Social Prescribing in Research
June 24, 2020

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Housekeeping

Click the orange arrow to open up your panel

Questions and Comments
Please type in the chat window circled in red throughout the meeting. Because of the large audience today, we’ll be keeping everyone’s lines muted.

Recording
This webinar and presenter slides will be recorded and shared.
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 evaluating social prescribing in the context of Community Health Centres

• Quick presentation from Dr. Amina Allalou from Vanier Hub

• Last 15 minutes for questions and discussion
Data tracking
Track client journey, follow up, and improve through a Learning Health System

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

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

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

Social prescription
Individual connected to social and community supports, with invitation to engage, co-create, and give back
1) How was SP implemented in CHCs?

2) What were clients and provider’s experience with SP?

3) What were the effects on client’s health and wellbeing?

4) What were the impacts on internal healthcare utilization?
Methodology
Implementation

• Call for participation – 11 sites were selected
• All sites attended training met with UK mentors
  • Operationalized their social prescribing project (link worker vs community champion vs hybrid)
• Community of practice was developed
• ‘Asset Map’ was developed
• On-going data support
• Sites had on-going support from UK mentors
# Data Collection

<table>
<thead>
<tr>
<th>Quantitative Data</th>
<th>Qualitative Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surveys:</strong></td>
<td><strong>Interviews and Focus Groups:</strong></td>
</tr>
<tr>
<td>• Organizational survey</td>
<td>• with clients at 3, 6, 12 months</td>
</tr>
<tr>
<td>• Experiential surveys with providers at 3, 9 months</td>
<td>• with providers at 12 months</td>
</tr>
<tr>
<td>• Health Outcome survey with clients at baseline and post-6 months</td>
<td></td>
</tr>
<tr>
<td><strong>EMR:</strong></td>
<td><strong>Field Notes:</strong></td>
</tr>
<tr>
<td>• Sociodemographic data</td>
<td>• Throughout duration of the pilot</td>
</tr>
<tr>
<td>• Referral patterns</td>
<td></td>
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<tr>
<td>• Utilization data</td>
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Key Outputs

- **147** PROVIDERS PARTICIPATED
- **1101** CLIENTS
- **3295** REFERRALS MADE
- **71** HEALTH CHAMPIONS
- **58** HEALTH CHAMPION CREATED PROGRAMS

Reason for Referral:
- Depression: 27.9%
- Anxiety: 37.2%
- Mental Health Symptoms: 8.8%
- Social Isolation: 19.2%
- Other: 6.9%
Key Finding #1: Improvement in Client Health

“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.”

- Participant, Rexdale CHC

<table>
<thead>
<tr>
<th>Client outcomes</th>
<th>% Change</th>
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<tr>
<td>Self-reported mental health</td>
<td>↑ 12 %</td>
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<tr>
<td>Sense of loneliness (Campaign to End Loneliness Tool)</td>
<td>↓ 49 %</td>
</tr>
<tr>
<td>Social support: Involvement in social activities</td>
<td>↑ 19 %</td>
</tr>
<tr>
<td>Self-reported sense of community belonging</td>
<td>↑ 16 %</td>
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Key Finding #2: Health Care Providers find SP Useful

<table>
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<tr>
<th>Health provider survey</th>
<th>Difference between 3 &amp; 9 months</th>
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</thead>
<tbody>
<tr>
<td>SP has improved client’s health and wellbeing</td>
<td>↑ 27 %</td>
</tr>
<tr>
<td>SP has decreased number of repeat visits by clients</td>
<td>↑ 37 %</td>
</tr>
<tr>
<td>Feel supported in referring clients</td>
<td>↓ 13 %</td>
</tr>
<tr>
<td>Sufficient resources are available to support SP</td>
<td>↑ 14 %</td>
</tr>
</tbody>
</table>

“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. It also helps us explain to our clients, and really looking at the client as a whole and exploring their interests. I find that’s the beauty of this approach.”

- Nurse, CSC du Temiskaming
Key Finding #3: Deeper integration and co-creation between clinical care, interprofessional teams, social support, and community

“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.”

Dietitian, Centretown CHC

[Co-creating solutions] gives me a feeling of, “you know what, you’re not useless.”

Client and peer leader, Guelph CHC
Limitations

Minimizing burden on clients and staff → Limited statistical analysis

No dedicated funding → Small sample size for health outcomes, issues with referral uptake, data incompleteness

Lots of data coming from a few centres → limited in looking at contextual differences

Positive experiences → Selection bias in data
Suggestions for Practitioners and Researchers

Track the client’s SP journey:

1. Client identifier
2. Type of referral
3. Reason for referral
4. Referral uptake
5. Sociodemographic data
6. Outcome measures
   a) Client Level - Examples of PROMs
   b) Provider Level
   c) Health Systems Level
Contributions to the Literature

Our contributions:
• Understanding how social prescribing could improve access to team-based primary care and community supports in Ontario
• Client engagement in care delivery
• How social prescribing could benefit people with barriers to access (e.g. DOH)

Future contributions:
• Health care usage
• Significance of actually receiving a prescription vs access to programs
• Figuring out what works and for whom
Thank You
Merci
Miigwech

To learn more:
www.allianceon.org/Social-Prescribing
Dr Allalou, Amina
June 24th 2020

The Museum & the Hub
Disclosures: No conflict of Interest

Acknowledgement: Dr Heather Dunlap, Esther Briner, Dr Alison Krentel, and Dr Sue Bennett (PI),

Grant: CPS
Improved social support network

Decreased loneliness

Sense of purpose

Increased motivation

Sense of accomplishment

Sense of accountability

Improved collaboration

Increased self-confidence

Source: The Alliance for Healthier Communities Final Report, March 2020
Social Prescribing Meets Social Pediatrics

① Museum visits
A Day at the Museum

Research Objectives

• To prescribe underserved and high needs families attending the Vanier Hub

• Explore thoughts and feelings experienced by children, youth, and caregivers with regards to the museum experience

• To better understand the previous access to community activities in Vanier Hub patient population
Method

• Pre-visit and post-visit interview with photovoice to include children’s perspectives
• Thematic analysis approach (Braun & Clarke, 2006)
• Basic demographic information collected via chart review
• Ethics from Children’s Hospital Eastern Ontario REB
Discussion

• Frequently used words: happy, fun, good
• Positive impact of connecting families and especially children, to cultural experiences through social prescribing
• Evidence for greater wellbeing among families when connected to social and community supports
• Findings will help promote access to cultural experiences
Next Steps

① Museum visits

② Museum Workshops
Thank you!

Questions? Feedback?