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Environmental Scan

Social Prescribing Initiatives in Alberta Primary Care Networks

Prepared by:
Adeola Adewara, Campion Cottrell-McDermott, Hanna McBain, Keji Mori, Madelyn Curle, Sarah Djuric

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GLOSSARY

- **Link worker:**
  - Link workers act as the community connectors; they help the client make a plan by dedicating the time and effort to better understand the client's concerns to address their non-medical concerns by linking the client to the relevant resource or support (National Academy for Social Prescribing, n.d.). Link workers can be involved on a referral basis from a licensed healthcare provider.

- **Primary Care Network (PCN)**
  - PCNs provide care to Albertans through a team-based model, including doctors, nurses, social workers, dietitians, and mental health therapists, to ensure all primary healthcare needs are met (Alberta Primary Care Networks, n.d.). Currently, there are 39 PCNs located throughout Alberta ensuring everyday health needs are met for almost 3.6 million Albertans (Alberta Primary Care Networks, n.d.).

- **Non-medical social need**
  - Non-medical social needs encompass any non-clinical needs, such as education, housing, social activities, financial support, mental health support, food programs, etc. (Alliance for Healthier Communities, n.d.).

- **Social determinants of health**
  - The social determinants of health are non-medical conditions that affect health and influence health inequities and include conditions like housing, income, race, age, education, food insecurity, etc. (World Health Organization, n.d.).

- **Social prescribing**
  - Social prescribing addresses the gap between medical needs and social care by connecting, or prescribing, clients to social services depending on their needs and wants (Alliance for Healthier Communities, n.d.). This connection can happen through a link worker and can happen differently depending on the location (Alliance for Healthier Communities, n.d.).

INTRODUCTION

The COVID-19 pandemic has vividly highlighted the importance of addressing health-related social needs at the client level. As a result, there is a growing interest in understanding how healthcare and social service organizations form intentional partnerships to address health needs. The term **social prescribing** refers to a holistic community-based approach to healthcare that bridges "the gap between clinical and social care by referring clients to local, non-clinical services that are chosen according to the client's interests, goals, and gifts" (Muhl et al., 2023). Social prescribing involves recognizing and supporting someone's **non-medical health-related social needs** (Healthy Aging Alberta, n.d.) by seeking to identify and address the broader yet relevant social determinants of health underlying one's health concerns.

Social prescribing is a non-medical prescription (Healthy Aging Alberta, n.d.). In brief, it is a referral pathway process that aims to strengthen one's physical, mental, and social health by developing and enhancing an individual's connections to community support (Healthy Aging Alberta, n.d.). Social prescribing is initiated when regulated and licensed healthcare providers see clients in a community or clinic, screen clients for non-medical health-related social needs, and then refer to a community-based program to better support their overall health and quality of life (Healthy Aging Alberta, n.d.).

From here, a community "**link worker**" contacts the client where they will collaboratively determine how best to meet their identified needs through discussion on the most applicable and available community support (Healthy Aging Alberta, n.d.). As link workers tend to have strong ties with the community and a greater understanding of their resources, they are uniquely positioned to develop more meaningful and trusting partnerships with clients (Muhl et al., 2023). Examples of health-related social needs that may be identified among clients include financial support (e.g., assistance in navigating available/eligible government benefits and applying for them), food insecurity, housing insecurity, and/or transportation assistance (e.g., subsidies for city bus fares).

> **80%** of an individuals health is influenced by the sDoH

This environmental scan was initiated under the premise of social prescribing being relatively novel in Alberta, while recognizing the undue benefits that such an approach has the potential to provide. This includes recognition of the fact that 80% of an individual's health is dependent on the **social determinants of health (sDoH)** (Healthy Aging Alberta, n.d.) and that a social prescribing approach can help mitigate health inequities, including those experienced by vulnerable populations (Muhl et al., 2023).

PURPOSE

The purpose of this environmental scan was to **determine the scope of social prescribing practices in Alberta Primary Care Networks (PCN)** by examining current social prescribing initiatives and programs employed within PCN clinics. Specifically, this environmental scan sought to better **understand the specific pathways** PCN healthcare providers use with clients to identify their health-related social needs when they come into contact with a PCN and to use these findings to identify existing gaps that could be addressed in future work.

OBJECTIVES

To meet the overarching project purpose, the key objectives of this environmental scan report that guided this work were as follows:

01 To assess the specific **social prescribing processes and practices** used within Alberta *Primary Care Networks (PCN)*, in-depth interviews with licensed and regulated healthcare providers working in PCNs were conducted.

02 To create a **general service map** of current social prescribing initiatives and programs reaching Albertans according to the findings of our in-depth interviews.

03 To **identify gaps and make practical recommendations** for future methods PCNs can increase the accessibility of social prescribing services within their communities.

METHODS

Survey design
The survey was designed using a combination of factors, including insightful information gathered from engaging conversations with Alberta Health Services (AHS) and Healthy Aging Alberta partners, a literature review, and a preliminary pilot test among a PCN already known to be using social prescribing within its clinics. It aimed to understand the formal and informal social prescribing (SP) processes employed by PCNs across Alberta. This survey was designed to qualitatively and quantitatively assess social prescribing practices among healthcare providers working in PCNs. For efficient data collection and secure storage, the survey was entered into REDCAP, which is an online research software platform. The use of REDCAP also facilitated greater accessibility in data entry among the graduate student project team, as the software has no associated cost for university students.

METHODS

Interviews

Surveys were conducted via telephone calls between individual University of Alberta Masters of Public Health (MPH) graduate students who comprised the student team (interviewers) and healthcare providers employed at PCNs (interviewees). Prior to the start of the interviews, the student team individually reached out to the PCN healthcare providers through telephone and/or email addresses to inform them about this project and gauge their interest in partaking as potential interviewees. All PCN healthcare providers who indicated their interest to participate in this exercise were provided with an information sheet for their own personal reference, which included comprehensive information on the project's purpose, data collection tools and analysis, how data would be used, processes for how data would be shared, and further contact information of the project's leads, should interviewees have any questions. Interviews were scheduled on the day/time most convenient for the interviewees. All interviews were conducted during regular work hours, while the interviewee was at work.

Interviewees included social workers, clinical nurse managers, program managers, community liaisons and other managerial staff (Table 1). Phone calls were guided by an interview script prepared with a prior review by the AHS and Healthy Aging Alberta organizational mentors. This ensured clarity, consistency, and comprehensiveness in the information asked by interviewers and gathered from the interviewees. Before the start of the interview, interviewees were given another brief overview of the project and were asked if they had any questions. A total of fourteen (14) questions were asked to interviewees, including two (2) demographic questions and twelve (12) questions pertaining to social prescribing practices used within their PCN (Appendix 1). The interviewees were also asked follow-up questions if needed to gain a deeper understanding of social prescribing practices at their PCN. Interviews took approximately thirty minutes to complete and were conducted between October 3, 2023, and November 10, 2023. Data were collected from the interviews using shorthand notes and quotes. The interviews were not recorded or transcribed. Rather, the interviewer simultaneously filled in the online REDCAP survey form while engaged in telephone conversations with the PCN healthcare provider or immediately after the interview was complete.

METHODS

Data analysis
The method of data analysis used in this study drew upon reflexive thematic analysis (Braun & Clarke, 2021; Muir, 2023). Reflexive thematic analysis emphasizes the incorporation of a researcher's lived experiences into the building of theory. Themes from the data were collaboratively co-produced through discussions between the research team and stakeholders. These themes informed the creation of this environmental scan report detailing existing social prescribing initiatives and programs within the Alberta PCNs. Additionally, a service map was created to visually illustrate the diverse range of social prescribing practices and approaches used within the Alberta PCNs.

The MPH student team summarized the collective findings regarding the distribution of social prescription initiatives in Alberta. These findings were used to identify key gaps and recommendations for AHS, Healthy Aging Alberta, policy makers, and relevant stakeholders, aiming to enhance social prescribing initiatives and programming in the province. To achieve this goal, the environmental scan and service map tools were shared with AHS, Healthy Aging Alberta, and participating PCNs.

RESULTS

Demographics
Out of 39 PCNs in Alberta, 23 were reached and agreed to participate (n=23). Interviews were conducted with PCNs located in all AHS zones: North, South, Central, Edmonton, and Calgary zones (Table 1). Interviewees held various positions within their PCN; social workers represented a large majority (39%) of interviewees (Table 1). 15 (68%) of the interviewed PCNs had a social worker or designated link worker at their PCN who participated in social prescribing initiatives (Table 1). *[Note: Data regarding the presence/absence of a social worker was missing for 1 PCN.]*

RESULTS

TABLE 1. DEMOGRAPHICS OF ALL INTERVIEWED INDIVIDUALS (N=23), BY ZONE AND POSITION.

Demographics	Interviewed participants n (%)
Zone of PCN	
North	4 (17.4%)
South	1 (4.3%)
Central	6 (26.1%)
Edmonton	7 (30.4%)
Calgary	5 (21.7%)
Position at PCN	
Clinical nurse manager	2 (8.7%)
RN	2 (8.7%)
Social worker	9 (39.1%)
Manager of central operations	2 (8.7%)
Senior Advisor	1 (4.3%)
Program manager	2 (8.7%)
Community liaison	1 (4.3%)
Office manager/improvement facilitator	1 (4.3%)
Executive director	1 (4.3%)
Clinical lead	1 (4.3%)
Professional practice lead	1 (4.3%)
PCNs with a social worker or designated link worker	
Yes, have a social worker	15 (68%)
No, do not have a social worker	7 (22%)

Note: *Data regarding the presence/absence of a social worker was missing for 1 PCN.*

RESULTS

What is the scope of social prescribing practices used in PCNs in Alberta?

TABLE 2: EXAMPLES OF SOCIAL PRESCRIBING SERVICES OFFERED IN PCNS ACROSS AHS ZONES

Type of Support Service/Program	Examples	AHS Zone Where Example is Offered
Financial Supports	Assistance filing federal tax forms, AISH, CPP, AB adult health benefits, disability supports, LAPP, pension benefits, GEF	CZ, EZ, SZ, NZ
Educational Supports	Caregiver support groups	CenZ
Food Security	Good Food Box, Food Rescue Program, food bank, 'Food with Friends', 'Bow Valley Food Alliance'	CZ
Housing	Horizon Housing, Step 1 housing (addiction/mental health), shelters	CZ
Transportation	City bus passes (Calgary transit, ETS), volunteer driver programs	EZ, CZ
Mental Health	Youth anxiety workshops, youth mental health summit, immigrant and refugee programs; Wellspring	CZ, CenZ
Exercise	Free/discounted memberships to local gyms or recreation centres; Active Living Consultant	CZ, CenZ
Social and Community Supports	"Trelis", 'Canmore Young Adult Network', 'Banff Life', child and youth forum, youth empowerment, social game nights, Family Support Services (FCSS), Voices for Albertans with Disabilities	CZ, EZ, CenZ
Seniors	Senior housing (e.g., lodges, Trinity Place, Kirby Centre), home care, senior benefits, disability supports, Golden Circle, Sage, Elder Abuse, medical equipment	CenZ, CZ, EZ, NZ
CZ: Calgary Zone; CenZ: Central Zone; EZ: Edmonton Zone; NZ: North Zone; SZ: South Zone.		

***Please note** this list is designed for illustrative purposes to demonstrate the range of social prescribing services offered throughout PCNs in the province. It is not inclusive to all social prescribing done within PCNs.*

RESULTS

WHAT ARE THE KEY CHALLENGES AND GAPS FACING PCNS IN ALBERTA REGARDING USING A SOCIAL PRESCRIBING APPROACH?

Five major challenges and gaps were identified within Alberta's PCNs through thematic analysis of the interviews.

01

Resource limitations were identified in many interviews with PCNs. This included limited funding which impacts service provision, staff shortages and turnover affecting capacity, and insufficient services available in rural areas.

The PCNs also identified bureaucratic and systemic barriers to social prescribing. These barriers could present administrative hurdles affecting the assistance process or a lack of updated, centralized community resource directories. In addition, strict eligibility criteria and paperwork add to these barriers in addressing SDoH. One PCN noted that "many clients have a difficult time managing online applications and paperwork."

02

Communication and referral issues were noted as another major challenge in providing social prescribing services. Interviewed PCNs noted that there was limited awareness and perceived importance of SDoH among healthcare professionals. One interviewee noted that a "major gap is that physicians do not know or address the social determinants of health... if the doctor isn't asking, we do not get the referrals." Discrepancies also exist in physician referrals for social prescriptions.

03

Additionally, **no official referral system or formalized process** for PCNs has led to challenges in social prescribing. Currently, in many interviewed PCNs, social prescribing is not a formalized process; therefore, SP referrals are at the discretion of care providers. However, one interviewee noted a "more robust protocol with all the social determinants of health included would more effectively meet the needs of patients."

04

Some PCNs also noted **community specific challenges**. For instance, there may be unique challenges in rural areas, areas bordering larger urban centres or other provinces, and specific patient populations.

05

Additionally **transportation and financial issues** were noted to affect patient's access to services: "there are limited transportation options in rural communities and if there are options they are expensive."

DISCUSSION

Overall, across the five zones, variable social prescribing strategies were found between PCNs and among individual clinics under the same PCN. The use of an informal process was a recurring theme among most PCNs, with screening tools and HCP-patient conversations being the main social prescribing approaches. Where screening tools and conversations were held, these discussions tended to be initiated by the family doctor who then referred the patient to a social worker, or directly by the social worker if not initially seen by the doctor. Registered nurses and other allied health professionals were also found to make referrals to social workers. Most PCNs had a social worker (15/22, 68%); however, among the small handful of clinics that did not have a social worker, social prescribing was performed by the family doctor (Table 1). A less common approach seen was a 'reverse pathway,' whereby referrals were received to PCNs from community organizations/agencies. In PCNs where there were social workers present, they played instrumental roles in social prescribing and tended to do the bulk of this work.

Across all zones, there was significant variability in whether all (or some) of the patients were assessed for non-medical needs. In the South Zone, PCNs reported no standard process for formally assessing all patients. In the Central Zone, the main strategy identified for assessing non-medical needs was through conversation. In the Edmonton Zone, PCNs reported utilizing various screening tools, conversational questions, and referrals within PCNs to assess non-medical needs. The Calgary Zone reported that mainly informal screening strategies, conversations, and referrals within their PCNs were the primary assessment methods.

The types of specific support that patients were referred to were highly variable and influenced by available programs/services in their communities; however, across all AHS zones, there was a *universal* need for income support. The ability to support a patient's financial needs was identified by a large proportion of interviewed healthcare providers as critical to being able to meet any other non-medical social needs of the patient. In the aftermath of the COVID-19 pandemic, many HCPs had identified limited capacity to fully meet the needs of their patients, and simultaneous frustrations with the lack of, or reduction of, services available to refer clients to for support. Follow-up with patients was generally informal. As social workers were the ones primarily making patient referrals to community supports/programs, follow-up was variable and at their individual professional discretion, based on patient needs.

ADDITIONAL FINDINGS

- The term “social prescribing,” while used formally in research settings, was found to be rarely used among healthcare providers when communicating with their clients. Healthcare providers who were familiar with the term tended to gravitate towards only using the term when doing individual non-client work.

- Healthcare providers indicated they shy away from using the term “social prescribing” due to lack of familiarity with clients, ambiguity of the term, and potential misperceptions among clients, confusing it with a medical prescription due to its pharmaceutical connotation.

- Interestingly, the term “social prescribing” was a new term to a small proportion of healthcare providers, despite the fact that they were doing social prescribing work in their clinics. Healthcare providers who lacked familiarity or preference for the term “social prescribing” tended to use some of the following example terms instead: “community resources”, “resources”, “community networks”, or “building community partnerships”.

STRENGTHS

Three major strengths of social prescribing were identified within Alberta PCNs through thematic analysis of interviews. Firstly, **approaches to social prescribing were patient centred**. There was an emphasis on addressing the SDoH of all patients and community members. At the assessment level, some PCNs adopted comprehensive assessments of non-medical social needs. Additionally, there was a recognition of holistic care implemented and provided by healthcare providers, particularly nurses, dieticians, and social workers.

Further, there was an **emphasis on community engagement and relationships**. PCNs across Alberta furthered their social prescribing initiatives by fostering close relationships with community organizations, resources, and supports. PCN staff were also united with the community resources to address the needs of the community. One PCN made this clear by stating "once we refer the patient, there are strong relationships between the community supports and the PCN team... it is transparent to the patient or client that they are still supported by the PCN as well as external social supports."

Finally, a **team-based care approach** is used, which involves a collaboration between various healthcare professionals. Thus, a team-based care approach leads to enhanced identification and addressing of health needs because "all teams and health professionals are aware and knowledgeable of available services for clients." This approach to patient care ties into the holistic nature of social prescribing, in which the healthcare team aims to address the needs of the whole patient.

PROJECT LIMITATIONS

This environmental scan has several limitations. Firstly, while all PCNs in Alberta were contacted once at minimum, and upwards to three times using various communication modalities (i.e., phone call and email), only 23 of 39 (59%) total PCNs in Alberta were interviewed. As a result, while we were able to interview PCNs from all five AHS zones, this environmental scan is not inclusive of all social prescribing processes in Alberta PCNs. Additionally, as the scan was focused on PCNs, the findings are restricted to SP initiatives in PCNs. However, SP may be offered in other settings such as community spaces.

Another limitation of the study is that interviews were conducted by six different members of the student team. Due to the flexible nature of the interview and follow up questions, this could have resulted in different aspects of the social prescribing process being captured or emphasized in the data. Finally, summary notes were taken of interviews, rather than interviews being recorded or transcribed. This has the potential of impacting the validity of the theming analysis due to interviewers projecting bias into the summary notes.

ASSUMPTIONS

- The definition of social prescribing used that guided this project was based on the definition proposed by Muhl et al., 2023. We recognize social prescribing is an evolving term as it is a relatively new concept in the public health world with definitions still up for debate (Muhl et al., 2023)
- We projected the term “social prescribing” onto practices the PCNs are doing, regardless of whether or not the PCNs call their practices “social prescribing”.

GAPS

Several challenges associated with using social prescribing approaches were identified.

01 Patients

- **Access to services:** Patients, especially in rural areas, face challenges in accessing non-medical services due to limited resources, transportation issues, and geographical barriers.
  - *"Transportation is a major challenge. There are limited options and if there are options (for transportation) they are expensive."*

    - Edmonton PCN participant

- **Delayed or Inadequate Support**: Bureaucratic processes, long waiting lists, and administrative hurdles delay patients' access to financial or support services
  - *"Services could be more tailored to better meet patient needs. A big challenge is getting to speak to a client and provide them services when they need them or in the moment that they are considering accepting the support"*

    - Calgary PCN participant

- **Limited Awareness**: Lack of public education about addressing social determinants of health during doctor visits leads to missed opportunities for patients to discuss non-medical needs
  - *"Patients don't know it's okay to talk to their doctors about these things and the doctor isn't asking these (SDoH) questions"*

    - Edmonton PCN participant

GAPS

Several challenges associated with using social prescribing approaches were identified.

02 Healthcare Providers

- **Healthcare Resource Utilization and Constraints:** Healthcare providers face challenges in dealing with administrative processes, limited staffing and lack of physicians to meet the demand and needs of the population, especially in rural and remote areas. To get referred to many of the SP services, you need to be connected to a PCN and have a family doctor. High service burdens due to inefficiencies in the system.
  - *"We can only work with people who have family doctors. In our catchment area of roughly eighty thousand people, more than thirty thousand can't get a doctor"*
    - Edmonton PCN participant

- **Communication Barriers:** Lack of integrated systems and communication gaps between healthcare providers leads to missed referrals and challenges in coordinating care.
  - *"Increased communication between physicians would be beneficial, ensuring that the information gets to the physician and vice versa. Currently communication is done either by EMR or over the phone, but things can get lost"*
    - Central PCN participant

- **Limited Awareness and Engagement:** Some healthcare providers lack awareness or may not fully realize the impact of social determinants of health, leading to lower engagement in social prescribing initiatives. Many doctors are not aware of, interested in, or able to refer their clients to non-medical interventions that address the SDoH, such as housing, food, education, and income
  - *"There is a lack of buy-in or incentive for physicians to participate in social prescribing or SDoH screening"*
    -Edmonton PCN participant

GAPS

Several challenges associated with using social prescribing approaches were identified.

03 Community and Support Systems

- **Resource Constraints:** Limited funding and staffing issues within community organizations limit their capacity to support social prescribing initiatives
  - *"Community organizations and AHS have had a lot of turnover, due to decreased staffing positions, leading to smaller teams and reduced capacity. As well there has been decreased program funding from the Government."*

    \- Calgary PCN participant
- **Fragmented Systems**: Lack of a centralized hub for community resources makes it challenges for both healthcare providers and patients to identify and access available services
  - *"Having a centralized place as to what is available to you in your community would be good. Knowledge sharing could be improved."*

    \- Central PCN participant

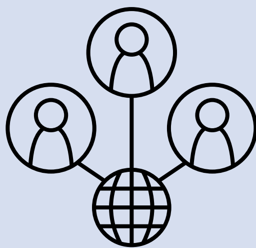
CONCLUSIONS

This environmental scan provides useful information to develop a sense of the social prescribing and related practices that are currently being conducted within Alberta PCNs. Specifically, it provides a general overview of the varying pathways healthcare providers within PCNs use to identify the health-related social needs of their clients and the subsequent referral processes that take place. Interestingly, there is considerable ambiguity surrounding the term social prescribing, causing challenges in identifying and categorizing which practices constitute social prescribing and highlighting the need to determine more clear and consistent terminology. As such, careful consideration of these findings should be used when informing future social prescribing strategies and practice. The majority of PCNs interviewed utilized an informal process as their social prescribing strategy, bringing attention to the need to develop a more formalized approach to social prescribing. This scan provides a number of examples of successful social prescribing strategies that have been implemented by PCNs in Alberta, as well as an inventory of social prescribing services offered in communities. It also provides a comprehensive list of commonly identified non-medical social needs of clients. Notably, income support was universally identified as a significant social need requiring considerable support across Alberta.

The authors hope that this scan will be a useful resource in the development of social prescribing initiatives in Alberta.

FUTURE RECOMMENDATIONS

Where do we go from here? To inform and guide the plan in looking forward, key recommendations are proposed.



Recommendation 1: Enhancing Community Resources and Support

- **Centralized Resource Hub:** Develop a centralized and easily accessible platform, such as *ClicSocial.ca,* wherein healthcare professionals can rapidly identify and prescribe their clients non-medical services. Creating a tool that catalogs available community resources, social prescribing information and initiatives will leverage services to benefit the entire population. This hub should be regularly updated and shared among clinics and healthcare providers to ensure they have current information on community services.

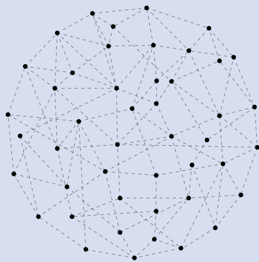
- **Improved Communication:** Establish streamlined communication channels between healthcare providers and community agencies. This includes sharing directories like the AHS directory to ensure clinics are updated on service changes, minimizing confusion, and enabling efficient referrals. Engage with government representatives to advocate for simplified administrative processes, including extended availability of government workers and user-friendly online application systems for financial support. Streamlined procedures for HCP assisting clients with paperwork will allow for more time in appointments to have conversations around SDoH.

- **Increasing Awareness:** Initiate public education programs within communities to encourage discussions about social determinants of health (SDoH). Empower clients to feel comfortable discussing these factors with their healthcare providers. Utilize existing resources like 211 effectively.

- **Increasing Availability of Services in Rural Areas:** Conduct a comprehensive needs assessment in rural areas to identify specific gaps in services and the most pressing needs of the communities. Collaborate with local community organizations, telehealth providers, and government agencies to expand and diversify available services.

FUTURE RECOMMENDATIONS

Where do we go from here? To inform and guide the plan in looking forward, key recommendations are proposed.



Recommendation 2: Address Systemic Challenges

- **Funding Allocation:** Advocate for increased funding to support social prescribing programs and community services, especially in rural or underserved areas. Address the bureaucratic hurdles and financial constraints that hinder the efficient completion of paperwork and access to essential services. Advocate for increased funding for social prescribing programs by highlighting their impact and long-term benefits. Collaborate with stakeholders to develop proposals and business cases that demonstrate the value and return on investment.

- **Staffing Issues:** Staff capacity is a huge barrier in effectively integrating social prescribing. Focus on retention and recruitment of social workers and family doctors within PCNs. Each PCN and clinic should have a social worker. Implementing social prescribing requires support and buy-in from the entire team.

- **Standardizing Protocols:** Develop formalized processes and referral systems within PCNs to ensure consistent identification and referral of clients with non-medical social needs. This could involve integrating SDoH screening questions into EMRs or incorporating them into routine assessments. Similarly, standardizing protocol around follow-ups with clients who receive social prescriptions should be implemented.

FUTURE RECOMMENDATIONS

Where do we go from here? To inform and guide the plan in looking forward, key recommendations are proposed.

Recommendation 3: Strengthen Integration and Collaboration

- **Culture Change:** Social prescribing requires a fundamental shift in how PCNs and healthcare providers view healthcare. It will need the willingness and ability of organizations to view clients from a strengths-based perspective, rather than illness-based, and identify health equity, social connectedness, and the social and structural determinations of health as foundational to PCNs. Foster a culture of collaboration and co-creation among health and social care providers as a standard practice.

- **Community Integration:** Establish deeper integration of social prescribing initiatives within the community by involving grassroots organizations and lived experiences in decision-making processes. This integration should reflect a comprehensive understanding of diverse community needs and avoid tokenistic approaches. This may take the form of conducting community consultations and engagement sessions to identify the specific needs and preferences of diverse populations, ensuring cultural sensitivity and inclusivity.

- **Data Pathways:** Standardize data collection and reporting methods across and within PCNs and social prescribing programs. This would help to ensure the consistency, accuracy, and comparability of the data, as well as to reduce the burden on staff who are involved in data entry. Develop a common data platform that can facilitate sharing and integration of data among different stakeholders, such as health providers, social prescribers, community partners, and researchers. Strengthen data literacy and capacity of staff. This would help to enhance their skills and confidence in using data for planning, monitoring, evaluation, and decision-making, as well as promote the importance of data completeness and tracking of referrals.

APPENDICES

1 - Social Prescribing Environmental Scan Survey

Part 1: Participant Demographics

1. Which is the AHS Primary Care Network (PCN) you work at or are located in?
* must provide value

- North Zone
- South Zone
- Central Zone
- Edmonton Zone
- Calgary Zone

2: What is your formal position at the PCN?
* must provide value

- Clinical Nurse Manager
- MD
- RN
- RD
- Pharmacist
- Social Worker
- Nurse Practitioner
- Other

Part 2: Interview Questions

1. When someone comes a clinic within a PCN, what are the strategies healthcare professionals use to better understand their non-medical needs? Select all that apply.
* must provide value

- Active signposting approaches: a method involving having engaging conversations with clients to determine what matters most to them, and based on conversations providing them brief information to direct (i.e., signpost) them to services deemed most appropriate
- A questionnaire to gather client/patient information
- A screening tool where clients/patients are screened for their non-medical needs by a licensed health care provider at the PCN
- No formal strategies are used

2. Is the social prescribing strategy (strategies) employed by the clinics within your PCN a formal process, whereby the non-medical social needs of all patients/clients is (are) assessed?
* must provide value

- Yes approach is used on all patients/clients
- No approach is not used on all patients/clients
- Social prescribing is offered to all, but services are self-selected (ex. posters in waiting room, QR codes that clients self-scan)
- Approach is used on some populations (ex. Older adults)
- Unsure
- Other

APPENDICES

1 - Social Prescribing Environmental Scan Survey

3. Which population demographics and equity seeking groups are primarily served by the social prescription referrals used in your PCN? Select all that apply.
* must provide value

- Youth (24 and under)
- Adults (25-65)
- Older adults (65+)
- Immigrants and newcomers
- BIPOC
- Indigenous peoples
- Military
- Post-secondary students
- 2SLGBTQIA+
- Women
- Other (please list)

4. Is this social prescribing strategy (strategies) employed at your PCN universally used by all healthcare professions? That is, are the strategies at your PCN similar or variable among healthcare professions?
* must provide value

- Yes approach is used by all healthcare professions
- No approach is not used by all healthcare professions
- Unsure
- Other

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5. Do you have a social worker or designated link worker working with your PCN?

- Yes
- No

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6. What types of non-medical social needs are being addressed using social prescribing? Select all that apply.

- Food insecurity
- Housing insecurity
- Employment or financial assistance
- Emotional and mental health
- Medication affordability
- Family support (e.g., domestic violence, childcare)
- Social isolation (e.g. connecting to community and/or cultural programs)
- Other (please list)

7. What strategies are used to engage clients and increase their understanding and awareness of social prescribing?
* must provide value

Expand

APPENDICES

1 - Social Prescribing Environmental Scan Survey

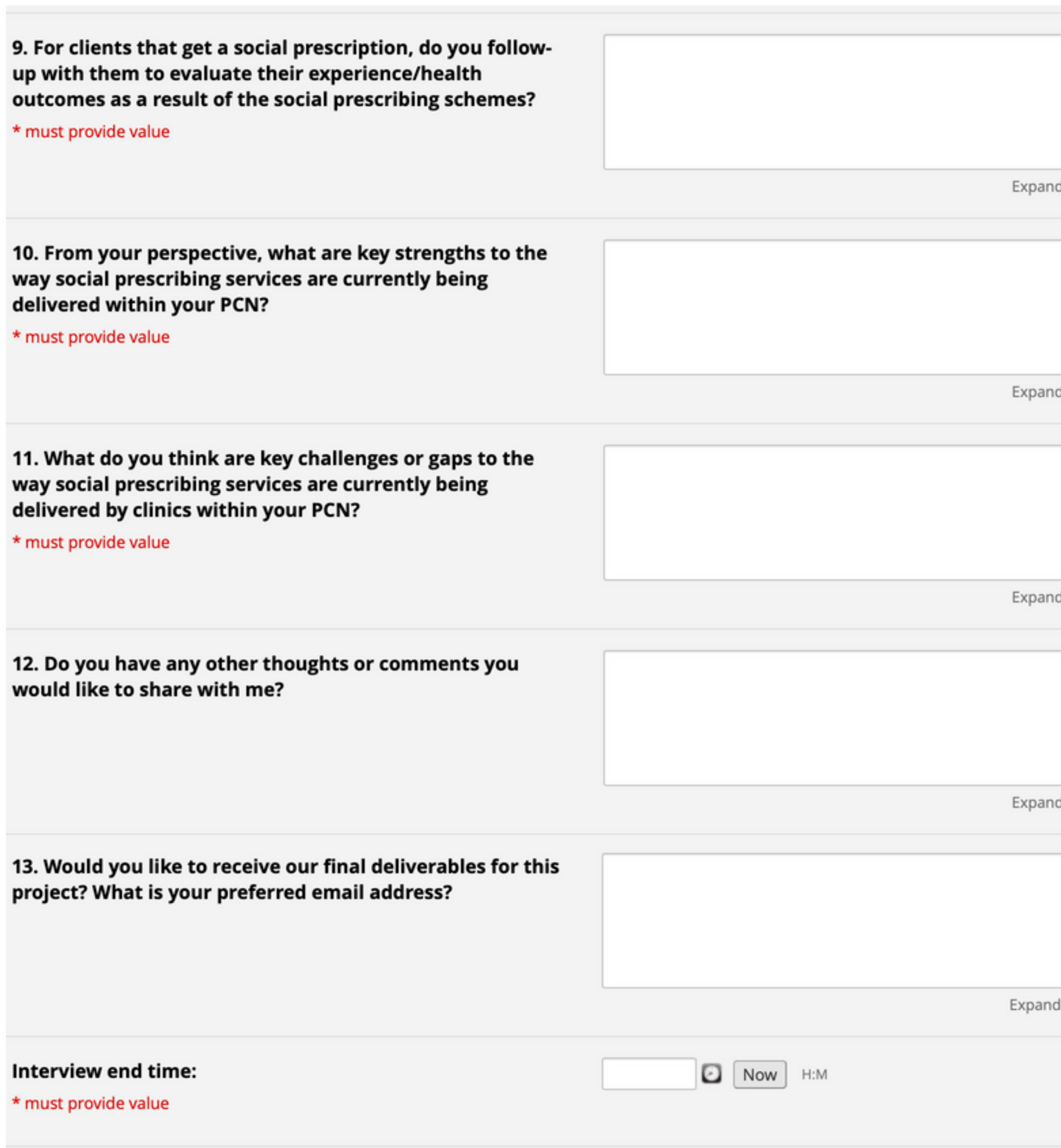
8. What types of support services and/or programs are clients/patients referred to, to meet their identified non-medical social needs?

* must provide value

- [ ] Housing support organizations
- [ ] Community food programs/supports (e.g., Meals on Wheels, Food Bank)
- [ ] Cultural or Newcomer organizations (e.g. Multicultural Health Brokers)
- [ ] Faith-based institution (church, mosque, temple)
- [ ] Community social service organization (e.g. Catholic Social Services, Islamic Family and Social Services Association)
- [ ] Mental Health Supports
- [ ] 211
- [ ] Nutrition Services
- [ ] Addictions and Harm Reduction
- [ ] Physical Health
- [ ] Seniors (e.g., seniors association)
- [ ] Legal
- [ ] Military and Veteran
- [ ] Women
- [ ] Indigenous
- [ ] BIPOC
- [ ] 2SLGBTQIA+
- [ ] Family Supports
- [ ] Other

APPENDICES

1 - Social Prescribing Environmental Scan Survey



9. For clients that get a social prescription, do you follow-up with them to evaluate their experience/health outcomes as a result of the social prescribing schemes?
* must provide value

Expand

10. From your perspective, what are key strengths to the way social prescribing services are currently being delivered within your PCN?
* must provide value

Expand

11. What do you think are key challenges or gaps to the way social prescribing services are currently being delivered by clinics within your PCN?
* must provide value

Expand

12. Do you have any other thoughts or comments you would like to share with me?

Expand

13. Would you like to receive our final deliverables for this project? What is your preferred email address?

Expand

Interview end time: Now H:M
* must provide value

APPENDICES

2 - First Point of Contact Communication Script

First Point of Contact Script:

First contact (Speaking with Administrative Personnel in the PCN):
"Hello, my name is [your name] and I am an MPH student with the University of Alberta. As part of our practicum experience, our team is conducting interviews with primary care networks in Alberta on behalf of Alberta Health Services and Healthy Aging Alberta. We are conducting an environmental scan focused on social prescribing or related services within primary care networks in Alberta, and we'd like to provide some context for our purpose. Social prescribing involves recognizing health-related social needs beyond traditional medical care. For instance, it could include referrals to community agencies like Meals on Wheels or Multicultural Health Brokers to address issues such as limited access to food or cultural-specific health needs.

Our primary goal is to understand the process of social prescribing at each of these PCNs. Specifically, we're interested in learning about the process for individuals with identified social needs when they come into your PCN.

If this sounds applicable or relevant to the work done at your PCN, could you kindly direct us to an appropriate contact person within your network, preferably a social worker, clinical manager, or executive director, who can provide us with more information regarding these services?

Your assistance in connecting us with the right individual would be greatly appreciated!
I hope you have a great day!

Speaking with interviewee:
Hello, my name is (XXX) and I am an MPH student with the University of Alberta. As part of our practicum experience, our team is conducting interviews with primary care networks in Alberta to collect data on social prescribing initiatives on behalf of Alberta Health Services. We are seeking to gain a deeper understanding of the valuable work your network is doing. Specifically, we are conducting an environmental scan focused on social prescribing services within primary care networks in Alberta, and we'd like to provide some context for our purpose. Social prescribing involves recognizing health-related social needs beyond traditional medical care. For instance, it could include referrals to community agencies like Meals on Wheels or Multicultural Health Brokers to address issues such as limited access to food or cultural-specific health needs.

Our primary goal is to understand the process of social prescribing at each of these PCNs. Specifically, we're interested in learning about the pathway for individuals with identified social needs when they come into your PCN.

We want to ensure that you are aware that interviews will not be recorded verbatim and that data collected during the interview will be confidential, and it will be retained only until the end of December. Subsequently, the findings and data will be shared with Alberta Health Services and the Alberta Health Ministries for research purposes.

If this sounds like it is relevant to your PCNs work and would like to participate, we would like to arrange a phone interview ideally between October 2nd and October 13th. The interview would take approximately 30 minutes. Could you please share your availability during this timeframe?

Which phone number is best for us to contact you?

Additionally, we will provide you with an information sheet outlining the objectives of our project, along with a consent form, prior to the interview. To ensure you receive these documents, could you please provide us with your preferred email address?

Thank you so much for your time. We look forward to speaking with you in the near future!

Context (if needed): Within our scope, social prescribing ecompasses recognizing health-related social needs that extend beyond traditional medical care These needs could include issues like limited access to food or precarious housing, which significantly impact the health of patients or community members, but fall beyond the scope of medical care. Following identification of unmet needs, a link worker connects individuals with necessary social support systems to address these health-related social needs to improve the health of the community member. For instance, connecting an individual with Meals on Wheels or with a Cultural Health Broker.
Our team is working to conduct interviews and an environmental scan with primary care networks in Alberta in order to generate findings about social prescribing services offered in Alberta. We would love to send you a copy of our findings once it is completed!

APPENDICES

3 - Information Sheet and Consent

INFORMATION SHEET

Project title: Social prescribing initiatives in AHS Primary Care Networks (PCN) - an environmental scan

Principal Investigators:
Mary Modayil, MSPH PhD
mary.modayil@ahs.ca

Beth Mansell, MPH
beth.mansell@healthyagingalberta.ca

Backgrounder:
The pandemic highlighted the importance of addressing health related social needs at the client level. As a result, there is interest in understanding how healthcare and social service organizations form intentional partnerships to address health needs. The term 'social prescribing' is used to refer to a more holistic approach to healthcare that bridges "the gap between clinical and social care by referring patients to local, non-clinical services that are chosen according to the client's interests, goals, and gifts."

Alberta Health Services and Healthy Aging Alberta are working together to support social prescribing activities through several initiatives. AHS has partnered with our group of six students completing a Masters in Public Health through the University of Alberta to conduct interviews with Primary Care Networks in order to complete an environmental scan of existing social prescribing practices in Alberta.

Why am I being asked to take part in this survey?
You have been identified as a potential participant for this project because of your affiliation with an AHS Primary Care Network (PCN) and due to your involvement and/or awareness of social prescribing services.

- We are asking you to help us better understand
  - Social prescribing initiatives and strategies being used in PCNs
  - Support services being provided
  - Key strengths and barriers to social prescribing in Alberta

What will I be asked to do?
- You are being asked to participate in a **30-minute** phone survey and conversation
- We will ask you questions about
  - Social prescribing in your PCN
  - Your thoughts on social prescribing initiatives
- Your answers will be recorded directly in a secure database (e.g., REDCap)

1

Voluntary Participation:
- Participating in this survey is your choice. If you decide to initially participate, you can change your mind and stop participating at any time.
- You can refuse to answer any question.

Confidentiality:
- During the survey we will be collecting data. We will do everything we can to make sure the data is kept confidential.
- Any personally identifiable information (e.g., your name, your formal position or job location) will **not** be disclosed in the final report or any related publications.

Data Storage:
- We will keep your name and contact information separate from your survey answers. We will use a code number on the survey so that your identity remains anonymous.
- A secure data management service (REDCap) will be used to store your answers for three months. We will store all project data in a secure area available only to the students partaking in this project.

Data Sharing and Use:
- We will share the final results of the project with people who work with or plan services for social prescribing in Alberta.
- The results generated will be used internally within AHS to examine the scope of existing social prescribing practices and their details (e.g., populations served, type of social prescribing services offered, challenges faced), in order to inform current service gaps that can be used to improve future work in this area
- Findings will be analyzed summatively in visuals (e.g., graphs or maps) and text (i.e., key themes).

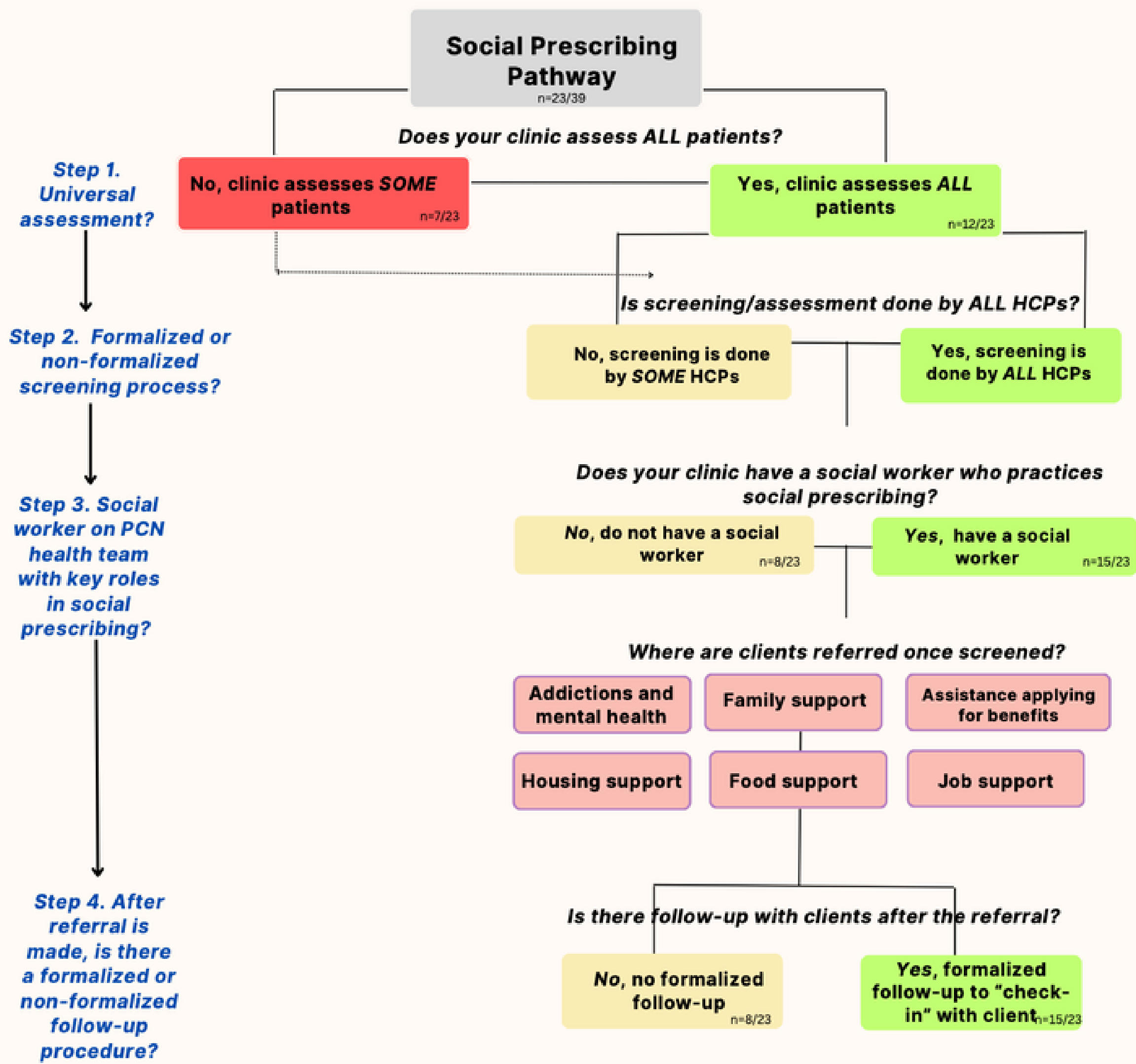
Questions or concerns:
- If you have any further questions regarding this project now or in the future, please contact Mary Modayil, mary.modayil@ahs.ca, or Beth Mansell, beth.mansell@healthyagingalberta.ca.

If at any point during this conversation you change your mind you can let us know and we can end the conversation.

2

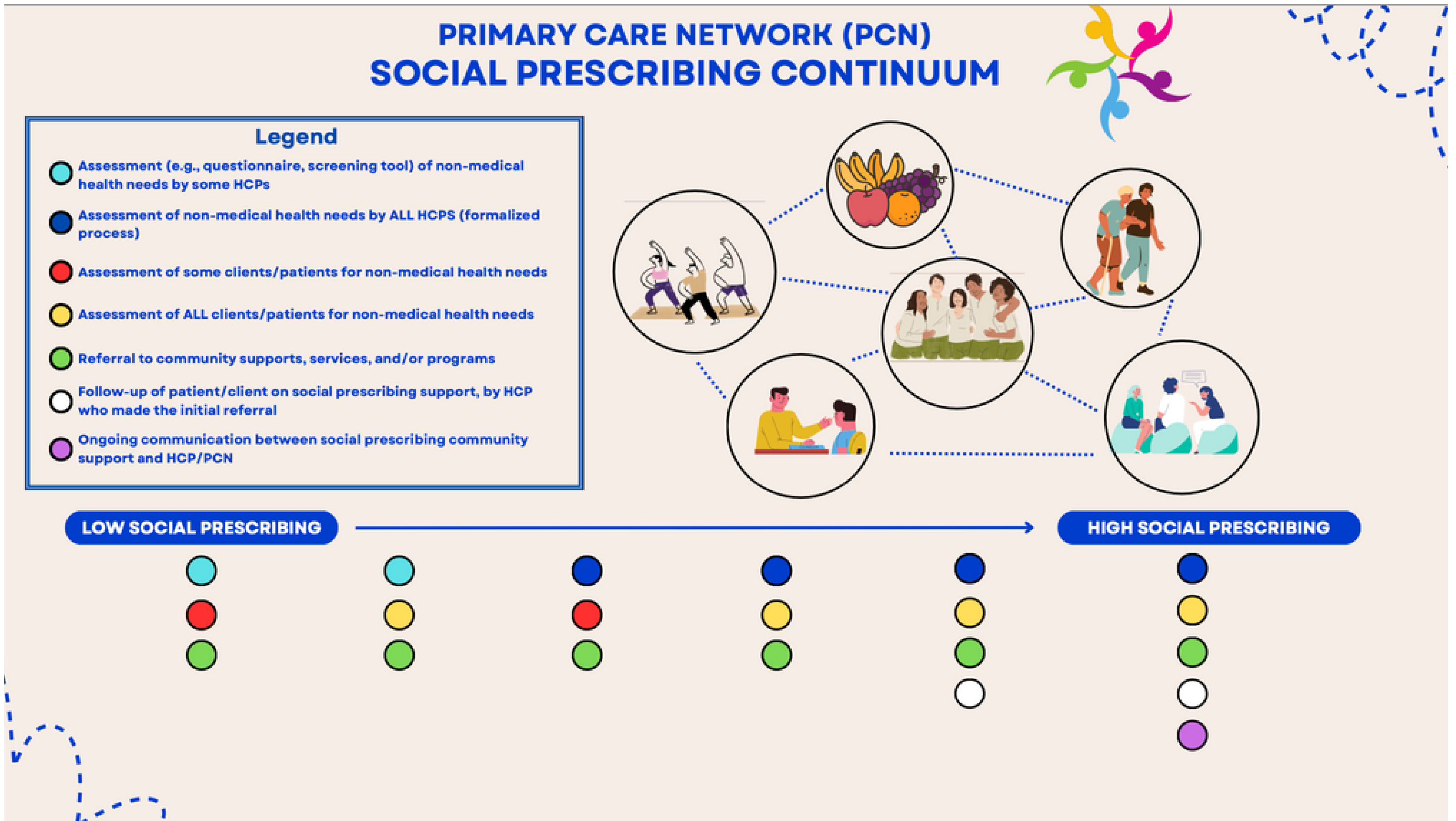
APPENDICES

4 - Social Prescribing Pathway



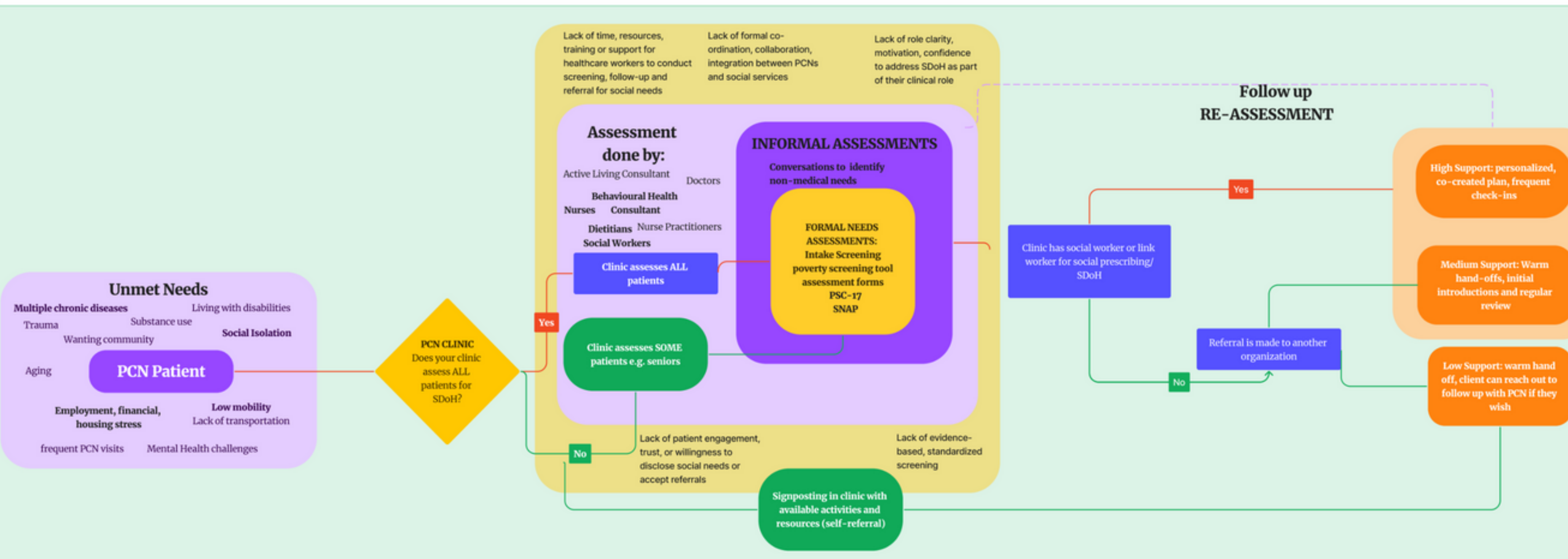
APPENDICES

5 - Social Prescribing Continuum



APPENDICES

6 - Social Prescribing Clinical Pathway



APPENDICES

7 - Additional Resources

The following social prescribing resources were not included in the report due to information not being provided by survey respondents, however, they may be useful for future social prescribing initiatives in Alberta.

Service	Description	Contact Information	Location
PaRx	Program for Physicians to prescribe a free Parks Canada Pass to clients who can benefit from spending time in nature	https://www.parkprescriptions.ca/	Online
FoodFit	A program that helps low-income people improve their health and cooking skills through nutrition education and physical activity		
Mission Drive Happiness	Volunteer-based service that provides affordable and accessible transportation for seniors	drivehappiness.ca	Edmonton
Friendly Calls Program	Canada Red Cross matches people over the age of 18 with trained Red Cross personnel who connect with them regularly to check in, provide emotional support, encourage healthy coping strategies, and suggest well-being resources and community connections to other existing services	Call 1-833-979-9779 toll-free from 9 a.m. to 5 p.m. on weekdays	Remote
Canadian Red Cross Short Term Health Equipment Loan Program	Individuals can receive aids such as wheelchairs, walkers, bath seats, benches, commodes and toilet seats, crutches and canes, bed handles and other durable medical equipment. Referrals required from physician.	https://www.redcross.ca/in-your-community/alberta/health-equipment-loans/short-term-loan-program	ABHELPProgram@redcross.ca
FoodRx Participate	Provides low-individuals with type 2 Diabetes financial support in accessing healthy foods	foodrxalberta.ca/participate.html	EdmontonCalgary
HelpSeeker	App that connects users to social services	helpseeker.org	Online
Calgary Dollars	Can be used to help purchase goods and services from businesses and other users. Local currencies like Calgary Dollars aim to help foster stronger community connections by facilitating and encouraging local consumption.	https://www.calgarydollars.ca/	Calgary
The Genwell Project	Platform that provides resources and tools for creating and maintaining social connections and reducing loneliness	https://genwellproject.org/	Online
Caregivers Alberta	Website that provides information on and support for caregivers of seniors	https://www.caregivercare.ca/	Online
Men's Sheds Canada	A network of community spaces where men can socialize, learn new skills and contribute to their community	https://www.mensshedscanada.ca/	AirdrieBeaumontCamroseInnisfailCold LakeEdmontonCalgaryGr and PrarieInnisfailJasperSherwood ParkSprucegroveSpruceview
YouQuest	Provides a wellness community for young-onset dementia (under 65) and their families	https://youquest.ca/	Calgary

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This report has been designed using accessible templates available on the Canva public web domain.

We thank all readers for your engaged interest.

Contributors

MPH Graduate Students:
Adeola Adewara
Campion Cottrell-McDermott
Hanna McBain
Keji Mori
Madelyn Curle
Sarah Djuric

Organizational Mentors:
Mary Modayil, PhD, MSPH
Shawna McGhan, MN, RN
Beth Mansell, MPH