Promising practice: Addressing older adult loneliness through the *Rx Community* social prescribing pilot

What you need to know

- The Alliance for Healthier Communities completed a social prescribing pilot in community health centres across Ontario. Social prescribing formally connects health care and community services by having health providers prescribe non-medical activities and supports.
- Clients of the Rx Community pilot reported that there was a 49 percent decrease in their sense of loneliness, a 12 percent improvement in their mental health, and a 16 percent improvement in their sense of community belonging.
- When working with older adults, care providers should acknowledge older adults' knowledge and expertise, recognize how giving back to the community can be empowering, and actively reach out through multiple forms of communication during periods of isolation.
- A first step to bringing social prescribing to your organization is to complete an asset map of existing resources in the community and intentionally screen clients for their social needs.

The background

In Canada, between 10 to 50 percent of older adults report feeling lonely.[1,2] Loneliness and social isolation are associated with a number of adverse outcomes, such as increased mortality, falls, cardiovascular disease, functional decline, depression, dementia and elder abuse.[1,3] Lack of meaningful social connections and other formal/informal supports may also lead to a lower quality of life and increased emergency department visits and long-term care admissions.[1,4] With the onset of COVID-19, older adults' need for connection is even greater as they are at a greater risk of experiencing severe illness and longer periods of social isolation.[5,6]

In order for older adults to reach optimal health, care providers need to look beyond clinical care and recognize the need for social support and a sense of belonging in the community.[7] The social determinants of health (SDoH; the circumstances people are born, live, work and age in) account for 80 to 90 percent of health outcomes, whereas medical care only accounts for 10 to 20 percent.[8]

The Alliance for Healthier Communities (the Alliance) responded to this need by bringing social prescribing to Ontario with a pilot project called *Rx: Community*. Social prescribing is a tool to formally connect health care and community services.[8] Health providers work with the client to co-create a solution that goes beyond a medical diagnosis, such as prescribing cooking classes, volunteering, attending bereavement groups or connecting to other community supports.

We spoke with Dr. Kate Mulligan, Director of Policy and Communications at the Alliance, about the pilot and how social prescribing can be a useful tool to support lonely and isolated older adults.

The promising practice

The Alliance completed the pilot across 11 community health centres (CHCs) in Ontario, where providers referred over 1,100 clients (53 percent of clients were over the age of 61) to 3,295 social prescriptions. The client-reported results show that there was 49 percent decrease in clients' sense of loneliness, 12 percent improvement in mental health and 16 percent improvement in sense of community belonging.

For the detailed evaluation results, read the Rx: Community – Social prescribing in Ontario final report.

Overview of interventions

CHCs have provided health and social services under one roof for a long time. However, the innovation of the pilot was formalizing existing work and tracking the intentional pathways between clinical care and social supports. While social prescribing can look different depending on the community needs and organization's capacity, Rx: Community pilot provides an evidence-informed model for social prescribing with five key components:

1. **Client**
   - The client is someone who has social and health challenges. They have their own goals, expertise and interests, all of which should be taken into consideration.

2. **Prescriber**
    - The prescriber can be primary care providers, hospital clinicians, public health nurses, community support workers, social workers, hospice workers or home care workers.
    - The prescriber meets with the client, intentionally screens for their social needs and gives the client a social prescription: a direct referral to an activity or a referral to a navigator.
3. **Navigator**
    - The navigator can be a staff member, such as an outreach worker, health promotor, social worker, or a trained volunteer.
    - Their support can range from advertising resources that are already available in the community, to providing an assessment, co-designing a solution with the client and following up with them.
4. **Social prescriptions**
    - These are non-medical prescriptions to activities or community supports, such as food security services, walking groups, volunteering, or arts-based programs.
5. **Data pathway**
    - All participating CHCs shared an electronic medical record (EMR) system that would track the client's journey and follow up.

Lessons learned for working with older adults

1. Acknowledge older adults' knowledge and expertise

When working with older adults, it's important to tap into the expertise and knowledge that elders bring to the community. The first step can be as simple as asking what they need. For many isolated older adults, connecting with a prescriber or navigator may be the first time they've been heard, which can have a positive impact on the individual and community.

Country Roads CHC is located in eastern Ontario, in a community where many older adult couples retire and often deal with the loss of a partner. Since it is a community in a rural area, no formal supports were in place. In conversation with the community, the need for a bereavement group was recognized and, in partnership with leadership from the community, it was created. As a result, there were reduced health care visits and medication use for anxiety and depression that stemmed from grief and loneliness.

2. Recognize the power of giving back to the community

Prescribing volunteering or giving back to community can be empowering and remind older adults of what they have to offer. In many CHCs, older adults volunteered and became leaders of their own programs, and many have led or been involved in active outreach since the COVID-19 pandemic.

3. Use active outreach in multiple mediums

When physical distancing measures were first put into place during the COVID-19 pandemic, the CHCs started active outreach in every medium to make sure isolated older adults could still access services and information. This included:

- supporting older adults to use technology and creating safe online spaces to connect
- drop offs (e.g., food, medication) and home visits to ensure people's social isolation needs were also met
- telephone trees, where people call to check up and connect with one another
- mailing out care packages (e.g., health and COVID-19 information, treats and crafts) to people who were not online and followed up with a phone call.

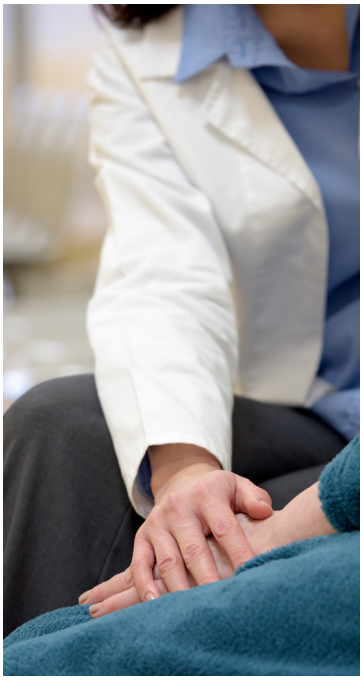
While not all of the initial work happened through a structured referral, connecting the outreach to healthcare would allow new clients to access programming and for the work to be measured.

Implementing the promising practice

The health inequities of COVID-19 have prompted a conversation on the need for addressing the SDoH. However, often what's missing from the conversation is connecting social services and healthcare. Social prescribing is something that can be implemented in many different settings to help address people's social needs in real time. Below are just a few suggestions for how to bring this promising practice to your work.

In clinical practice:

- Intentionally screen clients for their social needs (e.g., ask if they are involved in any social activities or content with their friendships and relationships).
- In providing a solution, move beyond asking "what's the matter with you?" to "what matters to you?"
- Make use of existing resources in your community. A first step is to develop an asset map to understand what services and partnerships are available. Another source for social prescriptions is to co-creating activities with volunteers and peers from the community.



Outside of clinical practice:

- Reach out to a primary health care team, Family Health Teams, CHCs, Aboriginal Health Access Centres or Nurse Practitioner Community Clinics so that they are aware of your services and can refer clients to you.

References

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