EXPLORING THE CONTEXT FOR SOCIAL PRESCRIPTION IN THE HALTON AND HAMILTON REGION

MITACS ACCELERATE PROGRAM

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INTRODUCTION

Despite its growing presence in healthcare delivery, social prescription (SP) itself is still a vague term, with no consensus on a single definition (2). As a result of this ambiguity, practices of SP have varied significantly. The purpose of this study is to understand how SP has been conceptualized and practiced in different locations, to better understand the range of models and approaches discussed in the literature and seen in practice. This has been accomplished through a scoping review of the academic literature and a supplemental search of grey literature. The academic literature was first reviewed to identify different models of SP, and used to develop a typology that describes the models in terms of their conceptual elements and core components seen in practice. We define conceptual elements as the philosophical values and beliefs that reflect the intentions that underlie different programs. Core components are the features and practices that operationalize these conceptual elements. The search of the academic literature resulted in a total of 13 articles that met all inclusion criteria and were used to develop the typology. These studies were mostly conducted in the United Kingdom (n=10), with some representation from Canada (n=1), Australia (n=1) and the United States (n=1).

In addition to the conceptual elements and core components identified in the literature, we also identified two main justifications for adopting an SP approach: an economic and a prevention justification. Although these often linked closely to the conceptual elements of various models, we separated these out and describe them as broader justifications found in the literature, as they often applied across several of the identified models.

This typology of models was then used to classify a set of existing programs that had been identified through interviews conducted by United Way of Halton and Hamilton with community partners. Further grey literature searches were conducted to round out our understanding of the practical details of the identified programs. A total of 26 local programs were classified through this process.

While we have identified a typology of models, it is important to recognize that there is variation within each model described here. This arises because a core feature of any SP program is the flexibility to be adapted to the local context in which it is implemented, meaning no two SP programs are identical (5, 6). Factors that may influence local differences include the governance structure of the health and social care systems, the needs of the local community, and availability of resources (5-7).

METHODS

A scoping review of both academic and grey literature was conducted for this project. Scoping reviews are suitable for exploring a broader array of literature, without following a specific research question (8). This study followed Arksey and O'Malley's methodological framework for scoping reviews, which encompass the following steps: identify the research question, identify relevant studies, study selection, charting the data, and collating, summarizing and reporting the results (8).
The overarching research question driving this study was, *What are the conceptual elements of SP that are described in the academic literature and the core components of SP models that are observed in practice, and how have these models varied over time and in light of changing principles and objectives?*.

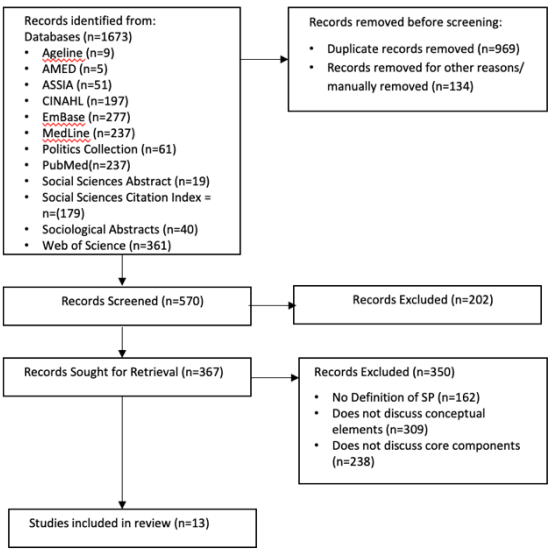

FIGURE 1. PRISMA DIAGRAM

Academic literature was systematically identified using database searches. Grey literature selection was largely informed by the community partner, through community consultations. Some of the grey literature included in this study also came from searching reference lists of the academic literature.

The databases included in the academic literature search were Ageline, Allied and Complementary Medicine Database, Applied Social Sciences Index and Abstracts, CINAHL, EmBase, MedLine, Politics Collection (Public Affairs Information Service, Policy File Index, Political Science Database, Worldwide Political Science Abstracts), PubMed, Social Sciences Abstract, Social Sciences Citation Index, Sociological Abstracts, Web of Science. The selection of databases reflected the interdisciplinary perspectives of social prescription, as being both a health and social services, as well as being a health policy issue. A search strategy was developed in consultation with the community partner, and a roundtable of community stakeholders. Additional support was provided by the McMaster University Health Sciences Librarian, LB. Some of the search terms that were used included "social prescr*", "social medicine", "link worker", "social refer*", and

"community refer*". The individual search terms were adjusted for each database. For a complete table of our search terms, please refer to the appendix.

As seen in Figure 1, from the initial search, a total of 1673 articles were found. After duplicates were removed, 570 article titles were screened for relevance. Of these, 367 articles were retrieved for title and abstract screening. 10 of these articles were randomly selected and reviewed by team members (LD and GM) independently. Team members reconvened to discuss inclusion criteria. The resulting criteria were: (a) to have a definition of social prescription, (b) to describe the core components of practice, and (c) to describe some of the conceptual elements of social prescription. Study protocols, poster descriptions, and conference proceedings were excluded from review. With these criteria, LD reviewed the selected articles, resulting in 17 articles that were retrieved for full text review. LD and GM both independently reviewed articles. In cases where there was disagreement on inclusion, team members would discuss until they came to a consensus. After this process, a total of 13 articles were included in the study. Consistent with scoping review methodology, the quality of studies were not considered in the inclusion process (8).

Three articles were chosen at random for data extraction by both members. This process was conducted to ensure consistent in data extraction. Team members extracted data independently and reconvened to compare findings. Once consistency in extraction was assured, LD continued to extract data from the remaining articles. Analysis of the data was done inductively, in which emergent themes were identified and coded as they were discovered. Coding was done as an iterative process, in which one team member (LD) would code and consult with the other (GM) on agreement of codes and emergent themes. The research team met with the community partners to discuss the emerging themes on several occasions and their feedback further informed the developing typology of models. These themes then informed further iterations of coding. Analysis was conducted until different models could be identified from the data and a consensus in their interpretation was achieved among the research team and community partners..

Conceptual Elements

The conceptual elements are intrinsically defined and shaped by the outcomes they seek to achieve. Some programs aimed to improve health, as defined by the World Health Organization (WHO) as, "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (9). Outcomes related to health are traditionally associated with healthcare interventions.

Other programs aimed at a broader concept of 'wellness', defined by the WHO as,

> "…the optimal state of health of individuals and groups. There are two focal concerns: the realisation of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfilment of one's role expectations in the family, community, place of worship, workplace and other settings"(10).

In additional to differing with respect to these beliefs about health outcomes (i.e. *What does health mean?*), the social prescription models defined below can be distinguished by different beliefs about healthcare systems *(i.e., what should healthcare do?);* core values of healthcare delivery (*i.e., how should healthcare be designed or delivered?);* intent of SP (*i.e., what is SP intended to do?);* relationship of SP to the healthcare system; and instrumental use of SP (*i.e., what are the implicit goals of the SP model?).*

Core Components

Core components are the observed features of SP programs in practice that align with and reflect these conceptual elements. The core components described in this report take Polley et al.'s (2017) description of an SP scheme as a point of departure, which includes: a health or allied health professional that creates the prescription, a link worker, and a variety of social and community services that are available to the individual. While the link worker role takes many names across the literature (e.g., system navigator, community connector, community navigator, etc.), this study will use the term link worker (LW) for consistency throughout all models.

In the table below, we provide an example of a program that fits each of four models and use each example to illustrate differences across programs in terms of distinguishing core model components observed in practice. These include the point of entry into the program; the reason for the prescription, the role of the link worker, and the role of the voluntary and social sector. The point of entry describes the method by which an individual is introduced to the SP process. This is often done through a health professional or service provider's referral, or "prescription". The reason for the prescription describes the stated reasons why individuals are referred to the SP program. The link worker role refers to the intensity of involvement of the link worker with the individual, where interactions can range from a simple referral to other services to a long-lasting relationship spanning multiple appointments (11, 12). Finally, the models differ in terms of the role of the voluntary and social sector in the SP process. This can range from being the provider of services Polley's (2017), to being the administrator of the model, the employer of LWs, or as an advocate for the community (13-15).

- ## Clinical Model

Conceptual Elements

This model is built upon the existing biomedical model of health, in which ill health is believed to be a result of biological and physiological determinants (16) and the aim of care is to reduce the symptoms of disease using clinical expertise to assess, diagnose, and treat illnesses. Core values that are reflected in this model include evidence-based and professionally led care, in which care providers are extensively trained and typically, professionally licensed. In this model, the intended use of SP is to treat clinical conditions through a broader array of services that include non-clinical treatment options. Professional status is seen to offer legitimacy to the broader array of treatment options that SP brings (17).Link workers in these models can sometimes also be called system navigators.

Market Greens Program

In this program run by Community Food Centres of Canada, physicians are invited to prescribe Market Greens services to patients that are at risk, or vulnerable to, diet-related diseases such as obesity, diabetes, or hypertension, to provide patients with access to healthier foods. Physicians use clinical indicators such as weight and body mass index (BMI) as a basis for the initial referral, and for social prescription renewals. In this example, there is no link worker. While adhering primarily to the conceptual elements of the clinical model, the business case often focuses on illness prevention, reductions in healthcare spending and increasing sustainability of healthcare systems.

Core Components

In practice, the clinical model is commonly put forth as a means of providing comprehensive, patient-centered healthcare, in which each patient can be provided with bespoke healthcare treatment plans. As implied by this objective, the doctor-patient role is central to this model's practice (18). The point of entry into the SP model is through a referral by a physician, most commonly a family doctor. Through a traditional medical visit, a physician's attention may be brought to symptoms caused by factors that can be addressed through services or approaches that are not within a physician's scope of practice. To address this, the physician would refer to a service external to the healthcare sector that will provide necessary services.

This model may or may not include the presence of a link worker. In some cases, physicians can directly refer to a particular service, or to an organization that fulfills the link worker role. In cases where a link worker is present, often they have extensive training, and their role is to refer patients to specific services that may not be immediately available to the physician yet could be beneficial to help the patient with respect to the physician's diagnosis, although medical treatment is seen as primary, with the SP offerings as an optional complement to the medical treatment.

- ## Holistic Model

Conceptual Elements

In the holistic model, health is viewed as being influence by not only biological and physiological determinants, but also social factors that are often beyond an individual's control, consistent with a social determinants of health approach. A holistic approach must consider the social conditions in which an individual lives, as well as their biological and physiological health to alleviate symptoms. Core values of this model include the notion of holistic care, and considering individuals as 'people' within a social context rather than 'patients', and therefore valuing person-centered (as opposed to patient-centred) care (18). SP acts as a tool to broaden available services tailored to the mix of biological and social determinants of individual patients. The necessity of considering both biological and social factors, means both are given equal weight in this model.

First Link Program

This program run by the Alzheimer's Society of Ontario (ASO) aims to provide access to activities and resources to individuals who have recently been diagnosed with Alzheimer's and their caregivers (3, 4). With the patient's permission, healthcare providers can send their health information to ASO(4). A First Link Navigator (link worker) will then reach out to the patient to better understand their social needs and circumstances to direct patients to appropriate services within ASO. Services include conversation groups with others diagnosed with Alzheimer's, exercise classes, and socialization groups that aid both the patient and their caregiver with the recent diagnosis.

Core Components

In practice, this model holds many similarities to the clinical model. Stated objectives of practicing programs often emphasize how they address the SDoH. Point of entry is most commonly a healthcare professional, though allied health practitioners may play a role (e.g., social workers) and self-referral has been seen in practice. Prescriptions are given to address a specific medical or social condition. Link workers are often found in holistic models, and act as system navigators, with appropriate training to work with the program's target population. The most significant differentiator in practice between the holistic model and the clinical model are the services provided. Services provided in this model may not directly address the clinical condition identified by the prescriber, but rather may focus on social aspects related to the patient which may in turn affect their clinical condition.

- ## Empowerment Model

Conceptual Elements

The Empowerment model of SP falls under a category of models that aim to improve wellness by considering biological and social factors of the individual, in keeping with the holistic model, but also aims to foster greater individual empowerment. Additional core values in this model include adopting a co-produced nature to each individual's social prescription and adopting strengths-based approaches. The intent of SP in this model is to "[unlock]a person's potential irrespective of their situation [so that] those who felt forgotten find a way to live the life that they want to live" (Polley, 2016). To do this, SP works as a means to promote greater social inclusion in an individual's life by providing them with opportunities to increase social capital and to empower them to take greater control of their own health. It is notable that the language in this model is of 'the client' as opposed to 'the patient' or the 'the person' as seen in the clinical and holistic models respectively.

Guelph CHC Social Prescription Pilot

In this pilot program run by a Community Health Centre (CHC) in Guelph, Ontario, prescribers were a part of the interprofessional health team, which included physicians, nurses, dieticians, community support workers, and occupational therapists. Prescriptions were given based on perceived unmet social needs of clients. Identified clients could access services directly or could co-produce their prescription with a community connector. A Health Promotor coordinates activities of Peer Leaders, who are clients of the CHC who act as volunteers in planning and creating different activities for fellow clients. Some activities created by the Peer leaders include 'soup and crochet with Grandma Penny', Create Connections (a board game/ art/ karaoke drop-in group), and a volunteer-run front desk support service. Rather than being based on a specific diagnosis, there was considerable effort to target individuals who were frequent users of primary healthcare, to reduce overall healthcare costs, while improving health, well-being and empowering clients.

Core Components

In practice, stated objectives of programs that fall under the empowerment model emphasize the health impacts of social isolation, and the importance of empowerment. Point of entry into these programs tends to be within interdisciplinary healthcare centers, such as community health centers or family health teams. Prescribers identify individuals with unmet social needs to participate in the program, though these individuals are often from older populations. Prescriptions given can be to specific activities, or to a link worker. The link worker provides more individualized, intensive support, in which a deeper relationship (than that often between a patient and doctor) is established. Through this process, link workers come to understand the interests, strengths, and goals of clients. Using this information, link workers co-produce a prescription with the client to determine which services would best suit their needs, or if none are available, link workers can provide opportunities and help support clients in creating their own services. The development of the prescription is a much more than a simple referral as is often found in the clinical or holistic model. The co-produced nature of the prescription gives the person much more say over what services they are directed to. Services in this model are often less directly relevant to clinical health conditions and are often catered toward creating social connections amongst clients.

- ## Healthy Community Model

The Healthy Community Model also falls under the wellness improvement aim. However, it diverges from the other models in that it addresses the health and well-being of the local community as a unit, as opposed to being targeted to the individuals within the community. In this model, health is understood as a sense of "connectedness and community"(19) . Healthcare services are viewed as part of the community that must "…actively work with and support local community assets, which will in turn help to establish and deepen community connections" (5). Values that underlie this model are asset-based community development, and extensive stakeholder engagement. SP is implemented with the intent to foster "health-creating communities, wherein community members can take care of themselves and each other" (2). This model strays from healthcare services and is more closely aligned with community development.

Project Smith

Located in Lambeth, United Kingdom, it is one of few programs that have been found to practice this model (1). Project Smith entails two "streams": community connector training and a well-being fund. Community Connectors are community members who have volunteered to participate. Training on supporting behavioral change, the community's assets, and resources is provided to volunteers. Volunteers are then encouraged to go out into their communities and engage with their individual social circles and refer them to community resources if needed. Community Connectors are then gathered monthly, at a 'safari', where they discuss their experiences and learn more about local services. The Wellbeing Fund is intended to have community members collaborate to propose a community-enhancing service or activity.

Describing this model in practice is particularly difficult as it is unique to the community in which it resides. Stated objectives relate to creating stronger and more resilient communities. While improving health may be one goal of the program, it is one of many. Point of entry into this program is exclusively self-referral, where individuals voluntarily reach out to participate. There

may not be a physical prescription of any kind in this model, due to lack of interaction with the healthcare sector. However, programs in practice still frame it as social prescription, and emphasize the health benefits of community connection. Link workers in this model are both facilitators and participants of the program. Service providers are intended to make use of pre-existing assets in the community.

TABLE 1. MODELS OF SOCIAL PRESCRIPTION

Ideal Outcomes	**Health**			**Wellness**
Model Name	**Clinical**	**Holistic**	**Empowerment**	**Healthy Community**
Belief about Health (*What is health?)*	Health is a result of *mainly* biological and physiological factors	Health is a result of biological, physiological, and social factors	Health is a contributing factor to overall wellbeing	Health is defined as a sense of "connectedness and community" (19)
Beliefs about Healthcare Systems (*What should healthcare do?)*	Healthcare should reduce clinical symptoms	Healthcare should reduce symptoms caused by clinical and social factors	Healthcare should "empower a person to live their life with meaning, purpose, and fulfilment" (6)	Healthcare must identify and actively work with and support local community assets, which will in turn help to establish and deepen community connections (5)
Core Values of Healthcare (*How should healthcare be designed or delivered?)*	• Evidence-based • Professionally- Led • Patient-centered	• Holistic • Person-centered • Individualized	• Co-produced • Strengths—based approach	• Asset-Based Community Development • Stakeholder Engagement (6)
Intent of SP (*What is SP intended to do?)*	SP as treating clinical conditions with non-clinical treatments	SP as introducing a means to address social aspects of individual health	SP as a means of "unlocking a person's potential irrespective of their situation" so that "those who felt forgotten find a way to live the life that they want to live" (6)	SP has the "potential to nurture social capital in localities and catalyze it to make health-creating communities, wherein community members can take care of themselves and each other" (2)
Relationship of the SP program to the healthcare system	Clinical system is primary, and SP is an optional enhancement	Both clinical and social care systems are needed to provide holistic care depending on individual needs	Beyond offering holistic care, the SP program offers opportunities for individual to be empowered and experience greater social inclusion	The SP program fosters a thriving community of which healthcare is one element.
Instrumental Use of SP (*How is SP operationalized strategically?)*	• Broadening available services/ Expanding the scope of healthcare • A formalization of non-clinical treatments for clinical conditions • Justification for system navigation within existing health & social services	• Broadening available services • Addressing social and contextual determinants of health affecting the individual	• Support individuals to take greater control of their own health • Increase individuals' social capital	• Local approach, working at a street and neighborhood level • Support the community and its people in building
Core Components of Models in Practice				
Name of program	**Market Greens**	**First Link**	**Guelph Community Health Center**	**Project Smith**
Description	"Market Greens is a CFCC (community food centres of Canada) program that increases affordable access to fruits and vegetables through non-profit community markets and produce prescriptions."	"Many families are told about the Alzheimer Society and dementia care services, but few make a phone call until a crisis occurs. First Link® removes this barrier by ensuring that individuals and families are referred directly to First Link®-approved health services and information. This occurs at the time of diagnosis or as soon as possible after a diagnosis is made" (3)	"We reduce health inequities by providing interprofessional primary health services and community programs, focused on the populations we prioritize, in collaboration with community partners." (20)	"Project Smith is a community development project in the London Borough of Lambeth. It takes a local approach, working at street and neighbourhood level, to support the community and its people in building and improving their own capabilities and local connections and thereby improving their health and wellbeing and that of others" (21)

Stated Objective	• Promote health • Reduce risk for diet related disease • To provide comprehensive care	• To link individuals with dementia with available supports as early as possible in the disease process.(McAiney et al., 2012) • To provide person-centred care to patients with dementia	• Help build resilience among people at-risk of health declines due to social isolation	• Recognize that community and people are assets to good health and wellbeing • To avoid a health crisis • To reduce social isolation
Point of Entry	• Healthcare providers enroll patients based on health factors associated with chronic diet related disease	• Patients give permission to their healthcare provider to share information with ASO • Patients are also able to self-refer	• Primary care providers (physicians & NPS) • Interprofessional team (Nurses, dieticians, social workers, community support workers, and occupational therapists)	• Local people volunteer to be trained as community connectors
Reason for Rx	• Individuals demonstrating risk factors of diet-related diseases	• Recent diagnosis of Alzheimer's Disease	• Social Isolation • High use of health care services	• Information not available
Role of LW	• N/A (direct referral)	• Connecting to patients • Providing support to patients and caregivers	• Peer Leader	• Community Member
Services Provided	• Patients receive $10-$15/wk to spend at subsidized food markets • Prescription can only be refilled if they are seen by their physician	• One-on-one support • Group support • Social groups • Minds in Motion (exercise group)	• Soup and Crochet with Grandma Penny • Create Connections, a board games/ art/karaoke drop in group • Volunteer-run front desk support service	• Community safaris • Community Connector Training • Wellbeing Fund

JUSTIFICATIONS FOR ADOPTING AN SP APPROACH

Throughout the literature, it became apparent that there were two main rationales that were used to justify the adoption of an SP approach. These stated justifications were put forth in addition to the conceptual beliefs and values of each model, as demonstrated in Table 2.

• PREVENTION

While beliefs about health vary across models, there is the underlying understanding that ill health is inherently preventable. Therefore, it is the role of healthcare services to implement preventative measures before ill health occurs through proactive and personalized care. The rationale of preventative care was present to some degree across all models, where clinical and holistic approaches can prevent deterioration of conditions, and empowerment and community models provide individuals with the skills and mindset of living healthier lives that would prevent ill health from occurring at all (2). Language of prevention is often present in program descriptions, and it seems to be directly related to the acknowledgement of the rise of chronic illness that has been across healthcare systems in countries such as Canada and the U.K (22, 23). Themes of prevention are not necessarily unique to SP. Rather, it appears that there is a growing acknowledgement across all healthcare systems that there is a need for preventative care, with SP being one possible solution.

• ECONOMIC

Closely tied with the themes of prevention, SP has also been justified through an economic lens, in which health is viewed as a commodity that will inevitably use resources, and therefore, healthcare must be delivered as effectively and efficiently as possible. Similar to themes of prevention, rationales of economic sustainability appear to be more of an overall goal of the healthcare system, rather than specifically for SP. Through this lens, SP reinforces values of sustainability of healthcare systems, efficient and effective healthcare delivery, and limiting or cutting costs.

Stated objectives of different models in practice often align with economic justification. In the U.K., where social prescription is a government-supported program, funding is given to both health and social care services within a community to implement social prescription services (7, 24). In countries where social prescription is not government supported, the evidence for its efficacy and financial benefit have been alluring to potential funders, healthcare providers, and social care providers, incentivizing intersectoral collaboration (5). Therefore, stating these objectives clearly is necessary to attract further funding. These objectives are also often related to positive health outcomes, thus the use of the term can be seen in models with the improvement aim of health, such as clinical and holistic models (7, 19, 23).

In practice, SP can be seen as a form of delegation that some argue promotes efficiency within health systems in three specific ways (2, 5, 6, 24-26). First, social prescription diverts patient flow from healthcare services to local social or community services. Link workers act as community connectors or system navigators, roles that often don't need the same time or investment in training as other health care professionals. General practitioners' time is allocated to assessment, diagnose, and identifying patient needs, while the link worker would takes the time to understand the patients' unique needs and assists in navigating the different services available. Second, social prescriptions assist in reducing the need for clinical or health care services. Evidence suggests that social prescriptions have positive outcomes in terms of mental health and wellbeing(2, 24). By doing so, social prescriptions result in fewer appointments made with GPs, less need for pharmaceutical drug prescriptions, and a decrease in emergency room visits (2, 6). It is important to note, however, that social prescriptions have not been used as a replacement for pharmaceutical drugs, but rather as a supplement (19). Finally, social prescriptions not only aid in the sustainability of healthcare services, but may also support additional funding for community and social care services. Both government funded and non-profit social care services are often subject to unreliable and inconsistent funding(7, 24). In communities where social prescription programs have been put in place, it has been found that referrals to previously overlooked services have increased, demonstrating greater need for those services and therefore, more consistent funding (7, 17, 24, 25, 27).

TABLE 2. STATED JUSTIFICATIONS FOR SOCIAL PRESCRIPTION

	Economic	**Preventative**
Belief about Health (*What is health?)*	Health is a universal concern that will inevitably consume resources	Health is a result of biological, physiological, and social factors that can be addressed before illness occurs

Beliefs about Healthcare Systems (*What should healthcare do?)*	Healthcare should reduce symptoms in the most efficient way	Healthcare should prevent ill health
Core Values of Healthcare (*How should healthcare be designed or delivered?)*	• Sustainability • Efficiency & Effectiveness • Cost-Cutting	• Proactive • Adaptable/Personalized (Jani & Gray, 2019)
Intent of SP (*What is SP intended to do?)*	SP as having "the potential for saving money and bringing about a 'slimmer, fitter, and more patient-focused [healthcare system]" (Robinson, 2018)	SP is a preventative approach for patients to be more reliant on a healthy lifestyle, and prevent ill health (Islam, 2020)

Social Prescription within the Halton-Hamilton Region

In conjunction with this scoping review, United Way Halton-Hamilton (UWHH) consulted with the local community to understand the gaps in services that exist and the potential to adopt SP to address these gaps. Through these discussions, several local programs emerged as being either clear examples of social prescription, or in some cases to be "social prescription-like", without capturing all the of the features of any one model. Through this process, 26 programs were identified for further exploration and comparison of their conceptual elements vis-à-vis the models in the typology, based on readily available public-facing information, such as stated objectives and descriptions on program websites. Further exploration into their practice is needed to understand how conceptual elements, core components, and outcomes work together in these programs.

Table 3 summarizes the different SP models found in the Halton-Hamilton region with respect to their alignment with the models in the typology. Of twenty-six programs, eleven were found to have the key features of social prescription, as described by Polley et al. (2017). Seven of these were found to share features of the holistic model, four aligned most closely with the clinical model, and three demonstrated the empowerment model. Three of these programs shared features of multiple models. None aligned with the Community Model. Appendix 2 provides a listing of each of the 26 programs, including what could be found from publicly available data on their conceptual elements (Table A2.2) and core components (Table A2.2).

Clinical Programs

Four programs resembled the clinical model of social prescription. Populations served by these programs varied, though they all were individuals living with complex and chronic conditions. Generally, these programs offer navigation or coordination services for patients. Services from these programs were in response to a new or existing clinical diagnosis. For example, the Complete Cancer Care program is initiated in response to an abnormal mammogram result, whereas the Reach Out Centre for Kids (ROCK)'s Coordinated Service Plan serves families and children with multiple complex needs (28, 29). Due to the need for a clinical diagnosis, healthcare professionals are the most common point of entry, followed by other service providers (28-30). Link workers in these programs generally act as case managers with specialized, usually medical, training (28, 31). The nature of the link worker-patient relationship is rooted within clinical care, as demonstrated by the Complete Breast Care Program, in which the patient coordinator is a clinician that can help schedule future appointments, receive results, and discuss immediate concerns regarding abnormal results (28).

Holistic Programs

The holistic model was found the most common SP model identified locally. Three out of the seven programs included navigation services for specific populations, such as Indigenous people and people living with dementia and their caregivers (32, 33). Other programs were for more generalized patient groups and had a particular interest in expanding services to address social and contextual influences on health (13, 34, 35). All programs under the holistic model included healthcare professionals' referrals, and most were based within primary healthcare settings. Services targeting specific populations had the additional option of self-referral into the program, such as the Alzheimer's Society's First Link Program, in which patients are encouraged to call their local chapter of Alzheimer's Society when they feel comfortable with sharing their health information with the organization (32, 33).

Link worker roles were fulfilled by coordinators or system navigators, who were responsible for understanding the unique contextual and social factors affecting the individuals' health and referring them accordingly. For example, the McMaster Family Health Team's (FHT) System Navigation program assisted patients in improving quality of life and overall well-being. This included filling in paperwork to qualify for government support, or even scheduling apartment viewings for patients in unstable housing conditions (13, 36). Link worker roles were often held by professionals with extensive knowledge of the population of interest, such as nurses or social workers (33, 35).

Empowerment Programs

Among the 26 local programs examined, three was no clear demonstration of all elements of the empowerment model. However, three programs that at the core were mostly closely aligned with either the holistic or clinical model had the additional goal of increasing individual self-efficacy and overall confidence in participating in their own healthcare. For example, the Aboriginal Patient Navigator Program expands available healthcare services to include more socially and culturally aware services, falling under the holistic model, but also works to provide culturally safe spaces for Indigenous patients to practice and actively engage in their own healthcare, which aligns with the empowerment model (32). The Hospital 2 Home program follows the clinical model of SP in that it provides services that aim to alleviate symptoms of chronic conditions to avoid future hospitalizations, but also includes specially tailored sessions that teach patients how to notice their own symptoms and how to prevent and address them, allowing them to understand their own health and play a larger part in their healthcare (30, 37)

TABLE 3. SOCIAL PRESCRIPTION MODELS IN HALTON-HAMILTON

Name	Clinical	Holistic	Empowerment	Healthy Community	Unknown	Comments
Aboriginal Patient Navigator Program (Hamilton,ON)		✓	✓			The Aboriginal Patient Navigator Program expands the existing services provided to include culturally safe care, and in doing so, provides Indigenous patients opportunities to actively engage in their own healthcare.
Community Navigators (211 Hamilton)					✓	211 Hamilton provides a service navigation for community members. They are completely independent from the healthcare system. Its conceptual elements seem to fall within the Healthy Community model. However, its model of practice does not seem to include a healthcare referral.
Community Nursing Navigator Pilot (Hamilton, ON)		✓	✓			The Community Nursing Navigator pilot demonstrates several aspects of holistic and empowerment model. While its stated objectives describe a program primarily focused on addressing SDoH and providing community members tools for self-efficacy, its outcomes include some aspects of community-development.
Community Paramedicine (Hamilton, ON)					✓	While CP@Clinic does provide evidence-based clinical assessments to patients, it meets patients, particularly marginalized populations, in community settings to overcome structural barriers of accessibility. In doing so, it also addresses issues of social isolation in patients. However, their practice does not seem to align with conventional SP programs.
Compass Community Centre (Hamilton, ON)					✓	Compass Community Health Centre is a health center that provides holistic healthcare through various programming that addresses different physical, social, and contextual factors influencing health on site. There is no link worker equivalent in its practice.
Complete Breast Care Program (Brant, ON)	✓					The patient navigator assists individuals with abnormal screening results to navigate services.
EMBOLDEN (Hamilton, ON)					✓	EMBOLDEN is an ongoing research project taking place in Hamilton, ON. Due to this, there is insufficient evidence of its practice. However, its descriptions and stated objectives reflect values similar to that of holistic and empowerment models. As it has yet to be implemented, its practice is unknown.
First Link (Alzheimer's Society)		✓				First Link provides social and contextual supports for individuals recently diagnosed with Alzheimer's.
Green Initiative (Hamilton, ON)					✓	The Green Initiative from McMaster FHT promotes a more environmentally conscious healthcare system. While this does look at factors beyond biological and physiological influences, it also looks at healthcare beyond the scope of the individual and community. However, it does not include a link worker.
Hamilton Social Medicine Response Team					✓	HAMSMaRT meets patients in the community through the use of a mobile clinic. Through consideration of SDoH, this program falls within the holistic model. However, its practice does not start with a healthcare referrer.
Health Links Ontario					✓	Health Links allows for more efficient communication between healthcare providers, including some community services. Most of the communication is done between healthcare providers to better understand clinical symptoms and to maintain continuity of care. There is no link worker equivalent.
Health Tapestry (Hamilton, ON)					✓	Health Tapestry uses innovative technology to meet patients where they're at (in the community) to provide a more comfortable environment for patients to share their needs and goals. However, their model of practice does not seem to fall within the models of SP outlined above due to the lack of a link worker role.

Home and Community Care Support Services' Care Coordinators (Hamilton Niagara Haldimand Brant, Mississauga Halton LHIN)				✓	The Home and Community Care Support Services' Care Coordinators assists in healthcare delivery for chronically ill seniors. However, limited information is available regarding how the program is practiced.
Hospital 2 Home Program (Hamilton, ON)	✓		✓		The Hospital 2 Home (H2H) Program provides a patient-centered approach to care for complex, chronic illnesses. Through developing an in-depth relationship with patients, the H2H team supports patients in actively taking part of their own health through providing skills to avoid hospitalizations. These skills are focused mostly on clinical symptoms and there is limited consideration to social and contextual factors.
Indigenous Cancer Care Program (Hamilton, ON)		✓			While having a particular focus on clinical diagnosis of cancer, the Indigenous Cancer Care Program expands existing services to include culturally safe services to Indigenous patients.
Integrated System Navigation (Halton, ON)		✓			Coordinates services for individuals utilizing multiple services to ensure continuity of care. Services are within the social services sector rather than healthcare sector.
McMaster FHT System Navigator (Hamilton, ON)		✓			Despite being described as a case of economic sustainability of the FHT, the system navigator works with patients to address external stressors that are affecting their health and quality of life.
Reach Out Centre for Kids (ROCK)'s Coordinated Service Plan (Halton, ON)	✓				ROCK's coordinator service plan is a means of organizing and streamlining the multitude of different services that children and families need. While they may consider social and emotional supports, the intent is tied to the clinical diagnosis that children have.
REFUGE Newcomer Health (Hamilton, ON)				✓	Refuge Newcomer Health provides primary healthcare services to newcomers to Canada, with additional support in helping navigate the Canadian healthcare system. Limited information is available about navigation in practice. However, the consideration for cultural and social barriers lets this program fall within the holistic model. However, it does not have a link worker equivalent.
Shelter Health Network (Hamilton, ON)				✓	The Shelter Health Network provides primary care and relevant healthcare services to individuals experiencing homelessness. However, it does not include key components identified by Polley et al. (2017).
Social Navigator Program (Hamilton Police)				✓	The Social Navigator Program approaches individuals living with mental illness with an understanding of health, social, and contextual needs. However, this program does not include a healthcare referrer in the process.
TorCH (Toronto Coaching in Health) (Toronto, ON)				✓	TorCH provides one-on-one support for individuals to better manage their own health and provide skills for self-efficacy. However, this program does not include a healthcare referrer or a link worker in its practice.
Wellington Terrace Community Hub (Burlington, ON)				✓	Targeting chronically ill, underserved senior populations, the Wellington Terrace delivers healthcare with consideration of the social and structural barriers to care that exist for their specific population of interest. This program does not include a link worker equivalent.
Wesley's Supports for Seniors and Older Adults (Halton Region and Brantford-Brant, ON)				✓	Located within the community, Wesley's supports for seniors and older adults demonstrate conceptual elements similar to that of holistic models by addressing social and contextual factors of health. This program does not include a healthcare referrer.

CONCLUSIONS

Our scoping review of the academic literature suggests that social prescription is a new and evolving model that can have many different objectives. Among the four models we identified through our analysis, we note considerable differences in conceptual elements between models that are rooted in beliefs about health and well-being, the role of health and social care, how critical it is to adopt a social prescription approach as well as the target for health improvement (i.e. individual or community level). Even within each model type, there is considerable variation in practice. This suggests an opportunity for tailoring to local needs and to potentially mix and match components that align with particular core values of implementing organizations in different contexts.

The review of models in the local community suggest the holistic model was most commonly found, but that to a lesser extent there were specific examples of the clinical model tailored to particular populations. While many models are driven by a prevention and economic justification, there were several local models where aims of empowerment were added to the clinical and holistic objectives. To date there has been less attention to community models, however, this is not surprising given that SP appears to be in its infancy locally. The hope is that the typology presented can help readers cut through the variability and identify features that can work best in their context and align with their own beliefs and objectives when designing local models.

APPENDICES

Appendix 1 Search Terms Used

AgeLine (110)
("social medicine" OR "social refer*" OR "art prescr*" OR "arts on prescr*" OR "referral program*" OR "care navigat*" OR "community refer*" OR "exercise refer*" OR "museum prescr*" OR "museum on prescr*" OR "non-medical intervention*" OR "non medical intervention*" NOT "social prescr*") AND ("third sector" OR volunt* OR social* OR community* OR health*)
Allied & Complementary Medicine (61)
(("social medicine" or "social refer*" or "art prescr*" or "arts on prescr*" or "referral program*" or "care navigat*" or "community refer*" or "exercise refer*" or "museum prescr*" or "museum on prescr*" or "non-medical intervention*" or non medical intervention*) not "social prescr*").mp. [mp=abstract, heading words, title] AND (volunt* or social* or community* or health* or "third sector").mp. [mp=abstract, heading words, title]
Applied Social Science Index and Abstracts (297)
(noft("social medicine" OR ("social references") OR "art prescr*" OR "arts on prescr*" OR ("referral program" OR "referral programs") OR "care navigat*" OR ("community reference" OR "community references" OR "community referred" OR "community refers") OR "exercise refer*" OR "museum prescr*" OR "museum on prescr*" OR "non-medical intervention*" OR "non medical intervention*") AND noft("third sector" OR volunt* OR "social service*" OR community*) AND noft(health*) NOT noft("social prescr*"))
Limit: Scholarly Journals, Articles, English
EmBase (881)
("social medicine" OR "social refer*" OR "art prescr*" OR "arts on prescr*" OR "referral program*" OR "care navigat*" OR "community refer*" OR "exercise refer*" OR "museum prescr*" OR "museum on prescr*" OR "non-medical intervention*" OR "non medical intervention*" NOT "social prescr*") AND (social service* OR third sector OR voluntary sector OR social care OR community care) AND (health care OR healthcare OR primary care OR primary healthcare OR health services OR General Practice)
LIMITS: English-Only, Article, Human
Politics Collection- PAIS, Policy File Index, Political Science Database, Worldwide Political Science Abstracts (61)
"social medicine" OR "social refer*" OR "art prescr*" OR "arts on prescr*" OR "referral program*" OR "care navigat*" OR "community refer*" OR "exercise refer*" OR "help hub*" OR "help seeking pathway*" OR "help-seeking pathway*" OR "museum prescr*" OR "museum on prescr*" OR "non-medical intervention*" OR "non medical intervention*" OR "people-powered care" NOT "social prescr*"
AND
social service* OR third sector OR voluntary sector OR social care OR community care OR health*
LIMITS: Scholarly Journal
MedLine (193)
"social medicine" OR "social refer*" OR "art prescr*" OR "arts on prescr*" OR "referral program*" OR "care navigat*" OR "community refer*" OR "exercise refer*" OR "help hub*" OR "help seeking pathway*" OR "help-seeking pathway*" OR "museum prescr*" OR "museum on prescr*" OR "non-medical intervention*" OR "non medical intervention*" OR "people-powered care" NOT "social prescr*"
AND
social service* OR third sector OR voluntary sector OR social care OR community care
AND
health care OR healthcare OR primary care OR primary healthcare OR health services OR General Practice
LIMITS: English-Only, Humans
PubMed (652)
social medicine OR social refer* OR art prescr* OR arts on prescr* OR referral program* OR care navigat* OR community refer* OR exercise refer* OR museum prescr* OR museum on prescr* OR non-medical intervention* OR non medical intervention*
AND
social service* OR third sector OR voluntary sector OR social care OR community care OR health*
AND
health care OR healthcare OR primary care OR primary healthcare OR health services OR General Practice
LIMITS: Journal Article, English, Humans

Social Science Abstracts (294)
(noft("social medicine") OR (noft("social references")) OR noft("art prescr*") OR noft("arts on prescr*") OR (noft("referral program") OR noft("referral programs")) OR noft("care navigat*") OR (noft("community reference") OR noft("community references") OR noft("community referred") OR noft("community refers")) OR noft("exercise refer*") OR noft("museum prescr*") OR noft("museum on prescr*") OR noft("non-medical intervention*") OR noft("non medical intervention*")) NOT noft("social prescr*") AND (noft("third sector") OR noft(volunt*) OR noft(social*) OR noft(community*)) AND noft(health*)
LIMITS: English
Social Sciences Citation Index (924)
((ALL=("social medicine" OR "social refer*" OR "art prescr*" OR "arts on prescr*" OR "referral program*" OR "care navigat*" OR "community refer*" OR "exercise refer*" OR "museum prescr*" OR "museum on prescr*" OR "non-medical intervention*" OR "non medical intervention*" NOT “social prescr*”)) AND ALL=(social service* OR third sector OR voluntary sector OR social care OR community care)) AND ALL=(health*)
LIMITS: English, Articles, Review Articles, Proceedings Papers, Editorial Materials, Early Access
Sociological Abstracts (666)
(noft("social medicine") OR (noft("social references")) OR noft("art prescr*") OR noft("arts on prescr*") OR (noft("referral program") OR noft("referral programs")) OR noft("care navigat*") OR (noft("community reference") OR noft("community references") OR noft("community referred") OR noft("community refers")) OR noft("exercise refer*") OR noft("museum prescr*") OR noft("museum on prescr*") OR noft("non-medical intervention*") OR noft("non medical intervention*")) NOT noft("social prescr*") AND (noft("third sector") OR noft(volunt*) OR noft(social*) OR noft(community*)) AND noft(health*)
LIMITS: English

APPENDIX 2: LOCAL PROGRAMS

Table A2.1 below provides further details on the descriptions and stated objectives of the programs described in the report as local programs. These details have been taken directly from publicly available sources. Some quotes or sections have been colour-coded to identify alignment with the models of SP.

Legend: **Clinical**, **Holistic**, **Empowerment**, **Healthy Community**

Table A2.1: Conceptual Elements of Local Programs

Name (Location)	Description	Stated Objective
Aboriginal Patient Navigator Program	"The APN program provides services to First Nations, Metis and Inuit individuals and families in the Hamilton, Niagara, Haldimand-Norfolk and Brant region."(32)	"**Bridging the gap between indigenous peoples, health services and supports** "(32)
Community Navigators (211 Ontario)	211 connects people to the right information and services, strengthens Canada's health and human services, and helps Canadians to become **more engaged with their communities** (38)	"The vision for 211 Ontario is consistent with the vision for 211 in Canada – to be the primary source of information and gateway to human services for individuals and planners. What this means for individuals – or their family members, neighbours, friends & colleagues — looking for help is that 211 is a number they know and trust to provide the right resources, the first time. **211 will help people connect to their communities and maintain a good quality of life.** For community and government agencies, 211 will be a trusted resource to help them find services for their clients, and to receive qualitative caller needs data that **provide additional insight about the needs in the community.** For emergency responders and emergency managers, 211 will provide a channel for authoritative information to the public regarding non-urgent needs and services, allowing them to focus their resources on their core mandate. Finally, for government planners and other decision-makers, 211 will provide rich data about caller/user needs that will help inform their investment and policy decisions regarding social, health and government services."(38)
Community Nurse Networker Pilot (Hamilton, ON)	"In order to facilitate and improve access to programs and services, the pilot developed the Community Nurse Networker (CNN) role. This role employed a highly skilled Public Health Nurse who had worked in the priority neighbourhood in which the pilot took place."(35)	"Specifically, the CNN pilot aimed to support people who, due to the impact of the **Social Determinants of Health (SDOH),** were unable to access available health programs and social services"(35)
Community	"Community Paramedicine at Clinic (CP@clinic) is an innovative, evidence-based chronic disease	• "Improve older adults' health and quality of life, and **reduce their social isolation**

Paramedicine (Hamilton, ON)	prevention, management, and health promotion program"(39)	• Better connect older adults with primary care and community resources • Reduce the economic burden of avoidable 911 calls by older adults"(39)
Compass Community Centre (Hamilton, ON)	"From its beginning, Compass Community Health has been committed to providing **accessible services and primary healthcare to individuals and communities**, as well as **wellness and illness prevention care**."(40)	"Through an interdisciplinary team of health professionals, Compass, provides an all-encompassing suite of services that adapt to the changing needs of the communities we serve. The ongoing commitment to work toward 'no obstacles' that was innovatively pioneered at NHCHC continues with Compass."(40)
Complete Breast Care Program (Brant, ON)	"The Complete Breast Care Program is a specialized, patient-centred approach to breast care in Burlington. When it comes to your breast health, we've got your front."(28)	"The Complete Breast Care Program at Joseph Brant Hospital is more than a mammogram. We're dedicated to providing rapid, specialized breast care throughout your breast health journey. Our team of experienced specialists, combined with cutting-edge technology and guidance from your Patient Navigator, will ensure you receive all the care you may need on the road to complete breast health." (28)
EMBOLDEN (Hamilton, ON)	"The aim is to co-design new programs that align with and leverage existing community programs, address service gaps, and meet community needs that will be evaluated through research. Experiences of older adults and community service providers are critical partners in this work."(41)	"The overall goal of the EMBOLDEN research program is to promote physical and community mobility of older adults who experience difficulties participating in community programs and reside in communities of high health inequity. Building on existing best practices and local evidence, researchers together with local older adults and community service providers will co-design an innovative community-based program to promote mobility amongst community-dwelling older adults."(41)
First Link (Alzheimer's Society Ontario)	"Many families are told about the Alzheimer Society and dementia care services, but few make a phone call until a crisis occurs. First Link® removes this barrier by ensuring that individuals and families are **referred directly to First Link®-approved health services and information**. This occurs at the time of diagnosis or as soon as possible after a diagnosis is made." (3)	"Ultimately, First Link aims to increase understanding of and effectively reduce the **personal and social consequences** of ADRD by enhancing and strengthening the linkages between primary care physicians, other healthcare providers, diagnostic and treatment services, community service providers and the Alzheimer Society, increasing access to progressive education and comprehensive and coordinated support earlier and throughout the disease process for individuals with dementia and their family caregivers, as well as promoting, facilitating and supporting education for healthcare providers."(42)
Green Initiative (Hamilton, ON)	"Good healthcare and green healthcare often go hand in hand, which is why HFHT's Green Initiative was launched in late 2019. We've brainstormed practical ideas, created evidence-based tools, and tried all of our initiatives in primary care to ensure they work." (43)	"… we can make our healthcare delivery more environmentally friendly on our shared journey toward a healthier Hamilton" (43)

Hamilton Social Medicine Response Team (Hamilton, ON)	"An outreach service of general internal medicine and infectious diseases physicians, registered nurses, midwifery and outreach workers whose goal is to provide clinical care to individuals who have difficulty accessing care in the traditional medical system. Acts through a mobile service specializing in patients with chronic or infections diseases who are affected by poverty, homelessness, and addiction. Operates in association with McMaster University's Department of Medicine and the Hamilton Shelter Health Network."(44)	"Goal is provision of excellence in clinical care to patients poorly served by traditional medical system"(45)
Health Links (Ontario)	"Health Links is an integrated **patient-centered approach** to care that focuses on enhancing and coordinating the care for patients living with multiple chronic conditions and complex needs."(46)	"The goal of the Health Links approach to care is to create seamless care coordination for patients with complex needs, by ensuring each patient has a Coordinated Care Plan (CCP) and ongoing care coordination."(46)
Health Tapestry (Hamilton, ON)	"Health TAPESTRY brings together people, communities and health care teams".(14)	"The Health TAPESTRY approach is moving primary health care from disease-centred care to **person-focused care.** Health TAPESTRY is increasing access to health and community-based programs that can help a person stay healthier for longer where they live. We do this by bringing together interprofessional health care teams, volunteers, community engagement and technology. System navigation helps people access and learn about health and community resources. 'We need to stop thinking about aging as a disease and start thinking about it as a success in Canada,' said Oliver. **"By allowing adults to be in charge of their own care, when their care is delivered, where it is delivered, and how it is delivered**; that's how Health TAPESTRY is attempting to make this a brighter world."(47)
Home and Community Care Support Services' Care Coordinators (Hamilton Niagara Haldimand Brant, Mississauga Halton LHIN)	Care Coordinators are **regulated health professionals** with expertise in nursing, social work, occupational therapy, physiotherapy or speech therapy, who work directly with patients in hospitals, doctor's offices, communities, schools and in patients' homes. (48)	"Care Coordinators are the heart and soul of home and community care. They not only manage your initial contact and assessment when you are a new patient, they also ensure that you receive, and continue to receive, the ongoing care you need, when you need it."(48)
Hospital 2 Home (Hamilton, ON)	"Hospital 2 Home is an innovative, community-based group of health professionals who partner with patients, caregivers, primary care, and other community service providers to address health	"'Hospital 2 Home collaborates with patients to optimize their health and quality of life by identifying needs and developing a coordinated care plan with primary care teams and health, community and social

	disparities and **facilitate easier access to health services**" (37)	service partners,' says Kelly O'Halloran, director of community & population health services at HHS." (37)
Indigenous Cancer Care Program (Hamilton, ON)	"Hamilton Niagara Haldimand Brant (HNHB) Region is home to many First Nations, Inuit and Métis people (FNIM) and has the largest reserve in the country. Screening is a critical cancer control strategy and Ontario has organized breast, cervical and colon cancer screening programs, however participation rates for First Nations, Inuit and Métis peoples are lower than the general population (Aboriginal Cancer Strategy III, pg. 20). The Regional Cancer Program has a Regional Indigenous Care Lead, an Indigenous Patient Navigator and an Indigenous Outreach Worker"(49)	In collaboration with Cancer Care Ontario (CCO) and core Indigenous health boards, advisory committees, and community representatives in the region, the HNHB RCP works **to improve cancer outcomes** and **experiences of the cancer journey for Indigenous patients and their families**. (50)
Integrated System Navigation (Halton, ON)	"Integrated System Navigation (ISNs) is a **holistic approach** to human services integration in the department and across systems within the community"(34)	• "create a client experience that is simplified and integrated • Actively engage individuals and families in planning and decision-making • Be a trusted support and source of information of services in the community • Provide a coordinated and collaborative approach to services in social & community services • Provide and non-judgemental and non-punitive environment for individuals and families"(34)
McMaster Family Health Team System Navigator (Hamilton, ON)	"Our system navigator can assist you with questions or concerns about health and social services in your community. They can assist with providing information about local services, connecting you to these services, and with commonly used forms or documentation required by these services."(36)	"Ensure that all patients have equal and fair access to health care and essential social services and community resources"(13)
Reach Out Centre for Kids (ROCK)'s Coordinated Service Plan (Halton, ON)	"In 2014, the Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Education and the Ministry of Health and Long Term Care unveiled the **Ontario Special Needs Strategy** initiative to improve services for children and youth with special needs. Coordinated Service Planning (CSP) is one of the initiatives in this strategy."(29)	"CSP will provide children and youth with multiple and/or complex special needs and their families with seamless and family-centred service and will provide a more intensive level of than **Service Coordination** so that families and children/youth with multiple and/or complex special needs will: • Have a clear point of contact for CSP (their Coordinated Service Planner) and know who is accountable for developing and monitoring their child/youth's Coordinated Service Plan • Not have to repeat their stories and goals to multiple providers. This means **one family, one story, one plan.** • Have a single Coordinated Service Plan that is responsive to their child/youth's goals, strengths, and needs • Experience a family-centred process that recognizes that each family is unique, that the family is the

		constant in the child/youth's life, and that they have expertise on their child/youth's abilities and needs • Know that providers will be communicating with each other about the needs and goals of their child/youth"(29)
REFUGE Newcomer Health (Hamilton, ON)	"The Centre is comprised of a group of client-focused, community-driven, diverse interdisciplinary healthcare professionals, who provide comprehensive healthcare services to Hamilton's new immigrant and refugee population. The Centre addresses the health disparities and the **needs specific to newcomer populations**. Our primary focus is to reduce barriers to healthcare access as identified by those client populations"(51)	• "Newcomers have equitable, **barrier-free and timely access to primary healthcare** and health-related services within a community setting • Newcomers are actively engaged in decisions affecting their health and wellbeing through **participation, health education and advocacy** • Newcomers **become integral community members** to further enrich our understanding of cultural competence and diversity"(51)
Shelter Health Network (Hamilton, ON)	"Established in 2005, the Shelter Health Network is a collaboration of health care professionals and social service organizations serving a high risk population without stable housing and who have complex health problems."(52) "We provide **primary care** to patients at several locations in Hamilton. These include shelters and transitional housing programs, drop-in centres, addiction facilities and mental health facilities. Our patients often face numerous barriers in accessing the traditional health care system: • not having health cards nor the ID necessary to obtain one • not having a phone or address to receive appointment information • feeling stigmatized when they access care. We **bring health care directly to people who face the most barriers in accessing it**. The Shelter Health Network is also committed to teaching medical students, post graduate residents and other health professionals. Our experienced health care providers help learners understand the social determinants of health."(52)	• "Improve health, **social stability and quality of life.** • Decrease emergency department visits. • Provide inter-professional health education learning environment for health and social service professionals. • Strengthen 'bridges' between acute health care, primary health care, social housing programs and social service agencies. • Always be open to new patients in need of our services by linking more stable clients with community family physicians."(52)
Social Navigator Program (Hamilton, ON)	"The SNP is a cooperative Police and Paramedic Service program intended to **address health and social issues** for vulnerable individuals that are often suffering from mental health and addictions issues." (53)	• "Connect and support individuals through a referral process, by engaging all social and healthcare agencies in the City of Hamilton • **Reduce reliance on the judicial and healthcare system** by navigating our clients towards the appropriate agency while improving the health, safety, and quality of life for all citizens."(53)
TorCH (Toronto Coaching in Health)	"TorCH (Toronto Coaching in Health) is an exciting partnership between the South Riverdale Community Health Centre (SRCHC) and Findhelp|211 Central (211) that will bring health	•

(Toronto, ON)	coaching and system navigation support to marginalized individuals in their homes."(54)	
Wellington Terrace Community Hub (Burlington, ON)	"A working group co-chaired by Halton Region and the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) has been assessing the feasibility of a pilot community hub at Halton Community Housing Corporation's 410 John Street (Wellington Terrace) Burlington location utilizing elements of a U.S. program known as the Program for All-Inclusive Care for the Elderly (PACE). PACE programs generally provide home and community-based health care and social services to help chronically ill, low-income adults maintain their independence in the community. "(55)	"There are 14 agencies that currently support residents of 410 John Street. The pilot's objective is to better coordinate these services and support vulnerable seniors to live independently. "(55)
Wesley's Supports for Seniors and Older Adults (Halton Region and Brantford-Brant, ON)	"Wesley is a long-standing local non-profit, offering support for people experiencing poverty, homelessness, and barriers in the community. We provide programs and services to meet diverse community needs in Hamilton as well as Halton Region and Brantford – Brant."(56)	"Wesley collaborates with community partners to mobilize resources, create opportunities, and realize potential for those most in need. We contribute to social impact by creating innovative programs and services that transform people's lives."(57)

TABLE A2.2. CORE COMPONENTS OF LOCAL PROGRAMS

Name (Location)	Point of Entry	Reason for Services	Role of LW	Services Provided
Aboriginal Patient Navigator (Hamilton, ON)	• Self-referral; patients are to call navigators directly (32)	• Seeking culturally safe care	"Aboriginal Patient Navigators (APNs) work to support the Aboriginal community with the access to culturally appropriate health-care & to promote the empowerment of Aboriginal people in determining their own health care needs."(32)	"Services Include: • **Culturally appropriate** resources for health care providers & individuals from hospital and to home • Linkages and liaison between the health care system & community services/support (e.g. acute care, residential treatment, mental health, addictions etc.) • Assistance on a patient's journey to health and healing through **traditional healing, traditional practitioners, medicines and cultural practices** as well as assistance with western models of care that can be foreign and complex • Collaboration with service providers about the needs of aboriginal people **based on a number of factors including intergenerational trauma and the legacies of colonization** • service care navigation across the health care system • identifying and addressing challenges and barriers to health care needs • assistance and collaboration with discharge plans • referrals and linkages to community services • connection to **traditional healing programs** and services • Enabling open lines of communication between individuals and health care providers

				• **supporting individuals and family members to understand and participate in their plan of care**"(32)
Community Information Exchange (San Diego)	• Self-Referral/ Opt In (58)	The goal of CIE is that you can live a happier and healthier life, and that if there is something you need, you can get access to all available help and have better support along the way. Participating in CIE means that more providers can work together to help you have your needs met. (58)	N/A	"Within a CIE, network partners commit to redefining a patient/client thinking beyond their individual programs and services. Network partners are willing to re-engineer their business processes to better connect individuals to services and share new levels of information necessary for collective impact to address systemic needs and realize a shared vision for a healthier community. Partners contribute to a CIE in different ways based on their organizational capacity and role within the community. They also share challenges and best practices, inform policy decisions, champion expansion of the network, and contribute to the ongoing development of the technology platform."(58)
Community Navigators (211 Ontario)	• Self-referral/ Telephone (38)	"Advocates say the system is most often used by the vulnerable and isolated in a community and helps to deploy faster help that can avoid a crisis. Call-takers can access a translation service offering 150 languages."(59)	"Calls are answered by "certified information and referral specialists" who are trained to provide information, ask questions, search through more than 56,000 programs and services province-wide and advise callers about how to access the help they need."(59)	N/A
Community Nurse Networker Pilot (Hamilton, ON)	"The CNN worked primarily out of two locations in the neighbourhood: the community center and a HFHT family	• Those impacted by SDoH	"The CNN had experience working in the mental health sector, had nursing experience across the age continuum, had excellent communication, problem-solving and conflict management skills and was knowledgeable regarding community resources and programs. The CNN used a motivational interviewing and brief solutions	"Throughout the pilot, the CNN had over 500 interactions with clients at the community center and connected approximately 80 individuals to family doctors. The CNN supported clients in **breaking down barriers and addressing issues** related to the following: • health care • mental health

	practice. However, she also met with teaching staff and families at local schools and completed home visits when necessary."(35)		model in addition to her expertise in nursing assessment and intervention skills."(35) "While the aim of the CNN was to assist people in navigating the health care system, the role did so by **building capacity** so that the individual would eventually be able to transfer skills to new situations without the aid of the CNN."(35)	• addictions • recreation • child care • legal aid • housing • parenting • finances • employment • education The CNN's extensive knowledge of community resources and programs facilitated a rapid response in directly connecting residents to the appropriate services. In order to provide warm hand-offs to other service providers, the CNN created networks with over 200 service agencies and/or providers" (35) "The CNN also worked collaboratively with the neighbourhood to identify gaps at the community level. The CNN **then supported the community in building capacity and taking coordinated action to address the identified needs.** The CNN pilot initiated or mobilized the following community initiatives that addressed gaps in service: • Our Community Clothing Closet • McQuesten Youth Opportunities Creators (MYOC) • Jobs4Jobs (Youth Employment strategy) • Ontario Works Community Placement at Hillcrest school • Transportation to Rotary Summer Literacy Camp • St. Charles ESL classes at the Community Center • Community Calendars for Children and Youth Programs in McQuesten" (35)

Community Paramedicine Clinic (Hamilton, ON)	• Community (39)	• N/A	Community paramedics meet **clients in accessible locations**, often in common rooms of subsidized housing, shelters, or community centers. The paramedic is able to measure blood pressure, assess risk of diabetes and other chronic conditions, and provide tailored health information to each client (39)	"After the participant gives written informed consent, paramedics: • conduct several evidence-based health assessments • provide referrals to primary care and community resources • assist participants in navigating the health care system • provide participants with tailored health education • engage participants in healthy lifestyle discussions • set health goals with participants" (39)
Compass Community Centre	• Health Centre	• N/A	N/A	• A Variety of services including: ○ Health Wellness- Rehab & Foot Care ○ Health Promotion Services ○ Client Advocacy ○ Pathways to Education (40)
Complete Breast Care Program (Brant, ON)	• Hospital	• Abnormal findings on Mammogram	"Your Patient Navigator is your dedicated point of contact, assisting you immediately following abnormal findings on your mammogram. They are **clinicians and equipped with all the knowledge and expertise necessary to support you**. They will help you schedule breast screening appointments, obtain mammogram test results and are always available to answer questions or simply chat about your needs and concerns. "(28)	"We use the very latest technology to provide fast and accurate detection throughout the screening process. You can rest assured knowing our team is leveraging the highest level of mammography technology available." (28)
EMBOLDEN (Hamilton	• N/A	• N/A	N/A	• N/A

First Link (Alzheimer's Society Ontario)	• Family Caregiver • Self-Referral • (4)	"Connecting to support and information in the early stages of the disease is important. Through the support provided by First Link®, you **won't have to face your journey alone**"(4)	"[The] First Link coordinator… provides the individual with information about dementia, the available community services and relevant education sessions offered by the Alzheimer Society."(4)	"By referring that person to First Link®, they can see their quality of life improve in many ways. They can: ○ Receive one-on-one or group support, ○ Get access to local health and community services, ○ **Meet other people in similar circumstances and exchange experiences**"(3)
Green Initiative (Hamilton, ON)	• Family Health Team	Promote a more environment-conscious healthcare system (43)	N/A	• Promoting Plant Rich Diet • Nature Prescriptions • Nutrition Prescriptions (43)
Hamilton Social Medicine Response Team (Hamilton, ON)	• Mobile Clinic (44)	"The registry includes two arms: (1) Individuals in hospital in Hamilton undergoing inpatient addiction treatment; and (2) Individuals in the Hamilton community who experience barriers to participating in standard health care delivery settings and processes"(60)	N/A	"Provides health services for people with chronic or infectious diseases who are unable to visit the doctor's office. Services are provided by physicians, registered nurses, midwives, and outreach workers." (44)
Health Links (Ontario)	• Family Care Providers (61)	"Ontario is improving care for seniors and others with complex conditions through Health Links. This innovative approach **brings together health care providers** in a community to better and more quickly coordinate care for high-needs patients."(61)	"The Health Link Clinical System Navigator **will work with your family doctor** to identify your health problems and treatment to help you plan your care. The Clinical System Navigator will meet with you individually to start the coordinated care plan. A team conference may take place which would include any health care providers that could support you in reaching your health goal."(62)	"When different health care providers work as a team to care for a patient, they can better coordinate the full patient journey through the health system, leading to better care for patients. Health Links will help to ensure that patients with complex conditions: • No longer need to answer the same question from different providers. • Have support to ensure they are taking the right **medications** appropriately. • Have a care provider they can call, eliminating unnecessary provider visits.

				• Have an individualized comprehensive plan, developed with the patient and his/her care providers who will ensure the plan is being followed." (61)
Health Tapestry (Hamilton, ON)	• Primary Care Team (14)	"Health TAPESTRY is identifying people at risk before they need invasive and expensive interventions, like going to a hospital. We work with these people and their communities to help them be healthier, where they live, for longer."(14)	"Health TAPESTRY volunteers are involved in a wide range of activities. No matter what they are doing, our volunteers are working to help people stay healthier for longer by gathering information about clients' life and health goals. Some roles and responsibilities of Health TAPESTRY volunteers include: • visiting clients where they live, along with a fellow volunteer gathering information using a tablet and Health TAPESTRY technology, like the TAP-App • helping clients set-up a personal health record (PHR) • helping **motivate clients** to reach their health goals • connecting clients to community resources"(14)	"[volunteers] also learn more about a person's health needs. The stories people tell our volunteers are recorded and sent to their health care team using special technology. This helps the team learn more about that person's life, health needs, goals and how they can better work together to achieve goals and meet needs. Health TAPESTRY sees trained volunteers visit adults aged 65 and older where they live. **Volunteers ask questions related to their health and what matters most to them, recording the answers electronically**. This information is then shared with the person's health-care team so they may better understand how to work together to achieve these goals. "The spirit of TAPESTRY is communities volunteering to help older adults, and primary care teams working together to **empower older adults**," Oliver says." (47)
Hospital 2 Home (Hamilton, ON)	• Physician (37)	"Utilizing Ontario's Health Links Model of Care, the team uses **standardized criteria to identify patients** who are at the greatest risk for poor health outcomes and works with these patients in the community." (37)	"HHS' Hospital 2 Home team views patients through a trauma informed care lens and utilizes motivational interviewing skills to develop true partnerships with patients – care plan development starts with asking patients open ended questions such as 'What is most important to you right now?'"(31)	"**Patients are supported to develop the knowledge and skills** required to be successful, such as self-management of chronic conditions"(31) "…the teams focused on teaching [the patient] **self-management skills**, including how to recognize worsening symptoms to help him manage his chronic illnesses at home." (30)

Home and Community Care Support Services' Care Coordinators	"Care Coordinators are assigned to you once you become a **patient**. Referrals can be made by a health-care professional, a family member or friend, or even by you, yourself. Simply get in touch with us and we'll help you get started."(48)	Care Coordinators are connected to every part of the health-care system and can serve as your single-point of contact in obtaining services and information. (48)	Care Coordinators use their **professional health knowledge and assessment skills** to understand your individual needs, making recommendations based on your needs and goals. . (48)	We work hand in hand with you and your family to find out what care you need, and then work with you to develop a care plan that is right for you – whether it's nursing care, meal delivery, a day program, or help finding a family doctor. . (48)
Indigenous Cancer Care Program (Hamilton, ON)	• Physician • Self-Referral (50)	• **Diagnosis** of cancer (50)	"The Indigenous Patient Navigator provides support and advocacy for self-identified First Nations, Inuit, Metis, and Urban Indigenous (FNIMUI) patients and families in the region by facilitating and coordinating access to cancer services, palliative and supportive care, and addressing cultural and spiritual needs to **make the cancer journey a culturally safe experience**. The role of the Regional Indigenous Clinical Lead is to engage and collaborate with primary care providers to bridge patient and provider understanding of Indigenous cancer control and **advocate for addressing the primary care needs of Indigenous people** in the HNHB region.	"The Indigenous Patient Navigator provides **culturally sensitive support** and advocacy services for cancer patients and their families by: • Supporting Indigenous patients/families at clinic visits and helping them navigate the cancer journey • Enhancing communication between patients/families and JCC staff/physicians • Assisting with arrangements for language translation and transportation services • Assisting in identifying and accessing internal and external resources • Assisting patients in accessing traditional, spiritual and/or cultural Indigenous services"(50)

			The Indigenous Coordinator works to develop and maintain collaborative partnerships with key stakeholders in the region. The Coordinator supports the work of the Regional Indigenous Clinical Lead and **provides coordination and support for Indigenous outreach initiatives relevant to improving the cancer journey** with, and for, Indigenous people in the HNHB region." "(50)	
Integrated Service Navigator (Halton, ON)	• Service Providers (34)	"To be eligible for ISN supports an individual or family should: 1. Be a Halton resident 2. Be a SCS client (Children's Services, Employment & Social Services, Health or Housing Services) 3. Require support to effectively navigate the human services system 11 ✓ Challenges with self-navigation and has expressed need for support ✓ Challenges in completing required tasks ✓ Involvement in multiple services with requirements that appear outside of their capacity to successfully complete 4. Consent to receiving ISN supports and sharing information by signing the Electronic Communication Consent Form" (34)	"Coordination and support involves regular, pre-arranged check-ins to review progress, ensure supports are in place, and support implementation and updates of the action plan When appropriate, this may involve the facilitation of a case-conference with relevant stakeholders"(34)	"Support for Individuals & Families • Individualized navigation support • Assessment • Referrals • Information Supports for Staff • Consultation • Case conferencing • Information/training related to human services"

McMaster FHT System Navigator	• McMaster FHT	• Complex health issues • Flagged as high healthcare usage(13)	• "Provide support and advocacy • Work with all members of the Family Health Team (FHT) and community partners • Facilitate access to care and resources • Develop the case manager role within the primary care setting (FHT) • Collaborate with the IP team in the evaluation of services provided • Regular (i.e. weekly) case review with the IP team to assess needs and service delivery of complex patients" (13)	"From his welcoming office, Dan tackles **any stressor impacting a person's life and health**. It's a fluid role that offers people help with multiple stresses and strains, from quitting smoking to eviction prevention, applying for social assistance, filing taxes, contacting local shelters and food banks or scouring the web for a job or apartment."(63)
Reach Out Centre for Kids (ROCK)'s Coordinated Service Plan (Halton, ON)	• Service Providers (29)	• Children and youth who live in Halton under the age of 18 • Young people between the ages of 18 and 21 who remain in school • Must be connected with 2 or more services (29)	"Coordinated Service Planners (CSPs) encourage all the agencies involved with families to work together as a team. They support identified goals and work to ensure that a family's needs and concerns are heard and respected. • CSPs are knowledgeable about services and funding resources that could be beneficial for families. CSPs work on building caregiver capacity and provide advocacy for families' needs across multiple systems. • CSPs will make referrals/connections as new needs and potential supports are identified and/or call meetings with service providers when the family indicates that their goals have changed or that the plan needs to be adjusted. • At a minimum, the Coordinated Service Plan will be reviewed with the child/youth and family every six months. Goals will be revisited and confirmed or revised each time the plan is reviewed. • Some families may require more frequent updates at varying times. Plans should be updated more frequently around transitions in the child/youth's circumstances or	"Children and youth with multiple and/or complex special needs usually require services from multiple sectors and/or professionals and may experience challenges related to multiple areas of their development. They may require or need: • Rehabilitation services • Mental Health services • Autism services • Respite supports • Physical, intellectual, emotional, social, and/or behavioural development support • Severe physical and intellectual impairments requiring the use of technology" (29)

			services, for instance, upon transition into school, high school or adulthood."(29)	
REFUGE Newcomer Health	• Healthcare centre	• Hamilton's new immigrant and refugee population	• Health services navigation available (51) • Insufficient evidence available	• Variety of primary care, specialty services (e.g., pediatrics, psychiatry, internal med, etc.), and mental healthcare services
Shelter Health Network (Hamilton, ON)	• Multiple clinics available across the community, including within shelters (52)	• Individuals living with homelessness	• N/A	"As of 2017, our group consists of 17 family doctors, two nurse practitioners, four registered nurses, eight midwives, two internists and two psychiatrists. Our numbers continue to grow. We provide primary care to patients at several locations in Hamilton. These include shelters and transitional housing programs, drop-in centres, addiction facilities and mental health facilities." (52)
Social Navigator Program – Hamilton Police (Hamilton, ON)	• Law enforcement	"Many are marginally housed or homeless and further challenged by **multiple social determinants of health issues**. These individuals have great difficulty accessing social and healthcare services which in turn exacerbates their pre-existing conditions and leads to risky behaviour including criminality." (53)	"SNP works to provide equitable access to health care by providing wellness checks, referral to shelters, connecting them to Mental Health and Addictions services, housing/employment/financial supports and ensuring they meet any court mandated requirements."(53)	"The idea is to navigate people to social service or health-care programs — helping them get a spot in a shelter, fill out ODSP paperwork, or giving them boots or a winter coat."(64)

TorCH (Toronto Coaching in Health) (Toronto, ON)	• Self Referral	N/A	"Peer Health Coaches are trained individuals who also live with long term health conditions. A coach provides support and guidance to help you make the healthy changes you want to work on such as managing your health condition(s) and its complications, finding helpful community resources and taking action to live a healthy life. Their expertise stems from their shared experience with chronic conditions. Peer Health Coaches have successfully completed two-day training on coaching skills and self-management strategies. Peer Health Coaches are not health professionals, but they have been trained to help you in the day to day management of your health condition. Your coach will have a similar chronic health condition or have family members or friends who do. Therefore, they have – firsthand knowledge of the challenges that you may be facing. Your coach can help explain your options and the best ways of working with your health care team."(54)	"Peer Health Coaches will engage with participants by phone, once a week, for a 30 minute call for a period of up to three months. Registered participants will be paired with Health Coaches based on gender, age and/or shared chronic health condition(s). Health Coaches call their participants on a weekly basis at a predetermined time. Through this contact, Health Coaches: • Provide weekly phone support for 3 months • Provide education about self-management strategies • Work with participants to develop plans and goals to improve their health • Motivate participants to initiate and maintain behaviour changes • Provide social and emotional support • Help participants access community services and programs Peer Health Coaches provide a dimension of support that complements and enhances professional health care; they do not provide medical or clinical advice or treatment. Peer Health Coaches will also provider referral to 211|FindHelp to promote system navigation."(54)
Wellington Terrace Community	• Community	"It was agreed that Burlington seniors would benefit from increased integration of housing and health/social services through a community hub	N/A	"Current services provided at 410 John Street include: • Mental health supports; • Alzheimer and dementia services; • Services for developmentally delayed adults; • Personal Support Workers;

		model of delivery in which health care and social services would be co-located within a seniors' assisted housing building."(55)		• Supports for daily living; • Exercise programs for seniors; and, • Tenant and community supports. "(55)
Wesley's Supports for Seniors and Older Adults (Halton Region and	• Wesley Urban Ministries (56)	"Programs for **isolated, low-income and vulnerable** seniors to respond to a growing population and to assist in safe independent living using the aging in place model"(65)	N/A	• "Outreach programs for seniors including grocery shopping, activities and community referrals • Home visits through Hamilton's collaborative Senior Community Connections Program • Healthcare, recreation and social supports for seniors"(65)

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SERVICE OVERVIEW

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