perspective.
- Has fulsome knowledge of internal and external non-medical resources.

“We would go to a program with clients to introduce that program to them, because there is a fear of the unknown... 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.

**Light:** Referrals are made to address a specific need or achieve a specific goal. Usually no follow up.

**Moderate:** Referrals are made to address needs through partnership with a community organization. May involve light assessments and formal feedback to the referrer.

**High/Holistic:** The most comprehensive. Referrals are made in a formalized way. Link Worker co-designs solutions with client, and provides fulsome support to access resources.

BMJ: Social prescribing clinical update  [https://doi.org/10.1136/bmj.l1285](https://doi.org/10.1136/bmj.l1285)
Example in practice | Navigator / Link Worker

**Direct referral @ Centretown CHC**

- Physician
- Nurse
- Health promoter
- Outreach worker
- Volunteer coordinator
- Dietician
- + others

**Triaging @ Guelph CHC**

- Clinical encounter
  - Low to medium complexity
  - Multiple co-morbidity, high complexity
- Community Connector
- Health Guide
Example in practice | Navigator / Link Worker

System navigator @ West Elgin CHC

Pod model @ Carea CHC

PCP

Direct referral

System Navigator

Primary care

Therapist

HPCDS Partner
NHS Sample Personalised Care & Support Plan

Completed together by Link Worker & Client at start:

1. What matters to me
2. How best to support me, what people need to know about me and my life
3. Any health conditions that agencies need to know about
4. My goals
5. Summary of support that I am being connected to, including what I can expect from support
6. What I can do to support myself to meet my goals
7. Review – when shall we check how it’s going?
Digital referral platforms?
Key components: Social Prescriptions

• Internal programs and supports
• Cross-sector partnerships
• Co-creating with volunteers: Clients are invited and supported to work alongside clinical staff to identify needs and co-create solutions.
Cross-sector partnerships

• Good Food Organizations
• Arts & culture
• Library
• Older Adult Centre
• Businesses
  + more
Co-creating with Health Champions

“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

1. Wide invitation to clients and community
   • Posters
   • Phone calls + mail
   • Staff referral
   • Existing volunteers

2. Welcome workshop with community and staff

3. Regular meetings with volunteers/health champions to create programs
Key components: Data & evaluation

What we tracked:

1. Client identification  
   (including socio-demographic)
2. Reason for referral + type of referral
3. Referral uptake
4. Health outcomes
5. Client and provider experiences

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. 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.”

Nurse & System Navigator, South Georgian Bay CHC
Value add | A intentional pathway & deeper integration between teams

What we have been doing informally, but we’re structuring it and framing it formally now and do it in a more pronounced way.

Gave us momentum to work in a really integrated way across different positions in the centre.

Having conversations with the providers was really, really helpful because it got them to look at just all the different ways we can support them, not just medically.
Value add | Working in co-creative ways and increasing community capacity

Increase the capacity of the community to have the supports that are needed.

Staying true to letting volunteers drive the initiative was probably one of my biggest takeaways. Inviting them to give to their community in a way that meets them where they’re at has been just so refreshing and lovely.
Tracking data and impact, and a common language to share

The evaluation stuff is really important, because it validates the work that we’ve been doing all these years.

It’s a way for us to really talk about and measure what we’ve been doing.
Rapidly scalable and meets health systems goals (personalized + integrated care)

Social prescribing is:
• Connecting existing resources between health care and social support
• Adapted to community need
• Client centred and co-creative
• Especially relevant in COVID-19

What can broad implementation and scaling look like in Ontario/Canada?
What’s your role?

- **Alliance members**: Internal implementation and OHTs
- **Team-based primary care**: Signposting or referral to Navigator
- **Non-team primary care**: Referral to TeamCare
- **Public Health**: OHTs, local health partners, support regional conversations
- **Funders**: Support referral pathways, Navigators and digital integration
- **Community resource**: Support and prioritize SP in OHTs, reach out to local health partners
- **Digital**: Ensure databases talk to each other
- **Individuals**: Independent research, advocate, volunteer
Questions?

For more information, see Final Report: allianceon.org/Social-Prescribing
Thank You
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