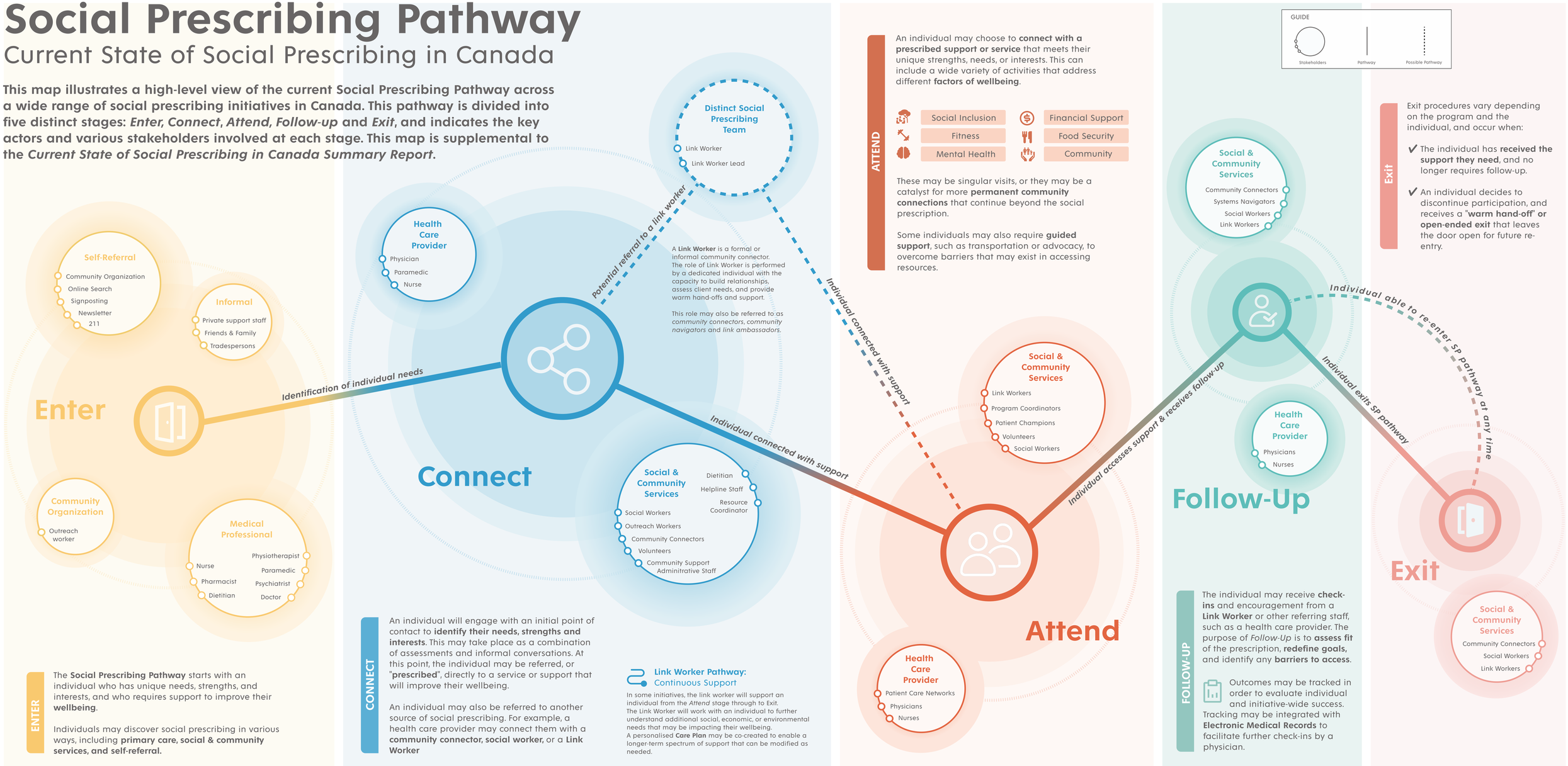
Social Prescribing Pathway

Current State of Social Prescribing in Canada

This map illustrates a high-level view of the current Social Prescribing Pathway across a wide range of social prescribing initiatives in Canada. This pathway is divided into five distinct stages: *Enter, Connect, Attend, Follow-up* and *Exit*, and indicates the key actors and various stakeholders involved at each stage. This map is supplemental to the *Current State of Social Prescribing in Canada Summary Report*.

GUIDE

Stakeholders | Pathway | Possible Pathway



ENTER

The **Social Prescribing Pathway** starts with an individual who has unique needs, strengths, and interests, and who requires support to improve their **wellbeing**.

Individuals may discover social prescribing in various ways, including **primary care, social & community services, and self-referral.**

CONNECT

An individual will engage with an initial point of contact to **identify their needs, strengths and interests**. This may take place as a combination of assessments and informal conversations. At this point, the individual may be referred, or "**prescribed**", directly to a service or support that will improve their wellbeing.

An individual may also be referred to another source of social prescribing. For example, a health care provider may connect them with a **community connector, social worker,** or a **Link Worker**

A **Link Worker** is a formal or informal community connector. The role of Link Worker is performed by a dedicated individual with the capacity to build relationships, assess client needs, and provide warm hand-offs and support.

This role may also be referred to as *community connectors, community navigators* and *link ambassadors.*

Link Worker Pathway:
Continuous Support

In some initiatives, the link worker will support an individual from the *Attend* stage through to Exit. The Link Worker will work with an individual to further understand additional social, economic, or environmental needs that may be impacting their wellbeing. A personalised **Care Plan** may be co-created to enable a longer-term spectrum of support that can be modified as needed.

ATTEND

An individual may choose to **connect with a prescribed support or service** that meets their unique strengths, needs, or interests. This can include a wide variety of activities that address different **factors of wellbeing**.

- Social Inclusion
- Financial Support
- Fitness
- Food Security
- Mental Health
- Community

These may be singular visits, or they may be a catalyst for more **permanent community connections** that continue beyond the social prescription.

Some individuals may also require **guided support**, such as transportation or advocacy, to overcome barriers that may exist in accessing resources.

FOLLOW-UP

The individual may receive **check-ins** and encouragement from a **Link Worker** or other referring staff, such as a health care provider. The purpose of *Follow-Up* is to **assess fit** of the prescription, **redefine goals,** and identify any **barriers to access**.

Outcomes may be tracked in order to evaluate individual and initiative-wide success. Tracking may be integrated with **Electronic Medical Records** to facilitate further check-ins by a physician.

Exit

Exit procedures vary depending on the program and the individual, and occur when:

- ✔ The individual has **received the support they need**, and no longer requires follow-up.
- ✔ An individual decides to discontinue participation, and receives a "**warm hand-off**" **or open-ended exit** that leaves the door open for future re-entry.

Designership 2022: Developing a National Framework for Social Prescribing

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