Leveraging Partnership & Networks

Health Aging CORE BC

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Fraser Health Authority

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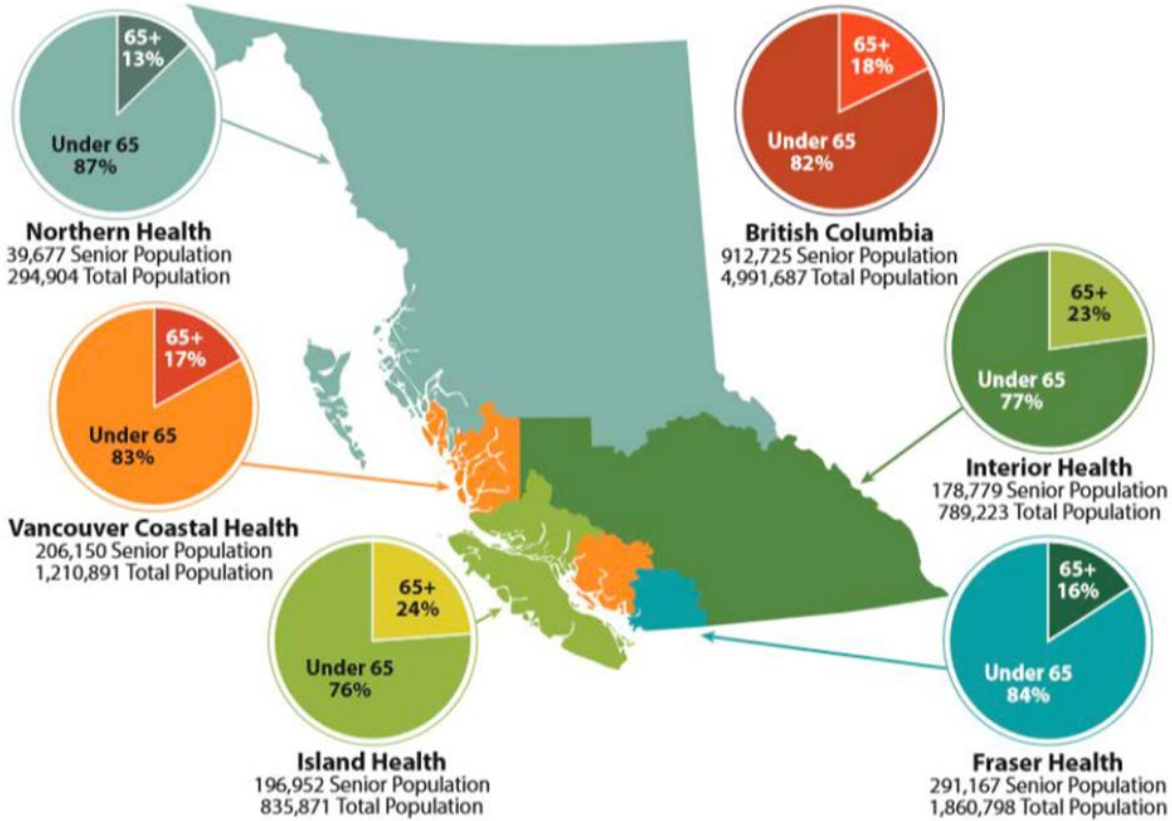
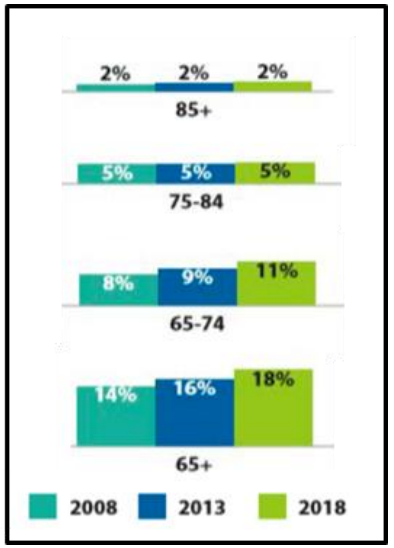
Better health. Best in health care.

The BC population continues to age





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Why Social Prescribing

- Health care is more than clinical interventions
- Social factors contributes to 80% of health outcome
- Older adults need support to age well; address Social Determinants of Health
- Social Prescribing reduced 23% of acute care admission

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Social Prescribing in Fraser Health

- Addressing Social Determinants of Health
- Barriers to Healthy living (physical, financial, cultural, psychological)
- AVOID frailty strategy (Canadian Frailty Network)
- Address social isolation (Canadian Coalition for Seniors Mental Health)
- Health Authority services & Gaps

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FH Social Prescribing Principles

1. Social Prescribing is a community resource in FH
2. Standardized referral forms and pathways
3. All EMRs in AC and community able to refer
4. Centralized intake and community referral allocation
5. Ability to monitor and track referrals through data collection

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United Way Partnership

19 Programs funded across province
3 year Demonstration project 2019
Evaluation and research in progress
Partnership to keep seniors well and continue living independently in the community
Funded by Ministry of Health (FH & UW)
Expanded in 2024! – 100 Community Connectors

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

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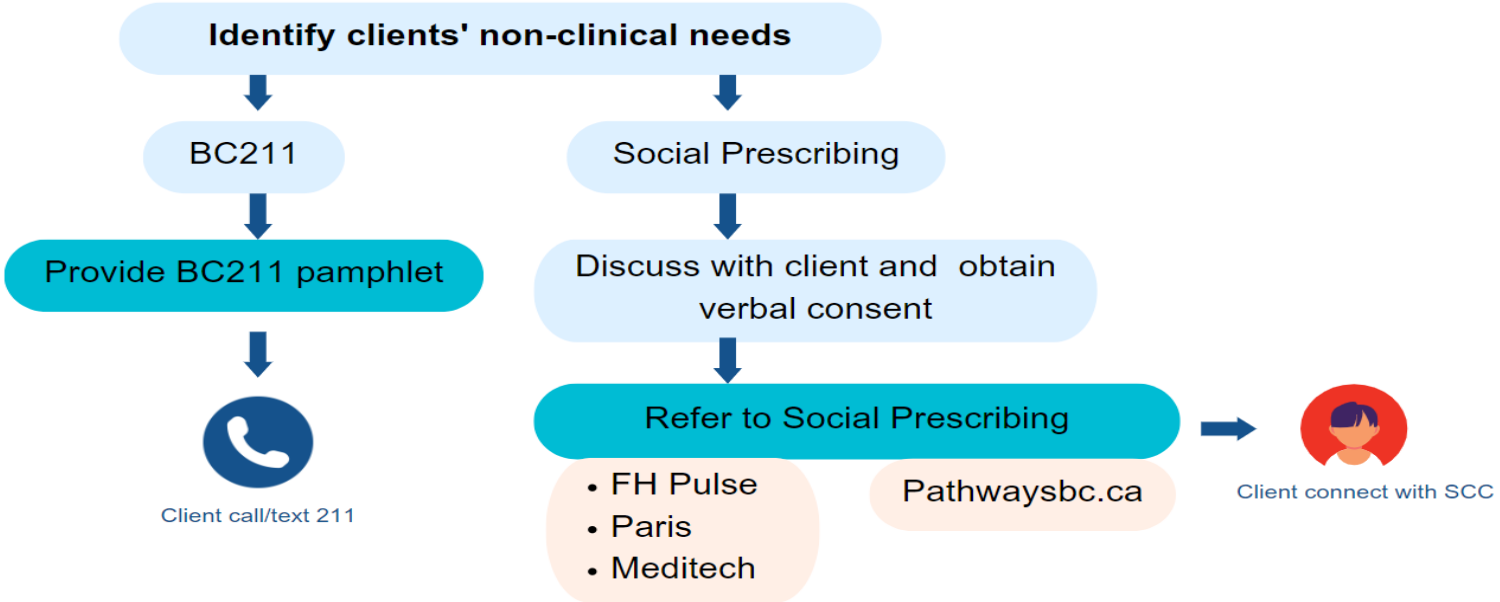
Infrastructure to Promote Healthy Aging

- Divisions of FP
  - Community GPs and NPs
  - UPCCs
- Primary Care Networks
  - RNs in Practice
- United Way – community NGOs
  - Seniors Community Connectors
  - Regional Development Workers
- Fraser Health
  - Homecare nurses, social workers
  - Geriatric Emergency Nurse clinicians
  - Assisted Living
  - DC planning for seniors after prolonged hospitalizations
  - Pre – elective surgery clinic

Sign Posting v.s. Community Connector
Fraser Health and United Way BC



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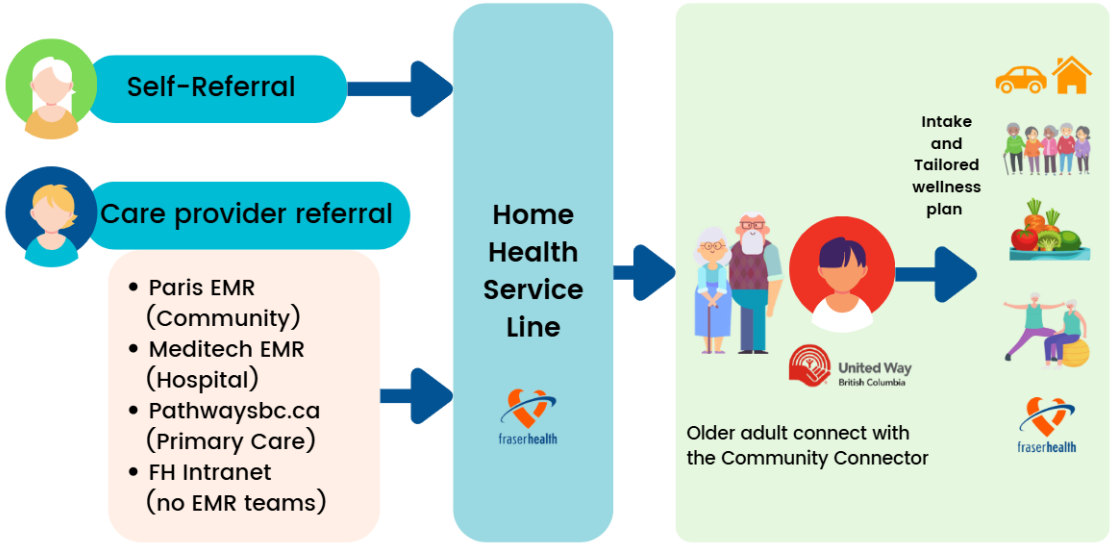
Fraser Health Social Prescribing Integration

Infrastructure: Change leads, operations director, nursing and allied health educators, Clinical Nurse Specialist , IT, Communications etc. Executive sponsorship, Regional oversight

Education: to 126 clinical service areas; over 2000 referrals to date



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Outcomes of Social Prescribing

- Increased quality of life for older adults
- Decreased ER visits
- Keeping older adults at home longer by identifying frailty early and implementing mitigations through care planning
- Decrease length of stay in the hospital
- Increase awareness and utilization of community services

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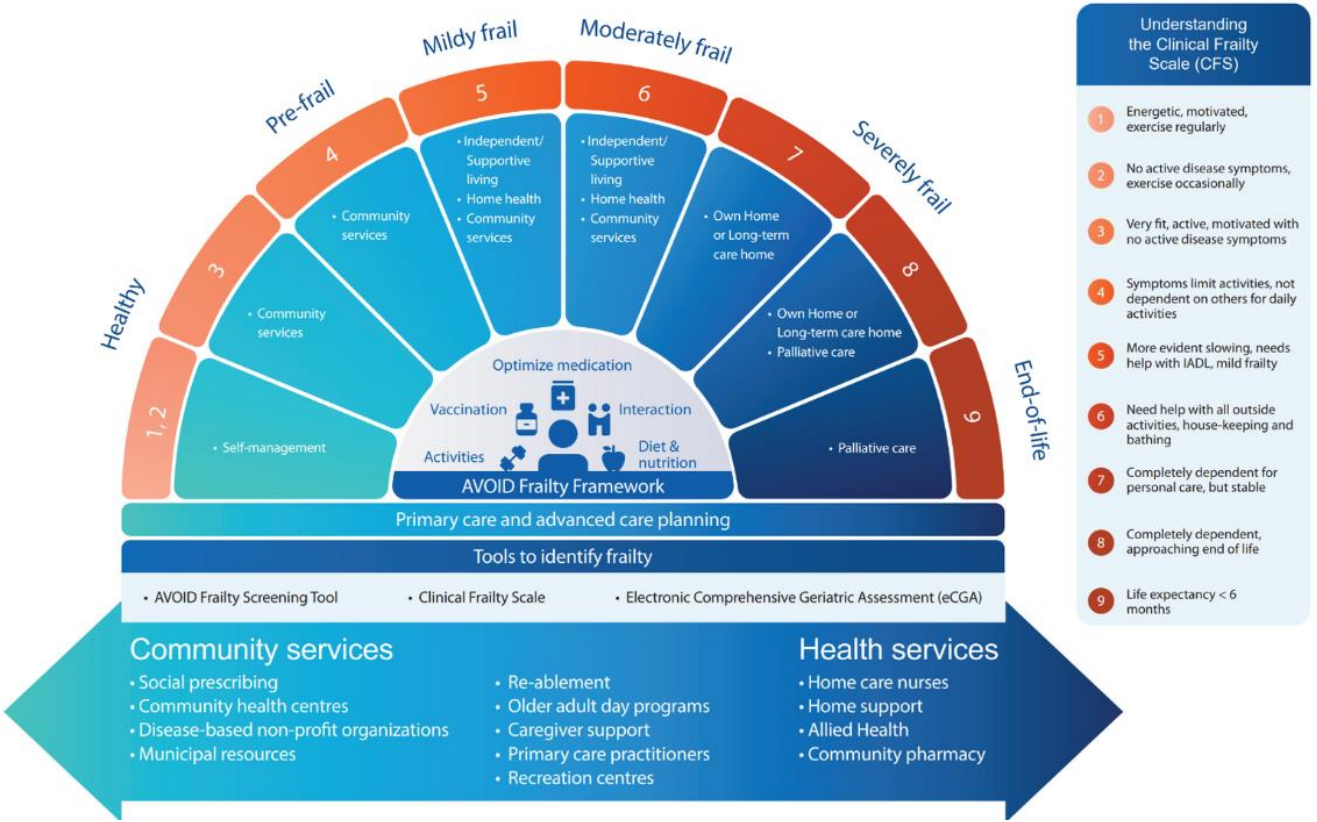
Frailty Pathway: Identify, Manage, Prevent Frailty



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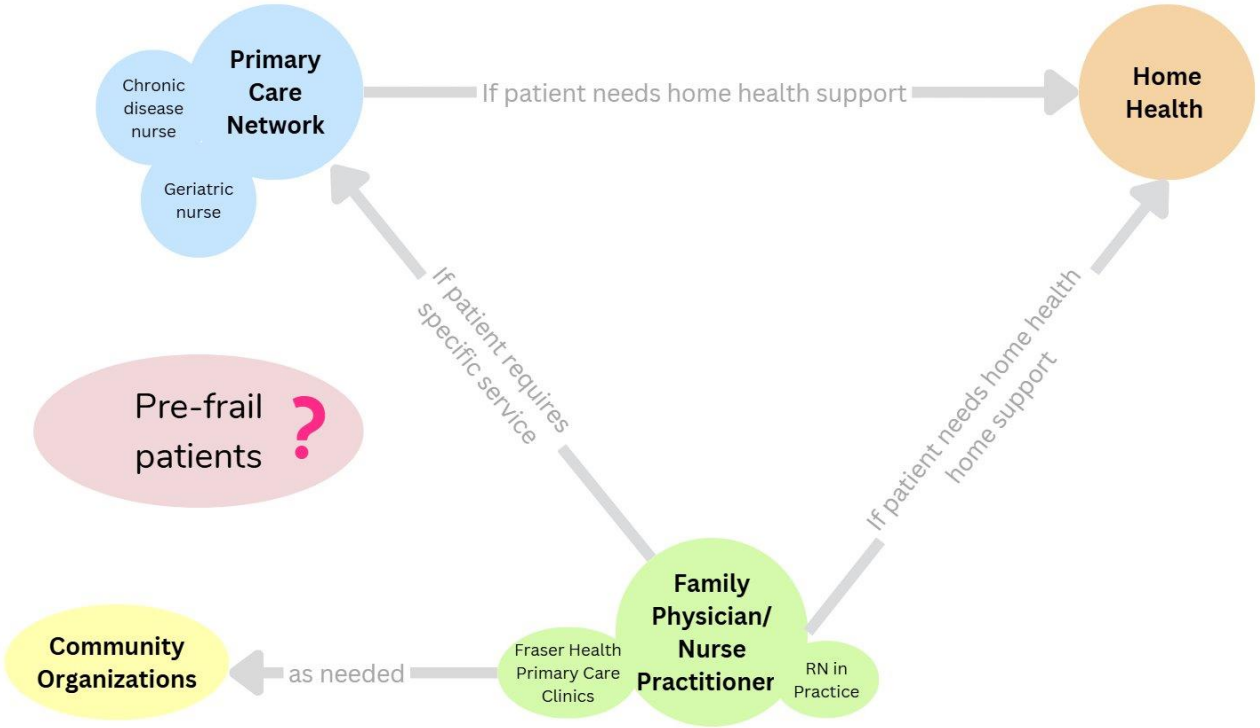
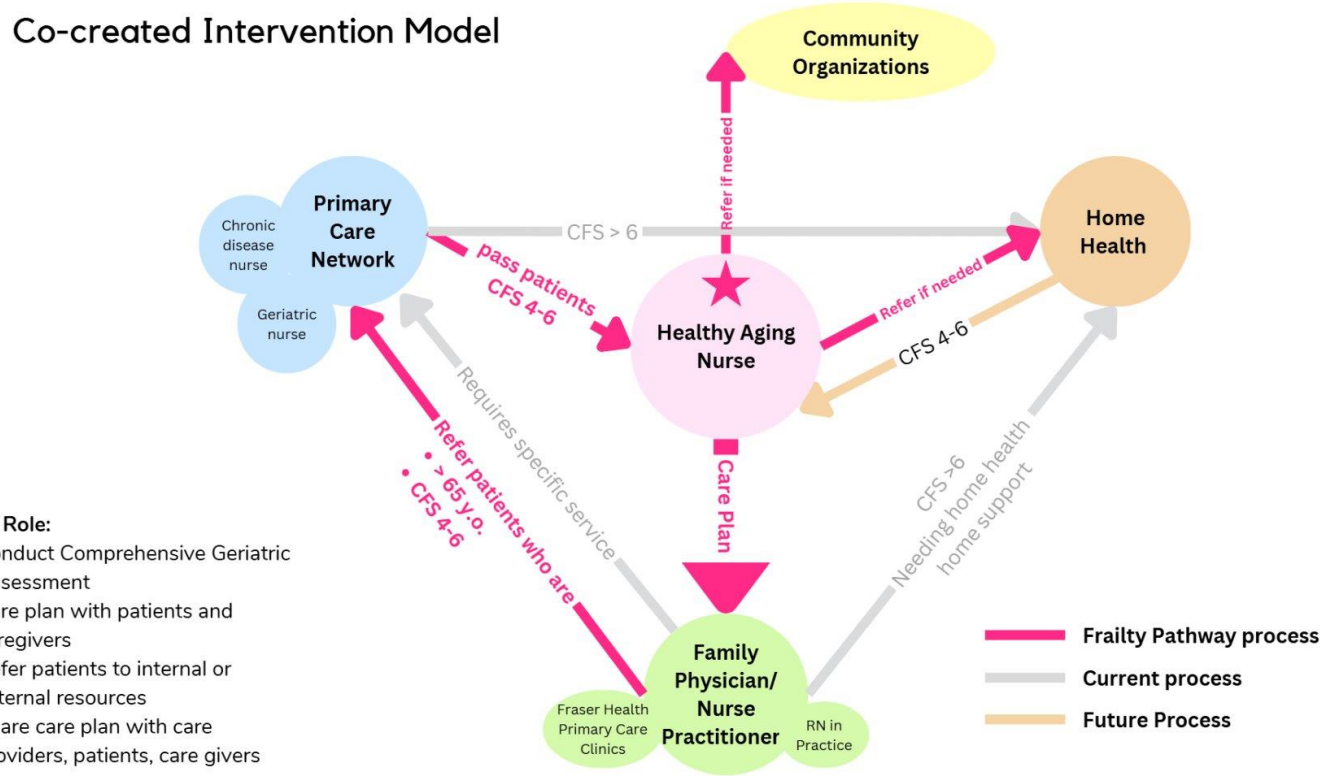
Original Care Model (Siloed)



Integrated Frailty Pathway model



Nurse Role:

1. Conduct Comprehensive Geriatric Assessment
2. Care plan with patients and caregivers
3. Refer patients to internal or external resources
4. Share care plan with care providers, patients, care givers

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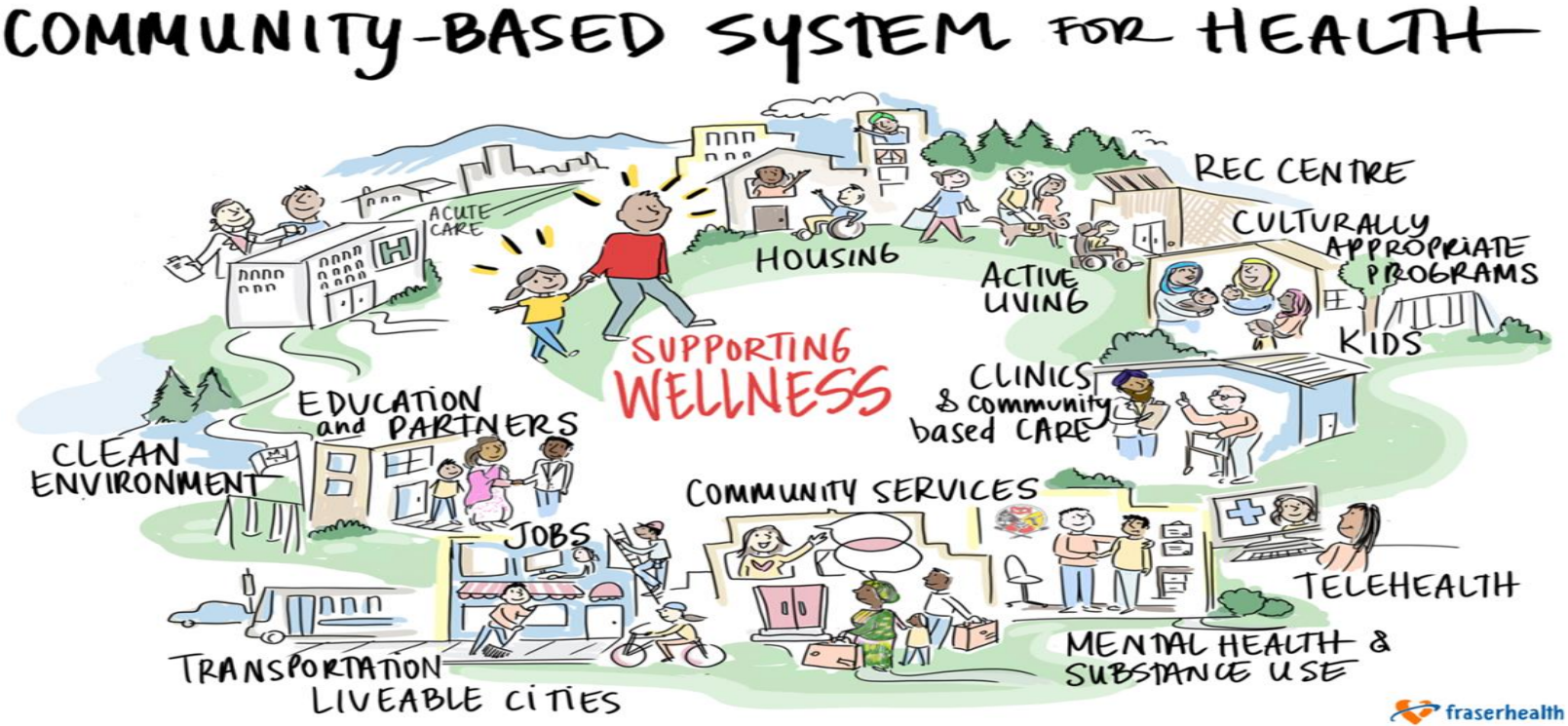
Primary & Community Care Redesign and CARES

Supporting “at risk seniors” in their communities



Questions?

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