



COMMUNITY  
COMMUNAUTÉ

# SOCIAL PRESCRIBING IN ONTARIO

## Progress Report

June 2019



Alliance for Healthier Communities  
Alliance pour des communautés en santé

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This report has been prepared by the Alliance for Healthier Communities. We represent community-governed primary health care organizations. Our membership includes Ontario’s Community Health Centres, Aboriginal Health Access Centres, Community Family Health Teams and Nurse Practitioner-Led Clinics.

We share a strong commitment to advance health equity. And we recognize that access to the highest attainable standards of health is a fundamental human right. Our vision is the best possible health and wellbeing for everyone living in Ontario.

## Acknowledgements

We would like to thank the pilot participants and Health Champions who have shared their insights, as well as all implementation staff at pilot sites for trialing this work with tremendous dedication and creativity.

We are grateful for the support of the Social Prescribing Advisory Committee and Research Committee, as well as UK mentors from Herts Valleys Clinical Commissioning Group and Altogether Better.

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Rx: Community – Social Prescribing in Ontario pilot is made possible through the Health and Wellbeing Grant from the Ontario Ministry of Health and Long-Term Care. The views expressed in the publication are the views of the Recipient and do not necessarily reflect those of the Province.



**Citation:** Alliance for Healthier Communities (2019). *Rx: Community – Social Prescribing in Ontario, Progress Report*.

# OVERVIEW

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What does it look like for the healthcare system to see a patient as a whole person, instead of focusing on just their medical diagnoses? What if, along with medication, doctors and nurse practitioners were enabled to prescribe dance lessons, cooking classes, volunteer roles, caregiver supports, single-parent groups, and connections to bereavement networks? What if clients were empowered to take control of their own health and co-create solutions? What if primary care centres became places of belonging?

This kind of “social prescription” is gaining recognition across the United Kingdom and internationally. The health system can do much more to support health promotion and prevention, not just providing care after someone gets sick. Every point of contact with the health system should be a gateway to better overall wellbeing – particularly in primary health care, which is most people’s main point of contact with Ontario’s healthcare system.

That’s why the Alliance for Healthier Communities has piloted *Rx: Community – Social Prescribing in Ontario* to adapt this model and measure its impacts in our context. Our member centres are already places of belonging, providing social and community supports as a part of comprehensive primary health care. The pilot formalizes this work of belonging by creating intentional pathways between clinical care and non-clinical supports, and tracking this process and its impacts on clients, providers and the wider community. Early results from the pilot corroborate what we know intuitively – that people are healthier when they are connected to social and community supports and when they are empowered to play meaningful roles in both their own health and the health of their wider community.

The principles of social prescribing resonate widely. In view of significant interest and emerging momentum from diverse sectors to engage in this work, this implementation-in-progress report has been produced to provide an overview of the Ontario pilot, share early findings and lessons learned, and offer suggestions for how organizations can initiate or participate in social prescribing.



*Soup and Crochet with Grandma Penny at Guelph CHC*

# Glossary

**Asset Mapping:** A strengths-focused process of identifying existing assets within a community, and documenting, categorizing and organizing these assets for easy reference. Examples of assets include community groups, businesses, public spaces, institutions, and physical structures.

**Collaborative Practice:** A model from [Altogether Better](#)<sup>1</sup> that engages clients and members of the community to become volunteer Health Champions and work alongside staff to co-create non-medical, community-based solutions. This model supports a new way of working that fosters interconnectedness between formal, professionalized healthcare, and informal, community-led supports.

**Comprehensive Primary Health Care:** A “whole-of-society approach to health and wellbeing.”<sup>2</sup> Rooted in a commitment to justice and equity, it is care for the physical, mental, and social health and wellbeing needs of the whole person throughout their lifespan. Comprehensive primary health care addresses the broader determinants of health and empowers people and communities to optimize their health. The Model of Health and Wellbeing (MHWB) draws from and expands this definition.

**Community Development:** An approach that builds on a community’s assets and strengths to contribute to the health and wellbeing of its members. An organization works with a community to determine what programs and services it needs for optimal health and wellbeing. Where resources are absent or inadequate, they work together to

create or improve them. One of the attributes of the MHWB is that health care is grounded in community development.

**Community Health Centre (CHC):** A non-profit, multi-service centre that provides primary health care, social and community outreach services with an emphasis on health promotion and health equity. CHCs are particularly positioned to serve vulnerable populations, including seniors, the LGBTQ community, those living with mental illness and addictions, the homeless, and newcomers to Canada.

**Health Champions:** Someone who gifts their time and skills to co-create social prescribing solutions alongside CHCs. They may lead activities, form groups, produce resources, or provide other social and community supports to socially prescribed clients.

**Health Promotion:** The principle and process of enabling people to increase control over, and to improve, their health. Key elements of health promotion include improving health literacy, advocating for healthier city-building, and mobilizing groups of people to work together to advocate for health care, deliver resources and services, prevent illness, and cultivate community involvement.<sup>3</sup>

**Implementation Evaluation:** An evaluation method used to study whether new and emerging projects and programs are implemented as intended. This approach is focused on understanding what works for whom, where and in what circumstances and contexts.

**Link Worker:** This role has a variety of names, such as systems navigator or community connector. In this report, the social prescribing

link worker specifically refers to a person who works with a socially prescribed client in a co-creative way to identify strengths and needs and connect them to appropriate, non-medical community resources or supports. This role can be held by people with diverse backgrounds and training, both clinical and non-clinical.

**Model of Health and Well-Being (MHWB):** [This model](#) supports the overall vision of CHCs and guides the delivery of primary care, and forms the principle undergirding the model of social prescribing. It consists of three guiding principles and eight attributes. The principles are *Highest Quality, People- and Community-Centred; Health Equity and Social Justice; and Community Vitality and Belonging*. The attributes are *Accessible; Anti-Oppressive and Culturally Safe; Community-Governed; Grounded in Community Development; Based on the Determinants of Health; Population Needs—Based; Interprofessional, Integrated, and Coordinated; and Accountable and Efficient*.<sup>4</sup>

**Primary Care:** Day-to-day health care a person receives from a doctor, nurse practitioner, or interprofessional primary care provider. It is generally the main point of entry into the health care system and may include care coordination. Primary care is an element of comprehensive primary health care; the difference is that comprehensive primary health care looks beyond individual medical needs to address the broader determinants of health at both the individual and community level.

**Primary Care Provider:** A physician or nurse practitioner who provides day-to-day clinical health care. Usually serves as the main point of contact for individuals in the health system.

**Social Determinants of Health (SDOH):** Determinants of health (DOH) are the “broad range of personal, social, economic, and environmental factors that determine individual and population health.” Social and economic factors within the DOH are collectively called the [Social Determinants of Health \(SDOH\)](#). They include socioeconomic characteristics like income and education; experiences of discrimination or trauma; physical environment; and social supports.<sup>5</sup> The [Model of Health and Wellbeing](#) recognizes that health and wellbeing are grounded in the DOH.

**Social prescribing pathway:** While CHCs and others have long recognized the importance of social and community support for improving well-being, social prescribing refers to a deliberate and structured way of referring clients from clinical practice to non-clinical supports when appropriate, with the goals of improving their overall health and wellbeing and decreasing the use of the healthcare system for non-clinical needs.

**System Navigator:** In CHCs, a system navigator is typically focused on supporting clients to navigate the health system. They may connect clients with more structural SDOH, such as housing, employment support, or transportation. System Navigators working to the fullest scope of their roles also help clients connect with community, social, and informal supports, in which case this role is equivalent to the role of a Link Worker.

# INTRODUCTION

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## The Need


Health and wellbeing refer to the highest attainable state of physical, mental and social wellbeing, including the ability to adapt and self-manage in the face of social, physical, and emotional challenge; not merely the absence of disease or infirmity.<sup>6</sup> Because health and wellbeing do not happen in a vacuum – they are relational, dynamic processes that reflect individual, social and ecological capacities and interactions – they are about more than just access to medical care: factors such as education, income, housing, nutrition, relationships, and self-confidence all play significant roles in our physical and mental health.

Increasingly, we are becoming aware of how important social connectedness is for health and wellbeing. Loneliness, exclusion, and stigma harm our physical and mental health – a sobering fact in our increasingly fragmented society. Ontario’s Chief Medical Officer of Health has identified loneliness and social isolation as major health threats, noting that “people with a weak sense of community belonging are more likely to be in the top five per cent of users of health care services; this five per cent accounts for more than 50 per cent of total health care spending... costs that could be reduced if these individuals were part of connected communities.”<sup>7</sup> Conversely, individuals with strong social relationships have a 50 per cent lower risk of premature death than those with poor relationships.<sup>8</sup>

Primary care providers and the health system are often an individual’s most trusted relationship with and connection to the community. In many cases, those who are lonely or are facing complex social challenges turn to the health care system for support. They may make frequent appointments for primary care, or they may visit the local hospital emergency room seeking attention and support. This puts unnecessary pressure on the healthcare system, is costly to the public, and it has little benefit to overall wellbeing.

Without adequate supports, those who are marginalized will continue to experience poorer health and continue to use the health care system at a high cost and with little benefit to them. With an increasingly fragmented population, it is imperative that we find sustainable and effective ways of addressing social isolation and loneliness.

“When you live at home by yourself day in and day out and don’t have anything beyond those four walls, depression does hit. Social anxiety hits. Before... not a thing would have been done, because I wouldn’t have come out to do it. But they give you such amazing support here that you’re able to go beyond that.”

– Social Prescribing Pilot participant, Belleville & Quinte West CHC 



# Social Prescribing in the United Kingdom

Social prescribing, as a movement, began in the United Kingdom and has since become a core component of the UK National Health Service (NHS) long term strategy. Evidence from the UK on the efficacy of social prescribing, while limited in scope, has been promising. Studies have shown that social prescribing has improved clients' sense of confidence and motivation, reduced feelings of anxiety, and improved their mood and overall view of life.<sup>9,10</sup> Individuals exhibited greater self-control over management of physical and mental health;<sup>11,12</sup> they fostered social connectedness and experienced a reduction in isolation and feelings of loneliness.<sup>13</sup> They ultimately experienced greater resilience and were equipped with more effective coping strategies.<sup>14</sup>

Furthermore, social prescribing has made an impact on the healthcare sector. An evidence review of multiple projects found an average drop of 28% in demand on GP services following a social prescribing referral, as well as an average reduction of 24% in Accident and Emergency (A&E) admissions.<sup>15</sup> While the evidence base on this new innovation continues to build, these early results demonstrate social prescribing's strong potential to improve individual wellbeing and ease the load on the health system.

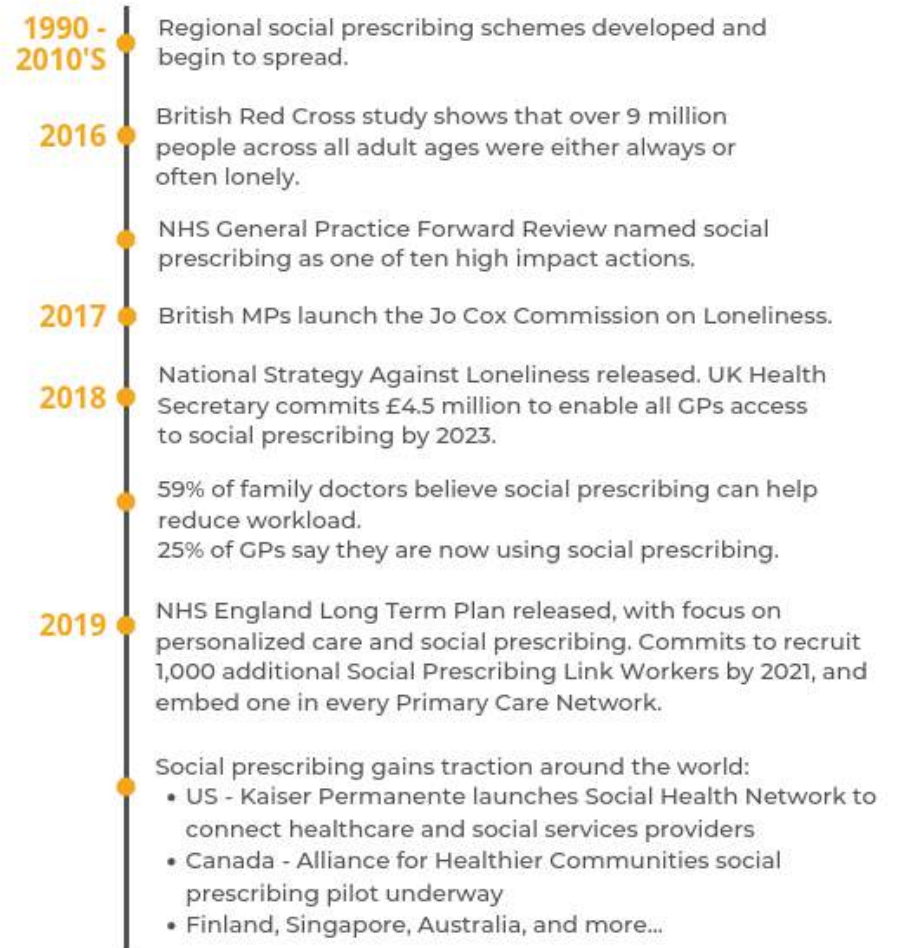


Figure 1: History of Social Prescribing in the UK

# Rx: Community – Social Prescribing in Ontario

Caring for the health of vulnerable people and communities is at the heart of the community health care (CHC) sector’s mandate. Recognizing the essential role of connectedness in this work, the Alliance for Healthier Communities is implementing *Rx: Community*, a Social Prescribing pilot project, in 11 CHCs across Ontario. These CHCs represent a diverse mix of urban, rural, Northern, and Francophone communities. Using client- and community-centred design thinking, participating teams identify non-clinical interventions, build a structured clinical pathway, and track the impact of this work on health outcomes and healthcare provision.

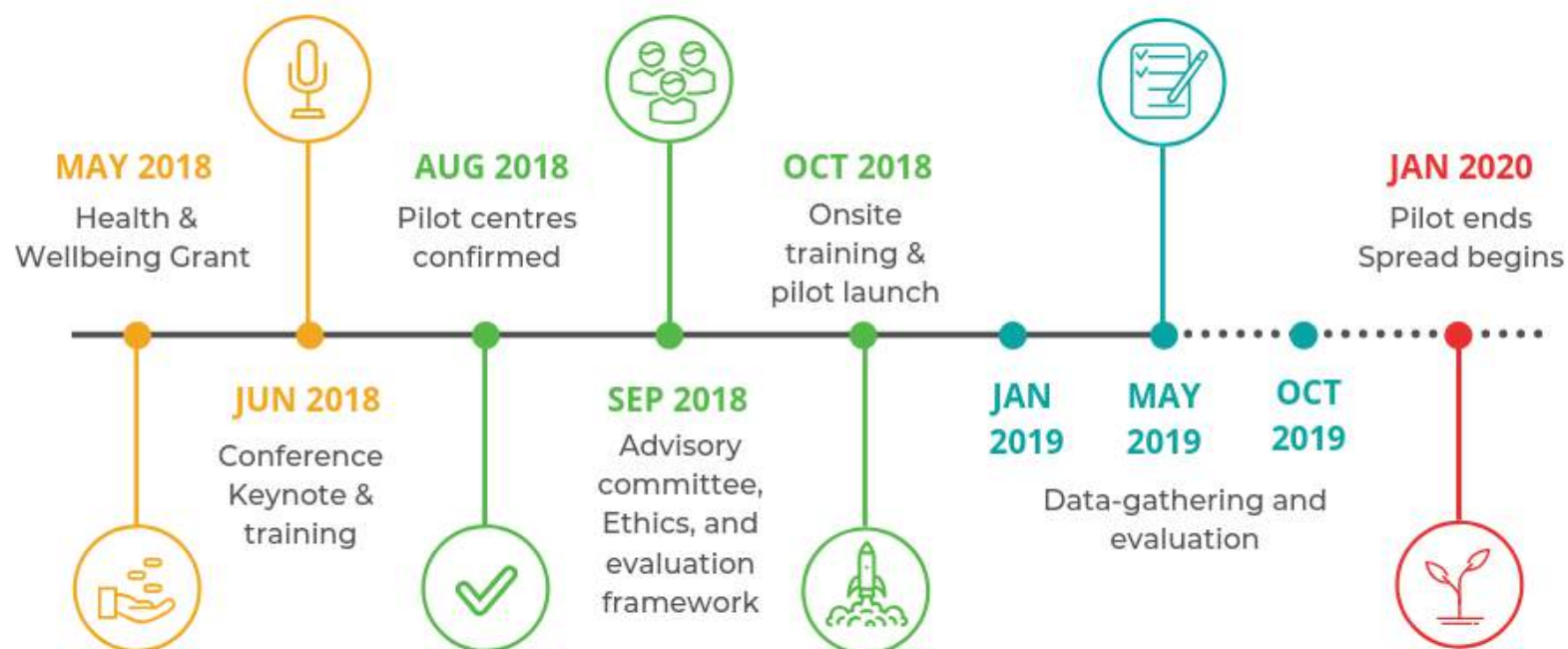


Figure 2: Timeline of Rx: Community - Social Prescribing in Ontario



# WHAT IS SOCIAL PRESCRIBING?

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Social prescribing is a simple yet transformative way of supporting patients' health and well-being by responding to their need for social connectedness. Whereas community programs and other non-medical supports have always been a part of the CHC model, social prescribing breaks new ground by building intentional links between health and community services.

Every client has unique needs, skills, and passions, and every community has unique resources. Thus, a diverse spectrum of community supports and services may be appropriate for social prescribing – including art classes, museum visits, fishing lessons, or knitting circles. For many clients, participation includes volunteering with a community partner or even becoming an activity leader. Social prescribing complements traditional clinical treatments, and it is a co-creative effort between a health care provider and a patient that recognizes and responds to a patient's strengths, interests and health needs.

Besides improving individual health outcomes, the social prescribing pathway is designed to create a system shift. It directs people away from expensive and over-utilized medical services, including acute care and hospital hallways (“downstream”), to less expensive community supports (“upstream”) for non-clinical issues where appropriate.

Social prescribing complements, but does not replace, essential primary medical care, investment in community, and public policy aimed at addressing the social and structural DOH.

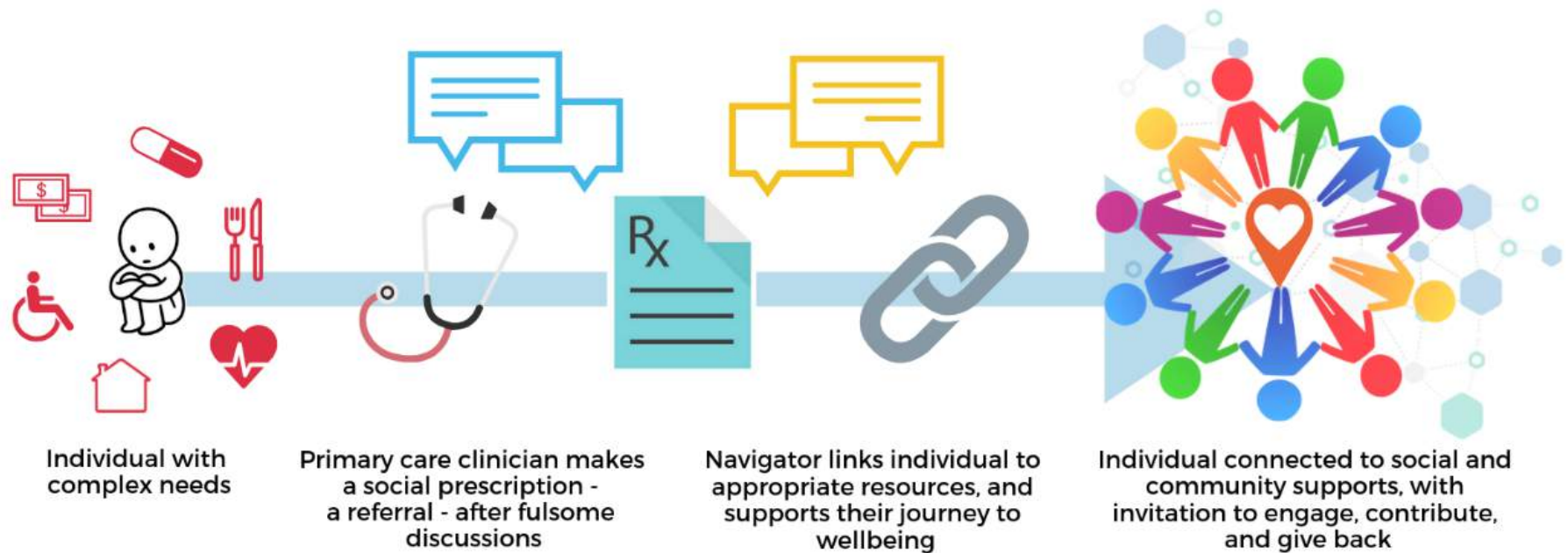
Building on the principles of health promotion to involve people in managing their own health and creating opportunities for themselves to volunteer and give back, social prescribing emphasises partnership and co-creation, connecting the formal, professionalized medical system to informal, community-led innovations. Social prescribing creates a space and support for true collaboration and belonging to occur, and helps to build a healthier and more resilient community.



*Digital literacy at Rexdale CHC*

# The Essential Components

Social prescribing looks different in different communities, depending on local needs and capacity. In general, the journey starts when a family physician or nurse practitioner refers a patient to a [link worker](#) or [system navigator](#). This person works closely with the patient and connects them to the most appropriate local social and community supports.



*Figure 3: Social Prescribing pathway*

## Primary Care Providers

When a socially vulnerable or marginalized person is experiencing poor health, their relationship with their primary care and interprofessional provider, such as a doctor, a nurse practitioner, or a nurse, may be a significant – or perhaps the only – trusted relationship they have. The primary care provider's advice and recommendations carry weight and authority.

It is important to distinguish the difference between social connecting and social prescribing. Many allied health care providers, such as social workers, community support workers, and health promoters, are used to connecting clients with community resources. This type of social connecting is core to the MHWB and plays a significant role in supporting an individual's wellbeing. Social prescribing emphasizes the integration between primary care and community supports, recognizing that primary care providers also have a role to play in referring clients to non-medical supports. It also ensures that clinical data follows the client's journey and captures a holistic, wellbeing-centred view of a person's health.

Evidence in Canada and the UK indicates that primary care providers spend at least a third of their time on social issues that can be better addressed by others.<sup>16,17</sup> With social prescribing, physicians and other primary care providers can work collaboratively with other team members to connect clients with appropriate non-medical resources and supports for their needs, and focus their energy on treating medical issues.

"Depending on the week, anywhere from 25% to 50% of the time my appointments are not medical in nature."

Primary care provider,  
South Georgian Bay CHC



### Brian's Story

Brian\* made an urgent, same-day appointment at one of the social prescribing pilot CHCs. When he arrived for his appointment with the Nurse Practitioner, he spent most of the session discussing his late wife who had died just over a year before. The NP recognized a need for social prescribing and made a referral. He was called by a Health Champion who invited him to join the "Learning to Live Again: Life Beyond Grief" social support group for widows. He attended the group and is now socializing with members of the group outside of the CHC, such as visiting Sugar Bush and going out for lunch.

\*Name has been changed to protect anonymity.



## Social Prescribing Link Worker

The connection between a client, their provider, and community supports. A trusted partner who supports and empowers social prescribing clients in their journeys. In most cases where social prescribing is implemented, the model employs a link worker – someone who provides intentional and purposeful support for clients to access non-medical services and serve as the go-between for clinical providers and community resources.

This role goes by various names: Community Navigator, Systems Navigator, Community Connector, Link Worker, or Health Coach. Different initiatives may utilize a spectrum of support, depending on client needs and available resources.<sup>18</sup>

In general, the link worker:

- Provides intentional and purposeful support for clients to access non-medical services that may include goal-setting, referral, accompaniment, follow up, and close-out conditions.
- Helps to establish a long-term relationship between client and formal/informal resources.
- Listens deeply and is guided by the client to co-produce local solutions.
- Recognizes people's abilities and works from an empowering perspective.
- Understands the SDOH and has fulsome knowledge of internal and external non-medical resources.

The role may be fulfilled by people from different professional backgrounds. These include nurses, health promoters, occupational therapists, and social workers. As it is an emerging role, a full understanding of the knowledge, skills, and competencies required for this role is still developing. Some of the key skills identified so far are listening deeply, showing empathy, and building strong relationships.<sup>19</sup>

### Spectrum of Support

**Signposting:** Advertise the resources available. Trust clients to self-refer or access the supports on their own.

**Light:** Referrals are made to address a specific need or achieve a specific goal. Usually no follow up.

**Medium:** Referrals are made to address needs through partnership with a community organization. May involve light assessments and formal feedback to the referrer.

**Holistic:** The most comprehensive. Referrals are made in a formalized way. Link Worker co-designs solutions with client, and provides fulsome support to access resources.

## Community Collaboration and Supports

For social prescribing to succeed, resources and supports must be available in the local community for individuals to be referred to. These supports will depend on community capacity, but they could include community gardening, cooking classes, hiking, and knitting groups as well as access to local activities such as visits to parks, museums and art galleries.

**Internal resources:** Operating within the MHWB, CHCs often already provide community supports and programming within clinical spaces that are open to both clinical clients and the broader community, facilitated by staff, peer volunteers, and in partnerships.

**Health Champions:** Recognizing that clients are people with passion and gifts to contribute, they are invited and supported to become Health Champions who work alongside clinical staff to identify needs and co-create solutions. In this way, social prescribing increases interconnectedness in the community and builds local capacity for community-based, non-medical supports.

**External resources:** By coordinating and working with community volunteers and partners, social prescribing builds a network of local relationships between healthcare and a wide range of sectors such as arts and culture, environment, and social services. By connecting with and leveraging existing assets of the community, solutions can be adaptive and responsive to local needs and strengths, and they can create a broad network of support for clients.

“The whole idea of eliminating the pressure on the professional team, and say what are the needs of society and how can we address it, was what spoke to me as a volunteer. This program said, ‘In fact, you identify the different needs in your local community, and then create the solutions they need.’ There’s no prescribed solution, it was a philosophy that we are creating the solution for each other. That really spoke to me. It’s given back to me so much.”

– Health Champion, South Georgian Bay CHC



# A Made-in-Ontario Approach

The social prescribing approach currently being piloted in Ontario is different from the general model emerging out of the UK in several key ways.



Figure 4: The Model of Health and Wellbeing

**Healthcare setting:** In the UK, social prescribing is mainly practiced in settings that consist only of primary care providers, such as General Practitioner (GP) offices. In Ontario, social prescribing is being piloted in CHCs, where interprofessional providers, including clinical and health promotion teams, are already working together. This enabled the social prescribing pilot to build on existing strengths to formalize and support the coordination of the relationship between the social and medical interventions provided to each client.

Moreover, CHCs and other Alliance members are committed to a vision of comprehensive primary health care, guided by the MHWB. According to this model, quality primary health care is based on DOH, recognizes the importance of community vitality and belonging, and is grounded in community governance and community development principles.

With this inherent holistic view of health and wellbeing, along with existing inter-professional staff and community programming capacity, social prescribing is a natural fit that helps to enhance the existing work of these centres, where many components of the social prescribing pathway are already in place.



**Diversity of context:** The Ontario pilot faces different challenges due to different geographies. Ontario is a large province with diverse population needs, and resources and challenges vary significantly in different geographical areas. The current pilot is spread widely across urban, rural, Northern, and Francophone communities, and capturing the unique assets, challenges, and best practices for social prescribing in these contexts. While being under the same pilot framework, with similar key components and shared evaluation, the implementation approach and operational details are unique at each pilot site.

**Health equity lens:** Alliance members are mandated to serve the estimated 20% of the Ontario population who have the most complex psychosocial and medical needs. This includes populations that face systemic barriers to health, including low-income, racialized, Francophone, LGBTQ+, and Indigenous populations.<sup>20</sup> For these individuals, stigma, exclusion and oppression combine to create conditions of isolation and loneliness.

Operationally, this means that *Rx: Community* link workers need to provide more intensive support for clients who receive social prescriptions, in order for those clients to fully access the needed social and structural supports. There is also a higher need for social prescriptions that include structural supports such as food, shelter, and income.

**Commitment to community empowerment:** Alliance members' community development approach supports and empowers clients of all capacities to co-create solutions and "give back" to their communities as peer-leaders and advisors. Differing from other contexts where volunteers and Health Champions are often retired professionals, centres participating in *Rx: Community* have found that dedicated staffing resources are required to enable their client population to participate. While the level of staff support needed has been higher than expected, the positive impact on clients has been remarkable.

Social prescribing in Ontario builds on the MHWB and our commitments to health equity and community development. This means meeting people in their vulnerabilities and creating an environment of trust, non-judgement and radical acceptance. As a result, the centres in this pilot are places not only of healing but also of belonging.

## Terry's Story

Terry\* has congenital deafness, which they felt stigmatized by, and was very socially isolated. They exhibited difficult behaviors in primary care that escalated over time. Terry was encouraged to become a Health Champion, and was supported by staff to host weekly card games at the centre. These new social connections led to calmer and shorter primary care appointments. Moreover, Terry used to be very resistant to participating in group activities, but since becoming a Health Champion, they have now become involved with other groups like Living Healthy Life with Chronic Conditions. Being invited to become a Health Champion and supported to lead activities, Terry saw that they can be involved with other people in a trusting, accepting environment at the centre, which is having a transformative impact on their life.

\*Name has been changed to protect anonymity.



# Social Prescribing Snapshots Across Ontario



Figure 5: Map of community health centres in Ontario participating in the pilot

## Belleville-Quinte West CHC

A rural agency with two sites serving Hastings and Prince Edward County since 2010, BQWCHC has invited clients and community members to become Health Champions. The active group has started a craft group, walking club, breakfast and dinner clubs, a song circle and a social group for widows. Clients and community members have expressed deep appreciation for these new activities, and sees the centre being transformed into a place of belonging.

## Centretown CHC

Located in downtown Ottawa since 1969, this large CHC serves a diverse urban population with a focus on LGBTQ people. The centre is strengthening referral pathways between clinical and community supports, building volunteer capacity, and improving cross-team collaboration through the pilot. A core inter-professional team serves as Link Workers to connect clients to a multitude of services, such as newcomer networks and addiction support groups.


## Country Roads CHC

Serving the rural communities of Rideau Lakes Township, CRCHC initiated the training of staff and community in the UK Health Champions model in 2014, which has since become known as part of social prescribing. The rural prescriptions have a flavour of their own and include fishing, fiddle lessons, quilting, meditation, yoga, oral health and more. CRCHC Health Champions provide palliative visits, transportation, youth programming and supports for new parents, while social prescribing staff provide a formal link between primary care and an array of community supports.



*Craft-making workshop at South Georgian Bay CHC*

**“After I finished the addictions program I needed something to keep me going. I got connected with this group and I’ve been coming ever since. It’s been big for my recovery and staying sober to have this group – it’s become part of my backbone.”**

– Social Prescribing Pilot participant,  
Centretown CHC 

## Guelph CHC

An urban centre established in 1988, Guelph CHC is no stranger to innovative programming, such as the SEED community food project to increase food security. Building on strong existing peer programming, the centre is deepening linkages between clinical and community supports, increasing collaboration between staff and clients, and enhancing opportunities for co-creation of programs. The newest offering is “Soup and Crochet Social with Grandma Penny”.

## Gateway CHC

Serving the community of Tweed since 1991, Gateway has been a leader in connecting primary care with community services, particularly for clients with complex challenges. With a strong existing Systems Navigator role in place, the centre is a model for others, and aims to capture data and demonstrate impact in a more robust way through the pilot. Gateway CHC is also moving to empower clients and community members to co-design solutions through becoming Health Champions.

## Norwest CHCs

Based in Thunder Bay for more than 20 years, the large, dynamic centre saw the pilot as an opportunity to engage clients who are living isolated lives, disconnected from community and family supports. A number of programs have been created through Health Champions, including Grief and Loss, Wellbriety, Knit to Quit, Random Knits of Kindness, Transgender Group, and Arts and Craft Workshops. NorWest is also making social prescribing available to non-team physicians outside of the CHC through [TeamCare](#).

## Rexdale CHC

Located in one of Toronto's priority neighbourhoods, Rexdale CHC works with a diverse, often under-served population. Having piloted a Social Prescribing initiative in the summer of 2018, the centre is expanding upon this foundation to offer social and community-based interventions for families. Rexdale leads in building creative partnerships with non-traditional partners, including arts, cultural and environmental institutions, to link clients to a wealth of non-clinical supports.

“When you’ve overcome quite a bit, health-wise, and you emerge on the other side and you see someone else really struggling, you could say to them, hey, there’s hope, there’s light at the end of the tunnel, you can do it. [Now] I’m hitching my wagon to something bigger... I’m able to love myself better because I’m doing something good, and then it just goes round and round.”

– Health Champion, Guelph CHC 


## South Georgian Bay CHC

A rural centre serving the vast areas of Clearview Township, Wasaga Beach, Collingwood, Elmvale, and the Town of the Blue Mountains, SGBCHC has invited clients and community members to become Health Champions, starting new activities that include a robust Friendly Visitor Program. Being invited to co-design and implement innovative solutions has ignited a new passion in the SGBCHC community, with volunteers experiencing strong sense of empowerment and taking pride in their contributions to the community. SGBCHC is also engaged in innovative partnerships, such as with 211 Community Connection, to share information and referral resources.

## Stonegate CHC

Located in south Etobicoke, Stonegate CHC formed in 1992, and was excited for the opportunity to more fully engage clients and community members, utilizing their gifts and passions to co-create solutions with clinical staff. Health Champions have implemented a dementia workshop, a yoga class, a cookies and cocoa social group and a newcomer resource group. Stonegate CHC is also partnering with arts and culture institutions in Toronto that enables diverse social prescriptions.

“After being laid off, I had lost my pride. By getting involved as a Health Champion, I was helping to fight my isolation while helping people in my community fight their loneliness. I am now proud of myself, knowing that I offer others the chance to follow this good ‘prescription’... that of putting life into our lives!”

– Social Prescribing Pilot participant,  
CSC du Témiskaming 

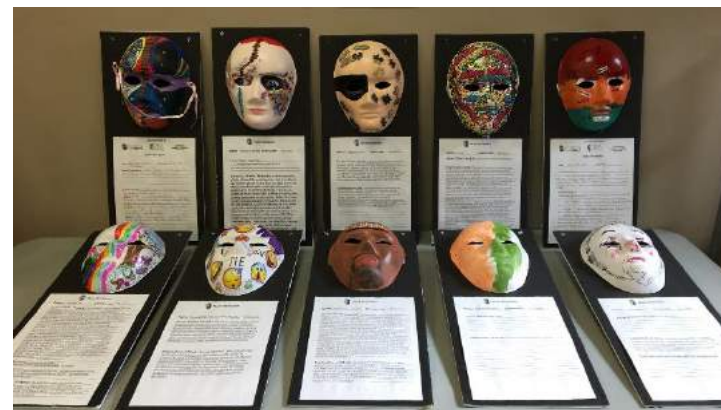
## West Elgin CHC

A mid-sized centre serving rural areas of Dutton, West Lorne and Rodney for nearly 25 years, the centre is building on the existing Systems Navigation program to strength interconnections between clinical service and localized community supports, and foster deeper community connections. An asset-mapping exercise uncovered surprising new partnerships in the community, and was turned into a resource booklet with local supports that clients can be referred to, in addition to the many services the centre offers such as cooking programs and others that address social isolation and SDOH.

## CSC du Témiskaming

Serving rural communities in New Liskeard, Kirkland Lake, and the surrounding areas, CSC du Témiskaming is focused on offering comprehensive primary care and community health services to the Francophone population.

The centre has formed a group of enthusiastic Health Champions who has identified innovative opportunities to support isolated individuals, such as a photography club and pet visiting program.



“Unmasking Brain Injury” by the brain injury support group in West Elgin CHC

# Partnerships and Public Interest

Social Prescribing has generated significant positive attention from the general public and across diverse – and sometimes surprising – spheres. In his 2017 annual report, *Connected Communities Healthier Together*, the Ontario Chief Medical Officer of Health emphasized the negative health impacts of loneliness, and presented *Rx: Community* as an innovative solution.<sup>21</sup>

Positive coverage of *Rx: Community* has come from front-page and prime-time coverage in the *Toronto Star*,<sup>22, 23, 24</sup> the *Globe & Mail*,<sup>25</sup> the Canadian Press<sup>26</sup> and the CBC.<sup>27, 28, 29</sup>

The concept of social prescribing resonates widely, and many individuals and organizations see how they can contribute to and benefit from the pathway. In the healthcare sector, hospitals, home and community care organizations, and professional associations have reached out with interest to explore how they can partner with CHCs and be connected to the social prescribing work.

The arts and culture sector has also been eager to support social prescribing, recognizing connections between arts and wellbeing. Formal partnerships have been formed with prominent arts and culture organizations such as the Royal Ontario Museum (ROM), the Toronto Symphony Orchestra (TSO), and the Art Gallery of Ontario (AGO). These partnerships have further created networks and communities of practices within the arts sector to discuss inclusion and wellbeing.

Are you interested in being a part of the Social Prescribing pathway? Contact an Alliance member organization near you to start the discussion.

"We are very proud to launch our social prescribing program in partnership with the Alliance... We know that art and culture have the power to positively impact individuals, and enhance the health and wellbeing of communities. By offering greater access to the ROM, our collections, and our programs, we know this new initiative will enrich the lives of many visitors."

– Christian Blake, Acting Manager of Inclusion, ROM







*Arts & Crafts program at South Georgian Bay CHC*

Additional interest has come from other sectors such as EcoHealth Ontario, a collaborative that champions the health benefits of protecting public greenspace, and 211 Ontario, which helps connect members of the public to local programs and services. We have also heard from organizations across Canada, coast to coast, who are interested in starting their own social prescribing initiatives.

Just as important are the many smaller community partners who have emerged wherever *Rx: Community* is happening. While their profiles may not be as high, these organizations make essential contributions to the project's success through the diverse activities and programs they offer in clients' home communities.

Many organizations have felt the need to break down silos and foster more interconnectedness among sectors, but did not know to achieve that. Social prescribing is emerging as an important tool to meet this need. Social prescribing is a key part of providing integrated care, expanding integration beyond healthcare professionals to create an interconnected network with a wide range of sectors.

“We are pleased to partner with the Alliance to facilitate access to and support for spending time in nature. We feel this is a very worthwhile endeavour in light of the growing evidence about the health benefits of time spent in parks and other greenspace, including reductions in risks of stroke, asthma and skin cancer and improvements in mental health and wellbeing.”

– Suzanne Barrett, Coordinator, EcoHealth Ontario



# Policy Landscape

In the United Kingdom, social prescribing has been a key lever in a health systems shift to “universal personalised care” delivered through networks of care providers.<sup>30</sup> A similar shift is underway in Ontario, where the provincial government has introduced a major health system transformation aimed at creating patient-centred, integrated Ontario Health Teams that incorporate both health and non-health partners in delivering on population health outcomes.<sup>31</sup> Importantly, Ontario’s 2019 health care legislation reinforces that “the public health care system should be guided by a commitment to equity and to the promotion of equitable health outcomes.”<sup>32</sup> Taken together, the commitment to personalization, team-based care, person-centredness and health equity create supportive conditions for the rapid scaling of social prescribing as part of the foundational role of comprehensive primary health care in Ontario’s health system – through approaches such as [TeamCare](#)<sup>33</sup>, which links patients of non-team physicians with more comprehensive care.<sup>34,35</sup>



The graphic features a collage of three photos: a woman smiling, a man with glasses, and an elderly woman. The NHS logo is in the top right. The main text is on a blue background.

Universal Personalised Care:  
**Empowering 2.5M people to have more choice and control over their own health and care by 2024.**  
#NHSLongTermPlan  
[www.england.nhs.uk/personalisedcare](http://www.england.nhs.uk/personalisedcare)



The graphic consists of a blue speech bubble containing a quote, with the name and title of the speaker below it.

**“Through Ontario Health Teams, patients will finally have a say in their health care journey.”**

**CHRISTINE ELLIOTT**  
MINISTER OF HEALTH AND LONG-TERM CARE

# EVALUATION

Social prescribing is designed to improve wellbeing and strengthen communities. Measuring these impacts is an essential part of this pilot project. Informed by the literature and lessons learned from the UK experience, and guided by an Advisory Council of external researchers and experts interested in social prescribing, we are building evaluation into the *Rx: Community* pilot project.

A mixed-methods implementation evaluation was deemed appropriate to understand and collect the practical lessons that emerged from implementing social prescribing in Ontario CHCs. In addition to understanding the components necessary for social prescribing, this evaluation has been designed to explore how social prescribing is impacting clients and clinicians and to identify key factors enabling successful implementation.

A common evaluation framework and a shared electronic medical record system empower us to conduct comparative analysis for outcomes across the diverse contexts of our pilots. In addition, through collecting sociodemographic data, we will be using an equity lens to assess the influence of sociodemographic factors on outcomes. At three points throughout our 18-month pilot, we evaluate our progress through organizational and provider surveys, electronic medical record (EMR) data extraction, and focus groups exploring the data elements shown on the right.

The objectives of this evaluation are to understand how social prescribing was implemented and the outcomes achieved in 11 diverse CHCs throughout Ontario. The goal is to build support and strengthen the evidence on what may work, with whom and in what circumstances given the complexities of this social intervention being implemented in a real-world setting. Iterative improvements will be made throughout the intervention based on data, feedback and through communities of practice and shared learnings.

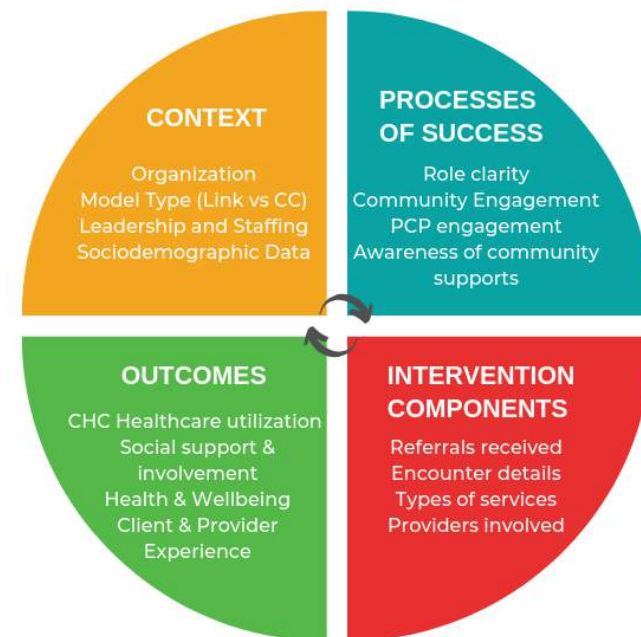


Figure 6: Overview of evaluation framework

# Early Findings

While pilot implementation and evaluation continues to progress, early results have been promising. As of March 2019, 55 providers have made over 600 social prescriptions to 221 clients. Individuals have been connected with social, learning, and physical activities, as well as food, shelter, and income supports, as shown in the chart below. In the first round of focus groups, participants shared the positive impacts social prescribing has had on their health and wellbeing, which fall broadly into two main categories: Sense of Community Belonging and Mental Health and Wellbeing.

## Vital Statistics

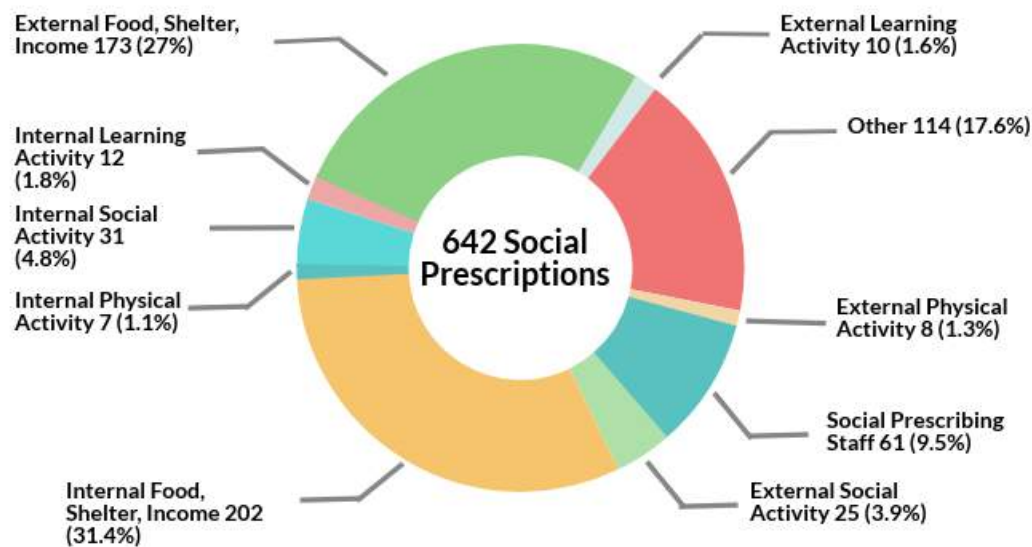


Figure 7: Breakdown of supports referred to through Social Prescribing

Sense of Community Belonging	Mental Health and Wellbeing
Improved social support network	Improvement in Anxiety and Depression
Opportunity to provide social support to others	Improvement in mood
Improvement in social isolation	Improved self-esteem
Increased collaboration between staff and clients	Improved self-confidence
Increased awareness of available social supports	Sense of purpose
Desire to increase awareness of available social supports	Feeling motivated
Sense of accountability	Sense of accomplishment

Table 1: Qualitative impacts reported by social prescribing participants

## Sense of Community Belonging

“By having these programs, you feel represented in the society, and by meeting other people, and having that opportunity to meet, you see yourself in your society, and that’s empowering in itself.”

– Social Prescribing Pilot Participant, Centretown CHC



Attending groups, forming new relationships, and developing a sense of accountability were the major contributors for clients’ increased sense of community belonging. For one set of clients who attend a brain injury support group, the opportunity to connect with others was described as being just as important as the educational (building skills around self-management of health) aspect of the group. They described a tendency to participate even when they didn’t feel up for it, in order not to disappoint their peers. Strong relationships among the participants fostered this sense of accountability and made it a powerful motivator for attending group sessions.

Health Champions value the opportunity to collaborate with staff, which strengthens their sense of feeling that they’re integral to the CHC and the broader community. The act of being personally invited to become Health Champions increased individuals’ confidence and made them feel honored that the CHC staff saw potential in them. Some did not realize they had something to offer until they were asked. Being invited helped them to discover their own potential. Although there were posters inviting participants to volunteer as Health Champions, they would have been less likely to step forward without a direct invitation.



*Music in the waiting room at Belleville and Quinte West CHC*

Overall, Health Champions appreciate not only the opportunity to receive social support but also the opportunity to provide social support to others. Using their experiences to help others who are going through a similar experience fosters a sense of purpose.

“I also value the sense of security I get from being a part of the community because of this.... it’s nice to know that I have made these relationships and I can trust people in the community. That’s irreplaceable.”

– Health Champion, Guelph CHC





## Mental Health and Wellbeing

Many clients and Health Champions reported that attending a program or leading a program improved their anxiety or depression. For clients, this change was enabled by spending time with others and socializing. This was often their sole motivation for leaving their homes.

A great example of improvement in mental health and wellbeing was exemplified by a client who had been suffering from PTSD. She had told her provider that she wanted to go off her anti-depressants and mood medication and instead try animal and art therapy. Through the help of the pain specialist, provider, and social worker, she was able to attend a nourishing farm where she had access to meditation as well as art and animal therapy. When asked about the impact this had for her, she described feelings of contentment, reduced anxiety, and a sense of “inner peace.” She says that these changes have been noticed by others, and her relationships and sense of social connectedness have improved. She credited her improvement in health and wellbeing to the nourishing farm and for the staff who encouraged her interest in trying something other than medication.

Health Champions cited the benefits of “giving back” to their community through their volunteer roles as a path to healing. They felt that having experienced challenges similar to those faced by the group members allowed them to provide meaningful peer support. They took pride in being part of something larger than themselves and empowering others to heal. In addition, they enjoyed a sense of continuous learning. These things give them greater confidence in their ability and desire to continue giving back, and this gives them a sense of empowerment and improved self-esteem.

“It has really helped with my mental health, the fact that I’m not stuck in my own head... It has helped with a lot of my emotional feelings, expressing my feelings and where I don’t actually explode and... keeps the wolves inside.”

– Social Prescribing Pilot participant,  
NorWest CHCs



“I had moved to a village of 700 people and shortly after, lost my wife. I was alone and for a year experimented with medications for depression. CRCHC eventually learned of my passion... fishing! They helped me find fishing gear and a fishing buddy who showed me some great spots. Today I take others out and share my joy with them... and no more medication!”

– Social Prescribing Pilot participant, Country Roads CHC



*Cards and games at CSC du Témiskaming*



## Provider Experience

“As a busy practitioner I often felt lost when trying to offer clients ways to engage in community resources. I knew this was important, as I myself navigated this when I moved here years ago. However I had the resources to reach out and engage in the programming available here and many of my clients do not have this luxury. I truly believe that Social Prescribing has positively impacted some of my most vulnerable clients and will lead to lasting change both in their health care use and their quality of life.”

– Primary Care Nurse Practitioner, West Elgin CHC 



Crafts program at Belleville and Quinte West CHC



Figure 8: Practitioner feedback for Social Prescribing

# Key Enabling Factors for Implementation

**Model of Health and Wellbeing:** Mentioned in the “Made-in-Ontario Approach” previously, the MHWB recognizes the DOH, is committed to community vitality and belonging, and grounded in community leadership and development. Along with interprofessional teams working together, the MHWB forms the foundation of social prescribing and enables its quick implementation with existing resources at pilot CHCs.

**Management Support:** Social prescribing requires changes at the organization level, including educating staff, reallocating roles and responsibilities, connecting with new partners, and implementing new work processes. Active involvement and championship from an organization’s executive leaders creates the necessary conditions for increased staff engagement and effective change management.

**Primary Care and Clinical Engagement:** As an intentional pathway that connects clinical and community solutions, social prescribing cannot be successful without engaging clinical providers. Primary care providers must be supported to understand the SDOH, how social and community supports can impact clinical patients, and their role in identifying where there are non-medical needs for which social prescribing referrals would be appropriate.

**Dedicated Implementation Staff and Staff Circle:** The current pilot utilizes existing resources within CHCs, where staff are implementing this work from the side of their desks, in addition to existing responsibilities. This has made it challenging for staff to reach the full scope of social prescribing. Evidence from UK schemes and early learnings from the Ontario pilot identify the importance of a dedicated link worker to support clients in the social prescribing pathway. This is particularly essential for providing the holistic, high-touch support that complex and vulnerable clients require. In addition, dedicated staff time is also required to support the co-creative contribution of clients and members of the community as Health Champions. Aside from implementation staff, an inter-professional staff circle of key champions within the organization is an excellent way to continue momentum, generate broader engagement, and provide space to raise site-specific challenges and solutions. This can be made possible by reallocating existing resources, roles and responsibilities to create dedicated staff capacity.

**Culture of Innovation:** CHCs participating in the pilot take a Plan-Do-Study-Act (PDSA) approach, where ideas are continuously being generated, tested, and improved upon. Centres have seen most success when staff and Health Champions are encouraged and supported to take risks, try new ways of working, and continuously innovate. One Health Champion described this “flexibility to be creative,” as what empowered them to contribute in a meaningful way.

# CONSIDERATIONS FOR STARTING A SOCIAL PRESCRIBING PROGRAM

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Are you working with a primary care organization that is already aligned with the MHWB, and with interprofessional teams and community partners that include both clinical and health promotion components? Social prescribing is a natural next step to build deeper integration and create a seamless pathway between different areas of care. You are well positioned to form the “backbone” of the social prescribing pathway in your community.

Starting a social prescribing program?  
Connect with us at  
[communications@AllianceON.org](mailto:communications@AllianceON.org) and be  
plugged in to a vibrant Social Prescribing  
Community of Practice!

## Collaboration and Partnership

Are you an organization or service that is dedicated to providing a particular component of care, such as physicians in a solo-practice, a home and community care organization, or a community group?

Collaborate and partner with a team-based, comprehensive primary care organization near you, and support a client’s journey in the social prescribing pathway with your particular strengths and expertise!

For a map of Alliance members, visit:  
<https://www.AllianceON.org/find-a-centre>

Concretely, this may involve participating in [Advancing Access to Team-based Care](#) (TeamCare), a real-time network that brings individualized medical and social care teams together to provide the highest level of care for their most medically and socially complex patients. Or it may mean advocating for and integrating the social prescribing pathway into your Ontario Health Team discussion.

# Are You Ready?

The following readiness checklist helps you to identify the existing strengths and gaps as you prepare to implement social prescribing at your organization:

## Social Prescribing Implementation Readiness Checklist

- Is there strong executive and management support for social prescribing?
- Do your primary care providers understand the SDOH?
- Do your primary care providers see the potential benefits of social prescribing?
- Are your primary care providers interested in participating in social prescribing initiatives?
- Is there a social prescribing implementation team, comprised of a role-diverse cross-section of staff?
- Do you have a designated staff to be the Link Worker?
- Do you have staff capacity to support Health Champions?
- Do you have internal capacity to offer social and community supports (e.g. internal programs and activities)?
- Are you aware of, and connected to, resources in your area that provide social and community supports?
- Do you have an established community partner table or network?
- Is there a culture of creative problem-solving and innovation at your organization?
- Is there strong commitment to capturing data related to social and community-related indicators?

# Getting Started

The details of the social prescribing scheme will look different depending on your organizational context, client population, and existing assets and strengths. To help you get started, the following is a suggested list of key activities that are broadly applicable.

## Key activities to consider for launching your social prescribing initiative

No	Activity	Details	Lead
1	Form core staff circle to support implementation	For example: implementation staff, clinical representatives, health promotion/community development representatives, volunteer coordinator, and administration staff.	Executive leaders
2	Delegate social prescribing roles and responsibilities	Designate Link Worker, volunteer support staff, and implementation leads. Staff may assume multiple roles, as long as existing duties are shifted to accommodate the additional responsibilities.	Executive leaders
3	Plan implementation	Draft a context-specific implementation plan to establish objectives, target population, structured referral processes, data collection methods, communication and feedback mechanisms, and timelines.	Staff circle, management
4	Implement data-collection pathway	It is vital to be able to formally capture the process of social prescribing and its impacts on clients and providers. Identify the how data will be tracked, by whom, and when.	Staff circle, data coordinator
5	Engage organization staff	Educate all staff on social prescribing, the implementation plan, and their role in identification and referral.	Implementation leads, management
6	Engage primary care staff	Make special efforts to engage primary care providers and help them understand their role. A useful tool is client appointment data over the previous 6 to 12 months. Focusing on the most frequent clients, providers can help identify those who may benefit from social and community supports.	Implementation leads
7	Asset mapping and partner engagement	Perform a rapid community asset mapping to understand existing resources in the community. Connect with existing and new partners to help them understand social prescribing, and their roles in the pathway.	Implementation leads
8	Begin social prescriptions	With a clear referral pathway and a strong foundation of staff and partner engagement, clients can now receive social prescriptions, and be supported to access non-medical supports that enhance their wellbeing!	All staff
9	Invite Health Champions	This component of social prescribing is transformative in empowering clients and creating a sense of community and belonging, but it is dependent upon organizational capacity to support this work. When there is organizational readiness, invite clients and community members to become Health Champions and work collaboratively with organizational staff to identify needs and create solutions.	Implementation leads

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