LEARNINGS

From the
2023 United Way British Columbia
Social Prescribing Programs Co-Creation Sessions

United Way
British Columbia

Working with communities in
BC's North, Interior, Lower Mainland,
Central & Northern Vancouver Island

UNITED
for seniors in need

ACKNOWLEDGEMENTS

We express our sincere gratitude to the numerous individuals and organizations whose contributions were essential to the success of the Social Prescribing Demonstration Project conducted between 2020 and 2023.

We would like to extend special thanks to Howegroup's Wynona Giannasi, Jennifer Hystad, and Elayne McIvor for their leadership in the evaluation process. Their expertise, guidance, patience, and support have greatly enriched the project and played a crucial role in its progression.

Furthermore, we are thankful to all the organizations and individuals who participated in the demonstration project and shared their insights and experiences. Their valuable contributions have significantly enhanced the project, and we appreciate their collaboration.

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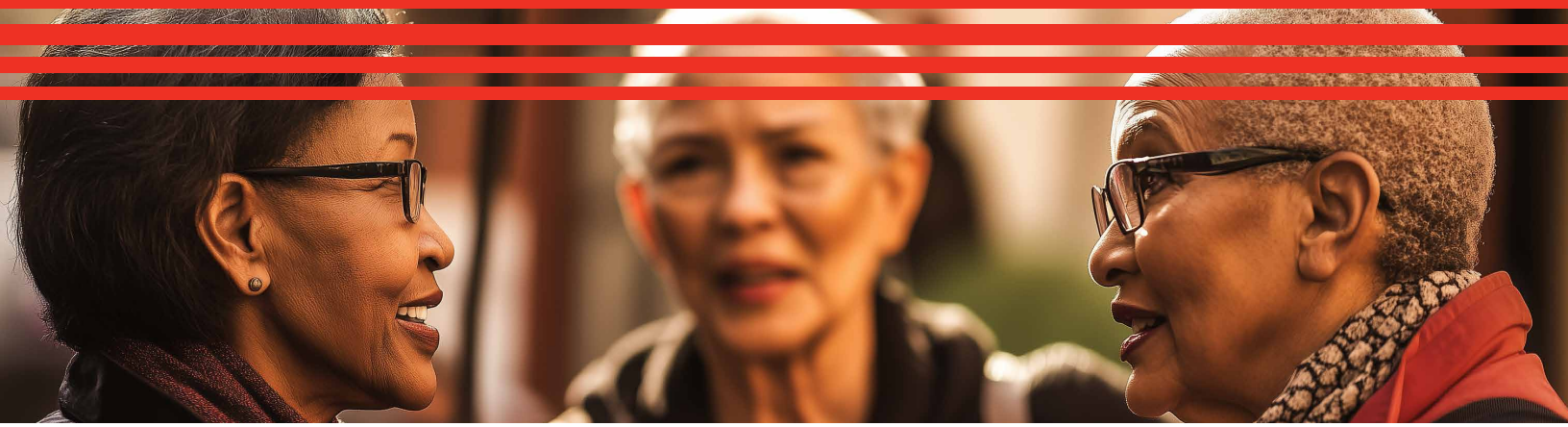
INTRODUCTION



Beginning in 2020, United Way British Columbia introduced 19 Social Prescribing (SP) programs across the province, spanning fourteen urban communities and five rural areas. From October 2020 to April 2023, UWBC collected data from these SP programs to assess their impact on older adults, and to evaluate the successes, challenges, and areas for improvement.

Despite the significant disruption caused by the pandemic, organizations adapted and established their programs as restrictions eased. Variations emerged not only due to the pandemic but also from the diverse contexts of different organizations and communities. It became essential to identify the core features of social prescribing programs and understand how they could remain flexible to meet the unique needs, priorities, strengths, and assets of each community.

In early 2023, three co-creation focus group sessions were held with 19 Community Connectors. These sessions were semi-structured, featuring discussion prompts and questions from facilitators, but also allowed for organic discussion. Additional feedback was gathered through close-ended polls. The goals of these co-creation sessions were to:

- Identify core features of the SP programs,
- Build consensus on program design and delivery,
- Identify areas for future support, and
- Provide guidance for a future program manual.

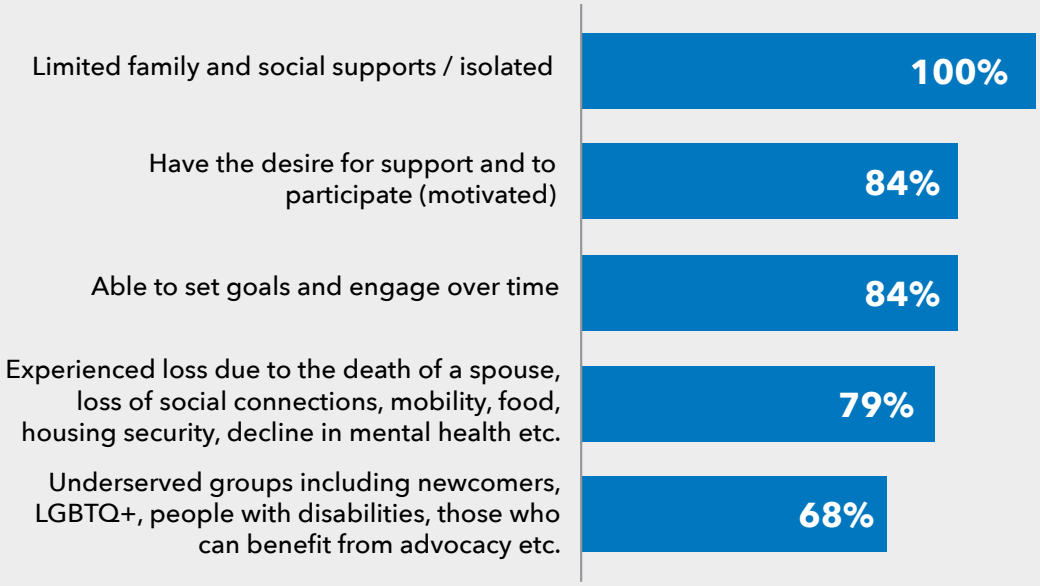
The key findings and insights from these sessions reflect the voices of the 19 Community Connectors. While the initial purpose of these co-creation sessions and this report was to inform the development of a UWBC Social Prescribing Program implementation guide, we hope to share these learnings to support other social prescribing programs to enhance program design, support best practices and implementation, encourage collaboration, and drive innovation.

1. PARTICIPANTS

Participants Who Benefit Most

SP programs had a high level of consensus on the characteristics of participants who benefit from the most from SP services and support of Community Connectors.

Figure 1: Agreement on characteristics of participants who benefit most from the SP program services and supports.



Short vs. Long-Term Participants

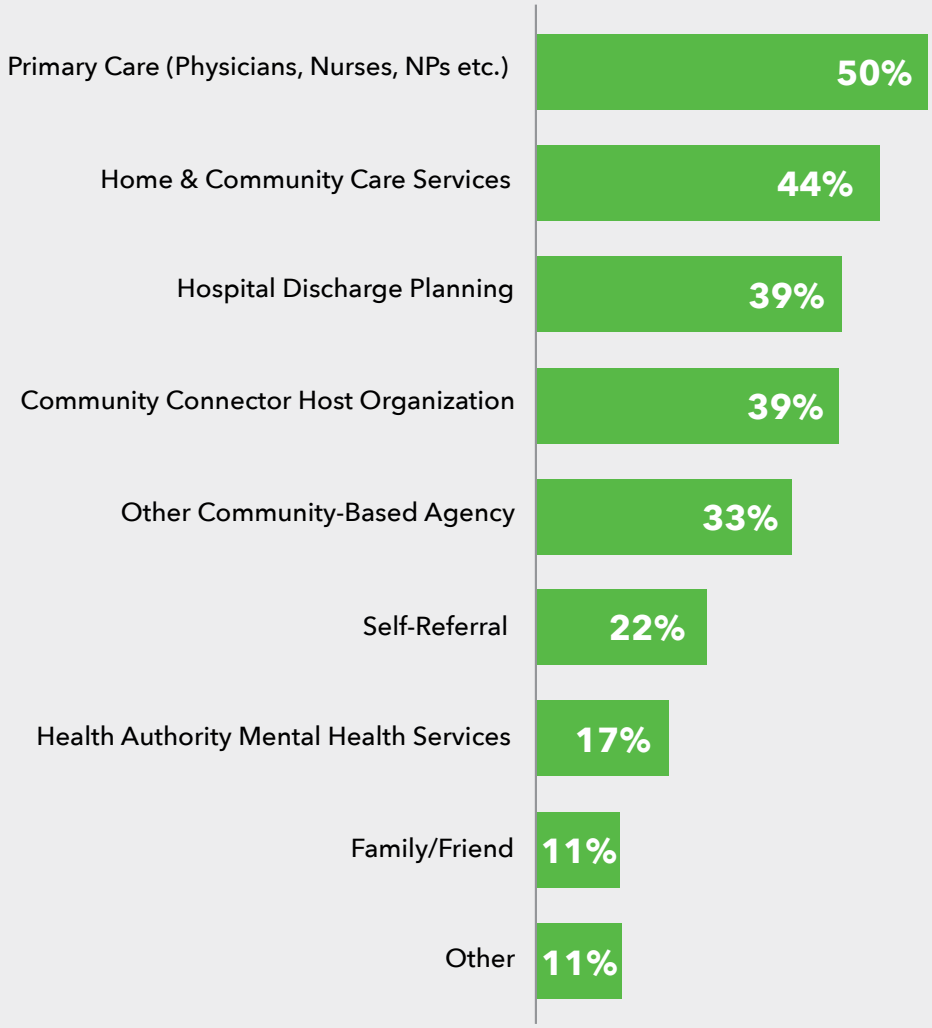
SP programs estimated that 60% of their participants are long-term, or have been involved for more than 3 months, while 40% were considered "short-term" or involved for three months or less.

2. REFERRALS

Referral Sources to the SP Program

Figure 2 provides an overview of referral sources for SP programs. Programs were asked to rate their top three referral sources.

Figure 2: Incoming Referral Sources (to SP programs)

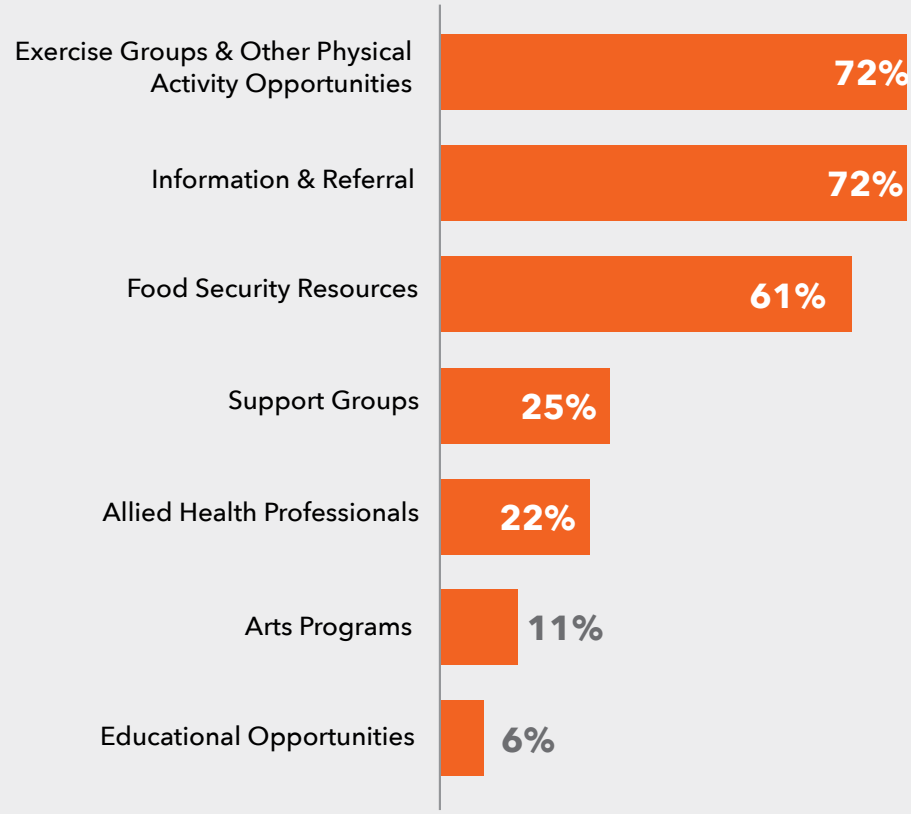


2. REFERRALS

Community Resource Referrals

Figure 3 provides an overview of the types of community resource referrals that were provided to participants. Programs were asked to rate their top three community resource referrals.

Figure 3: Community Resource Referrals



2. REFERRALS

Developing Relationships to Support Referrals

Community Relationships

SP Programs provided many examples of successful relationship building with community partners to support referrals and increase awareness of the SP program.

These include:

- Individual and regional networks of senior service agencies
- Community centres, seniors' centres, neighbourhood houses
- Rotary clubs and legions
- Recreation groups
- Settlement organizations
- Indigenous organizations
- Meals on Wheels
- Food banks
- Grocery stores
- Housing providers (BC Housing, assisted/independent living)
- UWBC Healthy Aging funded programs (Better at Home, Family Friends & Caregivers, Therapeutic Activation Program)
- Private businesses
- Municipal governments
- Peer support programs and mental health support groups
- Universities (for intern/students)
- Libraries
- Local newspapers
- Seniors' fairs
- Police departments

Smaller communities reported leveraging personal connections and note the value of **community networking groups** such as SING: Senior Independent Networking Group, which is comprised of "everyone who can offer anything to seniors in the community."

Partnerships between SP programs and community partners involved:

- Receiving new referrals (i.e. new sources of "identifiers").
- Sharing and exchanging information and resources, and collaborative problem solving.
- Having shared programs and participants (i.e. two-way referrals).
- Working together to increase access to services (i.e. reducing barriers to entry by covering activity fees).

2. REFERRALS

Healthcare Professional Relationships

SP programs described successful relationships built with healthcare professionals, as well as factors that supported relationships.

Examples of such relationships include:

- Partnerships with Primary Care Networks (PCN), including ongoing communication and collaboration with social workers
- Divisions of Family Practice
- Community rehabilitation teams
- Urgent care centres & hospitals (particularly discharge teams)
- Older adult mental health teams
- Community paramedics
- Dietitians
- Healthcare professionals linked to local health authorities (mental health, primary care, home and community care)

Social workers, Nurse Practitioners, and hospital discharge teams were noted as particularly key sources of referrals.

Factors that supported successful relationships with healthcare professionals include:

- Working with key personnel, such as physician champions, salary-based providers, and connecting directly with medical office assistants.
- Enhancing program communications and promotion by developing materials and presentations for healthcare professionals with clear and succinct descriptions of what the program can offer and how it can benefit their older adult patients.
- Fostering relationships and collaboration by making a conscious effort to connect with PCNs over time, leveraging a history of previous collaborations with PCNs, and promoting mutual respect between programs and providers.
- Developing readily accessible paperwork and referral forms for providers to use.

Common Referral Forms

While most SP Programs supported the idea of a common referral form, there is a preference for local adaptation. The Fraser Health Authority referral form was proposed as a good starting point, in collaboration with input from established programs.

2. REFERRALS

Social Prescribing Program

SENIORS' COMMUNITY CONNECTOR REFERRAL FORM

Please review the **Referral Guide** on back of form for Social Prescribing Program description.

Please Fax Referral to the Seniors' Community Connector (SCC) in the patient's community (see page 2). For questions related to urgent cases (< 1 week) or specific needs—please call the SCC prior to referral.			
Referral Date:_____		**Patient Verbal Consent Obtained** ☐	
Patient's Name: Date of Birth: Address: Phone #: Caregiver or support person phone # & relationship:		Referral Criteria: ☐ Seniors 55+ (plus one more criteria below) ☐ Frailty ☐ Lacks informal supports and/or lives alone ☐ Social isolation/ Emotional support	
☐ Acute Care Patient (fill out information with asterisk*) ☐ Surgical pre-admission ☐ Community Health Expected surgery date (if known): _____		☐ Funded Assisted Living ☐ Primary Care ☐ Virtual Care Team	
Clinic/Office			
Unit*		Patient Care Coordinator*	
Hospital*		Unit Direct Phone/ Local *	
Expected Date of Discharge*			
Patient requires contact prior to discharge* ☐ Patient prefers contact after discharge* ☐			
Referral Reason (see examples on pg. 2)	☐ Nutrition support/food access concerns ☐ Assist with discharge home from hospital* (e.g. transportation, prescription, equipment) ☐ Physical Activity Needs ☐ IADL Resource Navigation ☐ Social Engagement/ Leisure Activities ☐ Caregiver Support Explain if Checked:_____		
Current Services Involved	☐ Home Health ☐ Mental Health ☐ Seniors Clinic ☐ Other services: ☐ Primary Language_____ Need Interpreter? ☐ Yes ☐ No		
Additional patient information (i.e. hearing and visual loss, mobility device, etc.)			
Referrer Information			
Full Name		Job Title	
Phone			
Family GP/NP		Family GP/NP Phone	

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2. REFERRALS

Social Prescribing Program

SENIORS' COMMUNITY CONNECTOR REFERRAL FORM

What is Social Prescribing?	Social Prescribing is a non-medical, non-clinical referral with the purpose of meeting the need for social and community supports.
How does social prescribing work?	Identify socially vulnerable patient > Conversation between patient and health provider > **Obtain verbal consent** > Referral form faxed to Seniors' Community Connector > Community connector works with patient to create wellness plan > With patient's consent, health provider/family GP is kept informed of patient's progress and recommends adjustments to wellness plan > Patient is referred to additional services or discharged to self-care
Script for obtaining verbal consent	"Seniors who live alone or have few supports experience better health when connected to community supports. Do you consent to sharing your personal information listed in this referral to a Seniors' Community Connector so that they may contact you to tell you more about community services that may be of interest to you? Your family practitioner may receive a report on your progress with your consent."
Examples of Seniors' Community Connector Support	**Nutrition support/Food access concerns:** Patient says they need help with meals/groceries. SCC connects patient to meal delivery/food bank programs. **Assist with discharge home from hospital:** Patient says that they have no one to help with tasks related to discharge. SCC connects with patient to talk about specific needs related to getting home (e.g. pick up Red Cross equipment). **Physical activity needs:** Patient says they would like to be more active. SCC connects patient to community exercise programs/community centers. **Instrumental Activities of Daily Living Resource Navigation:** Patient is homebound and/or lacks informal supports and says they need help with basic daily activities such as cooking, housekeeping & transportation services. SCC connects patients to community resources. **Social engagement/Leisure activities:** Patient feels lonely. SCC connects patient to peer support and/or social activities such as community center/men's group.

City	Organization Name	Phone	Fax
Abbotsford	Archway Community Services	604-743-0393	604-859-6334
Burnaby	MOSAIC	604-438-8214 ext. 115	604-438-8260
Chilliwack/Agassiz/Hope	Chilliwack Community Services	778-539-5435	604-792-6575
Coquitlam, Port Coq., Port Moody, New Westminster	SHARE Family & Community Services	604-540-9161 Ext. 567	604-540-2290
Langley	Langley Senior Resources Society	778-871-5366	604-532-1320
Maple Ridge/Pitt Meadows	Maple Ridge/Pitt Meadows Community Services	604-868-4501	604-677-6647
Mission	Mission Community Services Society	604-826-3634	604-820-0634
South Delta	KinVillage Association	236-880-4120	604-943-1911
Surrey/North Delta	DIVERSEcity Community Resources Society	604-507- 2266 604-307-4024 (Urgent needs)	604-597-0488
White Rock/South Surrey	Brella Community Services Society	604-531-9400 ext. 204	1-855-510-5701

Please fax an internal copy of all referrals to 604-528-5487 to assist with data collection and evaluation. Thank you!

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3. PROGRAM ELEMENTS

Core vs Optional Elements of Social Prescribing Programming

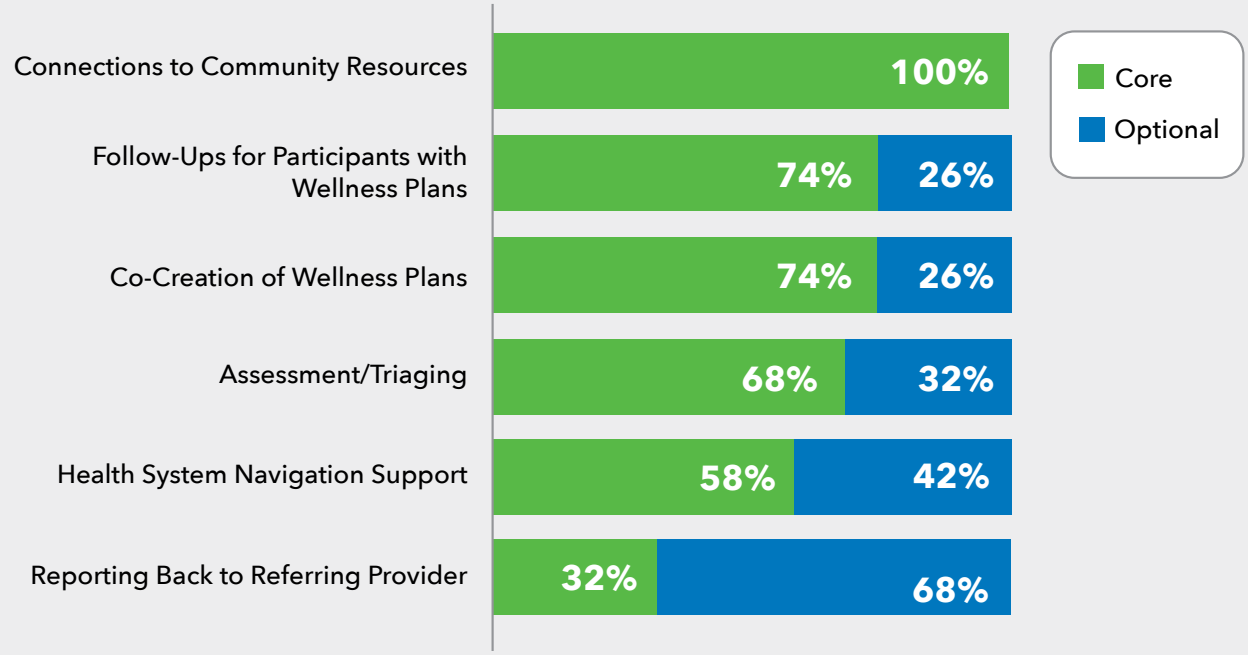
Most SP programs suggested that the following should be core program elements:

- Connections to community resources as needed by participant. This includes food security, housing, transportation, social support, and/or accompanying the participant to any of these activities.
- Co-creation of a wellness plan.
- Ongoing follow-up & check ins for all participants with a wellness plan.
- Assessment & triaging. This is required for programs where referrals exceed capacity and/or where referrals are incomplete.

Most recommended that the following should be optional program elements:

- Health system navigation support as needed by participants.
- Reporting back to referring provider for everyone not self-referred.

Figure 4: Votes on Core versus Optional Program Elements



3. PROGRAM ELEMENTS

Intake Processes

Programs shared details about their current intake processes. Approximately half of the programs collected most of the intake information during the first visit, while the other half gathered information over time.

Program staff met with participants in person and/or via telephone. As telephone intakes were necessary during the COVID-19 pandemic, some programs have continued to conduct intakes via phone, while others have moved to a hybrid model dependent upon the participant's preferences.

Differences in intake processes depended on several factors:

- Experience and preference of the Community Connector. Some staff were overwhelmed by the data collection while others integrated it into other intake questions as part of getting to know the participant.
- Participants willingness to share information. In some cases, it took longer to build relationships with participants to allow them to feel comfortable enough to share personal information. Those with more experience and community development backgrounds were able to better gauge participants' needs and adjust the intake process as needed.
- Participants with urgent (crisis) needs. For participants in crisis or those requiring one-off supports, only the basic intake information was gathered, particularly during pandemic-related program shifts.

Barriers to collecting demographic data were identified:

- Participants questioned the purpose of certain data collection. At this time, Personal Health Numbers (PHN) were being collected as part of a research partnership evaluating health care utilisation. Community Connectors noted that seniors were particularly reluctant to provide this information due to an increase in scams targeting seniors. Additionally, others could not locate their PHN.
- Community Connectors felt uncomfortable asking personal questions, such as those about income. Some believed that collecting such detailed information was unnecessary for participants requiring one-off supports or for those in crisis. Others felt that the intake form was too lengthy.

Strategies to overcome barriers to collecting intake data were identified:

- Engaging participants through motivational interviewing techniques.
- Building relationships through establishing trust and rapport early in the intake.
- Adopting a conversational approach to the intake, gathering information through natural conversation instead of verbatim questioning.
- Providing clear and consistent information developed by UWBC to both participants and referring providers about the importance of the data, including the reasons for its collection and how it will be used.

Person-Centred Support & Co-Creation of Wellness Plans

SP programs were asked to describe what "person-centred support" looks like in their work with participants. They shared a unified vision that involves the co-creation of wellness plans by listening to participants needs and desires and using a strength-based approach to empower them in goal setting and planning.

All programs emphasized the importance of building relationships and trust with participants, and the need for individualized planning that supports participants' desires. Many Community Connectors seek to understand their participants own perspective on why they were referred, which often differs from the referring provider's perspective. They also underscored the importance of motivational interviewing techniques, meeting the senior where they are, and practicing patience and active listening.

Most programs emphasized empowering participants to choose activities that interest them. Some highlighted the importance of understanding of participants' existing support networks, to help fill gaps in programming.

A few Community Connectors emphasized the need to keep wellness plans manageable to avoid overwhelming participants with too many activities and dates.

Notably, several Connectors emphasized a holistic and/or Indigenous approach to wellness planning.

4. BENEFITS FOR PARTICIPANTS

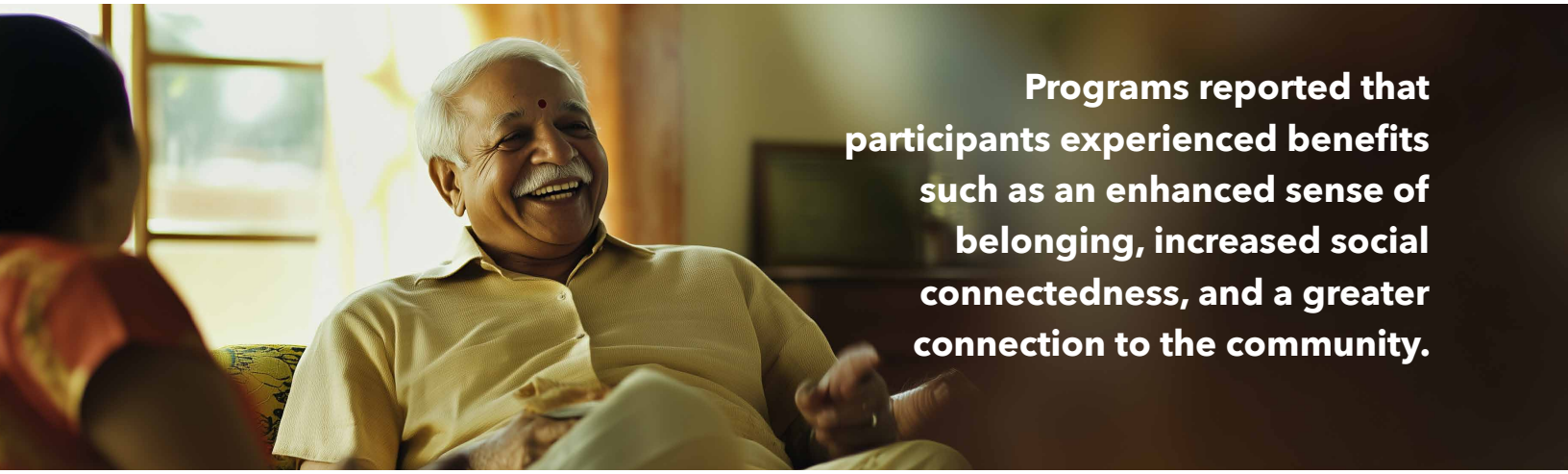
The following participant benefits were identified by SP programs and older adults.

Health and Well-Being:

- Enhanced access to social, physical, and nutritional supports.
- Improved physical health (such as through participation in physical activities or increased activity levels).
- Improved mental health (such as through a greater sense of feeling seen and heard).
- Upstream prevention of medical issues (such as through the identification of health issues, referrals to community resources, and encouragement to participants to seek medical care).
- Connection to and assistance attending medical appointments.
- Feeling safer living at home.

Social Connection & Community Involvement:

- Increased sense of belonging, social connectedness, and sense of connection to the community.
- More opportunities to meet people.
- Greater awareness of community services, increased ability to access these services and confidence to participate.
- Gaining the courage or confidence to attend activities for the first time.



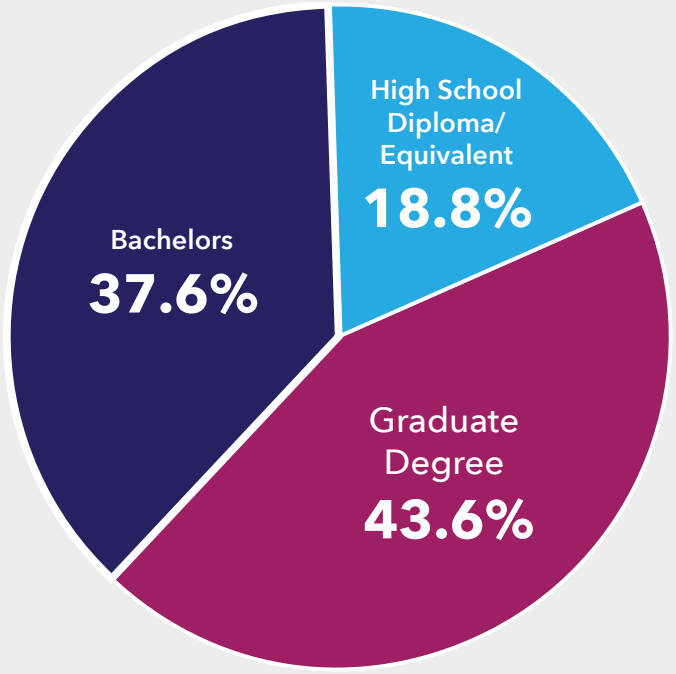
Programs reported that participants experienced benefits such as an enhanced sense of belonging, increased social connectedness, and a greater connection to the community.

5. SKILLS AND ATTRIBUTES FOR COMMUNITY CONNECTORS

Community Connector Educational Backgrounds, Experience, and Skills

As Community Connectors are non-clinical professionals without mandatory licensing or certification requirements, they possess previous experience or education in a wide range of fields, with a common emphasis on health and social disciplines.

Figure 5: Community Connector Education Levels



Specific Program Diplomas:

- Social Work
- Bachelors in Applied Psychology
- Communications
- Gerontology
- Healthcare & Marketing
- Health Sciences & Psychology
- Public Health
- Neuroscience-based Wellness & Movement Coach
- Master in Law
- Masters in Counselling Psychology
- Nursing

5. SKILLS AND ATTRIBUTES FOR COMMUNITY CONNECTORS

Work Experience in a Similar Field:

Programs reported significant skills among the vast majority of Community Connectors:

- Extensive knowledge of community resources and programs.
- Capacity to build trusting and meaningful relationships with older adults.
- Ability to establish connections and relationships with healthcare providers.
- Skilled in coordinating and working with volunteers to support their roles.
- Aptitude for identifying community program gaps and developing creative solutions to address them.
- Uses a supportive approach in encouraging participants to try new things, step out of their comfort zones, and take on new challenges.
- Proficient in motivational interviewing techniques.
- Able to explain the value of outcome reporting and data collection to participants.
- Community development skills.

5. SKILLS AND ATTRIBUTES FOR COMMUNITY CONNECTORS

Other notable skills include coaching, yoga, meditation and movement therapy.

Programs identified a range of skills and attributes for Community Connectors to have in the future, illustrated in the table below.

Skills	Attributes
• Critical thinking • Boundary setting • Active listening • Problem solving • System navigation • Case management • Motivational interviewing • Crisis intervention • Trauma-informed care • Action planning • Goal setting • Knowledge of social determinants of health • Understanding of prevalent diagnoses • Social work background • Knowledge of the health care system • Community development	• Empathy • Compassion • Flexibility • Creativity • Collaborative • Self-motivated • Tolerant and non-judgemental • Ability to build rapport • Ability to advocate • Ability to network and build relationships and partnerships with other community organizations

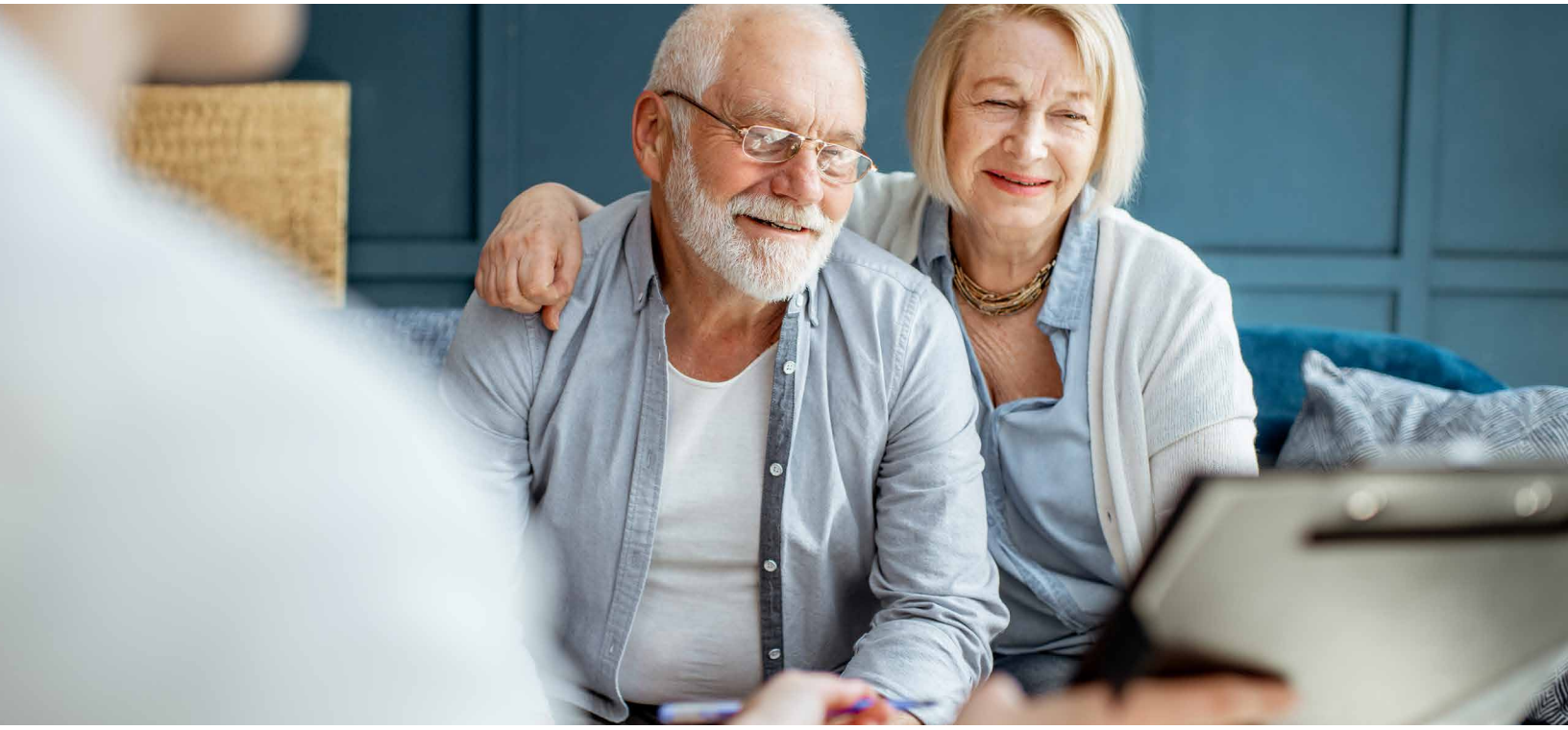
5. SKILLS AND ATTRIBUTES FOR COMMUNITY CONNECTORS

Training for Community Connectors.

SP programs were asked to identify potential training topics to enhance the delivery of social prescribing by Community Connectors. The top seven suggested training opportunities were:

1. Orientation on how the healthcare system works (79%)
2. Knowledge of available programs in healthcare and the community (68%)
3. Identifying mental health crises (63%)
4. Motivational interviewing (58%)
5. Boundary setting (58%)
6. Information on income sources for seniors (52%)
7. Dementia (52%)

Most programs recommended that future training be provided by established experts, such as the Alzheimer Society of BC. UWBC should support, promote, and coordinate these training opportunities.



6. COMMUNICATION

Communicating with Program Participants and Community

Programs provided consistent and supportive messaging about their programming for both community groups and participants. Key communication points included:

- Wellness-based, person-centered focus: Highlighting the program's emphasis on wellness, person-centred care, and strength-based approaches.
- Defining "Community Connector": Explaining the role of Community Connectors, including the resources they can connect seniors to, and providing printed materials for reference.
- Active listening: Emphasizing that Community Connectors will actively listen to seniors, giving them time to share their stories and feel heard.
- Supporting social connections: Providing examples of how the program can enhance seniors' social connections.
- Collaboration with family members: Communicating that Community Connectors will work collaboratively with family members if desired by the participant.
- Program offerings: Clarifying what the program offers, such as co-created wellness plans, connection to resources, accompaniment to programs, and regular check-ins/ follow-ups, while specifying that medical or therapeutic supports are not provided.
- Common interests: Providing examples of common resources seniors are interested in, such as physical or social activities, transportation, and food supports.
- Program accessibility and goals: Emphasizing that the program is free and aimed at supporting independence, choice, and the ability to stay active and happy in the community.
- Strength-based language: avoiding deficit-based language in communications (such as "vulnerable" or "frail").
- Avoiding unfamiliar terms such as "social prescriber": this term may lead to misunderstanding about the program and may carry certain connotations of formality that can deter potential participants.

6. COMMUNICATION

Communicating with Health Professionals

Programs highlighted communication strategies for their materials and interactions with health professionals:

- Supportive messaging highlighting the program's legitimacy and credibility, such as being funded by the Ministry of Health.
- Emphasis on older adults in need of social connections and support, and on the creation of tailored wellness plans that helps participants achieve attainable goals.
- Emphasis on the program's benefits to older adults, using brief impact and success stories from participants. Clarify the kinds of supports that their patient's will be connected with, and how these supports can improve their health and well-being.
- Clarify the programs scope (what kinds of support are offered and what kinds of support are not).
- Clarify that the program operates separately but is connected to health authorities.
- Emphasize the need for the program amongst older adults, stressing that the program targets under-served older adults who are most affected by the social determinant of health.
- Highlight the longevity and sustainability of the program (i.e. this is not a short-term, pilot project with limited funding) to ensure health professionals are more invested.
- Note who the program is appropriate for, i.e. those that can engage independently in activities or supports, or that can have a support person if needed.
- Use inclusive language (i.e. older adult instead of senior).

6. COMMUNICATION

Marketing tools

Programs would like a general brochure for use across the province that can be adapted with local information about the program.

- Brand recognition (include UWBC logo)
- General description of services and supports that older adults can be connected to (i.e. physical activities, social supports, income supports etc.) with emphasis that a wellness plan is tailored to each individual older adult's interests and priorities.
- Brochure audience is community agencies, seniors, family members, and language should be approachable to these groups.

A separate brochure is needed for health professionals that includes more detailed information about who is eligible for social prescribing, as well as more detailed information about the benefits

A rack card was also suggested as a take-home resource for seniors being directed to a Community Connector, to be distributed in doctors' offices, assisted living facilities, seniors' centres, senior housing, discharge planning etc.

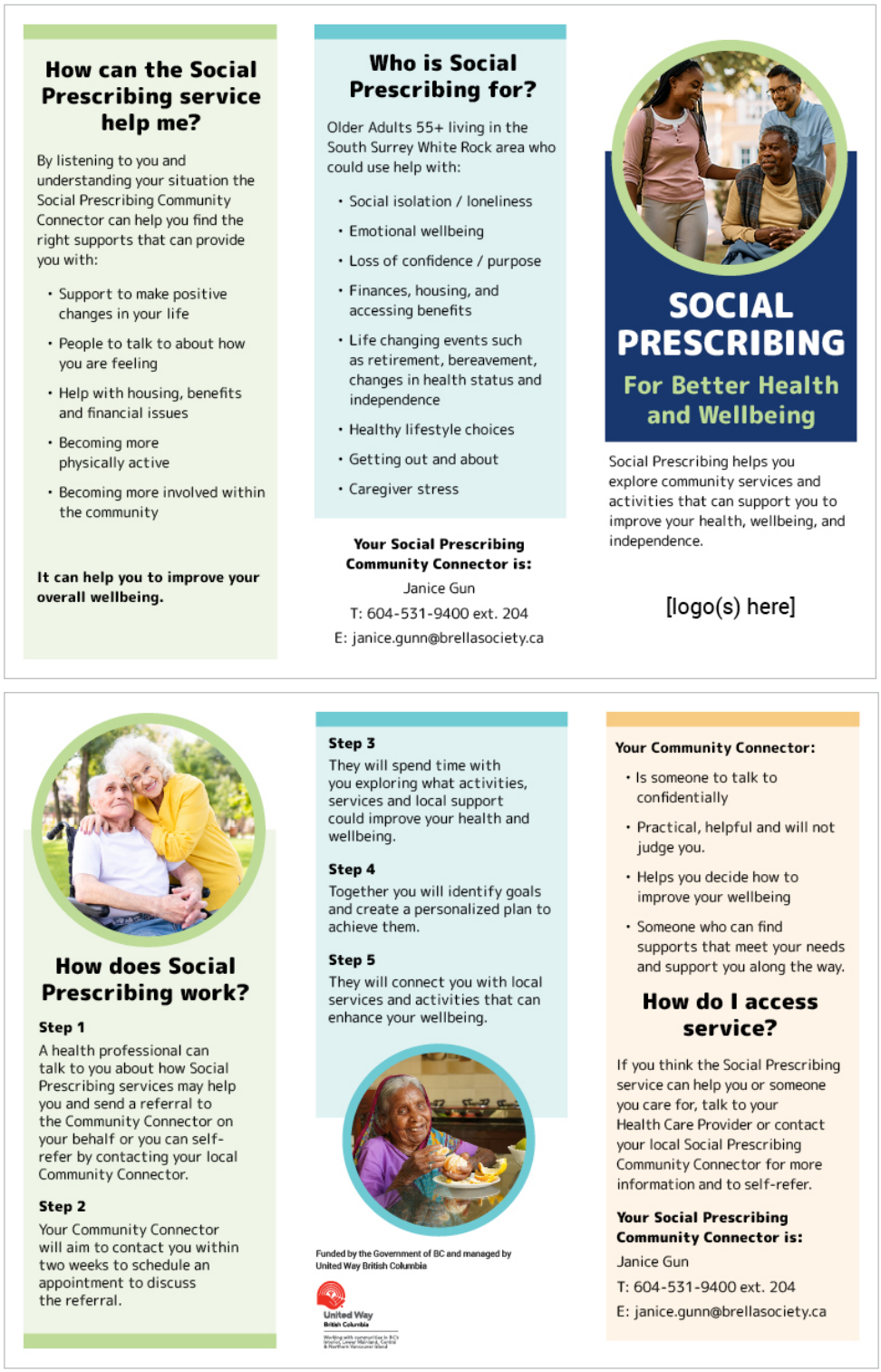
There was also interest from some programs posters to be placed in doctors' offices, urgent care centres etc.

Key wording, design, and images were identified:

- Content & wording:
  - Using term 'older adult' rather than identifying seniors with a specific age (i.e. "those 65+")
  - Using term "culturally appropriate" in reference to care and supports
  - Clear contact information
  - Simple, clear description of services offered (less-is-more).
- Design and images:
  - Using photos of real older adults (versus icons) where possible.
  - Clear visuals rather than text-heavy
  - Bright and inclusive
  - Multiple languages where appropriate
  - Large font

6. COMMUNICATION

Figure 6: Brochure Template Example



How can the Social Prescribing service help me?

By listening to you and understanding your situation the Social Prescribing Community Connector can help you find the right supports that can provide you with:

- Support to make positive changes in your life
- People to talk to about how you are feeling
- Help with housing, benefits and financial issues
- Becoming more physically active
- Becoming more involved within the community

It can help you to improve your overall wellbeing.

Who is Social Prescribing for?

Older Adults 55+ living in the South Surrey White Rock area who could use help with:

- Social isolation / loneliness
- Emotional wellbeing
- Loss of confidence / purpose
- Finances, housing, and accessing benefits
- Life changing events such as retirement, bereavement, changes in health status and independence
- Healthy lifestyle choices
- Getting out and about
- Caregiver stress

Your Social Prescribing Community Connector is:

Janice Gun

T: 604-531-9400 ext. 204

E: janice.gunn@brellasociety.ca

SOCIAL PRESCRIBING

For Better Health and Wellbeing

Social Prescribing helps you explore community services and activities that can support you to improve your health, wellbeing, and independence.

[logo(s) here]

How does Social Prescribing work?

Step 1

A health professional can talk to you about how Social Prescribing services may help you and send a referral to the Community Connector on your behalf or you can self-refer by contacting your local Community Connector.

Step 2

Your Community Connector will aim to contact you within two weeks to schedule an appointment to discuss the referral.

Step 3

They will spend time with you exploring what activities, services and local support could improve your health and wellbeing.

Step 4

Together you will identify goals and create a personalized plan to achieve them.

Step 5

They will connect you with local services and activities that can enhance your wellbeing.

Funded by the Government of BC and managed by United Way British Columbia

United Way British Columbia

Your Community Connector:

- Is someone to talk to confidentially
- Practical, helpful and will not judge you.
- Helps you decide how to improve your wellbeing
- Someone who can find supports that meet your needs and support you along the way.

How do I access service?

If you think the Social Prescribing service can help you or someone you care for, talk to your Health Care Provider or contact your local Social Prescribing Community Connector for more information and to self-refer.

Your Social Prescribing Community Connector is:

Janice Gun

T: 604-531-9400 ext. 204

E: janice.gunn@brellasociety.ca

7. PEER SUPPORT NETWORKING AND COMMUNITIES OF PRACTICE (CoPs)

Chairing CoPs

Most programs preferred content experts as CoP chairs due to their service delivery knowledge and experience. While some programs were interested in a co-chair model, many were concerned about limited time or capacity to co-chair meetings. If co-chairs are used, a 6-month commitment is recommended for a program co-chair, who would contribute to discussions and liaise with programs. The content expert co-chair would handle logistics, scheduling, and create agendas.

CoP Logistics

Content experts should meet separately with health authorities to better understand their needs.

Feedback also suggests monthly or bi-monthly meetings as the preferred frequency, with recordings for absentees, occasional in-person meetings for relationship building, and a mix of structured quarterly meetings and informal sessions. Open discussions and a pre-scheduled calendar of topics are also desired.

CoP Topics

Several possible CoP topics were identified:

- Information sharing based on experience
- Standardized workflows, templates, tools
- Strategies tailored to rural communities
- The healthcare system, including services provided by health authorities (and major differences between health authorities),
- Key roles within the healthcare system and their differences (social workers, occupational therapists, home health workers, case managers etc.)
- Supports for Indigenous participants
- Communicating with Primary Care Networks
- Relationship building to support referrals and knowledge sharing
- Working with difficult participants

8. BALANCING STANDARDIZATION WITH LOCAL FLEXIBILITY

Programs were supportive of the development of a UWBC standardized reference manual for SP programs, noting its potential benefits for onboarding new staff and managing transitions.

Suggestions included incorporating:

- Guiding principles of SP programs
- Participant eligibility criteria
- The scope of the Community Connector supports
- Evaluation and reporting requirements and tools
- Clear expectations for Community Connectors
- Key definitions
- Templates

Flexibility was emphasized as necessary for tailoring the program and referral pathways to community-specific needs and contexts. Key points include:

- Rural areas require flexibility due to dispersed populations and services.
- Community-specific relationships, particularly with health professionals and providers, are vital for program success.
- In smaller communities, agencies hosting the Community Connector may need to provide services directly due to limited resources and should have flexibility to initiate new services rather than just redirecting referrals.
- Larger programs may have more integrated services and connections with other community organizations, whereas smaller programs require additional funding support to integrate social prescribing effectively.
- Different neighbourhoods and communities have varying target populations with distinct socio-economic, racial/ethnic, and cultural needs.
- Outreach strategies should be adaptable, especially in communities with limited infrastructure, such as small rural communities without community centres.
- Flexibility in the age range of participants is important.