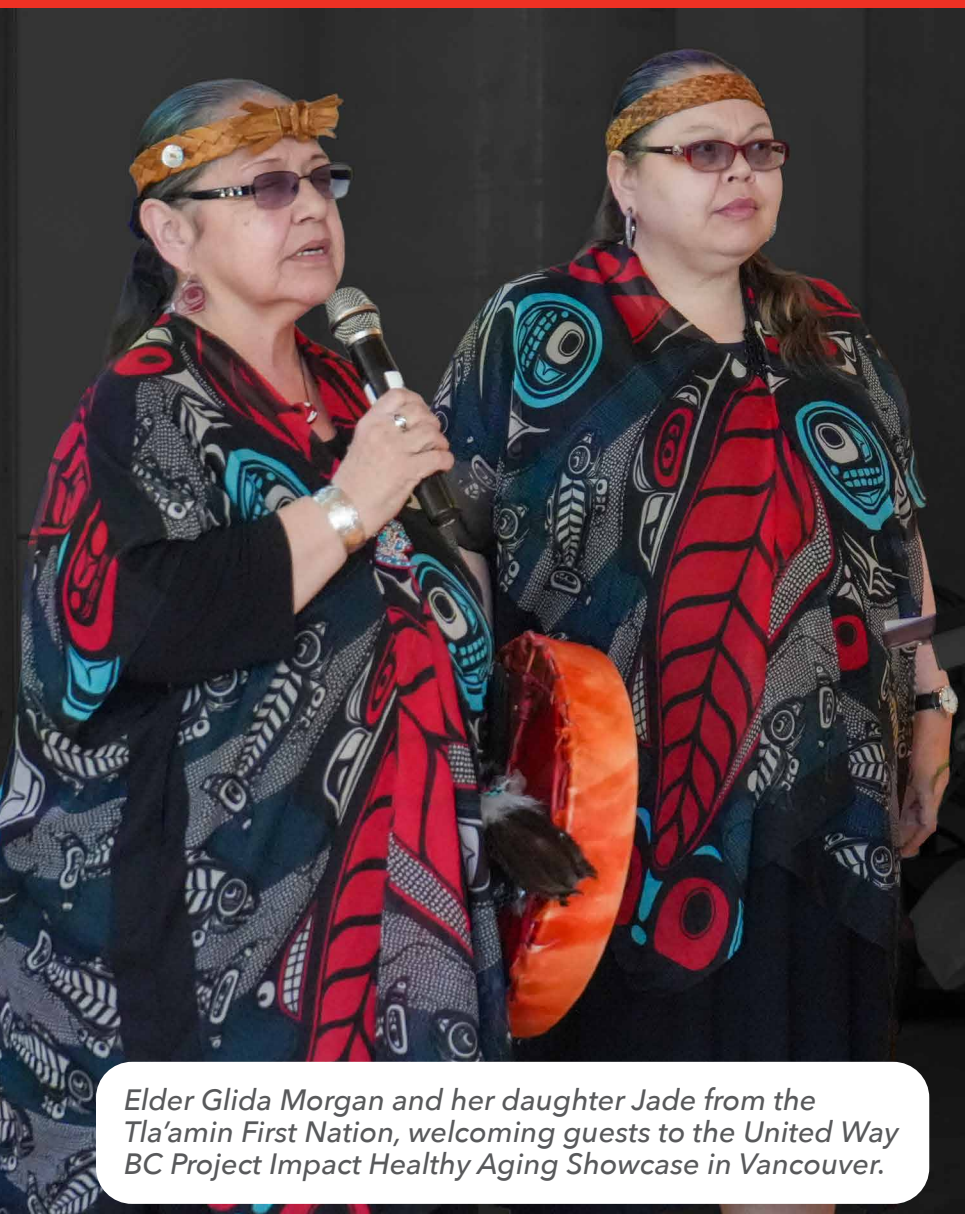
UNITED
for seniors in need

United Way
British Columbia

Learning & Impacts: Social Prescribing Programs

2024/25

Land Acknowledgement



Elder Glida Morgan and her daughter Jade from the Tla'amin First Nation, welcoming guests to the United Way BC Project Impact Healthy Aging Showcase in Vancouver.

We recognize the communities in which we work

At United Way BC, we dedicate ourselves to fostering understanding, respect, and an acknowledgment of the rich history of the lands and waterways we traverse. Our mission guides us across vast and diverse territories, each with its unique tapestry of languages, governance systems, traditions, and cultural heritage. The relationship with these lands and waterways has been stewarded by Indigenous communities since time immemorial, long before the establishment of contemporary boundaries, and we humbly recognize that many of these territories remain unceded.

We also acknowledge that our list of Nations is a work in progress, a testament to our ongoing process of improving our learning and understanding. Our commitment is to honor the cultural distinctiveness of each community as we continue to pursue improved and lasting partnerships built on the foundations of respect, humility, and open dialogue.

View the communities in which we work here:

Territorial Acknowledgement

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Looking Back: Reflecting on a Year of Connection, Learning, & Impact

This past year marked an important period of growth and reflection for Social Prescribing (SP) programs across British Columbia. Together, programs supported more than 6,500 older adults with over 51,000 services, creating meaningful opportunities for connection, wellness, and practical support. Behind these numbers are stories of resilience, where older adults found renewed confidence, regained independence, and built stronger ties within their communities.

Through our ongoing co-creation sessions, Community Connectors (CCs) shared candid reflections on both successes and challenges in delivering SP across diverse communities. We heard how strong referral pathways and trusted relationships with older adults enabled timely access to supports. We also learned about the barriers that remain, including inconsistent referral processes, data and intake challenges, and gaps in service availability—particularly around transportation, affordable housing, and mental health.

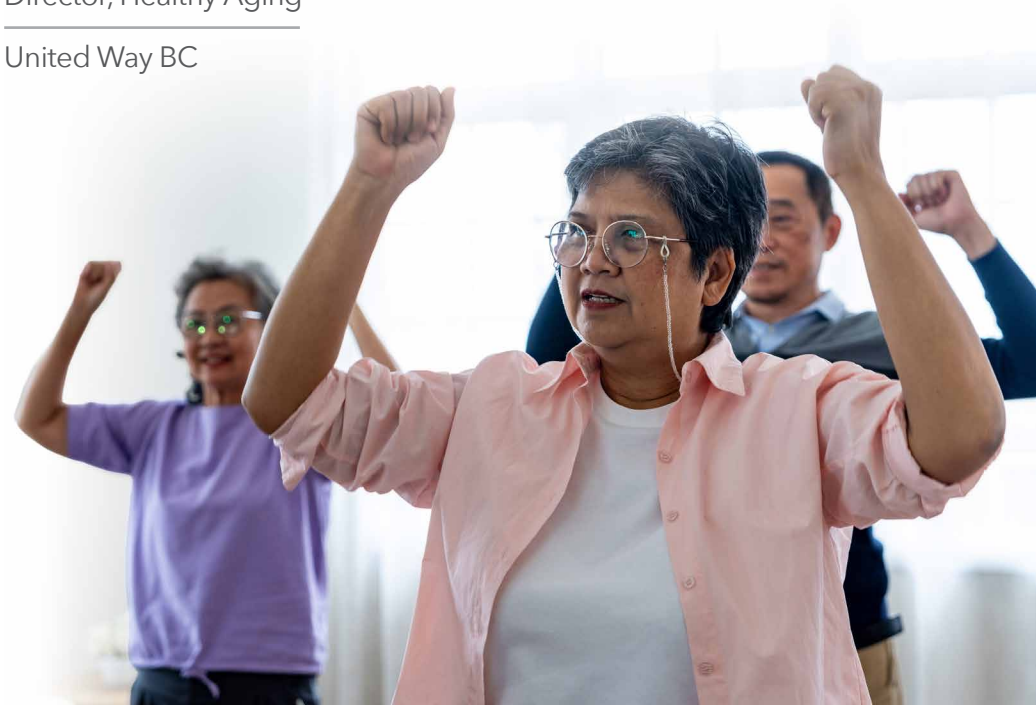
At the same time, programs demonstrated remarkable innovation and collaboration: forging new partnerships with health authorities and community agencies, creating culturally and linguistically inclusive services, and piloting creative solutions such as intergenerational programming, hospital discharge supports, and volunteer-driven initiatives. CCs themselves highlighted how peer learning, specialized training, and relationship-building opportunities have been vital to their success.

This past year reinforced the importance of collaboration and learning together. By listening closely to the voices of older adults, CCs, and program partners, we are better positioned to evolve our supports and strengthen the impact of SP across the province. The path forward is clear: continue building trust, expand access, and invest in the tools, resources, and relationships that allow every older adult to feel connected, supported, and empowered.

Sincerely,

Bobbi Symes
Director, Healthy Aging

United Way BC



What We Learned: Social Prescribing Co-Creation Session

Background

Facilitating co-creation sessions has become an annual activity for the Social Prescribing (SP) programs. These sessions create a dedicated space for shared reflection, learning, and forward planning. They also align with our Healthy Aging guiding principles, particularly our ongoing commitment to community-driven work and adopting a 'learning systems' approach.

- **Community Development:** Our work is driven by the community and dedicated to serving it. Our programs are grounded in real-world evidence of specific strategies and approaches that have proven to be effective in communities across BC. Ongoing learning from communities enables our work to shift and adapt over time.
- **Learning, Growth & Accountability:** Our programs are supported by a 'learning systems approach'. The main intention with this approach is to create a safe space where identifying and addressing areas of needed improvement is not seen as a failure or something to hide, but as a learning opportunity. In a learning system, data, evidence, and experience are continuously collected and integrated into practice to support agencies to improve their programming.

Session Overview

In March 2025, all SP programs were invited to participate in a co-creation session facilitated by United Way BC's Healthy Aging team.

Purpose: To connect with SP programs, reflect on progress, learn about on-the-ground implementation, and identify opportunities for support and adaptation moving forward.

Objectives: By the end of the co-creation session, we:

- Learned about real-world successes and challenges implementing SP programming.
- Fostered connection and opportunities for peer exchange and relationship building.
- Explored Community Connectors' (CCs) experiences with Health Authority referrals.
- Reflected on current data collection processes related to participant reach and impact.
- Discussed successes and challenges in building and maintaining multisectoral partnerships.
- Identified the types of support, training, and connections CCs need to thrive in their roles.
- Identified key areas where United Way BC's Healthy Aging team can provide additional support.

Participants

- 100+ staff representatives from SP programs
- 10 Healthy Aging staff and leaders

Key Learnings

Strengthening referral pathways

Referral practices vary across regions, with some sites using standardized Health Authority forms and others relying on informal referral methods.

- Benefits of shared forms: Streamlines referrals; improves appropriateness, supports cross-program connections, facilitates consistent data collection; and improves communication between CCs and Health Authority staff.
- Challenges with shared forms: Adaptations to forms; missing or incomplete fields; misalignment with local workflows or community-specific needs; and inappropriate referrals.
- Health Authority Referrals could be improved by: including complete participant details; confirming consent and readiness; outlining current supports and care plans; specifying reason for referral; providing safety or risk information (e.g., mobility limitations); ensuring eligibility; and using a standardized form.

Building consistency in intake & data practices

Intake and case management processes vary across programs.

- Some programs use the SP Intake Form, while others have adapted it to meet local needs and context.
- Some programs use iUnite, while others use agency-specific databases, spreadsheets, or data management platforms.
- Challenges with data collection: Lack of consistency across sites; limitations or usability issues with iUnite; duplication of data entry; unclear definitions of caseload; and limited capacity to capture community-building activities.
- Data collection could be improved by: Establishing clearer caseload definitions; streamlining or integrating data systems; ensuring intake forms capture both required and locally relevant information; incorporating space for qualitative stories; and providing training or guidance on efficient data entry and reporting.

Collaboration drives progress, yet demands ongoing adaptation

CCs collaborate across sectors, working with health system partners, community organizations, service providers, local businesses, volunteer organizations, faith-based groups, and with one another.

Approaches to collaboration vary, with some CCs embedded in well-established networks and others actively building new connections in their communities.

- Benefits of strong multisectoral partnerships: Expands referral pathways; increases access to diverse supports; fosters trust between sectors; enhances community visibility of the SP program; and enables innovative, collaborative solutions to meet older adults' needs.
- Collaboration challenges: Limited awareness of SP among potential partners; competing priorities and limited capacity in partner organizations; turnover in partner staff; difficulty sustaining engagement over time; and information sharing/communication barriers with the health care partners.
- Collaboration could be strengthened by: Offering clear, concise program information to partners; sharing impact stories to demonstrate value; creating regular touchpoints to maintain relationships; identifying mutually beneficial goals; formalizing referral and feedback pathways between health partners, community services, and CCs; and providing opportunities for peer-to-peer learning and knowledge exchange between CCs and partners.

Supports that make a difference for CCs

CCs identified several types of support and learning opportunities that had a positive impact on their ability to perform in their roles effectively.

- Peer learning and informal mentorship from other CCs built confidence, provided practical solutions to challenges, and offered reassurance when navigating new situations.
- On-the-job learning and trial-and-error helped address knowledge gaps in the absence of formal training, allowing CCs to adapt approaches to local needs.
- Specialized trainings such as NAV-CARE and CCMI deepened skills, clarified role expectations, and offered concrete tools for day-to-day work.
- Relationship-building opportunities within the SP network fostered a sense of belonging, encouraged collaboration, and created a supportive professional community.

Supports Needed from United Way BC

Programs shared a number of suggestions for how the Healthy Aging team can continue to strengthen its support for SP programs.

1. Enhance Regional CoPs and Peer Spaces

Programs value regional Communities of Practice (CoPs) for reducing isolation and fostering idea-sharing but suggested making them more interactive with clear topics, facilitated discussion, and tangible takeaways. Improving navigation and clarifying the purpose of Collaborative Online Resources and Education (CORE) could also increase engagement.

2. Reintroduce Provincial CoPs

Many CCs expressed interest in reintroducing provincial CoPs, ideally held quarterly or twice a year, with varied formats that combine presentations, small-group discussions, and peer-led sessions. They emphasized the importance of balancing practical training with the sharing of success stories and providing ample opportunities for networking and peer connection.

3. Strengthen Onboarding and Mentorship

SP programs suggested clearer onboarding materials and role expectations for new CCs, as well as mentorship pairings to help accelerate learning and skill-building.

4. Improve Supports for Collaboration with Partners

To strengthen multisectoral partnerships, programs suggested concise program information sheets, regular touchpoints with partners, and impact stories to demonstrate value. Opportunities for peer-to-peer learning across sectors were also recommended.

5. Build Consistency in Intake and Data Practices

SP programs expressed the need for clearer caseload definitions and revised intake forms. Training and guidance on efficient data entry, as well as opportunities to capture qualitative stories, would help strengthen consistency across sites.

6. Provide Streamlined Tools

SP programs would benefit from shared templates, streamlined tools to reduce administrative burden, such as templates for referral confirmations, participant follow-ups and outreach to partners.

7. Continue and Expand Training Opportunities

SP programs emphasized the need for ongoing training opportunities to strengthen CCs' skills and confidence. In addition to technical training on data systems, programs recommended professional development focused on community engagement strategies, effective partnership-building, and practices for maintaining personal well-being. Regular, accessible training sessions would help CCs stay current, build practical skills, and sustain their capacity to support older adults over the long term.

What's Next

The Healthy Aging team sincerely appreciates the insights and reflections shared by SP programs during the co-creation session. We clearly heard the areas where additional support and clarity can strengthen program delivery and our collective impact. This valuable feedback will directly inform our next steps as we work to improve resources, enhance communication, and better support the important work being done across the province to support older adults.

Based on the key learnings from the SP co-creation session, here is a list of our key next steps:

1. Strengthening the Referral Tools & Workflows

A simplified, flexible referral form and supporting tools will be explored to help programs clarify their intake processes with health and community partners, while accommodating local contexts and workflows.

2. Updating Intake and Reporting Resources

The intake form will be revised, with optional templates and a short guide added to support different types of engagement beyond long-term caseloads, ensuring consistent yet adaptable data collection.

3. Developing a Program Support Toolkit

A living toolkit will be housed in CORE, featuring implementation and onboarding guides, marketing templates, tracking spreadsheets, webinar recordings, and other resources that programs can adapt to their needs over time.

4. Continue to Provide Specialized Training to Support CCs

The Healthy Aging team will continue to provide access to specialized trainings to strengthen the skills and confidence of CCs in their roles. Ongoing training opportunities will also be supported as needs emerge.

5. Evolving the Community of Practice Structure

The provincial Community of Practice (CoP) for Community Connectors will now be held twice per year as extended, three-hour co-creation sessions focused on strengthening practice and advancing the Social Prescribing program as a whole.

6. Improving CORE for CCs

The Social Prescribing group on CORE will be reorganized to improve navigation, make tools easier to find, and feature peer-submitted resources gathered through CoPs and other sessions. New uploads will be promoted, and programs will be encouraged to share their tools and examples.

7. Enhancing Communication

Program updates will be easier to follow, with clear and concise emails, consistent timing, and direct links to updated tools, forms, and resources.

What We Accomplished: Key Findings from SP Reporting

This section provides a brief summary of key findings from the 2024/25 SP Quarterly and Annual Reports. We encourage programs to reflect on these results, both to recognize our collective achievements and to situate your respective contributions to the broader provincial picture. Together, let's celebrate the meaningful impact we have made for older adults across BC.

PROGRAM REACH

During the 2024/25 fiscal year, SP programs served a total of **6,597 older adults**.

*

including **4,697 who were new to the programs**.

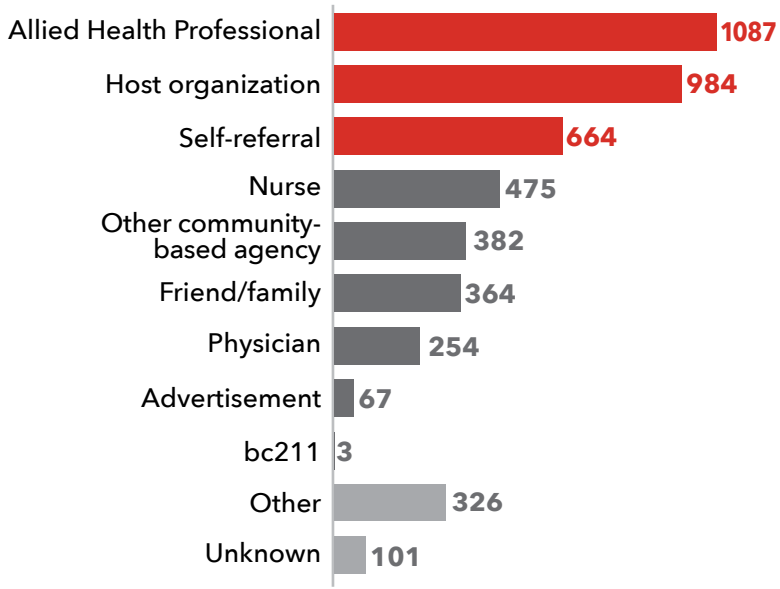
PRIORITY POPULATIONS

100% of SP Programs reported that they all serve the Healthy Aging Priority Populations, including:

- **Low to modest income**
- **Low to moderate frailty**
- **Social isolation/ loneliness**
- **Members of underserved/equity deserving groups**

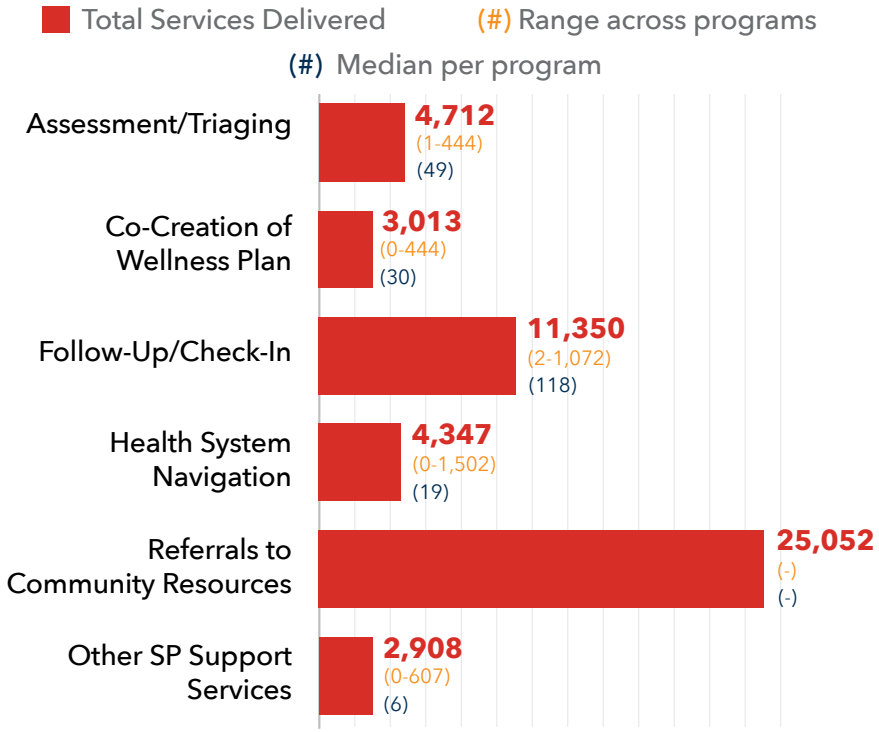
REFERRAL SOURCES

In 2024/25, the top 3 referral sources to SP Programs were: Allied Health Professionals, host organizations, and self-referrals.



SCOPE OF SERVICE DELIVERY

SP programs delivered a total of 51,382 services to older adult participants in 2024/25. Most services provided were for: (i) **referrals to community resources** (49%; N=25,052); (ii) **follow-ups/check-ins** (22%; N=11,350); and **assessment/triaging** (9%; 4,712).

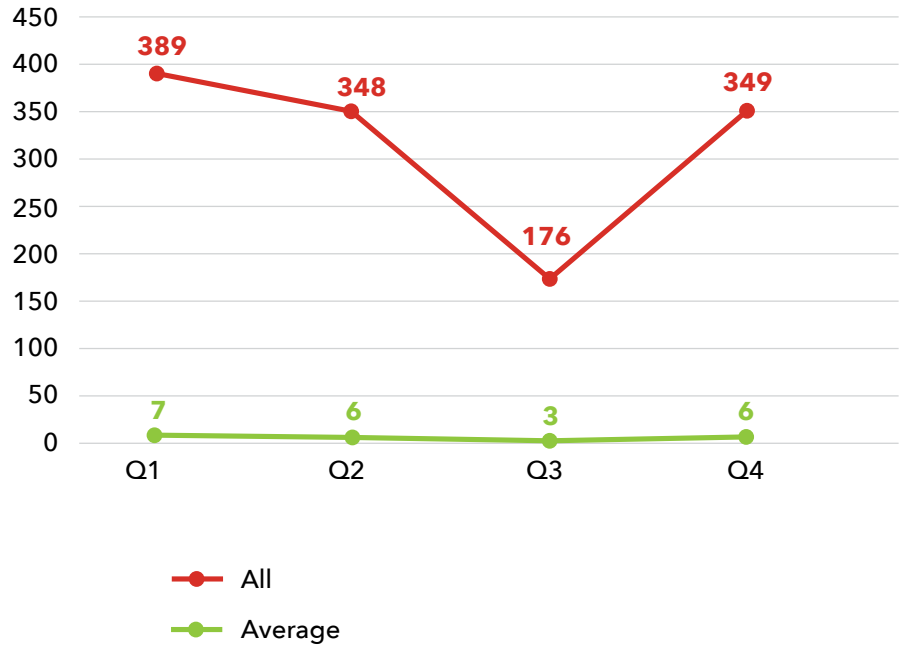


TOTAL SERVICES: 51,382

WAITLIST DATA

Over the 2024/25 fiscal year, the total number of older adults on the waitlist for SP services remained relatively steady, with the exception of a noticeable dip in Q3. In comparison to other Healthy Aging program numbers, the waitlist for SP services was higher, potentially indicating strong demand for this program. Waitlist numbers varied substantially across SP programs, ranging from 0 to 38 older adults. As of March 2025, a total of 349 older adults were waiting for support. For each SP program, there were an average of 3 to 7 older adults on the waitlist per quarter.

The **waitlist to access SP services remained relatively steady** over the 2024/25 fiscal year, with the exception of a noticeable dip in Q3.



Overall Successes & Challenges

Program Successes

SP programs identified key areas of success over the last year, highlighting how programs adapted, expanded, and deepened their impact to better meet the evolving needs of older adults in BC.

Building Trust With Older Adults

Establishment of strong, trusting relationships with older adults, enabling open conversations about needs and timely referrals to health and community services.

Community Partnerships

Strong collaborations with hospitals, health authorities, Better at Home, and other community organizations, leading to improvements in referrals, transitions, and wrap-around care.

Innovative Service Solutions

Creative responses addressed service gaps, such as funding one-time deep cleaning, launching transportation supports, or offering intergenerational activities like cooking classes.

Cultural & Linguistic Inclusion

Expanded access by providing services in multiple languages, creating culturally relevant groups, and engaging multicultural older adults through tailored outreach.

Social Connection & Programming

Creation and growth of new social groups (e.g., Wellness Wednesdays) that reduced isolation, fostered friendships, and improved well-being for participants.

Navigation & Social Support

CCs guided older adults through health and housing systems, supported government paperwork, and connected participants to key non-medical resources.

Supports for Vulnerable Populations

Initiatives like hospital discharge projects, equipment loan programs, and housing partnerships ensured vulnerable older adults received immediate, stabilizing support.

Community Collaboration & Advocacy

Local collaboratives and older adults' tables were launched to coordinate service delivery, advocate for systemic improvements, and strengthen regional networks.

Program Expansion

Success in launching new/additional CC roles or expanding to new rural areas, often filling longstanding service gaps.

Volunteer Engagement

Mobilization of volunteers for companionship, translation, transportation, and leadership in peer support groups, creating sustainable, community-driven impact.

Program Challenges & Solutions

SP programs faced a range of on-the-ground challenges in the last year, but implemented practical strategies in response, demonstrating adaptability and resilience across the sector.

Staff Capacity
Triaged referrals and prioritized urgent cases; shared caseloads where possible and leaned on peer/debrief supports while advocating for more stable funding/wage guidance.

Service Gaps & Long Waitlists
Worked through local tables to advocate for capacity, created stop-gap options (e.g., one-time deep cleans, subsidized services), and offered interim check-ins/peer support.

Transportation Barriers
Arranged staff/volunteer accompaniment, tapped small funds/vouchers, partnered with transit/taxi and divisions of family practice, and advocated for improved routes.

Affordable Housing Shortages
Helped participants navigate assessments and waitlists, built relationships with landlords/BC Housing, and used emergency funds to stabilize unsafe situations.

Limited Mental Health Supports for Complex Needs
Provided regular check-ins and warm handoffs, used Mental Health First Aid-informed approaches, coordinated with scarce providers, and advocated for older adults-specific counselling.

Inappropriate Referrals
Educated referrers on CC scope and eligibility, clarified discharge expectations, presented at rounds/meetings, and encouraged pre-referral consultations.

Barriers to Engaging with Hard-to-Reach Older Adults
Used gentle, repeated outreach (calls/notes/family links), ensured participants understood SP before intake, and built trust at the participant's pace.

Volunteer Recruitment & Retention
Increased targeted outreach and role clarity, used student placements/practica, and matched volunteers to culturally/linguistically appropriate roles.

Access to Health & Community Services in Rural/ Remote Settings
Built multisectoral collaborations, created local programming where none existed, and prioritized advocacy for regionally appropriate resources.

Impact Stories

FROM ISOLATION TO CONNECTION | PROGRESSIVE INTERCULTURAL COMMUNITY SERVICES SOCIETY

Abraham (pseudonym) is a visually impaired older adult facing health challenges and growing isolation. His caregiver was exhausted, and both were under immense stress. Through the program, Abraham received practical supports like housekeeping, meal delivery, and companionship, as well as access to food bank drop-off and transportation to medical appointments. Just as importantly, he joined community meal programs, which eased loneliness and created a sense of belonging. Weekly check-ins ensured he and his caregiver felt supported. Abraham regained independence and confidence, while his caregiver found balance knowing he was safe and thriving.

FINDING BELONGING IN COMMUNITY | RICHMOND CARES, RICHMOND GIVES

At 65, Maria (pseudonym) loved caring for her grandchildren but often felt exhausted, isolated, and unsure how to manage her own diabetes. Limited transportation, financial barriers, and difficulty navigating online platforms made it hard to access support. Through the Social Prescribing Program, she was connected to a Diabetes Education Centre, transportation services like HandyDART and Better at Home, and financial assistance through the Richmond Fee Subsidy Program. With guidance, she also gained digital literacy skills, joined two social groups, and discovered resources at the local library to enjoy with her grandchildren. With these supports in place, Maria now feels healthier, socially connected, and more confident in balancing her caregiving role with her own well-being.

REBUILDING CONFIDENCE THROUGH CONNECTION | COMMUNITY CONNECTIONS (REVELSTOKE) SOCIETY

After losing a loved one, Margaret (pseudonym), a once-active community volunteer, found herself increasingly isolated and disconnected. Through Community Connections, she was referred to the Social Prescribing program, where the Community Connector took time to build trust and understand her interests. Her first step back was attending a weekly older adults' coffee social, which gently reintroduced her to community life. From there, Margaret began joining Lunch and Learn sessions and, in a remarkable shift, even started encouraging and offering rides to other older adults—helping them find the same sense of belonging that helped her heal.

FINDING STRENGTH IN SUPPORT | EAGLE VALLEY COMMUNITY SUPPORT SOCIETY

When Wendy (pseudonym), a widowed older adult living alone in her condo of 15 years, lost the support of her granddaughter, she faced overwhelming anxiety. Without transportation, she struggled to reach critical weekly lab tests and monthly hospital infusions for dangerously low iron levels. On top of this, worries about food security, home care, and the costs of travel weighed heavily on her. Reaching out to the Shuswap Better at Home program changed everything. A trusted volunteer now drives her to appointments and helps clean her home, while the Community Connector linked her to food supports, gas cards, and even new dentures. Over the past seven months, Wendy's sadness has transformed into joy—she now attends weekly soup gatherings, bringing along her homemade apple tarts to share as her way of giving back. What began as a cry for help has become a story of resilience, community, and renewed purpose.

ACCEPTING HELP IN THE HARDEST OF TIMES | GALIANO HEALTH CARE SOCIETY

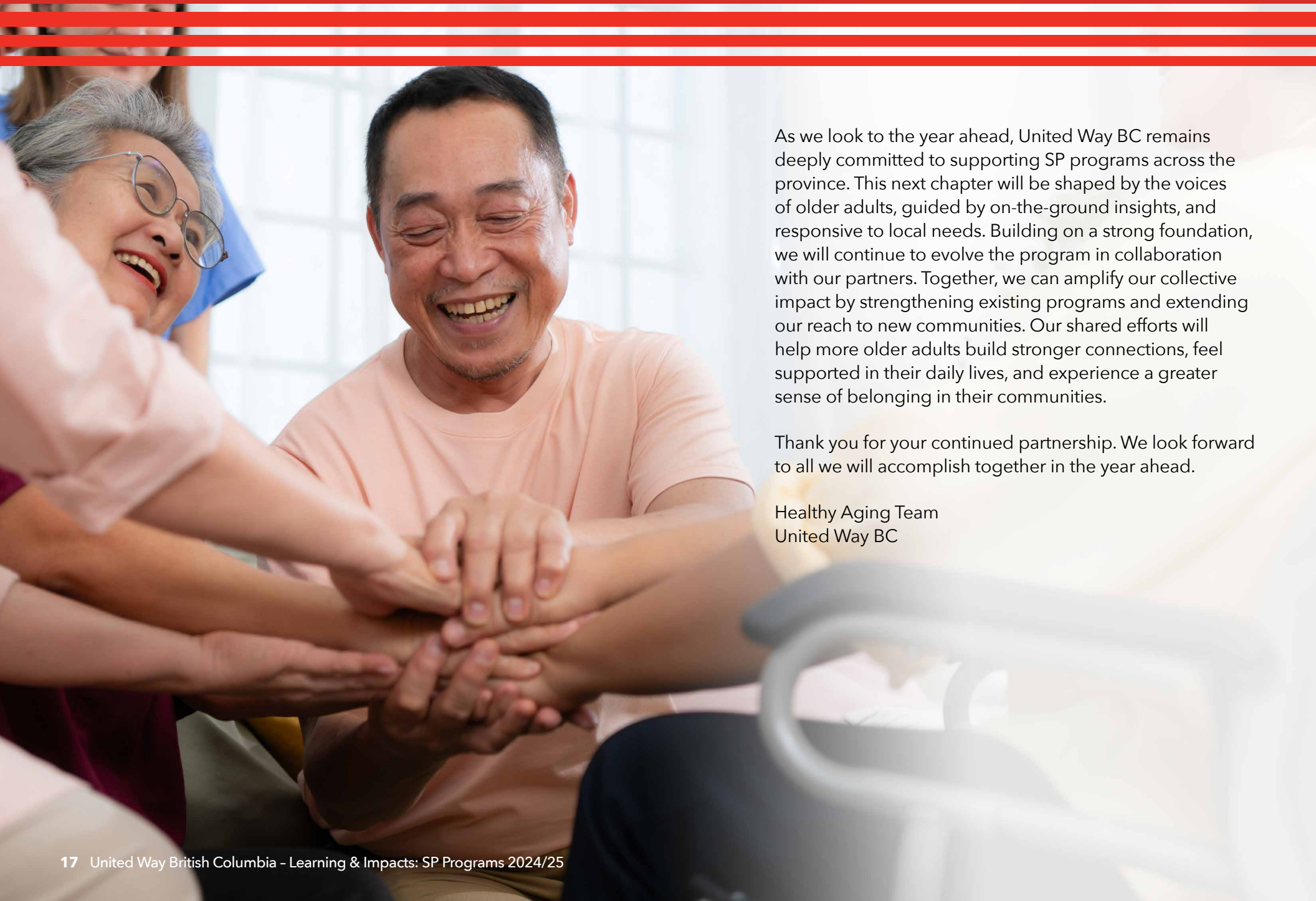
Terry (pseudonym) and her family are deeply grateful to the staff at Galiano Health Care Society for their extraordinary support during a difficult time in their lives. When Terry's stepfather was diagnosed with late-stage cancer and hospitalized, the family faced overwhelming emotional and logistical challenges. After he returned home for hospice care, the health care team quickly mobilized volunteers to step in and help. Their assistance allowed Terry's mother to rest and continue working, while also bringing comfort, companionship, and practical help. The team's compassion transformed a stressful situation into a meaningful and peaceful experience. The family is profoundly thankful for this invaluable community support.

A JOURNEY TO RESILIENCE | PRINCE GEORGE COUNCIL OF SENIORS

In the fall of 2024, David (pseudonym), a soft-spoken man in his 70s, came to the Prince George Council of Seniors after a sudden reduction in his pension left him without enough food for the month. With support through Social Prescribing, he received help completing Service Canada forms, emotional encouragement, and access to food programs.

A talented First Nations artist and wood carver, David gave back by donating a print and later creating a wolf carving for the Council's space. He also offered a prayer at a community event, sharing his culture and gifts. His journey is a powerful reminder of how timely support can restore stability while nurturing resilience and connection.

Looking Ahead: Our Path For the Future



As we look to the year ahead, United Way BC remains deeply committed to supporting SP programs across the province. This next chapter will be shaped by the voices of older adults, guided by on-the-ground insights, and responsive to local needs. Building on a strong foundation, we will continue to evolve the program in collaboration with our partners. Together, we can amplify our collective impact by strengthening existing programs and extending our reach to new communities. Our shared efforts will help more older adults build stronger connections, feel supported in their daily lives, and experience a greater sense of belonging in their communities.

Thank you for your continued partnership. We look forward to all we will accomplish together in the year ahead.

Healthy Aging Team
United Way BC

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Charitable registration number:
BN 108160185 RR0001

United Way
British Columbia

4543 Canada Way | Burnaby, B.C. V5G 4T4
P 604.294.8929 | F 604.293.0220 | Email: info@uwbc.ca

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