CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Linking Healthcare and Community:
Social Prescribing in Integrated Seniors' Care

Teaching Presenter: Krista Mulbery, Social Prescribing Project Manager,
Edmonton Seniors Coordinating Council, Alberta
Case Study: Colleen Derksen, Social Work Manager, Sage Seniors Association, Alberta
Tatiana Kastner, Program Manager, Jewish Family Services Edmonton, Alberta

Host: Jennifer Campagnolo, Canadian Home Care Association
February 12, 2025

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Reminders

- Say “Hello!” and introduce yourself via the chat! Remember to select “Everyone”.
- Use the chat function if you have any comments or are having technical difficulties.
- Captioning is available and can be activated through your Zoom options.
- Microphones are muted. **Please use the Q&A function to ask the panelists questions.** We will be taking time to answer any questions at the end of the presentation.
- This session is being recorded and will be available at **https://cdnhomecare.ca/chca-project-echo-integrated-seniors-care**
- Remember not to disclose any Personal Health Information (PHI) during the session.

Project ECHO ISC

Project ECHO Integrated Seniors Care, in partnership with the Canadian Medical Association, will enhance the competencies of home care and primary health care providers to meet the holistic and diverse needs of Canadian seniors with complex chronic conditions in home and community settings.

Project ECHO ISC

Mild Cognitive Impairment, Dementias

Integrated Clinical Practice Approach to Educational Content:

- Early Identification and Assessment
- Collaborative Care Planning
- Team-Based Care Delivery
- Shared Decision-Making and Communication
- Engaged Persons, Family and Caregivers
- Holistic Safety and Risk Management

With a focus on the:

SKILLS

KNOWLEDGE

ATTITUDES

needed by primary care and home care providers

Engaged Persons, Family and Caregivers

Engaging people and their caregivers through social prescribing strengthens integrated care through:

- Empowers people and caregivers in decision-making
- Enhances supports for caregivers within their community
- Creates a continuum between health, home and community
- Increases collaboration and coordination between healthcare and community providers

Introductions

Krista Mulbery
Social Prescribing Project Manager
Edmonton Seniors Coordinating Council

Colleen Derksen
Social Work Manager
Sage Seniors Association

Tatiana Kastner, MSW, RSW
Program Manager, Older Adult Services
Jewish Family Services

A PRESCRIPTION FOR CHANGE

Edmonton Seniors 55+ Social Prescribing Program

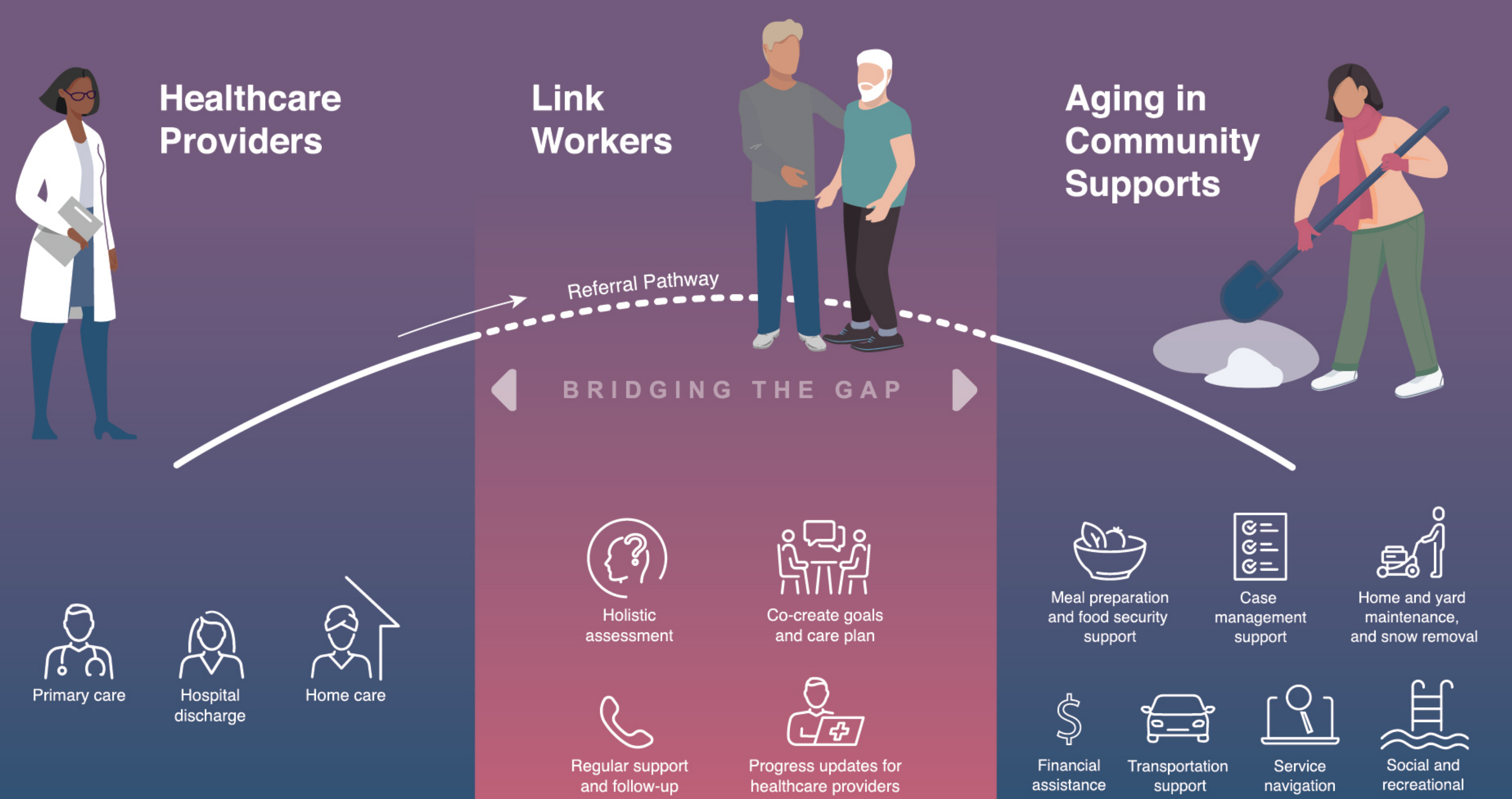
"…a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections." *(Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing Through Expert Consensus: A Delphi Study, 2022)*

A Prescription for Change
Social Prescribing in Alberta

SOCIAL PRESCRIBING

A FORMAL REFERRAL PATHWAY

Connecting healthcare providers to commmunity-based services for older adults



8 Principles of Social Prescribing

1) Social prescribing requires a formal pathway to connect medical care to community- based services.

2) Social prescribing begins with an identifier.

3) Social prescribing is a holistic, person-centred approach.

4) Social prescribing is strength-based.

5) Social prescribing is co-creative.

6) Social prescribing is community-led.

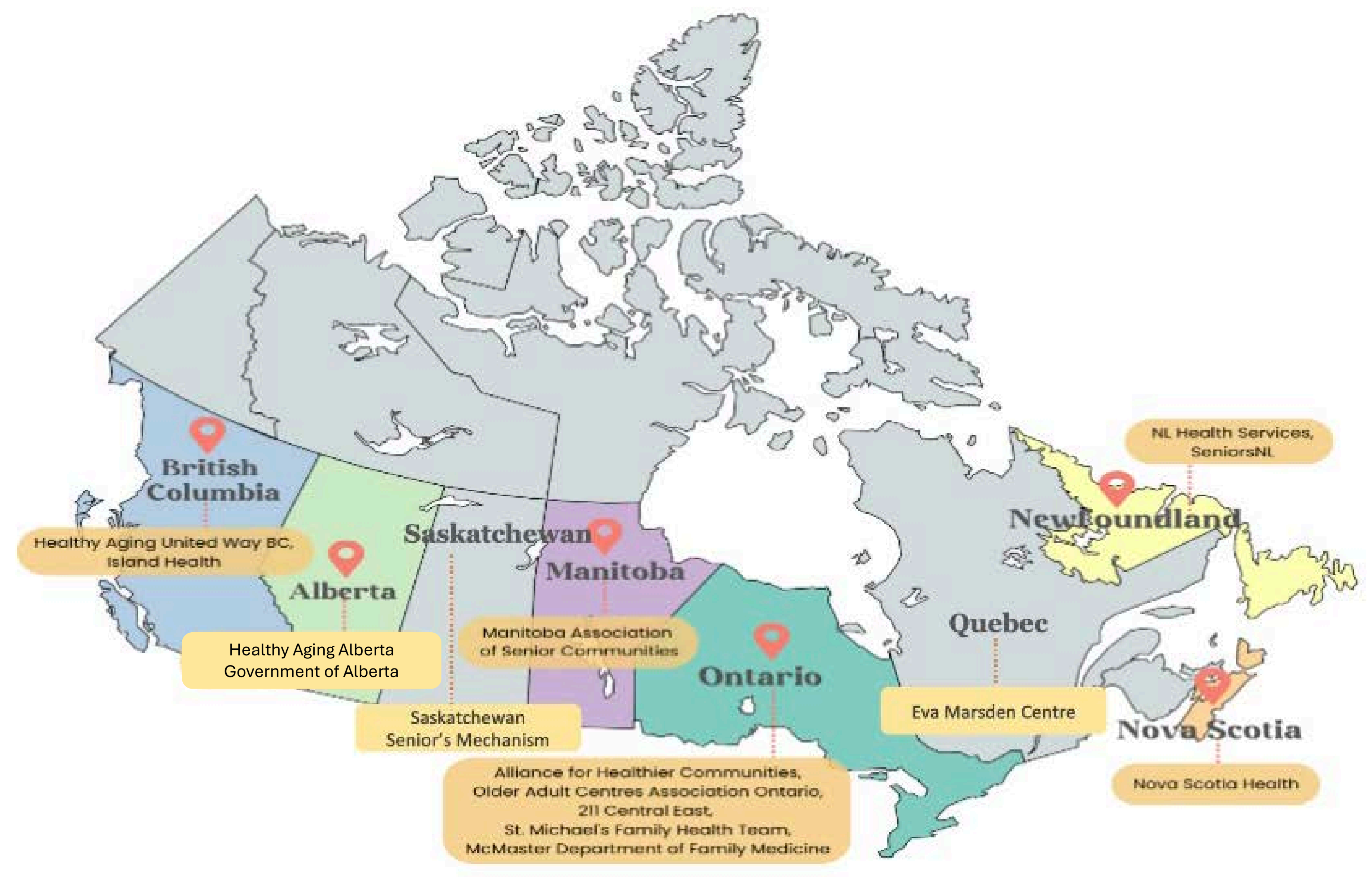
7) Social prescribing is not a one-size-fits-all approach.

8) Social prescribing is rooted in health equity.

Social Prescribing Across the Globe

Currently, Social Prescribing programs are being developed and implemented in 22 countries across the globe. Similar models of connecting people to non-medical care have existed though not united under the term social prescribing.

Social Prescribing Momentum in Canada



Calgary

The Way In Network and 403-SENIORS

Lethbridge

Community Connect Program

Lethbridge Seniors Citizens Organization

Rural Communities

Jasper

Whitecourt

Sylvan Lake

Innisfail

Red Deer County

Vulcan

Strathmore/Wheatland County

Seniors Social Prescribing Initiatives Underway

Alberta

Social Prescribing Edmonton Project

The Social Prescribing collaborative aims to purposefully link the health care system with community-based senior serving (CBSS) organizations by establishing a formal referral pathways and mechanisms for ongoing collaborative service delivery.

The project is supported by the Ministry of Seniors and Housing, Alberta Health and Healthy Aging Alberta to reduce the pressure on Alberta's health care system.

Social Prescribing Referral Form Edmonton Seniors 55+

Send completed form to: SRX@mysage.ca or via fax to: 780-426-5175 Attention: Social Prescribing.
Phone Number: 780-809-9411 *This form must be completed by a Registered Healthcare Provider

DATE: __________

REFERRAL MADE BY:
☐ HomeCare/ Home Living ☐ Family Doctor ☐ Hospital ☐ Primary Care Network
☐ Other __________

Full Name: __________ Phone #: __________ Fax #: __________
Email: __________ HC/ PCN Office: __________

* ☐ Consent to disclose healthcare information has been given prior to submission.
* ☐ Client is aware of the referral and agrees with the reason(s) for referral.

CLIENT INFORMATION:

Full Name: __________ Phone #: __________

Address: __________ City: __________ Postal Code: __________

Primary Contact if different than the Client: __________

Best time of day to call: __________ Can a message be left? ☐ Yes ☐ No ☐ Unsure

Building Type: ☐ Apartment ☐ House ☐ Other: __________

Date of Birth: __________ Gender: ☐ Male ☐ Female ☐ Gender Diverse (LGBTQ2s+)

Preferred Language: __________ Additional Languages: __________

Primary Source of Income (If known): __________

Living arrangements: ☐ Alone ☐ With Spouse/ Partner ☐ With Roommates ☐ With Dependents ☐ With Extended Family ☐ Housing Instability ☐ Other __________

Marital Status: ☐ Married/ Common Law ☐ Separated ☐ Divorced ☐ Widowed
☐ Involuntary Separation ☐ Single, never married.

Are there any identified risks for staff completing home visits? ☐ Yes ☐ No ☐ Unsure If yes, what risks have been identified __________

Client is receiving supports through Meals on Wheels?
☐ Yes ☐ No ☐ Unsure

Does Client have access to affordable and reliable transportation?
☐ Yes ☐ No ☐ Unsure Main form of transportation: __________

Client Equity Information: Select any/ all that may apply.
☐ First Nations/ Metis/ Inuit ☐ Member of Visible Minority (Non-Indigenous)
☐ Person with Disabilities ☐ Other __________
☐ Ethnocultural community/ Country of origin/: __________
Year arrived Canada: __________

REASON FOR REFERRAL:
Please select all that might apply
☐ Navigation of Community Supports & Services
☐ Financial Supports
☐ Meal Assistance/ Food Security
☐ Housekeeping
☐ Grocery shopping
☐ Assisted Transportation
☐ Socialization
☐ Housing
☐ Legal Assistance
☐ Snow Shoveling/ Yard Maintenance
☐ Recreation/ Leisure
☐ Other __________

Additional Comments (if applicable): __________

SPECIAL CONSIDERATIONS:
Please specify any circumstances for consideration:
☐ Cognitive or Memory Challenges
☐ Mental Health Issues
☐ Physical Mobility
☐ Clutter
☐ Hearing Impairment
☐ Visual Impairment
☐ Elder Abuse
☐ Grief and Loss
☐ Diverse Cultural Need
☐ Literacy Support
☐ Isolation
☐ Caregiver Concerns
☐ Health Challenges/ Barriers
☐ Other __________

Additional Comments (if applicable): __________

CLIENT HOSPITALIZATION DISCHARGE DATE (if applicable): __________

HealthCare Provider (if Applicable):
Does the client have a consistent primary healthcare provider?
☐ Yes ☐ No ☐ Unsure

Provider Information if known:
Full Name: __________ Phone #: __________
Fax #: __________

HOME CARE CASE MANAGER (if Applicable):
Full Name: __________ Phone #: __________
Fax #: __________ Email: __________
Services Provided: __________

CAREGIVER SUPPORTS :
☐ Has Caregiver Support ☐ Is a Caregiver ☐ Insufficient Caregiver Support
Full Name: __________ Relationship: __________
Phone #: __________ Email: __________

EMERGENCY CONTACT:
Full Name: __________ Relationship: __________
Phone #: __________ Email: __________

sage · JFS Edmonton · Edmonton Seniors Coordinating Council · MCHB · Drive Happiness · meals on wheels · Caregivers Alberta

Social-Prescribing-Nov-2024-Referral-Form.pdf

What is a Link Worker?

Link Workers are non-healthcare professionals who support clients to develop and achieve a personalized set of goals by engaging with community resources.

Link Workers do not replace the role of health providers, rather, they will add an additional support for the client.

Assist clients with personalized plans to improve well-being.

Build Relationships.

Assess Client Needs.

Monitor Progress.

Routinely Follow-up with Clients and Healthcare Providers .

Following a Referral:

- Central Intake will connect patients to a program “Link Worker” who works with clients to identify their social needs.
- If there is a determined need for ongoing long-term or complex need for support, clients will be connected with a Social Prescribing Case Manager who will work with the client to address these complex needs.

Staffing by April 1, 2025

- 5.1 FTE Link Workers
- 5.0 FTE Case Managers/Social Workers
- 1.0 FTE Central Intake Manager
- 1.1 FTE Home Support Coordination
- 1.0 FTE Project Man,/backbone services
- 0.4 FTE Supervision/ Program Development
- 0.1 Ethnocultural Network Coordination/ Program Development
- 0.6 FTE Transportation Coordination
- 0.6 FTE Kitchen and Delivery Support (yr 1.)
- 0.6 FTE Client Services Coordinator- Meals
- 0.5 FTE Volunteer Coordinator
- 1.0 FTE Housing Navigator
- 0.25 FTE Caregiver Coordinator
- Home Support Workers (4800 hrs)

Project Partnerships

EDMONTON
SENIORS
COORDINATING
COUNCIL

Brings people, ideas, and information together to build collaborative approaches to services, supports and circumstances affecting older adults.

Social Prescribing: Project Management & Network Coordination

"Inspiring and supporting seniors to be the best they can be."

Social Prescribing:

- Central Intake
- Case Management
- Link Workers

Offers programs and services that:

- address individual needs and build on personal strengths;
- connect people to information, resources, and each other;
- enhance the safety and well-being of older persons who are, or who may become, isolated, disadvantaged or at-risk in the community;
- assist older persons to participate as active members of the community and to reside safely in accommodation that meets their needs;
- recognize we each age uniquely and that we each have different needs and interests; and,
- look at the whole person.

Sage also provides:

- research and advocacy on issues affecting older persons.

JFS
EDMONTON

"We empower and support people, through service excellence, to overcome life's challenges."

Jewish Family Services Edmonton

Seniors Support Program provides:

- Case Management
- Referrals
- Resources to Seniors and Older Adults from all Backgrounds.

This may include support with navigating:

- Government and Health Services
- Seniors Home Support Options
- Help with Food Security
- Social Isolation
- Affordable Housing and Placement.
- Friendly Phone Calls
- Mental Health Services

JFSE also provides tailored services to Jewish seniors.

Social Prescribing:

- Case Management
- Link Workers

Multicultural Health Brokers:

- Serve over 2000 families each year within over 25 culturally and linguistically diverse communities in Edmonton.
- Offer inter-cultural competency training for government organizations, service providers, and companies.
- Offer holistic supports – working with families in a manner that respects their individual strengths, challenges and circumstances.
- Focus on prevention, and broad determinants of health.
- Support culturally-responsive practice and policy development in government and community organizations.

Connecting Communities

Social Prescribing:

- Link Worker & Network
- Resources to Support Ethnocultural Clients

DRIVE HAPPINESS

"To enhance mobility and connect older adults to the resources needed to live and age well."

Social Prescribing:

- Transportation Services

Drive Happiness core operations provide transportation services to seniors 65+ (exceptions made for younger clients with barriers) residing in 43 communities, in need of transportation services due to:

- Limited income
- Mobility
- Other health related issues

Edmonton Meals on Wheels is a local non-profit and registered charitable organization that intentionally connects with clients through home-delivered meals and food services.

Edmonton Meals on Wheels provides:

- Exceptional client service
- High quality, nutritious meals – fresh and frozen
- Minced, pureed, soft, cut-up, diabetic and renal diets available

Social Prescribing

Food Security & Nutritious Meals

How Caregivers Alberta Helps

Caregiver Support Services
Find the resources, community and support you need.

Weekly Caregiver Support Communities
Peer-support groups for caregivers, including a men's group, journaling circle and book club.

Educational Workshops
We offer the award-winning *COMPASS for the Caregiver* workshop and additional education session throughout the year.

Caregiver Coaching Sessions include:
- A discovery process to gather information about your caregiving situation
- Guidance to help identify your needs and plan next steps
- Strategies to stay healthy while being busy and under stress

780.453.5088
1.877.453.5088 (toll-free)

support@caregiversalberta.ca

Refer a caregiver HERE

Intake and Case Management

- Jewish Family Services Edmonton
- Edmontonians 55+ from all cultural backgrounds
- Internal programs: Older Adult Services, Outreach, Home Support social enterprise, Counseling, Resettlement services, and English classes
- Multicultural and multilingual staff
- Expertise in working with trauma survivors

Case Management Process

- SAGE central Intake
- Triage to SAGE, JFSE, MCHB
- JFSE Intake – most of the cases with home support needs
- Assessment: ecological model
- Intervention plan
- Connection to Home Support services
- Follow ups
- Discharge or continued supports

Needs at Intake

- Home support needs (housekeeping, meal preparation, personal care, etc)
- Food security: Meals on Wheels and other options
- Transportation: Drive Happiness and other options
- Housing
- Isolation

Challenges

- Complex needs
- Multiple health issues
- Limited mobility
- Mental health
- Addictions
- Cognitive issues
- No caregiver support
- Urgency
- Limited staff capacity: long wait list

Benefits of the SRx Model

- Case management team's perspectives:
- Collaborative work with health care professionals
- Multidisciplinary team
- Multi agency work
- Access to resources and knowledge within the network

Social Prescribing

Case Study

Jane Smith

- Referred to the Social Prescribing Program by Home Care Case Manager-66 year old Female recently released from hospital after a fall
- **Reasons for Referral**
- Navigation of Community Supports and Services
- Financial Supports/Legal Assistance
- **Special Considerations**
- Cognitive and Memory Challenges
- Isolation
- Grief and Loss

Jane Smith

- Receipt of referral and information Confirmed with the Home Care Case Manager, and Senior is contacted to set up a home visit for a conversation and assessment.
- Senior and Social Worker met at Seniors home. Social Worker explained the program, and gained some more insight into the senior's situation
- The HAAI Assessment to was used to assess and create goals
- Follow up visit planned for addressing Needs in order of priority

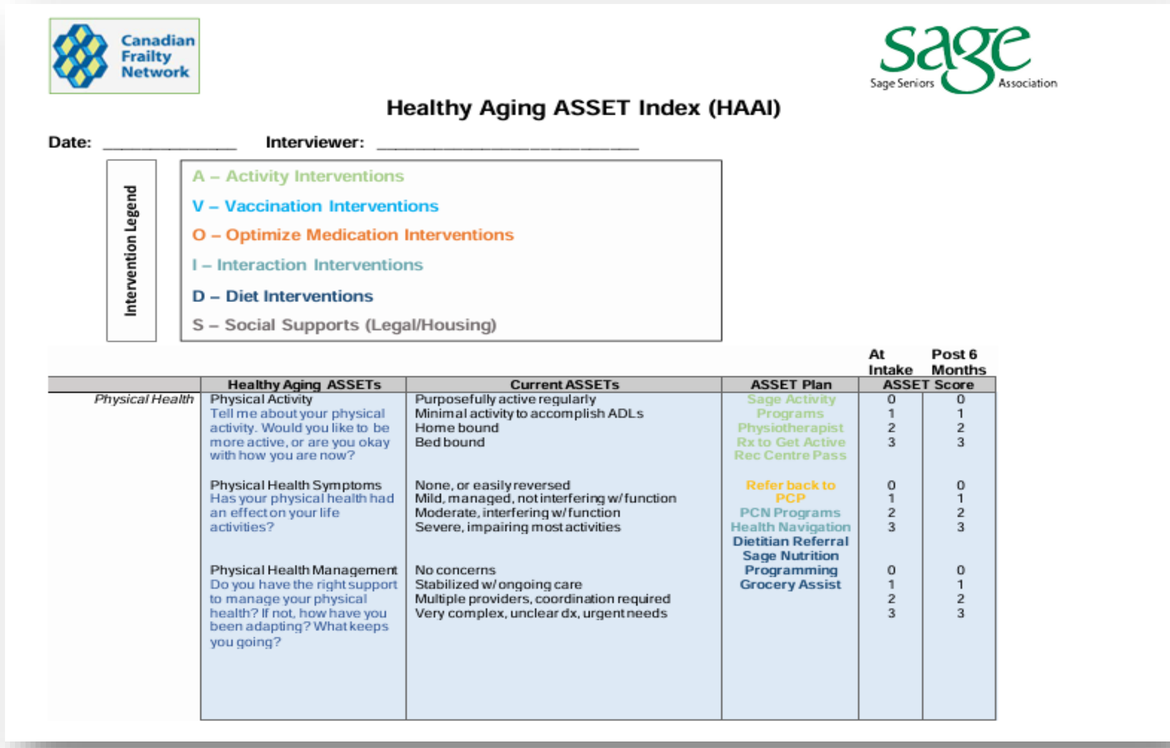
Jane Smith

- HAAI Assessment indicated that Senior recently lost spouse and was diagnosed with early stages of dementia.
- Senior concerned about housing security as income would be reduced due to death of spouse.
- Senior had no family to assist and reported being isolated from friends, as she had been main caregiver to spouse during illness.
- Senior reports struggling with grief and feeling overwhelmed
- Home Care Care plan for Jane was not extensive at this time.

Jane Smith

- **Healthy Aging Asset Index**-Assessment and Case Management Tool is an assessment tool that can be used to guide social prescribing by a variety of professionals in the community. The determinants of healthy aging can be used to inform social prescriptions in different domains. Seven Domains scored out of 9 for a total of 63.

- Physical Health/Personal Wellbeing/Mental Health/Social Support/Physical Environment/Safety and Security/Social Engagement
- Scoring-Jane scored 19 out of 63-with the highest categories being in Physical Environment 4/9,Mental Health 3/9, Social Support 4/9



Canadian Frailty Network

sage Sage Seniors Association

Healthy Aging ASSET Index (HAAI)

Date: ____________ Interviewer: ______________________

Intervention Legend

- A – Activity Interventions
- V – Vaccination Interventions
- O – Optimize Medication Interventions
- I – Interaction Interventions
- D – Diet Interventions
- S – Social Supports (Legal/Housing)

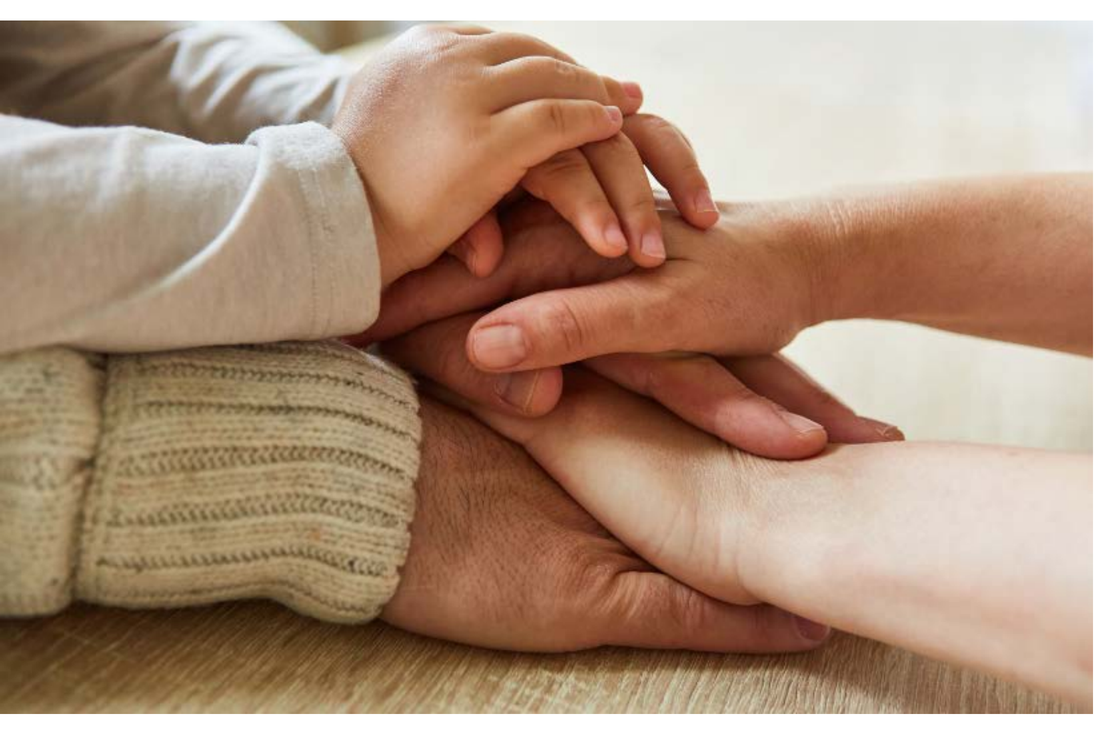
	Healthy Aging ASSETs	Current ASSETs	ASSET Plan	ASSET Score At Intake	ASSET Score Post 6 Months
Physical Health	Physical Activity Tell me about your physical activity. Would you like to be more active, or are you okay with how you are now?	Purposefully active regularly Minimal activity to accomplish ADLs Home bound Bed bound	Sage Activity Programs Physiotherapist Rx to Get Active Rec Centre Pass	0 1 2 3	0 1 2 3
	Physical Health Symptoms Has your physical health had an effect on your life activities?	None, or easily reversed Mild, managed, not interfering w/ function Moderate, interfering w/ function Severe, impairing most activities	Refer back to PCP PCN Programs Health Navigation Dietitian Referral Sage Nutrition Programming Grocery Assist	0 1 2 3	0 1 2 3
	Physical Health Management Do you have the right support to manage your physical health? If not, how have you been adapting? What keeps you going?	No concerns Stabilized w/ ongoing care Multiple providers, coordination required Very complex, unclear dx, urgent needs		0 1 2 3	0 1 2 3

Jane Smith

- Jane had expressed feeling overwhelmed with daily tasks since her loss, and had financial concerns, so a request was made with program partner, Meals on Wheels for meal delivery for short term relief
- With her recent diagnosis, she was now looking at giving up driving, so transportation became a concern. Program partner, Drive Happiness, could assist with upcoming trips with their volunteer driving program
- As Income was one of her main concerns, Social Worker arranged for pension applications to be up to date to reflect new single status that would allow for subsidies calculated on her income alone, and assisted Jane with ensuring all paperwork supplied. (NOAs, etc)

Jane Smith

- Jane expressed fears for ability to pay rent, Jane consented to have joint conversation with Landlord to ensure payments would be made, but possibly partial payments until new income would begin



- Jane is considering moving to more supportive housing as her condition warrants it, but wishes to remain in home with supports for now
- As Jane's Alzheimer's diagnosis was quite new, she had questions and concerns, so a referral was made to the Alzheimer's society for support, Community Geriatric Psychiatry was also discussed

Jane Smith

- As Jane's Alzheimer's diagnosis was quite new, she had questions and concerns, so a referral was made to the Alzheimer's society for support,
- Community Geriatric Psychiatry (CGP) was also discussed, and Jane showed an interest in this at a future date, but was more inclined towards grief counselling at this time. These resources were provided. The Home Care Case Manager was updated about possible referral for CGP to ensure this had not already occurred.

Jane Smith

- Jane required added assistance during tasks to meet goals, as her memory concerns dictated this. As the work progressed, she became more involved in the planning and follow through, as she became less overwhelmed with ever decreasing "to Do" list. "Home work" tasks for Jane were adjusted according to circumstances
- Though struggling with her new situation, her natural sense of humour became more apparent

Jane Smith

- Basic Needs being addressed, Social Worker and Jane had a discussion on Social Opportunities, as Jane had put socialization in hold as her husband's illness had progressed and her responsibilities increased
- Jane expressed an interest in both the activities at her local Seniors' Ctr and possibly attempting some online (Though Jane would join by phone) programming
- Access Leisure pass was applied for –this assists with ongoing public transportation as well as access to City of Edmonton Leisure facilities

Jane Smith

- Jane has expressed interest in Beginner Computer Classes, as well as continued involvement with Support groups and hopes to use online skills to access online when in person groups inconvenient
- Though Jane still struggles with loss, she is aware of resources and how to access
- Her closing score for the HAAI was now 10, and less immediate interventions are necessary. This is a more manageable situation, and Jane can contact resources as required.

Jane Smith

- Home Care was contacted while working with Jane to ensure no duplication of services and to provide updates
- Social Prescribing involvement with Jane was approximately four months, as some of Jane's plan required time lapses as documents were compiled. Jane had continued to heal from her fall during this time.
- Visits with Jane were a combination of home visits, phone conversations for check ins. Jane felt confident to attend groups on her own, so did not require assistance in this area

Social Prescribing Edmonton

Project Progress

Project Progress to Date (Dec 31, 2024):

- 1522 Referrals Received
- 1365 Funded Rides (Drive Happiness, Taxi & Bus Tickets)
- 7575 Funded Meals- Edmonton Meals on Wheels + 160 Grocery Cards
- Referred by: 48% Homecare, 28% Hospital, 11% PCN, 13% Other

Based on the Edmonton Seniors 55+ Social Prescribing: Evaluation Findings May 1 – October 31, 2024

The majority of clients in the program:

- Are 65 years of age or older (48%)
- Are Female (60%)
- Are Living alone (62%)
- Have a consistent primary care provider (91%)
- Have access to affordable transportation (56%)
- Have an annual income of less than $30,000 (72%).

Top 10 Reasons for Referral:

*Based on the Edmonton Seniors 55+ Social Prescribing: Evaluation Findings May 1 – October 31, 2024.

- Navigation of Services and Supports
- Housekeeping
- Food Security
- Social Support
- Transportation
- Financial Assistance
- Housing
- Recreation/ Leisure
- Legal Assistance
- Other

Evaluation

A Provincial-based Social Prescribing Client-Level Data Collection Guide has been developed in collaboration with HAA and PolicyWise for Families & Children (PolicyWise).

The guide aims to support organizations in measuring outcomes achieved with older adult clients receiving community-based services across Alberta.

Evaluation

Working together at local & Provincial level to understand client:

Demographics- Who are we serving, and might there be differences in the impact our programs have on people in different circumstances

Outcome Measures- Understanding needs, progress, and next steps.

Program Improvement- Why closing, and program improvement

The Edmonton Social Prescribing Project is grateful to our funders, healthcare providers and all of our community partners who continue to strengthen and support Social Prescribing in Edmonton.

Resources:

1. Retrieved from: Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing Through Expert Consensus: A Delphi Study | medRxiv (January 24, 2023)
2. Retrieved from: Social prescribing: Reference guide and technical annex for primary care networks- (February 3, 2023)- NHS England » Social prescribing: Reference guide and technical annex for primary care networks
3. Canadian Institute for Social Prescribing-Social Prescribing Resources
4. Edmonton Seniors Coordinating Council- Edmonton Seniors Coordinating Council (seniorscouncil.net)
5. SAGE Seniors Association- SAGE: Home (mysage.ca)
6. Jewish Family Services Edmonton- Jewish Family Services – Help with heart (jfse.org)
7. Multicultural Health Brokers- https://mchb.org
8. Drive Happiness- Drive Happiness – Seniors Assisted Transportation
9. Caregivers Alberta- https://www.caregiversalberta.ca/
10. Healthy Aging Alberta- https://corealberta.ca/

Discussion / Q&A

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Upcoming TeleECHO Clinics

CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in Home and Primary Health Care

Integrated Care Strategies for Dementia and MCI: Empowering Primary Care and Home-Based Teams to Assess and Act

March 27,   12 - 1pm ET

Dr. Rob Lam MD, Scarborough Health Network

Unison Health and Community Services Home Based Primary Care Team

CHCA Project ECHO Home-Based Palliative Care

All Teach, All Learn

Bridging the Knowledge Gap in Home-Based Palliative Care

Navigating Palliative Emergencies at Home

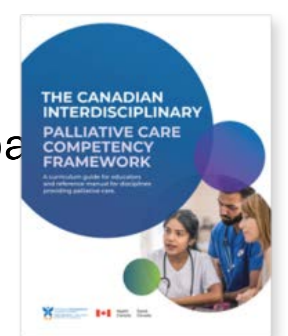
March 5, 12 – 1pm ET

Dr. Cornelius Woelk MD, Southern Health, Manitoba

Holistic Spirituality and Care at End of Life

June 11, 12 – 1pm ET

Simon Lasair, Saskatchewan Health Authority



Register: cdnhomecare.ca/chca-project-echo/