GUIDE 1: PRACTICE SET-UP AND SOCIAL PRESCRIBING IN PRIMARY CARE

ARC: Access to Resources in the Community/Accès aux Ressources Communautaires

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Contents

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1. Introduction

This Guide is the first of three guides intended to assist organizations in implementing a social prescribing (SP) program. These guides are the product of work done under the SP program Access to Resources in the Community (ARC) which aimed to increase equitable access to health and social resources. By health we mean health-related needs for which non-medical services are available in the community, including healthy behavior and health management (such as mental health, chronic disease self-management, and chronic pain). Note that most SP programs do not include health needs directly, but we encourage organizations to consider patients' health needs as these are often the entry way to identifying and acting on the social determinants of health.

This guide is focused on the strategies and pathway for **engaging primary care providers** in SP, approaches to **identifying patients** with unmet health and social needs, optimizing **patient engagement** for addressing patient's SDoH, and making **referrals to existing patient navigation** support.

What is SP

Briefly, SP involves the identification of patients with unmet social needs in family practice, the engagement of these patients in acting on their needs, and the provision of navigation support to access the needed services.

The ARC SP model

The ARC SP model has the following attributes:

1. Embedded in primary care for broad population reach and the role of that sector on prevention and health promotion.
2. A single point of entry for **all** patients to access navigation support for **any** health or social need.
3. Patient centered approach to provide services that are responsive to the individual's social context and priorities.
4. Navigation services delivered by a lay navigator.

The ARC SP model has been demonstrated to be feasible, effective, and highly valued by patients, and is reported by primary care providers to address an important gap in care delivery services. [1–4]

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The need for SP programs

The ARC SP model was developed after extensive consultations with multiple stakeholders which revealed that individuals, especially those who are socially complex, often do not know what resources exist in the community that they could benefit from. Similarly, primary care staff are often unaware of extent and type of community resources that could help benefit the health and wellbeing of their patients, and commonly do not have the time to guide them in accessing these services.

2. Population Served

This guide can be used to establish a SP program to cover the needs of patients across multiple primary care practices defined by a region or by a jurisdictional responsibility, such as for Ontario Health Teams, or the needs of a single practice. For the latter, community based sections do not apply.

3. Practice Engagement

The goal is to engage all practices within the defined region/jurisdiction to maximize the impact.

Community based

Potential community-based approaches to raise awareness and engagement in the SP program from practices and from patients who may ask their practice to participate:

- Engage Ontario Health Teams (OHTs) and other stakeholders (e.g., care services organizations, health planners, regional champions) so they can promote the program.
- Display posters in the region.
- Advertise (poster/flyers) at community events and social gathering places.
- Advertise/Interview in local newspapers.

Practice based

- Identify a practice Lead or manager to contact.
- Send information package to the practice lead
- Follow-up as needed.

A practice information package contains the following:

1. A description of the program (see Appendix Practice Information sheet as an example from ARC program). Suggested content:
   - ✓ Description of:
     - What is social prescribing?
     - The benefit of social prescribing to the patients
     - The anticipated benefits of social prescribing to the provider
     - A description of the navigation services offered.
   - ✓ What is expected from participating practices:
     - Displaying practice promotional material
     - Approach to identifying patients with unmet health and social needs
     - Establishing referral process (e.g., OCEAN)
   - ✓ List of partners:
   - ✓ Links to program information (if available)
   - ✓ Offer an information session
   - ✓ Contact information

A program brochure which provides a more succinct, higher-level, eye-catching information (See Appendix Practice Information Brochure as an example from ARC program). Suggested content:

- About the program
- Participating practices will receive …
- Participating patients may receive ….
- What are the services offered by the Patient Navigator?
- What impact can this have on your practice?

Practice information session

Offer an information session to practices expressing an interest and invite all individuals who would be involved in the decision to adopt the SP to attend the session.

The information session should address the same elements as the information sheet (See Appendix Practice Information sheet as an example from ARC program), but in more depth,

especially focusing on what will be required from the practice and the patients (see Appendix Practice Information Session as an example from ARC program).

1. Background: Impact of SDoH on health, community resources and access gap
2. Benefit of social prescribing for patients, including improving the patients' access to needed services
3. Brief outline of program components: processes for patient identification, needs assessment, referral, and navigation.
4. What's expected of the practice members, elements of the practice set-up
5. Role of navigator in supporting their patients, including ensuring that the service to which they are linked is appropriate, and having a warm hand off when necessary.
6. Breadth of existing community resources
7. Questions and discussions

4. Practice set-up

Ask practices agreeing to engage in the SP program to make small practice adjustments to accommodate the program. Begin by identifying a practice **"Champion"**; as a clinician or administrative staff person who will be the main point of contact and who will be responsible for the SP implementation.

Practice adaptations and establish SP processes

Waiting room promotional material

Practices will be encouraged to display posters, flyers, pamphlets in the waiting rooms and patient examining rooms to raise awareness of the patients regarding the potential benefits of community resources and the navigation support available to them, and the SP program that promote community resources. All promotional material will be tailored according to the priority issues of the patients in that practice. Use of promotional material can prompt and encourage patients to discuss with their providers about their health and social needs. Where feasible, all promotional material can be displayed in French and English.

Outreach

Practices may send flyers through emails or web portals or put the information on their web site to raise patient awareness.

Establishing processes for SP in practice

Work with the practice staff to establish processes to implement social prescribing in the practice. These processes should ideally have minimum impact on practice functioning and

prompt provider referral. In order to understand the context and set up the practices, first collect necessary information about the practices (See Appendix Establish Processes)

1. Establish patient identification mechanism. These could include active and opportunistic methods to identify patients who could benefit from social prescribing and / or navigation.
    - Active screening that can include
        - Patient self-identification of needs using a tablet in the waiting room
        - need assessment conducted by a practice staff;
        - Identify patients with needs from EMR records/ flag in EMR;
    - Opportunistic identification of needs – During a usual patient encounter, the provider becomes aware of unmet needs of patient.

2. Establish an in-practice referral process wherein the practice staff will refer the identified patients to the patient navigator (e.g., integrate referral forms into EMR, maintain hard copies and fax to the navigator, use OCEAN platform to make referrals to the navigator). Steps can include:
    - Adapt referral form (See Appendix ARC Referral form as an example from ARC program)
    - Integrate referral forms into the EMR
    - Identify who in the practice will be completing the referral form with patients and whether forms will be completed on a hard copy or electronically.
    - Identify a process for storing completed referral forms and transferring them to the patient navigator (e.g., fax, OCEAN)
    - Identify the optimal process to prompt provider referral, e.g., reception staff may add the referral form to each patient's file on a daily basis.

3. Establish communication mechanisms between practice champions/provider and Navigator.
    - Ask practices for preferred mode of communication (telephone, email, hard copy scan/fax or electronic secure messaging or EMR) to ensure efficient information sharing and prompt response; and determine the frequency of communication.
    - Determine the updates desired by the provider about their patients' progress (e.g. # of referrals received, types of resources recommended, patients' utilization of the resource, types of barriers reported by patients, etc.)
    - Discuss the process for the Navigator to contact the provider or vice versa, if the patient requires services beyond the scope of the Navigator.

4. Establish process to integrate the Patient Navigator in the practice
   The meetings between the Navigator and the patient can either take place in-person or by phone, in one of the reserved offices at the provider's practice or at an offsite location (public area, office etc.).
   - Determine how often the Navigator can meet with patients at the practice site. (Hours/day; Days/week; What day(s) of the week)
   - Identify office/room in the practice that is available for the Navigator to meet with patients on a weekly basis.

5. When the SP program is implemented by another organization, a program coordinator or program manager can monitor the set up and progress of SP implementation in the practice. (Appendices Practice Set-Up Log and Program Implementation checklist).

Training of PCPs

Schedule and hold an on-site training session for all personnels in the clinic, repeating the info on the practice information session, providing details on available resources in the community with an emphasis on resources addressing the priority issues of their patients, and the role of the provider, and what to expect from navigation team. (See Appendix Provider Orientation Session) The providers will also be trained on the following components of the intervention:

- **Identifying patients for referrals**

Train providers on active screening and opportunistic methods to identify patients who could benefit from social prescribing and / or navigation.

- **Engaging patients in self-care**

Train providers to engaging patient in self-care. The provider needs to do the following:

- Describe to the patient the impact of SDoH on health
- Use patient-oriented and motivational interviewing approach to understand patient's context and identify one or more needs
- Give the patient information about the SP program and role of patient navigator
- Engage patients in addressing these needs (self care) using shared decision making
- Determine whether navigation services (i.e., provided by the patient navigator) will be sufficient to support the needs of the patients referred. More complex patients may require continued assistance from social worker

- **Making Referral**

Train providers on the referral making process (See e.g., Appendix ARC Referral form) . The provider needs to do the following:

- Describe to the patient 'referral form' Obtain patient's verbal consent for sharing their contact information, gender, age and needs with the navigation services team
- Complete the referral form with the patient adapted to the practice needs/preferences; integrated in EMR)
- Send referral form to navigation team (fax); does not apply for practices using OCEAN or other online secure platform for information transfer.
- Print a copy of referral form and give to the patient[#]

[#]For patients with high vulnerability for whom there is concern that they may not respond to the navigator's follow up call, the provider may call directly the navigation services.

References (see Appendix Journal articles for full text)

1. Dahrouge S, Gauthier AP, Durand F, Lemonde M, Saluja K, Kendall C, et al. The Feasibility of a Primary Care Based Navigation Service to Support Access to Health and Social Resources: The Access to Resources in the Community (ARC) Model. International Journal of Integrated Care. Ubiquity Press; 2022;22.

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