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Alberta Social Prescribing Model – Network Coordinators

Introduction

Healthy Aging Alberta has recently secured a $3.14 million investment from a private donor to develop a provincial social prescribing model for older adults over the course of 3-years. Social prescribing is a person-centered, holistic, and structured approach to bridging health and social models of well-being through the development of formal referral pathways from a health care provider into community-based services.

This project has two core components: service delivery funding for six regional projects and capacity building for a provincial approach to social prescribing. In 2022, three regional projects will receive funding to implement social prescribing with link worker roles, social work capacity, and regional network coordination for three years. These projects are underway in Calgary, Edmonton, and Lethbridge. In 2023, seven additional regional projects were funded for two years. These projects are underway in Jasper, Whitecourt, Sylvan Lake, Innisfail, Red Deer County, Vulcan, and Strathmore/Wheatland County. The capacity-building work includes resources to support curriculum development and training for frontline workers in the CBSS and health sectors. This work will help align the social prescribing approach across the ten funded projects. Additionally, Healthy Aging Alberta hopes to introduce other communities and organizations into the Social Prescribing Network, including partners such as Caregivers Alberta.

Network Coordinator – Responsibilities

Network Coordinators will be assigned in each of the regional projects. These Network Coordinators be funded for a portion of their time depending on the size of their community, (5-10hrs per week) and will take a leadership role in their community to promote and support the development of the social prescribing project in their region.

The Network Coordinator will act as the primary liaison between the regional projects and the Provincial Project Manager.

This role description may evolve and change throughout the course of the project. The Network Coordinators will review these responsibilities every 12 months to ensure that it accurately reflects the work undertaken and is supporting the development of the social prescribing model regionally.

The Network Coordinators will:

- Build relationships with healthcare providers to facilitate the social prescription from health care to the Link Worker and Outreach Worker (when applicable)
- Build relationships with community-based programs and services that Link Workers can refer into
- Participate in provincial capacity building activities (i.e. curriculum development, evaluation framework development, communications, assessment tool development, etc.)
- Align and connect the social prescribing project into other regional work, with a lens towards sustainability
- Participate in appropriate Community of Practice(s) (to be determined) to learn and share best practices
- Support Link Workers and Outreach Workers in the model to align to social prescribing best practices established through the provincial capacity building activities (i.e. curriculum development, communications, assessment tools, etc.)
- Support the development of policies and processes within your regional model for service delivery to enable ease of access for clients
- Support data collection, collation, and analysis as per the provincial evaluation framework
- Promote the social prescribing model to potential stakeholders in their community

In some communities, these activities will be undertaken in collaboration with the Link Worker(s).