SOCIAL PRESCRIBING FOR OLDER ADULTS

Community Implementation Toolkit

PREPARED BY:
Healthy Aging Alberta

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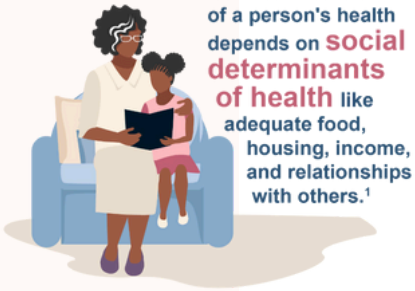


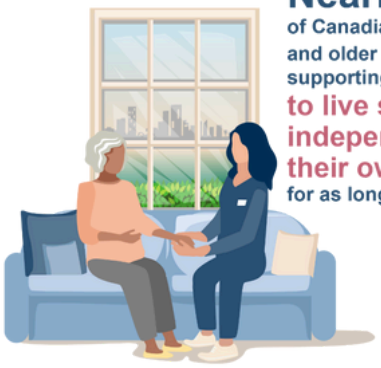
Over 80%
of a person's health depends on **social determinants of health** like adequate food, housing, income, and relationships with others.[1]

Social Prescribing[2]

+57% Improves patient rating of health and well-being*

-41% Decreases the number of repeat clinic visits**

*Three months post social prescription.
**Nine months post social prescription.



Nearly 100%
of Canadians aged 65 and older plan on supporting themselves **to live safely and independently in their own home** for as long as possible.[3]

Healthy Aging Alberta (HAA) is a rich network of community-based, seniors-serving organizations and allies across the province united by a shared vision: to make Alberta one of the best places in the world to grow older. HAA facilitates social prescribing programs for older adults throughout the province by supporting a consistent approach to service delivery.

Social prescribing is a holistic approach to healthcare that provides a formal referral pathway for healthcare providers to connect patients to community-based services. This provides much-needed assistance – to doctors and patients alike – and bridges the gap between medical and social care services.

This community implementation toolkit contains information and resources for communities to introduce and implement social prescribing for older adults. It outlines the steps required to develop and grow a social prescribing program, including sample materials that can be adapted to the local context.

How to use this toolkit?

There is no one-size-fits-all approach to social prescribing. This toolkit can be used as a self-assessment tool to support communities to consider where they are now and what they would need to do to be ready to implement successful and sustainable social prescribing. This toolkit will provide resources for community-based organizations, healthcare providers, and other community partners to feel confident and empowered to introduce social prescribing as a pathway to connect older adults to community-based programs and services.

Readiness Scale

Each section of this toolkit can be graded on the readiness scale

Pre-Contemplation
Action and/or change has not crossed key stakeholders' minds in this area

Contemplation
Key stakeholders are considering action and/or change in this area

Preparation
Key stakeholders are invested in action and/or change in this area

Action
Key stakeholders are making actions and/or changes in this area

Maintenance
Key stakeholders have made actions and/or changes in this area and are maintaining

Support from Healthy Aging Alberta

Healthy Aging Alberta (HAA) is committed to growing social prescribing programs for older adults across Alberta.

We hope to support communities who are interested in starting social prescribing, to move from idea to implementation. As you work through this toolkit, HAA has resources to support you.

- Coaching support for the Implementation Team
- Link Worker Training
- Access to communication materials to share social prescribing information with different stakeholders
- Invitation to join our Community of Practice meetings and learn from other communities implementing social prescribing
- A connection to national initiatives like the Canadian Institute for Social Prescribing
- Support and advocacy to system partners for future sustainable funding for social prescribing

1. Establish a Planning and Assessment Team

So your community has decided that it wants to explore implementing a formal social prescribing program for older adults! We suggest establishing a planning and assessment team to work through this toolkit. Identifying key champions across sectors early in the development process has proved to be more successful in the eventual implementation of a social prescribing program.

- Identify key champions who are committed to exploring the implementation of social prescribing in your community. This could be 2-3 people from different organizations who will lead this initial work.
    - This team should be multidisciplinary and have the ability to engage between sectors (health and community)
    - This team should have good knowledge of local organizational processes and team dynamics.
    - This team should have support from leadership in the community (i.e. FCSS, Municipal Council, Primary Care Network).
    - Key champions on this team could be a Program Manager from a local seniors serving organization, the Director from FCSS, a Clinic Manager, or a passionate community volunteer.
- The team could engage broader support by asking other members to join a steering committee that could oversee local implementation, if appropriate.
- The planning and assessment team will be responsible for working through this toolkit

Circle where on the readiness scale your community is in terms of establishing a planning and assessment team and securing support from leadership in your community.

You should be at the yellow, green, or blue level to proceed.

2. Enhance the Community's Understanding of Social Prescribing

It is important that all key stakeholders in your community, beyond the Planning and Assessment Team, share a common understanding of what social prescribing is, and what it will look like in your community before undertaking more formal work to establish a program.

Key stakeholders could include:

- Community-based organizations offering programs and services for older adults
- Grassroots or informal groups serving older adults
- Primary Care Network
- Medical Clinics
- Alberta Health Services - Home Care Teams
- Acute Care Discharge
- Pharmacists

Social prescribing is not an intervention by itself, but rather a pathway that helps to address the patient's needs and connect them to non-medical programs and services.
The concept of social prescribing, or pieces of the social prescribing approach may already be happening in your community. However, this might not be occurring in a formalized way, or perhaps pieces of the holistic model are missing.

These **resources** may help to enhance your understanding of social prescribing.

Circle where on the readiness scale your community is in terms of its current understanding of social prescribing.

If you are in the red, orange or yellow area, Healthy Aging Alberta could support you by presenting to, or faciliating a conversation with key stakeholders in your community.

You should be at a green or blue level to proceed.

3. Community Assessment

Congratulations! You've established a Planning and Assessment Team and worked to enhance your community's understanding of social prescribing.

The next step is understanding your readiness to undertake a Community Assessment.

A strong understanding of the community's current capacity and partnership network is crucial before starting a social prescribing program. Communities with strong connections between sectors are often more successful in their implementation stages than those that are trying to build partnerships while also starting to receive referrals.

Please flip through the next four pages to see what the assessment entails and determine if your community is ready to undertake the assessment.

Circle where on the readiness scale your community is in terms of being able to undertake a community assessment.

If you are in the red or orange area, consider what might be needed so that your Planning and Implementation and begin the assessment.

You should be at a yellow, green, or blue level to proceed.

3a. Community Assessment Activities

The below chart suggests activities that should be undertaken as part of the community assessment. These activities do not need to be completed in order. Healthy Aging Alberta can support you to complete some of these activities.

Each activity has a space for you to complete a response, and assign a score based on the criteria provided. You can assign half scores if you feel you are between scores

Activity	Response	Criteria	Score
Community			
Engage with stakeholders and community members to find out what they want from a social prescribing program		1 - Stakeholders and community members are not interested in engaging about social prescribing 2 - After engaging with stakeholders and community members, you have a mixed understanding of what they want and need from a social prescribing program 3 - After engaging with stakehollders and community members, you have a clear understanding of what they want and need from a social prescribing program	
What are the main health and wellbeing issues facing the community?		1 - The health and wellbeing issues facing the community cannot be identified 2 - The health and wellbeing issues facing the community have been identified, but you're unsure if social prescribing is the right fit to address them 3 - The health and wellbeing issues facing the community have been identified and a social prescribing program is the right fit to address them	

Activity	Response	Criteria	Score
Population			
Is there a large older adult population that could benefit from social prescribing?		1 - There is a very small older adult population that could benefit from social prescribing 2 - There is a reasonable older adult population that could benefit from social prescribing 3 - There is a large older adult population that could benefit from social prescribing	
Is there a need for inclusion and exclusion criteria to narrow down the target group (such as demographic and socio-economic factors)?		1 - You are unsure about the target population and any inclusion/exclusion criteria 2 - You have loosely defined a target population 3 - You have clearly defined the target population	
Are there any challenges/opportunities within the population, for example cultural attitudes or local behavioural trends that may impact the program?		1 - There are challenges in the community that may prevent successful social prescribing 2 - There are a mix of challenges and opportunities in the community that will contribute to successful social prescribing 3 - There are opportunities in the community that will contribute to successful social prescribing	

Activity	Response	Criteria	Score
Feasibility			
Consider the community dynamics. What is the current state of collaboration between and within sectors?		1 - There's limited collaboration between or within sectors 2 - There's a high degree of collaboration within sectors, but not between sectors 3 - There's a high degree of collaboration between sectors and within sectors	
Is there leadership support across sectors?		1 - There is limited leadership support in both the health or community sectors 2 - There is strong leadership support in one sector 3 - There is strong leadership support in both the health and community sectors	
Have similar programs already been implemented in the community? If so, are/were they successful? Is there any work that can be leveraged?		1 - Similar programs already exist, with limited success 2 - Similar program already exist, and there's some work that can be leveraged 3 - No similar programs already exist	

Activity	Response	Criteria	Score
Is there existing funding that can be leveraged for a dedicated Link Worker role? 1 FTE Link Worker, including overhead costs, supervision and mileage is estaimed between $70-80,000/year.		1 - There is no existing funding that can be leveraged for a dedicated Link Worker role 2 - There is limited existing funding that can be leveraged for a dedicated Link Worker role, or funders are hesitant to commit 3 - There is existing funding that can be leveraged for a dedicated Link Worker role	
If there's no current funding for a dedicated Link Worker role, what other opportunities are there to re-purpose existing roles to take on a Link Worker role?		1 - There are no other opportunities to re-purpose existing roles to take on a Link Worker role 2 - There are limited opportunities to re-purpose existing roles to take on a Link Worker role, or organizations are hesitant to commit 3 - Other opportunities to re-purpose an existing role have been identified and are supportive	
Network			
Map out all of the current points of contact between the target population and healthcare providers (this could include primary care clinics, hospitals, pharmacies, home care, etc.)		1 - Limited points of connection between the target population and healthcare providers exist 2 - Connection points between the target population and healthcare providers exist, but they are messy and confusing 3 - Clear connection points between the target population and healthcare providers exist and have been identified	

Activity	Response	Criteria	Score
Map out existing collaborations and referral systems between community organizations, and between community organizations and the healthcare system (if they exist)		1 - Limited collaboration between community organizations, and community organizations and the healthcare system exist 2 - Connection points between community organizations, and community organizations and the healthcare system exist, but they are messy and confusing 3 - Clear collaboration between community organizations and the healthcare system exists and is clearly identified	
Map out existing roles and responsibilities of healthcare providers and community organizations. Existing roles could include AHS Home Care Case Managers, Social Work within the PCN, Community Outreach, FCSS, etc.		1 - It is challenging to define current roles and responsibilities of healthcare providers and community organizations 2 - Roles and responsibilities of healthcare providers and community organizations have been articulated, but there's significant overlap and confusion 3 - Roles and responsibilities of healthcare providers and community organizations have been articulated and there is a clear understanding of scope and boundaries.	
Consider who could house the role of the Link Worker and how they could be integrated into the existing system (including supervision)		1 - There's no lead organizations willing to house the Link Worker role 2 - There's an organization willing to house the Link Worker role, but no understanding how they could be integrated into the existing system 3 - There's an organization willing to house the Link Worker role, and an understanding of how they will be integrated into the existing system	

3b. Community Assessment - Results

Total Score Out of 42

Congratulations! You've completed your Community Assessment.

The activities in the community assessment have hopefully prompted important conversations amongst stakeholders and prepared you to begin implementation.

A score above 35 indicates that your community has a high degree of readiness to begin a Social Prescribing for Older Adults program.

A score of 25-35 indicates that your community has some key elements necessary to begin a Social Prescribing for Older Adults program, but could still use some more support to build capacity and relationships between healthcare and community-based services. The HAA team can provide support to navigate these relationships.

A score less than 25 indicates that social prescribing may not be a good fit for your community at this time. We suggest more time to continue build capacity in the community and work with stakeholders.

Circle where on the readiness scale your community is in terms of support to begin the implementation workplan.

If you are in the red, orange, or yellow area, we suggest revisiting areas of the assessment with lower scores and reflecting on how you can improve capacity in those areas.

If you are in the green or blue, you can proceed to the Implementation Workplan section.

4. Implementation Workplan

This workplan template is a great start at some key actions that are necessary to complete to ensure a successful start to your social prescribing program. There may be other action items in your community that you want to add to this workplan.

The HAA team can help you to work through these activities and identify specific actions that may be helpful in your community.

Activity	Actions to Achieve Activity	Timeline	Status (Complete, In Progress, Not Started)
Governance			
Stakeholders agree on the target population (geographic boundaries, demographics, etc.)			
Stakeholders agree on their objectives, roles, and responsibilities of the Social Prescribing for Older Adults Program in the community			

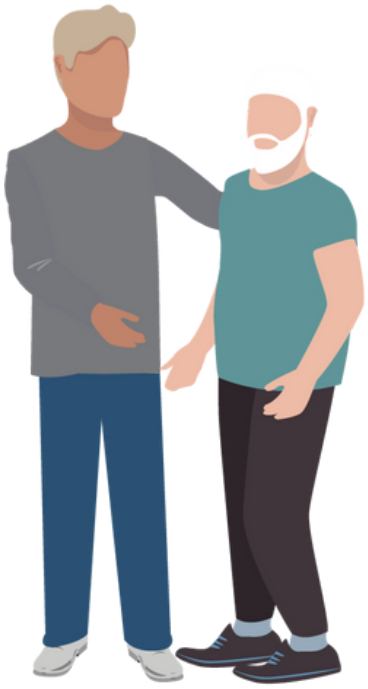
Activity	Actions to Achieve Activity	Timeline	Status (Complete, In Progress, Not Started)
Funding is secured, or is sought after			
Partnership is formalized through a Partnership Agreement/Memorandum of Understanding			

Activity	Actions to Achieve Activity	Timeline	Status (Complete, In Progress, Not Started)
Asset Mapping			
Undertake community asset mapping to align programs, groups, and services with determinants of healthy aging. This is a tool that the Link Worker will use to connect clients to programs.			
Determine if existing community programs, groups, and services have the capacity to serve additional clients. If not, can additional capacity be created.			

Activity	Actions to Achieve Activity	Timeline	Status (Complete, In Progress, Not Started)
Referral Pathways			
Determine how the social prescription will be made and create a referral form			
Develop and organize healthcare provider engagement strategy and training on social prescribing			
Determine process for how patient will be connected to the Link Worker, and how to determine what is an apporiate referral vs. inappropriate referral			

Activity	Actions to Achieve Activity	Timeline	Status (Complete, In Progress, Not Started)
Monitoring and Evaluation			
Determine how many clients can realistically be served by 1 FTE Link Worker in a timeframe (weekly or monthly)			
Determine if and how you will adopt HAA's Data Collection Guide			
Determine how progress and outcomes will be tracked and measured			

Contact Information



+780-913-9027

beth.mansell@healthyagingalberta.ca

https://calgaryunitedway.org/healthy-aging-alberta/social-prescribing/

Resources

Link Worker Job Description Example/Template
This is a Link Worker job description that is used in the Edmonton Regional Project. The overview section contains paragraphs that can be used to advertise for this position.

Network Coordinator Role Description
This role description was created in collaboration with the Network Coordinators from Edmonton, Calgary and Lethbridge. Network Coordinators act as a champion for social prescribing in their community and build relationships with healthcare providers.

Referral Form Examples

5. Calgary
6. Edmonton
7. Lethbridge

These are the referral forms being used in the Phase 1 Regional Projects. Many of the items that HAA is collecting data on are contained on the referral form.

The Healthy Aging Asset Index Assessment Tool

This is currently being used in Edmonton by Sage Seniors Association and Jewish Family Services Edmonton – our hope is for all of the social prescribing programs supported by HAA are eventually able to use this tool. Support for training and implementation of this tool is available from Sage Seniors Association. Sage has also developed a matrix to align the questions on the tool to HAA's Data Collection Guide, so that there is not a need to duplicate evaluation measures with assessment questions.

Shared Communication Materials

HAA Social Prescribing Education Q&A
This is a resource of key messages that respond to common questions. If you have questions about Social Prescribing, check if it's answered here. This is something that can be shared with stakeholders in your community as well.

Social Prescribing: A Holistic Approach to Health Video
This can be used as part of presentations to describe social prescribing and the Social Prescribing for Older Adults program

Client Level Data Collection Guide

This explains how the client level data collection measures were determined and how they should be collected. You can choose to follow this guide if you'd like to evaluate the impact of your program on a provincial scale.

Client Level Data Export Example

This is a very basic example of what a client level data export could/should look like if you report your client level data up to HAA.

Additional Resources Available on Request

- Program Budget Template
- Stakeholder Key Messages
- Draft Partnership Agreement/MoU
- Asset Map Templates