SOCIAL PRESCRIBING

IMPLEMENTATION GUIDE

July 2024

United Way British Columbia

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

CONTENTS

ACKNOWLEDGMENTS

We extend our sincere appreciation to the many individuals and organizations whose contributions have been integral to the development of this Social Prescribing Implementation Guide for Seniors Serving Agencies in British Columbia.

We are deeply grateful to Healthy Aging Alberta, the Alliance for Healthier Communities, the World Health Organization (WHO), Tamarack Institute, Aging Well Penticton, Fraser Health, the Canadian Institute for Social Prescribing (CISP), and the Canadian Alliance for Social Connection and Health. Their expertise, guidance, and provision of resources have significantly enriched the content and methodology of this guide. We thank them for their dedication to enhancing the well-being of seniors and their collaborative efforts in this endeavour.

Additionally, we appreciate the individuals within these organizations who generously shared their insights and experiences. Their contributions have enhanced the depth and breadth of this guide, and we are thankful for their collaboration. We acknowledge the network of partners, stakeholders, and experts in the field of senior care for their ongoing support and contributions to this project. Their collective efforts have strengthened the utility of this guide as a resource for senior serving agencies across British Columbia.

Finally, we recognize the dedicated team at United Way BC for their hard work and commitment to bringing this guide to fruition. Their passion for serving seniors and strengthening our communities has been fundamental to this initiative.

Together, we remain committed to promoting holistic approaches to senior care and fostering connected communities where every individual can thrive.

OVERVIEW

Social Prescribing in British Columbia: United Way BC's Vision

United Way British Columbia (UWBC) is leading the integration of Social Prescribing within the province, adapting this internationally recognized approach to meet the unique needs of British Columbia's communities. Initiated after extensive community consultations in 2018, UWBC's adaptation of Social Prescribing builds on the success of the "Better at Home" program started in 2012, aimed at enhancing the independence and community engagement of older adults.

Envisioning a future where community collaboratives strengthen partnerships and enhance the Community Based Seniors Service (CBSS) sector's ability to support older adults, UWBC promotes collaborative efforts among agencies and partners. This includes improving access to services, referrals, and coordination across sectors, with Community Connectors playing a pivotal role in providing streamlined access to a broad range of services for older adults.

Implementation and Impact

The Social Prescribing demonstration project, launched in early 2019, marks UWBC's foray into integrating healthcare with essential social support services. Despite the unforeseen challenges posed by the COVID-19 pandemic in early 2020, the resilience and collaborative spirit of non-profit organizations, healthcare entities, and government bodies have been pivotal. This collective approach has not only improved the delivery of essential services but also fostered stronger community connections, culminating in a comprehensive review of the program's reach and impact, which extended to over 25 communities by 2021.

Expansion and Sustainable Growth

Leveraging the learnings and successes from the initial stages, UWBC has been steering the expansion of Social Prescribing through the formation of Community Collaboratives since 2022. This strategy is rooted in the ethos of community service and collaboration, aiming to weave health and social care services more closely together to ensure a supportive network for older adults. The expansion is characterized by a thoughtful, phased approach, underpinned by targeted funding opportunities, to ensure a sustainable increase in the program's reach across the province, with aspirations for comprehensive coverage by 2025.

This expansion is informed by consistent feedback from the sector, emphasizing the need to enhance access to community-based services for seniors, increase the capacity of the CBSS sector, and strengthen collaboration within communities, with municipalities, and the health system. Addressing these priorities, the revised service and program design is transforming the way we support seniors living in our communities, focusing on fostering social connections as a core function of Better at Home and Healthy Aging programs.

Charting the Future: This Guide and Beyond

As Social Prescribing continues to evolve, it marks a new chapter in advancing community health and well-being across British Columbia. This guide is a part of the resources created by UWBC, to equip community partners and stakeholders with the knowledge and tools necessary for the practical application and rollout of Social Prescribing throughout the province. With the goal of establishing a network of connected, supportive communities, this initiative is set to foster a more inclusive and nurturing environment for all older adults, aiming to make a significant impact by 2026.

1. UNDERSTANDING SOCIAL PRESCRIBING

What is Social Prescribing?

Social prescribing is a means for healthcare providers and other trusted individuals in health and community settings to connect participants to a range of non-clinical services in the community to improve their health and well-being. Rather than simply treating symptoms of illness, social prescribing can help to address underlying causes of health and well-being issues. Social prescribing is a holistic, person-centred, community-based strategy aimed at addressing the social determinants of health.

How does Social Prescribing Work?

Social prescribing always involves a structured pathway that is adaptable to the strengths and needs of each community and targeted population. In Canada, this pathway varies across provincial, regional, and local initiatives. However, most social prescribing programs allow healthcare providers and other "identifiers" to refer their patients or clients to a specialized link worker, who will work with each participant to identify their non-medical needs and co-produce the personalized social prescription.

This involves taking time to build a trusting relationship with the participant, addressing barriers to participation in activities or accessing services, and routinely following up with participants to monitor their progress and to provide ongoing support. Link workers may also be referred to as community navigators, link ambassadors, or Community Connectors. More about the specific role of the UWBC Community Connector is discussed in Chapter 2.

Instead of: **"What's the matter with you?"**

Social Prescribing asks: **"What matters to you?"**

Social prescribing respects an individual's choice, agency, and capacity. While each "prescription" is unique to an individual's identified social needs and personal goals, common referrals may include supports for mental health, social isolation and loneliness, substance use, income, housing, food, transportation, and activities of daily living.

Together with a link worker, clients are encouraged to co-create social prescriptions that help them to develop their interests, goals and gifts while connecting with their community. Among other things, a social prescription could look like:

Art class, dance lesson

Community garden, hiking group

Good Food box to support food security

Bereavement network or support group

Caregiver or newcomer support

from Alliance for Healthier Communities, 2022

Social prescribing was first developed in the United Kingdom in the 1990s, and is now an integral component of their national healthcare system. The success of social prescribing in the UK sparked interest across the globe; today, social prescribing has been adopted in nearly 17 countries. In Canada, social prescribing has taken root across the country, creating a diverse landscape of program models.

Understanding the Social Prescribing Metaphor

The term "social prescribing" draws on the familiar practice of a doctor writing a prescription for a medication. Initially, this term was intended to leverage the authority of doctors as trusted providers. Like medication prescriptions, social prescriptions are individual, targeted, and intended to prove health outcomes, not by providing a pharmaceutical solution, but by addressing non-medical, social needs. For example, a doctor might "prescribe" time in nature or volunteer work, depending on the individuals interests and goals. This metaphor recognizes the influential role of healthcare providers in guiding their patients towards healthier lifestyles.

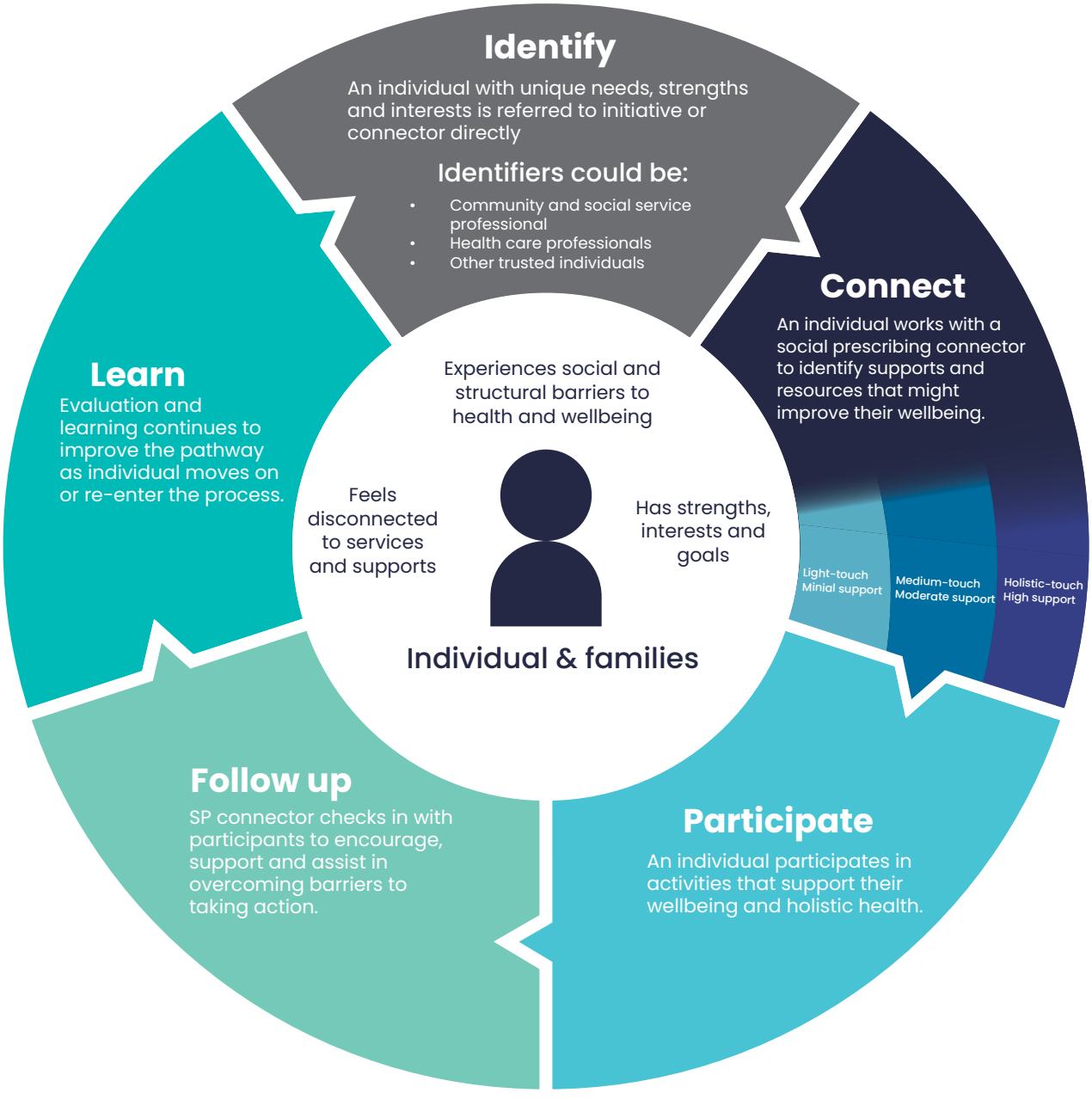
However, this metaphor must be used with caution. It is not intended to further medicalize life's problems. Rather, it symbolizes a shift in healthcare delivery that acknowledges and seeks to address the profound influence of social determinants of health.

"As we adopt the language of "prescribing," we must be wary of inadvertently reinforcing hierarchical relationships between health professionals and patients. The process should be a collaborative one, ensuring that patients are empowered to take an active role in their own health and wellbeing.

The metaphor of "social prescribing" also opens up discussions about cultural implications. We must be mindful of the potential for colonial influences within this model and ensure that we design our programs in a way that promotes inclusivity and respect for all cultural perspectives."

- Canadian Alliance for Social Connection and Health (2023), *Conceptualizing and Implemenzting Social Prescribing Programs.*

This visual summarizes a typical "journey" of an individual into five stages as they move through a structured social prescribing pathway.



Source: Canadian Institute for Social Prescribing

In practice, social prescribing programs exist on a continuum, where the level of support and range of social interventions provided to individuals vary. Many organizations may find that they are already practicing some elements of social prescribing, and the examples on the following page illustrate the wide range of programs and interventions that can fall along this continuum.

Light Touch

Contains a few elements of social prescribing principles and pathway, provides minimal support for connection to services, & focuses on a few types of social support.

Multi-unit housing operators run community-building programs and activities in the building and the local community to engage residents and improve sense of belonging, inclusion, and safety.

Patients being discharged from the hospital are attached to a care coordinator who supports them and their caregiver to connect with home and community care supports such as nursing, medical supplies, and personal support workers.

Medium Touch

Contains some elements of social prescribing principles and pathway, provides moderate support for connection to services, and encompasses a range of social interventions.

A caregiver calls a caregiver helpline. The helpline navigator refers them to a support group in the community, as well as programs for the person they are caring for.

Trained community volunteers offer weekly over-the-phone group chats with rural older adults in a three-pronged approach to combating social isolation: peer support, conversing with appreciative inquiry, and resource navigation.

Holistic Touch

Contains most or all elements of social prescribing principles and pathway, provides dedicated support for connection to services, and encompass a wide range of social interventions

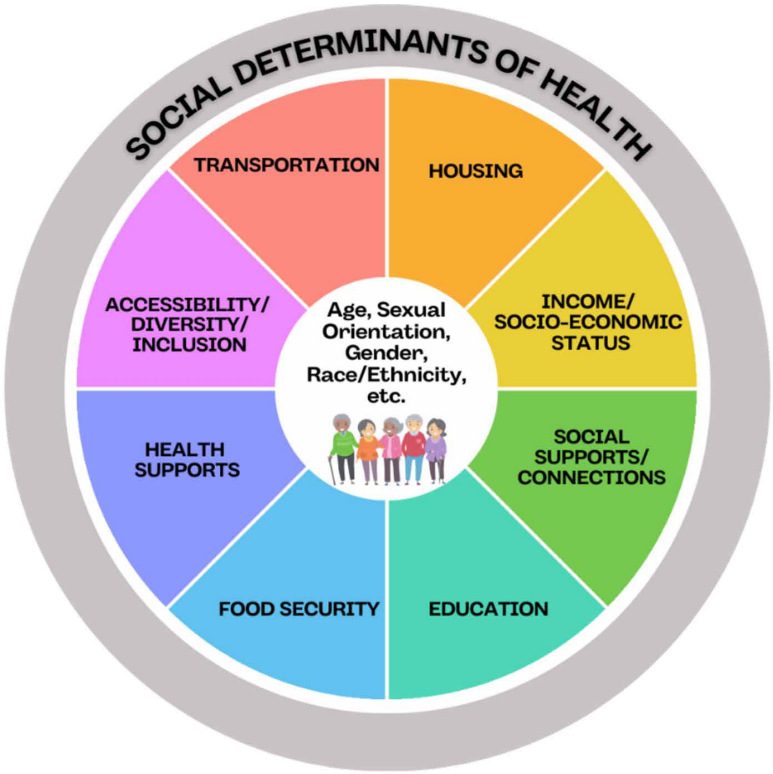
A Nurse Practitioner sees a patient with diabetes who is not eating well nor exercising. The NP refers the patient to a Community Connector, who connects the patient to a local food bank, a subsidized community-run produce market, and a walking group. The Connector reports back these referrals to the NP.

A Better At Home housekeeper notices a senior client is living with low-income and is at risk of eviction. They refer the client to a multi-service community organization who connects the senior to a tenant advocacy group, an income tax clinic, and helps them apply for the SAFER rent supplement.

Why Social Prescribing?

It is estimated that only 20% of a person's health outcomes are linked to medical interventions. In other words, **80% of a person's health is determined by non-medical factors, including individual behaviors and environmental and social factors**. Social prescribing is thus built on the evidence that addressing the social determinants of health (SDOH) is essential to improving an individual's health and well-being.

> **The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.**[1] - World Health Organization



The SDOH include factors such as income, education, employment, housing, and gender, but also include larger structural forces, such as systemic racism, the ongoing impacts of colonialism, and intergenerational trauma.

While the SDOH have impacts throughout the life course, SDOH have particularly significant effects on the health and well-being of older adults due to the many life changes introduced by the aging process.

HOUSING

Aging in place is attributed to better health outcomes; yet access to safe, affordable, and accessible housing restricts many seniors from aging in place. High housing costs also leave little room for other essentials like food, utilities, and medication.

HEALTH SUPPORTS

Older adults experience many barriers to accessing essential and quality healthcare supports, such as mobility concerns, lack of accessible or affordable transportation, economic constraints, and age-related bias from healthcare providers.

SOCIAL CONNECTIONS

Older adults with strong social connections have a lower risk of health conditions like heart disease, stroke, dementia, depression, and even premature death. However, loneliness and isolation are highest among seniors, whose social networks often decrease as they age.

INCOME

Income is deeply connected to other SDOH, and is thus a critical determinant of health and well-being of an older adult. Income security is essential for covering medical costs, housing expenses, nutritious food, and transportation. Older adults with lower incomes are even more likely to be socially isolated.[2]

RACIAL DISCRIMINATION

Older adults who have experienced racism throughout their lives may carry the psychological burden of chronic stress. Racism-related stressors, including discrimination, microaggressions, and social exclusion, contribute to higher rates of anxiety, depression, dementia, and other mental health disorders among older adults from marginalized racial and ethnic groups.[3] Chronic stress has also been linked to racial health inequities in cardiovascular disease and diabetes.

By connecting individuals with non-medical, social needs to services and supports in the community, social prescribing is a means to directly address the SDOH.

Social prescribing is becoming recognized as a powerful tool for supporting healthy aging. Existing research indicates a wide range of potential positive impacts, extending beyond the individual to both the community and systems levels.

For older adults, social prescribing can...	• Improve mental and physical health • Decrease social isolation and loneliness • Increase sense of belonging and social participation • Improve access to income supports • Increase autonomy and sense of purpose • Improve nutrition and access to food • Reduce reliance on medical supports
For communities, social prescribing can...	• Improve communication and information sharing between CBSS, health, and community agencies • Identify and address gaps in community resources • Improve the provision of culturally appropriate care for older adults and elders • Improve the recognition of community leadership • Improve the recognition of and support for barriers faced by a diversity of older adults
For health and social systems, social prescribing can...	• Decrease burden on health system via reduced use of primary and emergency care • Increase trust in and contact with health and social care providers • Decrease burnout of health and social care providers • Shift how we understand health and well-being in older adults

The Impact of Social Prescribing

Participants in the Alliance for Healthier Communities' research pilot Rx: Community – Social Prescribing reported

49% decrease in loneliness

12% increase in mental health

19% increase in social activities

The impacts of social prescribing go beyond each client's individual health and well-being. Healthcare systems also benefit from social prescriptions. Results from programs in Shropshire and Frome, UK (2017-2019) meant that from social prescribing, the healthcare system saw a:

14% decrease in emergency room visits

40% decrease general physician visits

20.8% reduction in costs to the health care system

Source: Alliance for Healthier Communities, 2022

Who is Social Prescribing for?

While social prescribing can benefit anyone, it is especially beneficial for individuals facing systemic and social barriers to health and well-being. People experiencing poverty, early-life stressors, unemployment, and social exclusion are more likely to experience worse health outcomes. Social prescribing can therefore benefit those most impacted by the SDOH.

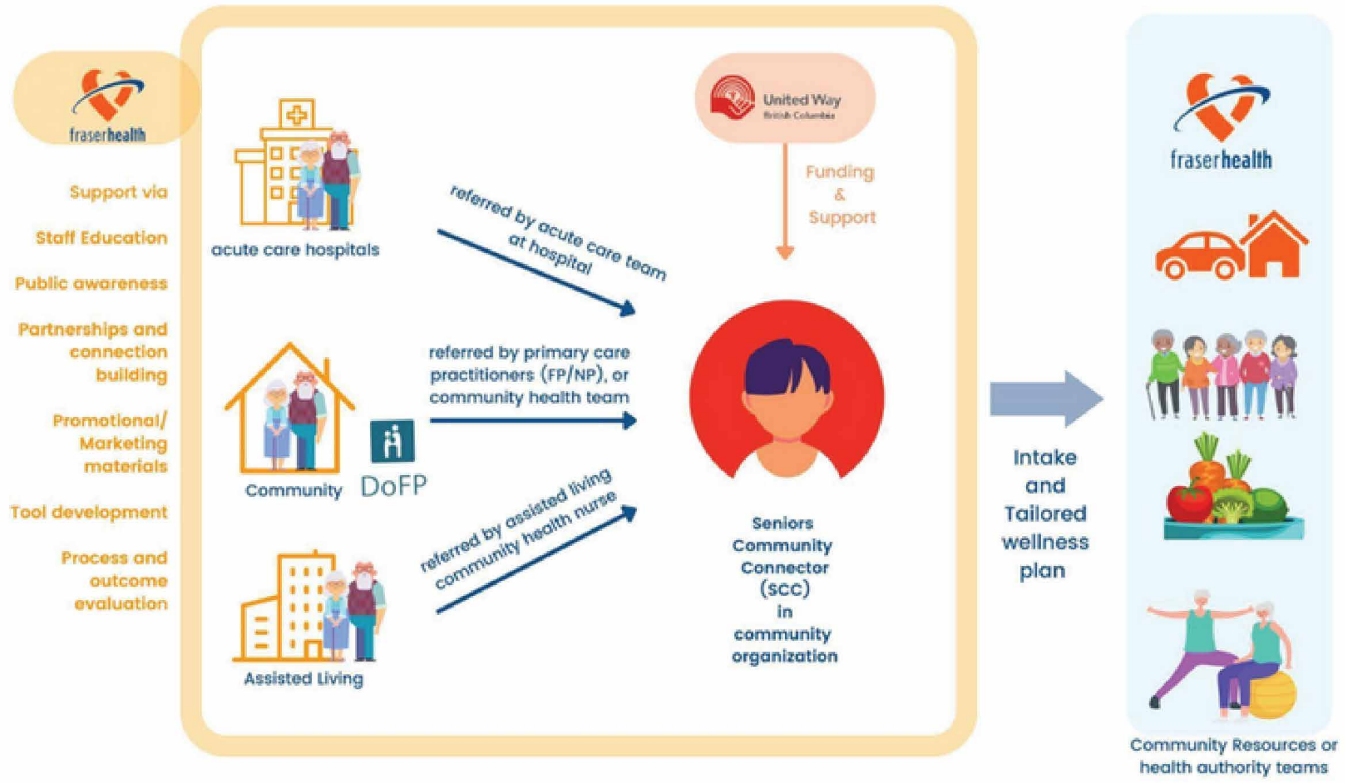
The profound impact of the SDOH on older adults' health and well-being is recognized in the new UWBC Healthy Aging Service Delivery Model which asks funded programs to focus on delivering services to vulnerable seniors. Vulnerable seniors are defined as experiencing two or more of the following:

- Low or modest income
- socially isolated / lonely
- low to moderate frailty
- member of an underserved population (immigrant and ethnocultural minorities, Indigenous elders, caregivers, 2SLGBTQIA+ seniors, and persons living with a disability)

In focusing service delivery on these groups, UWBC seeks to reduce the health inequities of older adults by targeting those who experience significant barriers to health and well-being. Social prescribing aligns with this approach, as it is most beneficial for older adults who are facing theses barriers.

Social Prescribing in Practice: Fraser Health Authority Seniors Community Connectors

Fraser Health has 10 Divisions of Family Practice, each working with a CBSS organization. In this model, each partner organization appoints a Seniors Community Connector who completes participant intake, assessment and wellness plan co-creation, and makes referrals to community services and supports.



Source: Bridgeable Current State of SP Summary Report 2022

Bevy-Ann's story below illustrates the kinds of support a Seniors Community Connector can provide, and the impact role they play in enhancing the lives of older adults.

BEVY-ANN'S STORY

For more than twenty years, Bevy-Ann lived with her soulmate Walter in California, until tragedy struck in 2020, when Walter lost his battle with cancer. With a heavy heart, she made the decision to return to Canada, settling in Fraser Valley where a friend lived. Yet, Bevy-Ann faced numerous challenges in resettling. With no income, social network, or suitable housing to accommodate her wheelchair disability, she felt isolated and alone.

"It was so bad that I was suicidal," Bevy-Ann bravely admits. But amidst her darkest moments, a ray of light appeared in the form of Trina, a Seniors Community Connector of the Social Prescribing Program at Archway Community Services.

After a hospital social worker referred Bevy-Ann to the program, Trina became Bevy-Ann's advocate, helping her apply for government benefits, ensuring she received Old Age security and the Guaranteed Income Supplement. Thanks to Trina's support, Bev-Ann's financial situation stabilized and she felt empowered. She also received grocery deliveries through a food bank, and housekeeping services through UWBC's Better at Home Program.

Guiding Principles of Social Prescribing

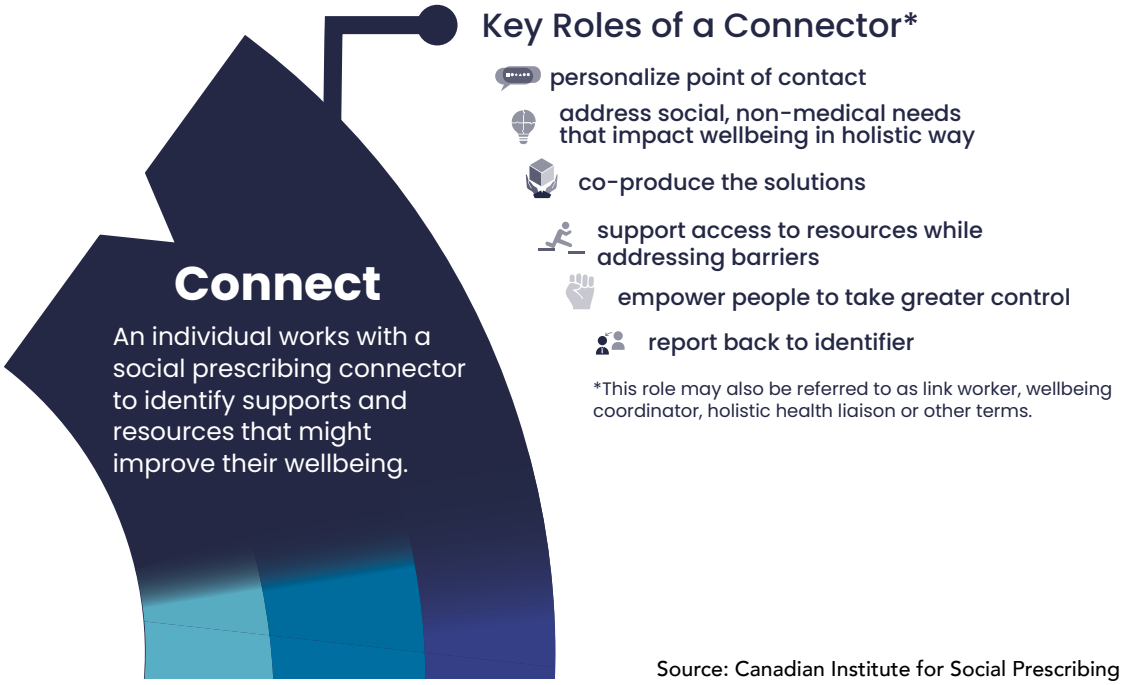
Social prescribing is an approach that is:

- **Person-centred**. The participant's individual choice, agency, and capacity to engage with and be the driver of their own health outcomes and life direction is respected and supported, shifting power dynamics between institutions, communities, and individuals.
- **Collaborative**. Social prescribing requires deliberate and consistent collaboration and communication between the health, community, and social sectors.
- **Relational**. Social prescribing is a longitudinal approach that fosters long term, trusted relationships and warm connections.
- **Community-led**. Social prescribing builds individual and community resilience by supporting participants to be connected to their communities and peers, and by recognizing existing expertise, strengths, and innovations in the community.
- **Equitable**. Social prescribing aims to reduce barriers and increase equitable access to supports for diverse populations, using anti-oppressive, anti-racist, and culturally safe approaches.
- **Holistic**. All aspects of health are integrated into social prescriptions, from structural, physical, psychosocial, cultural to spiritual, as well as the whole circle of care, including family caregivers.

> **The institutionalization of social prescribing is a step towards redefining our healthcare system, advocating for an integrated, person-centered approach. It aims not only to improve individual health outcomes but also to foster more cohesive communities. This approach reflects the understanding, long held by diverse cultures & practitioners, that health is a state of complete physical, mental, and social wellbeing, not solely the absence of disease.**
>
> - The Canadian Alliance for Social Connection & Health (2023), *Conceptualizing and Implementing Social Prescribing Programs*

2. COMMUNITY CONNECTORS

UWBC Community Connectors



Source: Canadian Institute for Social Prescribing

The Community Connector role is pivotal in expanding the Social Prescribing program across Community Collaboratives. These individuals are key to providing seniors with coordinated access to community resources and facilitating referrals within the healthcare system. Beyond supporting individuals, Community Connectors are instrumental in building community networks and strengthening the relationships between the CBSS sector, healthcare providers, and local government services. United Way BC's commitment to this program involves the phased appointment of Community Connectors in selected communities starting in April 2024. Each Connector will be embedded in and employed by an agency in the community, with the ambitious goal of achieving province-wide coverage by the end of the 2025-26 period.

What does a Community Connector do?

> **Link workers (Community Connectors), with their unique set of skills and community knowledge, perform a crucial role. They work one-on-one with patients to understand their social, emotional, and environmental health needs, developing personalized care plans that align with the patient's values, interests, and goals. In doing so, they alleviate the pressures faced by physicians, freeing up valuable tine and resources that can be reallocated directly to medical care.**
>
> - The Canadian Alliance for Social Connection & Health (2023), *Conceptualizing and Implementing Social Prescribing Programs*

In general, the Community Connector role comprises two main components: supporting older adults through social prescribing, and engaging in community development activities.

In UK models of social prescribing, link workers typically allocate approximately 60% of their time to working directly with social prescribing participants and 40% to developing networks and partnerships in their communities. For UWBC Community Connectors, while many may adhere to this workload division, the role is designed to be adaptable to each community's unique needs and priorities. For instance, in a community with limited awareness of social prescribing, the Connector might first prioritize building relationships with healthcare providers.

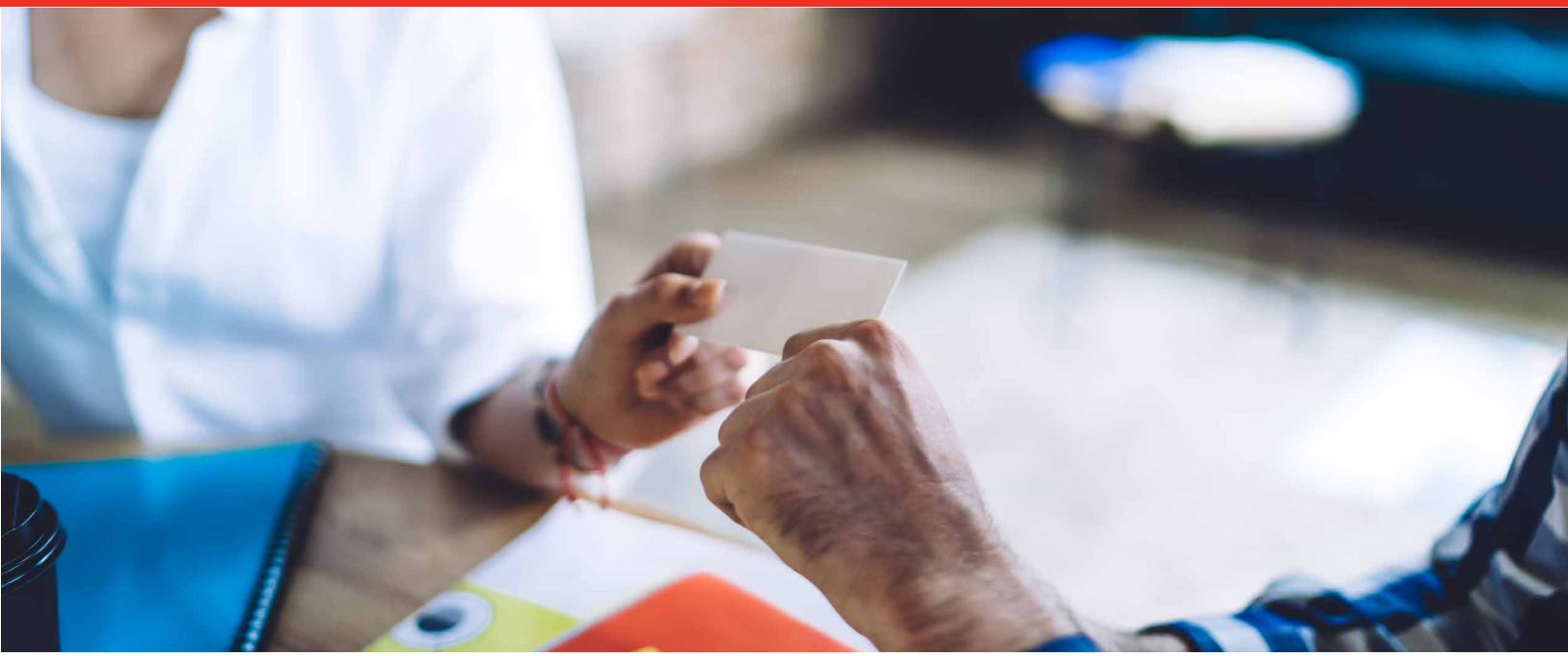
The following section describes the key responsibilities of Community Connectors in detail.

Community Development

- Builds and maintains networks within community and strengthen relationships within the community-based senior serving sector.
- Uses an asset-based community development approach to identify and mobilize individuals and organizations supporting older adults.
- Engages and participates in learning opportunities such as in communities of practice, planning tables or networking events.

Assessment and management of referrals

- Connects, liaises, and establishes partnerships with local health care professionals to create and maintain referral pathways.
- Maintains an active caseload of seniors with short-term needs through referrals from healthcare professionals and community agencies.
- Prioritizes referrals to meet individual participant's needs.
- Understands hospital discharge procedures; assist with supporting seniors transitioning back home following discharge.
- Implements safety precautions when visiting seniors in the community, including their personal residence.
- Completes intake process to assess strengths, needs, abilities, and risks using motivational interviewing techniques such as active listening, conflict resolution and observing behaviour.
- Uses various assessment tools to determine challenges, needs and risks related to healthy aging and develop routines, structures, and resource referrals to reduce risk of frailty.
- Interpret participants' complex physical requirements and social needs.
- Maintains a high level of confidentiality in all matters related to participants and community partners.



Wellness Plan Development

- Supports seniors to access appropriate range of activities and suitable community resources by developing individual wellness plans.
- Using a "what matters to you" approach, refers seniors to community-based services, observes and assesses the participant's engagement with resources, and modifies activities to meet the participant's changing needs.
- Effectively collaborates within the Agency's and community's Seniors Services to provide multidisciplinary care for the best interest of the senior.
- Assists with connection to a primary care provider.
- Engages and participates in educational training for seniors on topics such as healthy aging and other relevant topics.

Documentation of referrals

- Documents participant's interactions, wellness plans, reports, and other administrative duties as required.
- Provision of follow-up notes to continuing community health care provider if requested.

Evaluation

- Participates in evaluation of programs including collection of participant data, reporting at regular intervals, and attending communities of practices.

Who can fulfil the Community Connector role?

Community Connectors are compassionate professionals equipped with a diverse set of skills and attributes. While typically there are no specific educational requirements to become a Community Connector, Connectors must have strong knowledge of issues and challenges that seniors face in relation to healthy aging, experience supporting or working with older adults with different backgrounds, and knowledge of their community's resources, supports, and programs relevant to seniors.

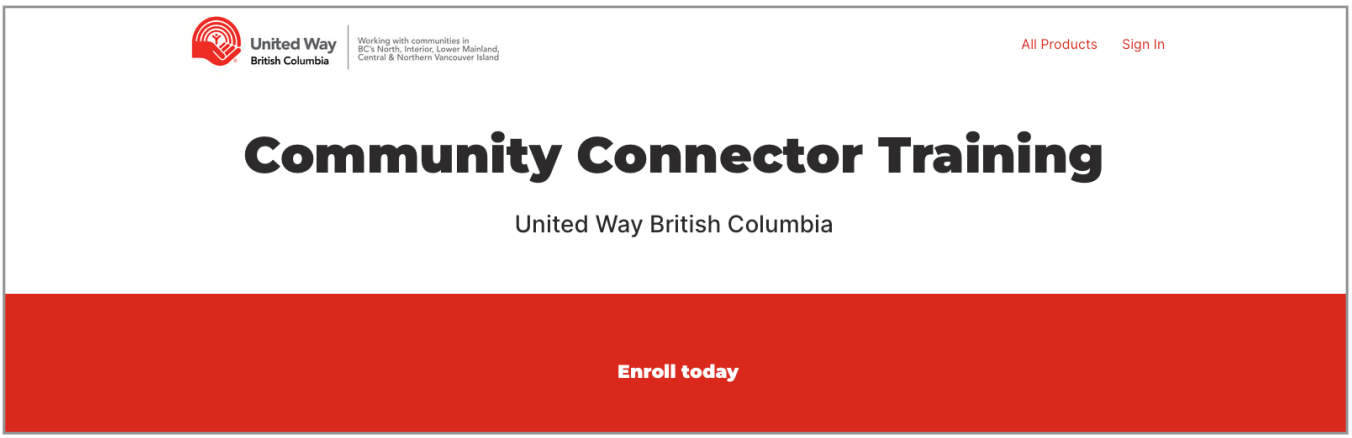
Within the CBSS and health sectors, there are many existing positions that may include aspects of addressing social needs, such as patient navigators or health coaches. Recruiting a Community Connector can involve shifting or expanding the role of an existing employee that may already be practicing elements of social prescribing in their work.

Presently, many Connectors have backgrounds as nurses, occupational therapists, social workers, community outreach workers, health promoters, patient navigators, or community volunteers. While many have experience in healthcare settings, Connectors are distinctly non-clinical professionals.

An ideal Community Connector...

- Listens actively and empathizes with the participant
- Communicates effectively
- Can foster trusting relationships
- Can build and grow community networks
- Is passionate about addressing social determinants of health
- Has experience supporting older adults and elders
- Can speak local languages and is sensitive to local cultures

Community Connector Training



United Way BC has developed a pilot training program for Community Connectors, offering a comprehensive curriculum covering foundational principles of social prescribing, the intricacies of the Community Connector role, and essential skills such as asset mapping, needs assessments, and network building. Participants will learn to create personalized wellness plans, navigate pathways to support, and prioritize safety and self-care. The program also emphasizes monitoring, evaluation, and understanding team dynamics. Accessible resources and guidance on utilizing platforms like Healthy Aging CORE and joining Communities of Practice ensure that participants are well-equipped to make a meaningful impact within their communities

To access the pilot training program for Community Connectors hosted by United Way BC, please visit the training program here.

The training is divided into two parts:

Part One:

This course focuses on the foundational aspects of being a Community Connector. You will delve into essential topics that build a strong base of knowledge and skills that will be instrumental in your day-to-day activities. It is recommended that you finish part one within 2 months. You can access Part One here.

Part Two:

This module provides additional content to further enhance your capabilities. It is designed to be completed within 2-4 months, after you have finished Part One. This content will broaden your understanding and prepare you for more complex challenges in your role. You can access Part Two here.

How to Sign Up:

To enroll in the training modules, please follow these steps:

1. Click the links to Part One and Part Two.
2. Create an Account: If you do not already have an account, click on the "Sign Up" button and fill in the required information to create your account.
3. Enroll in the Courses: Once your account is set up, log in and navigate to the Community Connector training modules. Click "Enroll" to sign up for Part One and Part Two.
4. Start Learning: Begin your training journey by accessing the first module and following the course curriculum at your own pace.

- As a pilot training program, your feedback is crucial to making these resources as effective and useful as possible. We have included a survey link here where you can provide feedback as you go through the training. Your insights and suggestions will be invaluable in refining and improving the training for future community connectors.

Community Connector training will cover the following areas:

Social prescribing. Connectors should have an understanding of the purpose and importance of social prescribing, who can benefit, and their specific responsibilities.

Social determinants of health. Connectors should have a strong understanding of the SDOH, how they can impact an older adults, health and well-being, and how social prescribing can address these issues.

Communication skills and techniques. As Connectors will interact with participants with complex health and social needs, they will be provided with training to strengthen their communication skills, in areas such as developing rapport, trust building, active listening, the use of open and closed questions, and motivational interviewing techniques. Connectors should be respectful, non-judgmental, and empathetic, and should understand the importance of establishing personal boundaries to prevent dependency, and how to ensure privacy and confidentiality.

Using social prescribing tools. Connectors should be able to use available tools to develop personalized wellness plans, and be trained on referral and intake processes. They should also be trained on how to collect required program data, including what data to collect, and when and how.

Participant interview and intake. Connectors should be provided with an assessment/ intake form to help guide their discussions. This intake should take the form of a naturally flowing conversation between the Connector and participant, rather than reading a series of questions from a script.

United Way BC has developed an interview guide with questions to help guide an initial conversation, that can be found in CORE BC Social Prescribing Intake Package.

An example wellness plan template

Name and contact details for person: _____	
NHS number: _____	
Part one – to be completed together at the start	
What matters to me:	
How best to support me: what people need to know about me and my life:	
Any health conditions that agencies need to know about:	
My goals:	
Summary of support that I am being connected to, including what I can expect from support:	
What I can do to support myself to meet my goals:	
Review – when shall we check how it's going?	
Part two – to be completed after 6 months	
What changes have taken place?	
I am happy to share my personal story?	
I am willing to complete a satisfaction survey?	
I am happy to participate in ongoing data collection and evaluation?	

Source: https://www.england.nhs.uk/publication/social-prescribing-link-worker-welcome-pack/

Developing a wellness plan. Following intake and assessment of a participants needs and goals, the Community Connector should work together with the participant to develop a personalized wellness plan. There are several templates that can be used, but there should be flexibility in how the plan is developed. An example personalized wellness plan template can be found above. When developing the plan, the Connector should consider privacy concerns, and ensure full consent, ensuring that the final choice of allocated resources or supports remains with the participant. Potential barriers that might be encountered, such as cost, waiting list, and distance should be considered.

Healthy Aging CORE BC

Healthy Aging Collaborative Online Resources and Education (CORE) is a platform to connect community-based seniors services organizations and allied agencies and individuals in British Columbia. CORE is designed to provide up-to-date information, resources, and training opportunities and to make it easier to communicate, coordinate, and collaborate in order to help build capacity, strengthen the network, and develop a collective and cohesive voice among volunteers, staff, and others who support healthy aging initiatives.

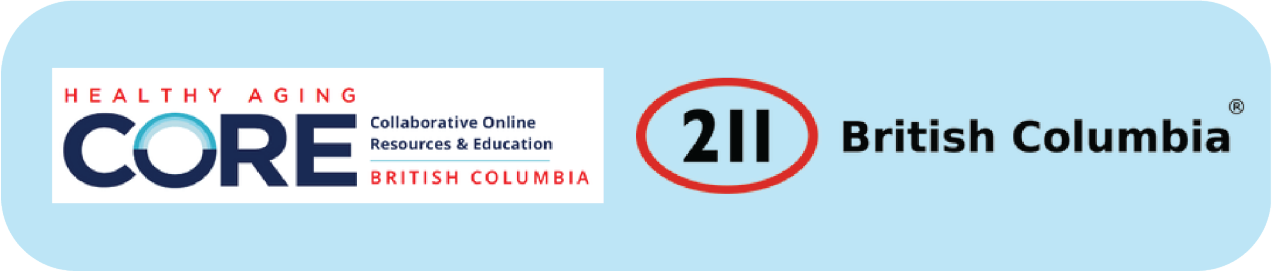
CORE features a dedicated group specifically for Social Prescribing. This group requires a separate request to join. Once part of this group, members have access to a range of resources related to Social Prescribing funding stream programs, along with opportunities for discussion and sharing of insights. This special segment of CORE is intended to further support the growth and effectiveness of Social Prescribing initiatives through targeted information exchange and collaborative engagement.

Social prescribing intake package includes:

- Participant Intake Form
- Participation Consent Agreement
- Photo Consent Form
- Interview Guide

Participant Referrals to Community Resources. While Community Connectors should typically bring a strong understanding of resources, programs, and activities relevant to seniors in their community, Community Collaboratives should provide the Community Connector with a community asset map as a starting point to building a comprehensive inventory of relevant resources that can be easily accessed and updated. Connectors can continuously increase their knowledge of the CBSS sector and other resources through online resources and by attending events and professional development opportunities.

CORE and 211 British Columbia are both excellent resources for Connectors to remain up-to-date on the CBSS sector and beyond.



Building relationships with the health and CBSS sector. These relationships are an essential part of delivering social prescribing, and Connectors will need appropriate skills to engage stakeholders, especially in areas with lower awareness of social prescribing. Connectors should be able to communicate the value of social prescribing, build trust and communication with organizations and providers, and align on common goals.

Referrals back to health-care services. In some cases, it will be neccessary to refer participants back to their providers, which may occur due to an inappropriate referral or if a Connector identifies a serious health issue that has not been attended to. It is important to specify in training that the Connector should maintain confidentiality unless in specified exceptional circumstances.

Follow-Up. Community Connectors should be trained in the follow-up process, and how to avoid creating dependencies and build self-efficacy for the participant. Frequency of meetings should be determined by the Connector and the participant, with more frequent contact occurring at the beginning to create momentum, but less contact with time so participants feel more empowered.

Communities of Practice (COPs)

UWBC hosts a once-monthly CoP that brings together Community Connectors, their community organizations, and UWBC staff. This CoP provides opportunities to learn from experienced Connectors, share successful practices, brainstorm solutions to challenges, receive updates from UWBC staff about changes in the CBSS sector, and access best practices and resources.

Self Care. There are aspects of the Community Connector role that can impact well-being over time. Connectors should be supported to recognize signs of fatigue and burnout, and employ strategies to support their well-being, including the development of self care plans, and how to set professional boundaries. Regular check-ins between supervisory staff and Connectors can also support in addressing wellbeing needs.

3. COLLABORATION IN COMMUNITY

Understanding Collaboration in Community-Based Initiatives

Collaboration lies at the heart of United Way British Columbia's approach to fostering a supportive environment for older adults. It's the catalyst that unites community agencies, healthcare providers, and local governments, creating a cohesive network dedicated to enhancing the well-being of seniors. The vision for a province-wide network of Healthy Aging Community Collaboratives is to amplify the CBSS sector's ability to offer comprehensive support. This means not only providing essential services but also ensuring that older adults have the opportunity to remain socially connected, access nutritious food, and engage in regular physical activity. Collaboration is essential because it leverages the collective strength of community resources, streamlines service delivery, and builds a more resilient societal fabric where every older adult can thrive. Through strategic partnerships and shared goals, these collaboratives exemplify how working together can lead to a more efficient, effective, and empathetic approach to community health.

Why is Collaboration Important?

Enhanced Service Delivery. Collaborative approaches lead to more comprehensive and accessible services, maximizing impact through the pooling of expertise and efforts.

Increased Creativity and Innovation. Bringing together varied perspectives fosters an environment ripe for innovation, allowing for the development of creative and effective solutions to complex issues.

Efficient Resource Use. Sharing resources among organizations leads to greater efficiency and prevents the duplication of services, ensuring efforts are complementary and impactful.

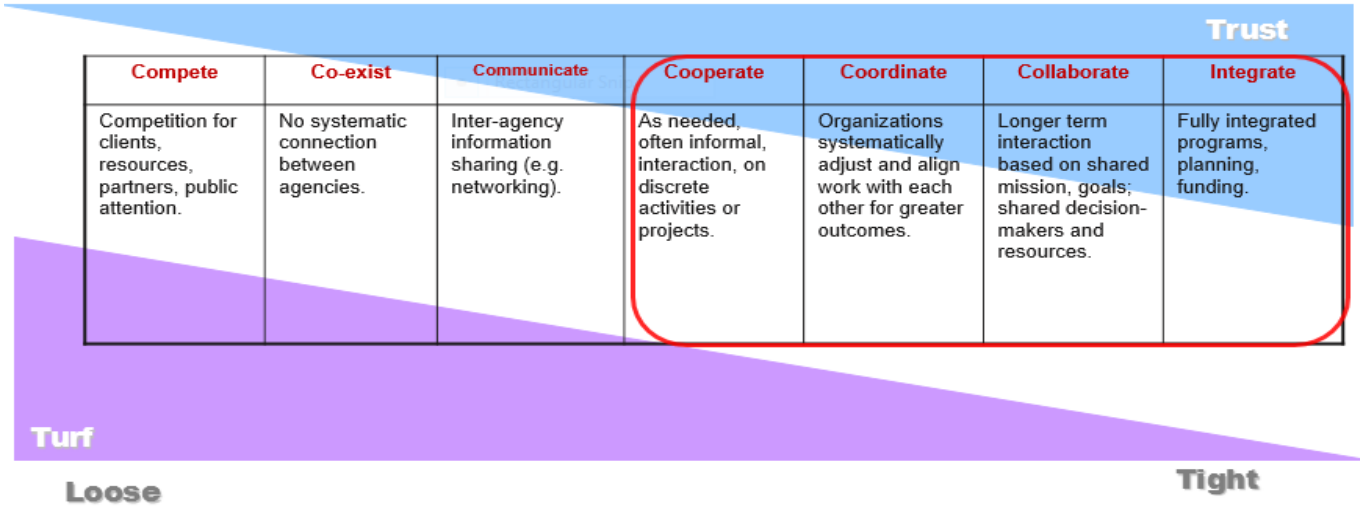
Strengthened Community Networks. Collaboration builds robust networks, enhancing the community's capacity to support its members and adapt to emerging challenges.

Amplified Advocacy. A united front among organizations can more effectively influence policy and decision-making, advocating for the needs and rights of older adults.

Learning and Capacity Building, Collaborative environments offer unique opportunities for shared learning and development, enhancing the collective skill set and service quality.

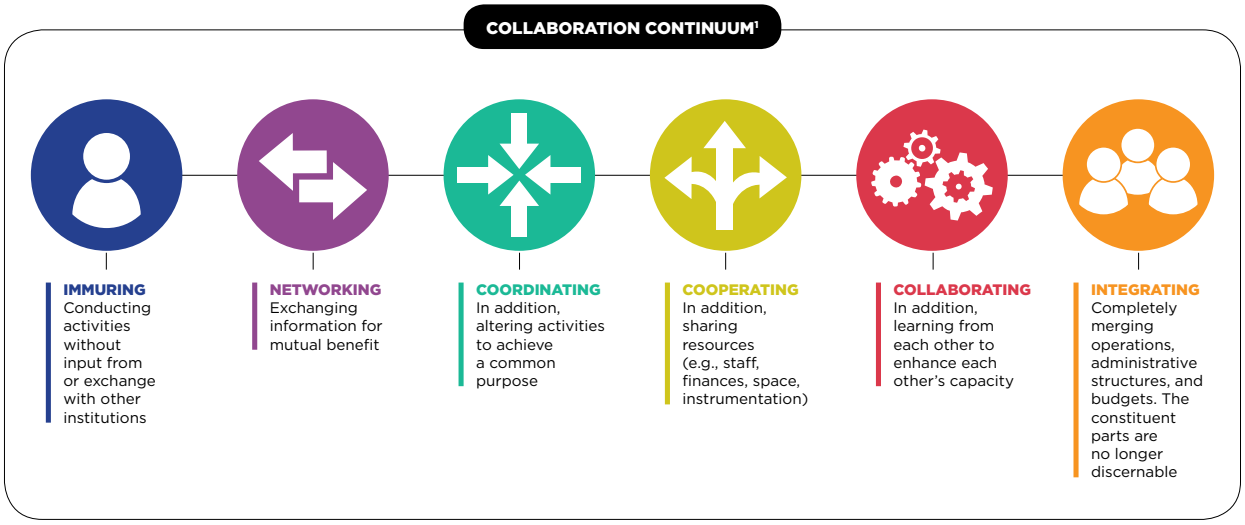
The Collaboration Spectrum

The "Collaboration Spectrum" visualizes the various stages of inter-organizational engagement, from initial contact to deep, integrative partnerships.



Source: Tamarack Collaboration Spectrum Tool

The following statements are helpful to assess where your community may be presently located on this spectrum.



Source: Mashek,D. (June, 2015). Capacities and Institutional Supported Needed along the Collaboration Continuum. A presentation to the Academic Deans Committee of The Claremont Colleges, Claremont. CA

Through Community Collaboratives, we aim to create a holistic support network for older adults - a network that is more than the sum of its parts. By moving through the Collaboration Spectrum we are working towards transitioning from siloed organizational efforts to a united front that stands stronger together for the well-being of our communities.

Fostering Collaboration: Factors to Consider When Working Collaboratively

The following factors and associated questions are important touch points for building collaborative relationships.[4]

- **Intent**: Do we agree on what we are trying to make happen?
- **Interests**: Do we share the same basic interests?
- **Values**: Do we share the same values? Where our values appear to be in conflict, can we see how they are actually complementary and both necessary to success?
- **Analysis**: Do our various analyses of what's going on with this issue complement one another, or compete in fundamental ways? Are my views and experiences meaningfully reflected in that analysis?
- **Need**: Why should we work together? What will that accomplish that I can't accomplish alone?
- **Empathy**: Do we really understand the needs and experiences of those we're trying to help?
- **Belonging**: Can I trust you? Will you look out for me and my needs and interests in this work together?

- **Contribution**: Can I contribute meaningfully to this work?
- **Capability**: Are we up to meeting this challenge?
- **Plans**: How will we do this? Are the plans enough to make this happen? Will we use my and others' time effectively?
- **Commitment**: Are we all truly committed to making this happen?
- **Momentum**: Does what we're doing seem to be working? Are we attracting the other people and resources we need to be successful?

Collaboration is essential for community organizations working to support older adults, amplifying their ability to provide comprehensive, efficient, and innovative services. By adopting a collaborative approach, we can leverage their collective strengths to create a more supportive and inclusive environment, significantly impacting the well-being of older adults in our communities.

Community Collaboratives across British Columbia

The following profiles illustrate several community collaboratives across the province that will be receiving Community Connectors as part of the first phase of the new Healthy Aging Service Delivery Model. While there is no one-size-fits-all approach to successful collaboration, these are examples of what Community Collaboratives can look like in practice and how Community Connectors will be integrated into their collaborative activities.

PENTICTON

Established in 2019, Aging Well Penticton, supported by the federal New Horizons for Seniors program, fosters collaboration to enhance seniors' social connection and sense of belonging. Hosted by OneSky Community Resources, its diverse partners includes mental health, dementia, and hospice care providers, several CBSS agencies, newcomer support services, Penticton Arts Council, city planners, and leadership from Interior Health and the Division of Family Practice. Aging Well meets monthly and is guided by a Collective Impact Framework that maximizes each partner's strengths.

OneSky will host Penticton's Community Connector, leveraging its existing information and referral services to support social prescribing.

Penticton's collaborative success is bolstered by active involvement from local government, that helps align municipal priorities and resources with community needs.

Aging Well Penticton Common Agenda

Source: Aging Well Penticton Collective Impact Plan

PORT HARDY

Port Hardy, a small remote community on the northern tip of Vancouver Island, is home to about 4000 residents, of which 35% are of Indigenous descent and 20% over 65. In part out of necessity, due to a historic lack of local health and social services, Port Hardy has cultivated a strong culture of collaboration.

Weekly meetings convene CBSS agencies, the municipality, local health services, and Island Health. Each participant views themselves first as Port Hardy citizens united to support seniors in the community, rather than as individual agencies with separate responsibilities.

The Hardy Bay Seniors Citizens Society leads advocacy for North Island seniors, and partners closely with the North Island Community Crisis & Counselling Centre Society (NCCCCS), who delivers the local Better at Home program. NCCCCS will host the Community Connector, serving seniors and elders across the North Island.

Given existing strain on resources, the CC must complete extremely detailed asset mapping, identifying both formal and informal assets. Engaging with Island Health and other provincial seniors planning tables will be crucial to ensure that the needs of North Island seniors are represented at all levels of decision-making.

TERRACE

Located in Northwest BC, Terrace is a regional hub to many First Nations and rural communities. Despite its smaller size, Terrace boasts a resilient network of social and community services. Employing a triage-based approach to prioritizing community needs, the Senior Advisory Committee brings together stakeholders from various sectors including social planners, Northern Health, CBSS agencies, First Nations, and a food security network.

Volunteer Terrace will host the Community Connector. As the local Better at Home agency, the organization is well-known amongst seniors and is deeply embedded in the community, offering several youth services including a restorative justice program.

The new CC role is envisioned as flexible and adaptable to Terrace's evolving needs, with special emphasis placed on establishing a strong relationship with Northern Health, in spite of frequent staff turnover.

SUNSHINE COAST

The Sunshine Coast has a significant population of older adults, comprising nearly a third of its 32000 residents. Despite its isolation, the area has unique natural assets and a vibrant arts community, complemented by lifelong learning opportunities provided by the Sunshine Coast Elder College.

The Sunshine Coast Seniors Planning Table (SPT) is a collaborative platform comprised of over 40 organizations totaling nearly 100 individuals who support seniors. Through extensive partnership building and advocacy, the SPT aims to ensure all older adult residents are healthy, valued, and involved community members. The SPT is hosted by the Sunshine Coast Resource Centre (SCRC), a new partner agency with UWBC and the future host of the Community Connector.

Arts organizations are an active participant in the SPT, evidenced by the recent research partnership entitled "Who Cares?". Partnering the SPT with Emily Carr University, Douglas College, and Deer Crossing the Art Farm, this initiative explores a new model of elder care that is grounded in arts-based practices.

BURNABY

Over the past several years, the integration of Burnaby's health and social sectors has accelerated, driven in part by the establishment of the PCN in 2019. This collaborative involves various CBSS agencies, the municipality, and other community organizations, all guided by a formal framework for an integrated model of health and well-being, with social prescribing as a crucial component. A supportive health authority has been a longstanding champion of social prescribing, supporting health professionals in understanding the Community Connector role and the value of social prescribing for older adults.

Three Connectors, positioned across two multi-service neighbourhood organizations, will streamline referrals through a central intake process. Each Connector will possess specific language skills and may specialize in areas such as data or volunteer management to prevent burnout and duplication of efforts. Regular communication between Connectors, the municipality (the Better at Home agency), and the health authority aims to maintain client and agency expectations, prevent service overload, and reduce unnecessary referrals back to the health system.

MAPLE RIDGE - PITT MEADOWS - KATZIE

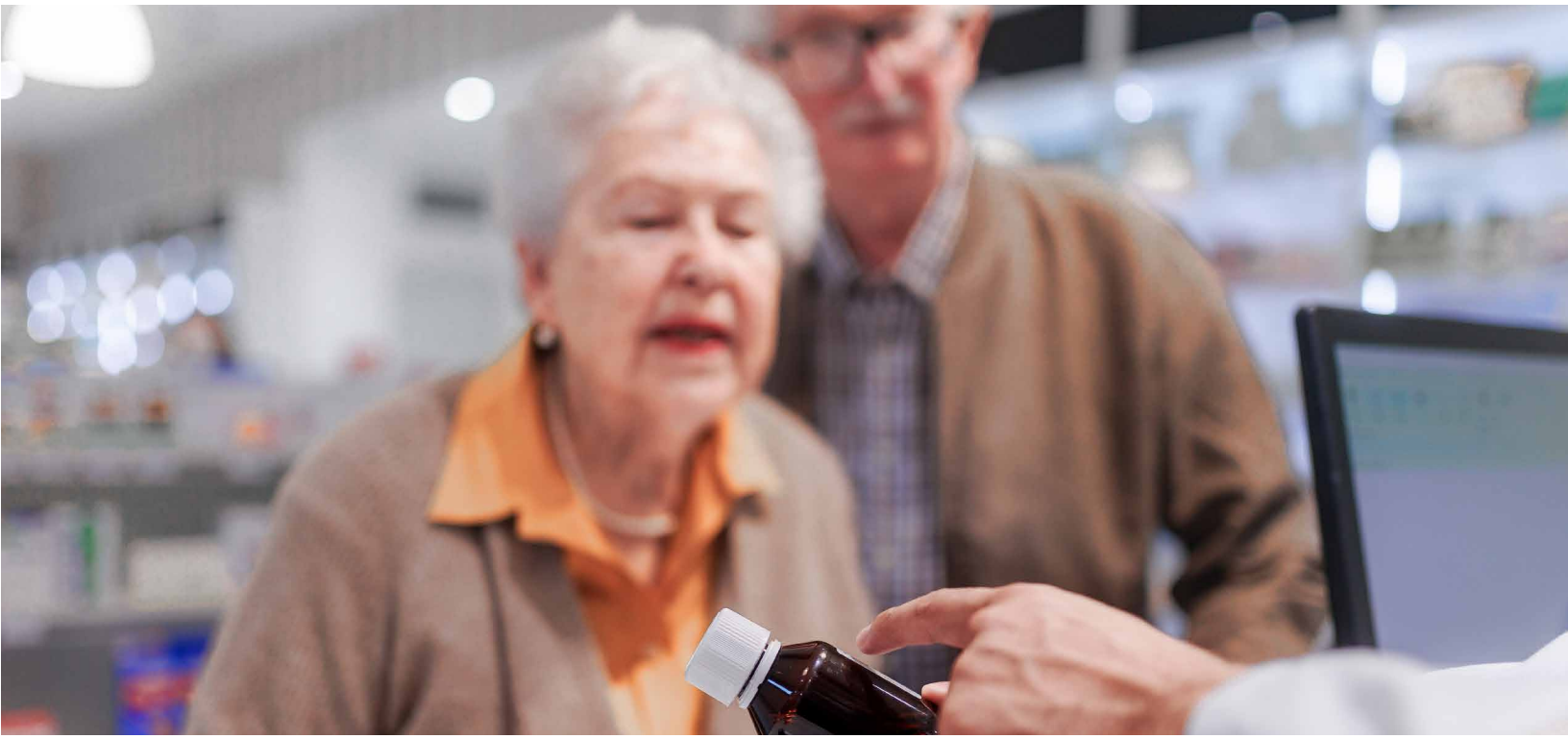
Established in 2008, the Maple Ridge, Pitt Meadows, Katzie, Seniors Network is a collaborative community response to senior's issues. Led by seniors, for seniors, the Seniors Network is made up of CBSS agencies, older adult community members, non-profit organizations, service clubs, government agencies, local health services, and Fraser Health authority. With funding from the City of Maple Ridge and the City of Pitt Meadows, the Seniors Network aims to increase the quality and quantity of resources for seniors to enhance their overall quality of life in the community. This is achieved through identifying gaps in services, avoiding service duplication and by planning for new services and programs.

Source: Seniors Network

Key initiatives of the Seniors Network include:

- An intergenerational garden, where senior volunteers teach elementary students to grow herbs, vegetables and flowers, on land provided by the City of Maple Ridge
- A Community Response Network, to address adult abuse, neglect, and self-neglect.
- The Grant Buddies Program, where seniors support students 5-12 by volunteering in local elementary schools.

4. ASSET MAPPING



Mapping Out Community Resources

In a social prescribing program, older adults may be connected to a diverse range of resources, supports, and activities. These usually already exist in the community, and may include:

- Light housekeeping, meal preparation, friendly visiting
- Food banks, meals on wheels, congregate meals, community gardens, cooking classes
- Caregiver support groups, 1:1 support, educational sessions
- Tax clinics, affordable housing services, rent supplements
- Walking groups, chair yoga, Aquafit, or other outdoor activities
- Medical & non-medical transportation, HandyDart, taxi savers
- Victim services, legal aid, elder abuse supports
- Mental health and dementia support services

During their work with social prescribing participants, the Community Connector may identify that a particular resource or activity does not exist locally but is in high demand. In this case, Community Collaboratives can work together to create new partnerships or programs to fill such gaps.

Prior to implementing a social prescribing program, identifying relevant and appropriate community resources is essential. An effective method of identifying existing resources is through community asset mapping.

What is Community Asset Mapping?

Community asset mapping is a strength-based approach to community and social development. The goal of asset mapping is to identify and document a community's existing resources, strengths, and skills. This information may be visualized as a map or infographic but can also be an inventory or spreadsheet.

Assets can be broken down into 6 main categories:

1. Physical space, such as parks, gardens, forests, playgrounds
2. Economic, such as jobs and businesses that provide livelihood.
3. Institutions, such as schools, libraries, museums, non-profits, social services
4. Associations, such as fitness clubs, religious groups, support groups, AA
5. Individual gifts, skills, knowledge, capacities of community members
6. Stories of community histories, resilience, and community development

For Community Collaboratives, asset maps are an invaluable tool for identifying insights into the existing strengths of a community and what resources can be leveraged to better support older adults. Furthermore, asset mapping can help identify gaps in services to help inform and develop future collaborations or partnerships.

For Community Connectors, a community asset map is an effective starting point to building an inventory of resources to build wellness plans for participants of social prescribing. The asset map will benefit from further development and detail as the Community Connector engages with the community.

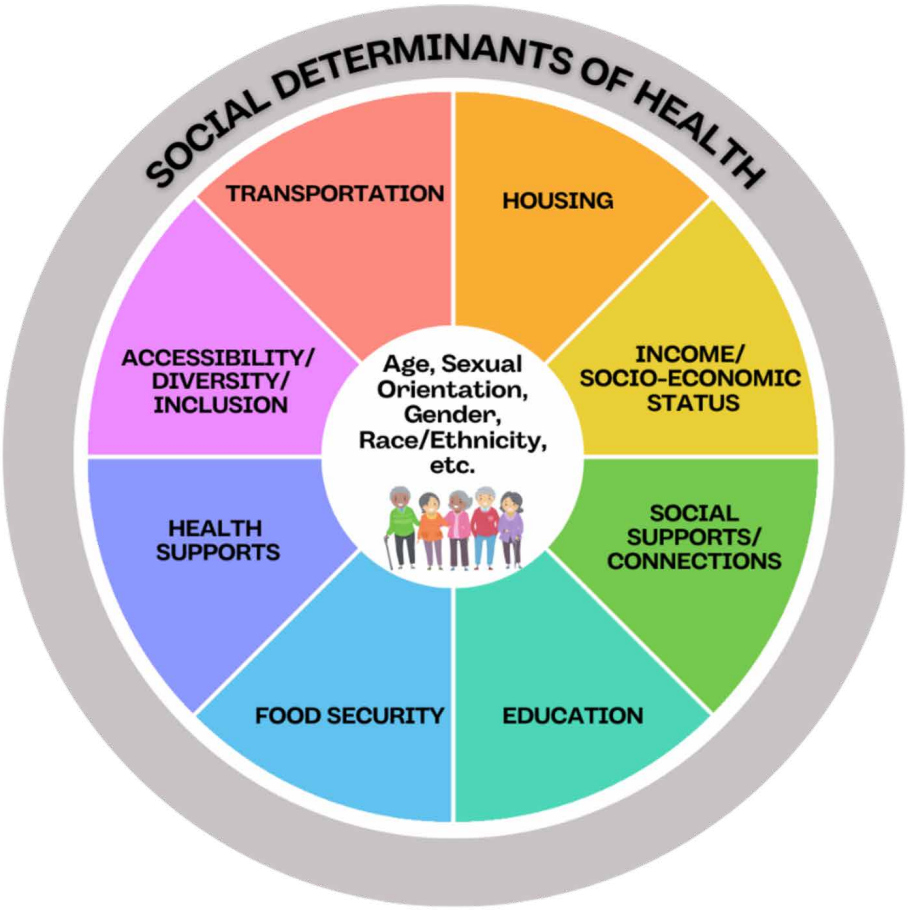
Creating a Community Asset Map

Creating a community asset map is typically a group exercise that should involve as many people relevant to the CBSS sector as possible: local seniors' centres, the food bank, the community rec centre, local health services, multi-service agencies and neighbourhood houses, faith-based groups, First Nations organizations, transportation agencies…and more!

Together, you will identify all the existing assets in your community available to support seniors to age well and in place, centred around the Social Determinants of Health.

The following steps summarize a typical process of community asset mapping:

1. **Identify and define the community**. For Community Collaboratives, this can be your self-defined geographic boundaries.
2. **Conduct research to identify potential assets**. This can involve online surveys, interviews, in-person visits, or a hosting a community asset mapping workshop. A guide for hosting a workshop can be found in CORE BC.
3. **Engage community members**. In addition to agencies and organizations relevant to the CBSS and health sectors, older adults and their families should also be engaged, as they can provide valuable insights about resources they value and may highlight less visible assets.
4. **Categorize assets**. UWBC has devised a wheel of Social Determinants of Health (SDOH), divided into factors that most affect older adults' health and well-being. This wheel can be used to categorize your community's assets.
5. **Evaluate asset readiness**. Consider each asset's readiness to be accessed by participants of social prescribing; consider capacity of each asset (i.e. existing waitlists), accessibility, and sustainability.
6. **Document and map assets**. Once assets have been identified and categorized, they should be documented, either in the form of a typical map showing asset locations, as a visual infographic, or as an inventory or list of assets that can be easily accessed and continuously updated by Community Connectors.



Social determinants of health of older adults that can be used to categorize community assets.

Evaluating Assets: Creating Inclusive and Appropriate Asset Maps

Step 5 of community asset mapping concerns the evaluation of assets in terms of readiness, sustainability, and accessibility. This step is especially crucial for providing social prescribing participants with a wide range of assets that reflect the diversity of backgrounds, abilities, and needs of older adults in a community.

Accessibility is a pivotal factor in identifying suitable assets for social prescribing. Spaces should be physically accessible, but should also be culturally sensitive, language-accessible, and considerate of varied cognitive and sensory abilities. Understanding the complexity of older adults needs is essential in this process. For instance, seniors with social anxieties may need environments that foster gentle social interaction. Those with disabilities might require specially designed programs or activities.

Community Connectors will play a large role in identifying appropriate assets. This work requires thoughtful, intentional conversations, and the development of meaningful partnerships with asset "owners" to ensure asset readiness and alignment with social prescribing.

> **Diverse and accessible assets ensure that every individual—regardless of their challenges or personal circumstances—has the opportunity to benefit from social prescribing. This tailored approach not only enriches the quality of the social prescribing initiative but also fosters inclusivity and holistic wellness in the community. By embracing diversity and prioritizing accessibility in community asset mapping, we can create more robust, effective social prescribing programs that truly cater to the needs of all community members.**
>
> - The Canadian Alliance for Social Connection & Health (2023), *Conceptualizing and Implementing Social Prescribing Programs*

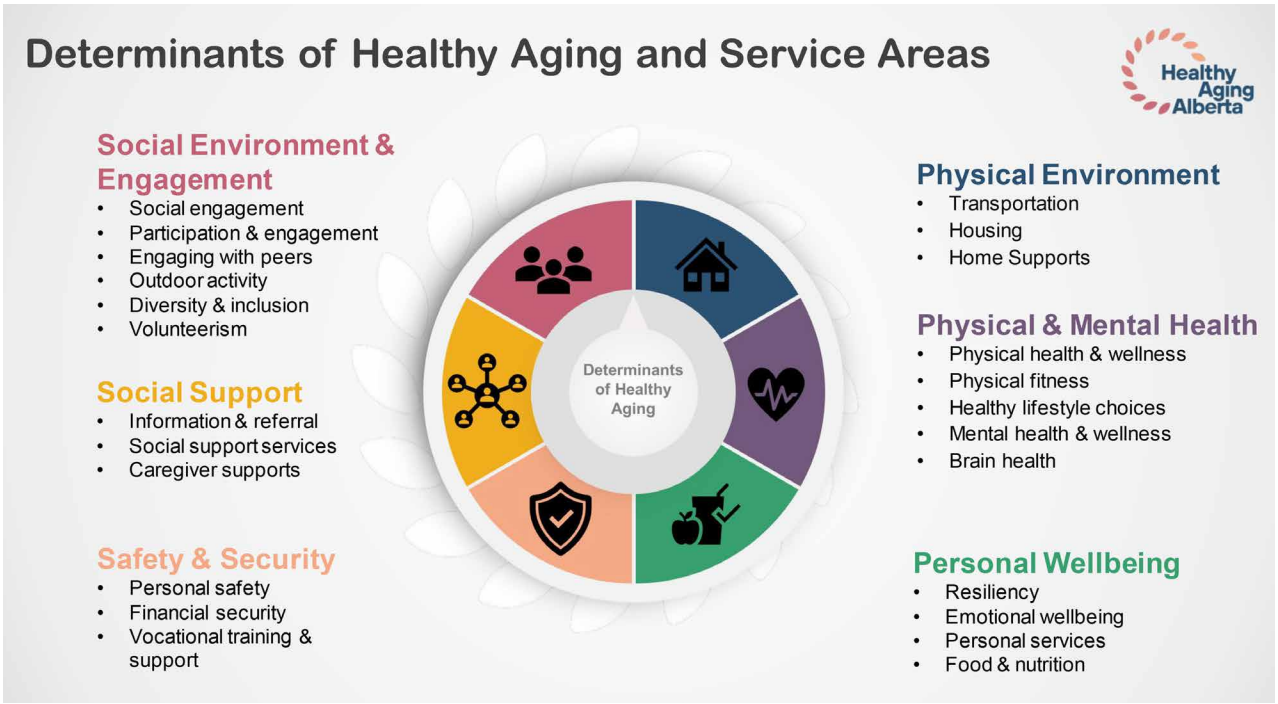
Templates and Examples

Below is an example template of an 'inventory' asset map, that has separate tabs for SDOH. To facilitate appropriate referrals, Community Connectors should keep the inventory updated with information regarding eligibility, catchment areas, accessibility, languages, cost, and so on. More guidance specific to Community Connectors and asset mapping is included in the UWBC Community Connector training.

Name	Address	Website	Contact Details	Description of Services	Hours	Eligibility

Housing | Income | Food | Transportation | +

This visual asset map was developed by Healthy Aging Alberta and CBSS organizations in Jasper. While the SDOH here are slightly different, this is an example of a high level visual asset map. A presentation that breaks down each determinant and associated assets into further detail can be found here,



Additional Resources

Asset Mapping Guides

- A Guide To Community Asset Mapping, Falls Brooks Centre
- Asset Mapping Guide, UCLA
- Participatory Asset Mapping, Community Research Lab Toolkit
- Asset Mapping Tool & Template NCFH
- Finding the Strength in Your Neighbourhood, Tamarack Community Webinar
- Weaving Asset Mapping and Community Development into Social Prescribing, Ontario SP COP
- Identify Community Assets, Community Toolbox
- Identifying Assets/Resources, Rural Health Information Hub

Additional Asset Map Examples:

- Frog Hollow Asset Map
- Healthy Aging Alberta Social Prescribing Asset Maps
- Squamish Lillouet Food Asset Map
- myCommunity BC Asset Maps
- Community Hearts Asset Mapping in the DTES
- PEI Helping Tree

5. LEARNING & EVALUATION

Theory of Change

A Theory of Change is an essential framework used to plan and evaluate the effectiveness of programs by detailing the processes and expected outcomes involved. It maps out the interventions needed to achieve a set goal and the mechanisms through which these interventions will lead to desired changes. In the context of United Way BC's Healthy Aging Program Model, the Theory of Change is designed to enhance the quality of life for older British Columbians, allowing them to remain healthy, resilient, and engaged in their communities.

Currently, our Theory of Change is in draft form and serves as a foundation for developing training programs and a comprehensive evaluation framework. This framework is critical for assessing the effectiveness and impact of our initiatives. The draft Theory of Change for the Healthy Aging Program outlines how various activities—ranging from providing person-centered supports to facilitating community collaborations—will contribute to improved health outcomes and social well-being for seniors. It identifies specific pathways through which seniors and their caregivers can access necessary resources and support, ensuring that every action taken is aligned with our strategic objectives. As this is a draft, the Theory of Change will continually be refined based on feedback and new insights to better meet the needs of the community and achieve our vision of enabling all older British Columbians to live life to the fullest in communities they call home.

United Way British Columbia | Working with communities in BC's North, Interior, Lower Mainland, Central & Northern Vancouver Island

THEORY OF CHANGE:
United Way BC's New Healthy Aging Program Model

VISION:
All older British Columbians live life to the fullest in communities they call home

IMPACT:
Seniors and elders age-in-place and remain healthy, resilient, and engaged in their communities.

LEARN & ADAPT: Continuous reflection, learning and evaluation for improvement

IT STARTS WITH: Connecting with, and listening to seniors, elders, and their caregivers

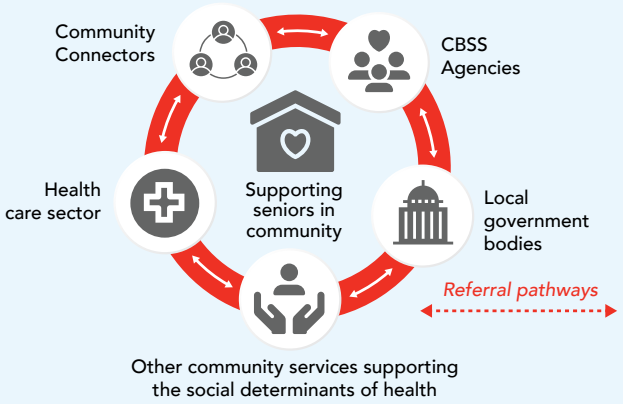
Using a health equity lens, the model will focus on community-dwelling seniors in BC who are facing vulnerabilities, such as:

- Low to modest income
- Social isolation
- Low to moderate frailty
- Member of an underserved population, including: immigrant and ethnocultural minority seniors, Indigenous elders, caregivers, 2SLGBTQIA+ seniors, and persons living with a disability.

THEN COMES: The Healthy Aging Program Model

COMMUNITY COLLABORATIVES

The Community-Based Seniors' Services (CBSS) sector will work collaboratively, as well as with the health care system and government bodies to expand access to resources and improve referrals and coordination across sectors. Community Connectors will provide one-on-one support for seniors to connect them with needed resources in community and facilitate referrals to and from the health care system.



SUPPORTS & ACTIVITIES

Holistic, person-centred supports that aim to address the social determinants of health given evidenced-based linkages to improved health outcomes for individuals.

- Referrals and connections to health care services, government supports, and community programs
- Help with day-to-day needs, non-medical needs, such as housekeeping, grocery shopping, light yard work and transportation
- Physical and recreational activities
- Nutritious meals in social settings
- Getting online and integrating technology and e-activities into daily life
- Opportunities for social connection
- Transportation to appointments and programs
- Education, and emotional support for seniors' and elders' unpaid family and friend caregivers
- Volunteer engagement, coordination, recruitment and retention

IT RESULTS IN: Key outcomes for individuals, communities, and systems

	SHORT-TERM	MEDIUM-TERM	LONG-TERM
SENIORS, ELDERS, AND FAMILY AND FRIEND CAREGIVERS	• Increased access and connections to resources that holistically meet needs	Increased: • social connectedness and community engagement • physical activity and access to nutritious meals • access to transportation • care coordination and ability to navigate health and social systems • ability to manage practical issues (e.g., debt, housing) • regular use of respite	• Improved health, well-being, and quality of life • Improved social determinants of health • Increased resilience of seniors and elders to live safely and independently in their own homes
COMMUNITY & SYSTEMS	• Increased multisectoral partnership and collaboration • Improved volunteer coordination and engagement	• Increased referrals and coordination within CBSS, as well as to and from the health care system • Increased focus on a mutually reinforcing plan of action • Reduced service gaps and duplication of services • Increased recruitment and retention of volunteers	• Increased capacity of CBSS to holistically meet needs • Improved health equity • Reduced costs and stress on the health care system

THEORY OF CHANGE NARRATIVE

The above theory of change was created to illustrate how activities within United Way BC's new Healthy Aging Program Model will result in changes for program participants, communities, and the health care system over time. A narrative description of the theory of change is provided below.

It Starts With: Connecting with, and listening to seniors, elders and their caregivers

A rapidly increasing number of older British Columbians are socially isolated, live in poverty, and experience cultural barriers to accessing the services they need. Alongside this growing issue, the systems to support seniors remain fragmented and communities are poorly designed for seniors to age-in-place. The Healthy Aging program strives to respond to these challenges. Using a health equity lens, the model will focus on community-dwelling seniors in BC who are facing vulnerabilities, such as:

- Low to modest income
- Social isolation
- Low to moderate frailty
- Member of an underserved population, including immigrant and ethnocultural minority seniors, Indigenous elders, caregivers, 2SLGBTQIA+ seniors, and persons living with a disability

Then Comes: The Healthy Aging Program Model

Community Collaboratives

Seniors, elders, and family and friend caregivers will be connected to 100+ Community Collaboratives across BC that will strengthen partnerships within communities and enhance the CBSS sector's ability to effectively support seniors. The Community-Based Seniors' Services (CBSS) sector will work collaboratively, as well as with the health care system and government bodies to expand access to resources and improve referrals and coordination across sectors. Community Connectors will provide one-on-one support for seniors and elders to connect them with resources in communities and facilitate referrals to and from the health care system. They will also play a role in building networks within their communities and strengthening relationships among multi-sectoral partners.

There are several pathways in which seniors, elders and family/friend caregivers could be referred and connected to supports within the new program model. While some participants may self-refer, participants could also be referred by a variety of other possible sources, such as the Community Connectors, the health care system, community-based agencies, and BC211.

Supports & Activities

Holistic, person-centred supports will be provided that aim to address the social determinants of health given evidenced-based linkages to improved health outcomes for individuals.

- Referrals and connections to health care services, government supports, and community programs
- Help with day-to-day needs, non-medical needs, such as housekeeping, grocery shopping, light yard work and transportation
- Physical and recreational activities
- Nutritious meals in social settings
- Getting online and integrating technology and e-activities into daily life
- Opportunities for social connection
- Transportation to appointments and programs
- Education, and emotional support for seniors' and elders' unpaid family and friend caregivers
- Volunteer engagement, coordination, recruitment and retention

It Results In: Key Outcomes for Individuals, Community and Systems

As a result of implementing activities within the new model, outcomes will be realized over the short-term, medium-term, and long-term. The theory of change illustrates intended changes for seniors, elders, and family and friend caregivers, as well as anticipated outcomes for the communities and the health care system.

Impact

The ultimate impact of the new model will be that seniors and elders age-in-place and remain healthy, resilient, and engaged in their communities.

Vision

The vision of the new model is that all older British Columbians live life to the fullest in communities they call home.

Learn & Adapt

The new Program and Service Design Model will embed ongoing opportunities for reflection, learning and evaluation to improve program design and delivery along the way.

REFERENCES

1 World Health Organization https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

2 National Institute on Ageing (2022). *Understanding Social Isolation and Loneliness Among Older Canadians and How to Address It*. Toronto, ON: National Institute on Ageing, Toronto Metropolitan University.

3 Centre for Addiction and Mental Health. (CAMH). Aging and Mental Health Policy Framework. Toronto: CAMH https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-aging-and-mental-health-policy-framework-pdf.pdf

4 Fostering Collaboration Factors to Consider. This list taken from https://cdn2.hubspot.net/hubfs/316071/Resources/Publications/Turf%20Trust%20and%20Co-Creation%20Paper.pdf