



**Open Social Prescribing
 Community of Practice Meeting**
Date: June 25th, 2026
Time: 9:00 a.m – 11:00 a.m
Location: Zoom Meeting

Meeting Minutes

The overarching goal of this CoP is to create a supportive place to connect with other organizations. This includes opportunities to engage in discussions about successes and challenges, share resources and strategies, and learn from one another. We encourage you to think about what you want this CoP to be, as it is YOUR community and your work.

Meeting Objectives:

- Overview of Social Prescribing in Alberta
- Discussion around Social Prescribing (Interest, worries, fit in organization, and implementation needs)
- Social Prescribing Alberta Experiences

1. What (Key Points & Highlights)

Agenda Item	Summary
Welcome <ul style="list-style-type: none"> • Agenda • HAA's role in social prescribing 	
Social Prescribing 101	What is Social Prescribing? <ul style="list-style-type: none"> • A holistic healthcare approach that connects patients (especially older adults 55+) to non-medical community supports. • Referrals come from healthcare providers to a link worker, who helps clients access services like: <ul style="list-style-type: none"> ○ Housing and financial supports ○ Transportation ○ Social/recreation programs ○ Food and home supports • The goal is to improve health and quality of life by addressing social determinants of health. Why It Matters ~80% of health outcomes are driven by social factors (e.g., housing, income, relationships). Evidence shows: <ul style="list-style-type: none"> • Improved well-being (57% improvement in a pilot) • Reduced healthcare use (41% fewer repeat visits) • Supports older adults to age safely at home, which most prefer.

	<p>How the Model Works</p> <ol style="list-style-type: none"> 1. Referral from healthcare provider 2. Link worker meets client (often in their home) 3. Conducts holistic assessment and co-creates goals 4. Provides ongoing support (3–6 months or longer) 5. Connects client to community services 6. Shares updates with healthcare providers <p>Key Components for Success</p> <ul style="list-style-type: none"> • Strong healthcare–community partnerships • A dedicated link worker role • A formal referral system • Available community programs/services • Shared understanding of roles and processes • Champions in healthcare to promote referrals <p>Current Landscape in Alberta</p> <ul style="list-style-type: none"> • 22 communities have programs • Main referral sources: <ul style="list-style-type: none"> ○ Home care ○ Hospital discharge teams ○ Primary care providers • Top needs identified: <ul style="list-style-type: none"> ○ Financial support ○ Housing and housekeeping ○ Transportation ○ Social isolation and food access
<p>Breakout Groups –</p> <p>Breakout groups will discuss:</p> <ul style="list-style-type: none"> • What interests you most about social prescribing? • Why do you believe social prescribing is a strong fit for your organization or program? • What worries or concerns do you have about social prescribing implementation? 	<p>Common themes:</p> <ul style="list-style-type: none"> • Value of relationship-based, wraparound care • Need to formalize existing informal referrals • Concerns about: <ul style="list-style-type: none"> ○ Limited community resources (especially rural areas) ○ Role clarity across organizations ○ Time and effort needed to build partnerships • Importance of cultural relevance and Indigenous perspectives
<p>Starting a Social Prescribing Program</p>	<p>Key themes/ideas that respondents had:</p> <ul style="list-style-type: none"> • Sustainable funding is essential to support key roles (like link workers) and ensure long-term viability. • Strong networks connecting healthcare, social services, and community organizations enable coordination and referrals.

	<ul style="list-style-type: none"> • Clear understanding of community assets (through asset mapping) helps identify available supports and gaps. • Early and ongoing stakeholder engagement ensures shared goals and alignment across sectors. • Collaborative partnerships with defined roles improve efficiency and outcomes. • Coordination to avoid duplication ensures resources are used effectively. • A formal coalition or interagency group can provide leadership, governance, and accountability. • Broad buy-in, supported by awareness and champions, is critical for adoption and success. • A needs assessment helps tailor the approach by identifying service gaps and community priorities.
<p>Social Prescribing Alberta Experiences</p>	<p>Strathmore/Wheatland Program</p> <ul style="list-style-type: none"> • Rural program (launched 2024) • Serving older adults across a large geographic area • Key results: <ul style="list-style-type: none"> ○ 109 clients served (40 active) ○ 52% supported with housing/home services ○ 56% supported with finances ○ ~70% experienced isolation/mental health challenges ○ 11% disclosed suicidal ideation <p>Key Practices:</p> <ul style="list-style-type: none"> • Meet clients where they are (often at home) • Provide ongoing, relational support • Build strong local partnerships (19+) • Conduct asset mapping of community resources <p>Impact:</p> <ul style="list-style-type: none"> • Addresses complex, overlapping needs • Reduces isolation (“relationships as medicine”) • Supports both clients and overwhelmed healthcare providers • Estimated return: up to \$4.43 per \$1 invested

So What? (Significance & Implications)

- Social prescribing strengthens the link between healthcare and community support systems.
- It requires time (often 6+ months) to build partnerships before launching.
- Success depends heavily on local collaboration and available services.

- It is particularly impactful for addressing loneliness, poverty, and access barriers among older adults.

Next Steps

HAA to review survey feedback and determine feasibility and interest in future open CoP meetings for the CBSS sector.