

**CONTACT US**

Burnaby Division of Family Practice

Shared Care

sharedcare@burnabydivision.ca

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# Social Prescribing

A BURNABY SHARED CARE PROJECT



# Shared Care at Burnaby

DEVELOPING PATHWAYS BETWEEN HEALTH AND SOCIAL PROGRAMS

The Burnaby Division of Family Practice Shared Care portfolio has received funding from the Shared Care Committee, a partnership of Doctors of B.C. and the B.C. Government, to provide social prescribing services in Burnaby.

This project aims to enhance patient health by improving access to community supports that address social determinants of health. **Social Rx Connect**—a digital platform developed for social prescribing initiatives within the United Kingdom’s National Health Service (NHS)—will be used in Burnaby to streamline referrals from health care providers and self-referrers to Health Care Navigators and Volunteer Connectors. The goal is to empower health care providers to collaborate and address patients’ social, economic, and psychological factors, ultimately improving health outcomes.



[sharedcare@burnabydivision.ca](mailto:sharedcare@burnabydivision.ca)



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# What is Social Prescribing?



Social prescribing helps health care providers and social service professionals link people to non-clinical supports and community resources, addressing needs based on **the social determinants of health**.

## Why social prescribing?

People's health can benefit from being connected to resources and supports in their communities. To provide comprehensive care, these supports should address both physical health and social factors that affect well-being, such as loneliness, insufficient income or housing, food insecurity, or a need for creativity, movement, or community connection. Social prescribing helps bridge the gap between what people need and what's available—supporting both individual well-being and reducing pressure on the health care system.

## How does social prescribing work?

Social prescribing is a method that integrates clinical and social care by linking individuals to community resources and supports through a referrer, such as a health care provider, community service provider, organization, or individual. A Health Care Navigator monitors the impact and outcomes of these prescriptions.

# Social Determinants of Health

Social determinants of health are non-medical factors that can influence health outcomes, whether positively or negatively.

The following list from the World Health Organization<sup>1</sup> provides examples of the social determinants of health:



Income and social protection



Education



Unemployment and job insecurity



Working life conditions



Food insecurity



Housing, basic amenities, and the environment



Early childhood development



Social inclusion and non-discrimination



Structural discrimination, conflict, and displacement of peoples



Access to affordable health services of decent quality

# The Pathway

## THE SOCIAL PRESCRIBING PROCESS

### 1. ENTER

An individual with unique needs, interests, and desires is referred to Social Rx by a health care provider, community social service agency or organization, or themselves.



Enter

### 2. CONNECT

The individual works with the Health Care Navigator that receives the referral into Social Rx to co-create personalized plans that align with their unique needs. Together, they craft plans that truly matter.



Connect

### 3. PARTICIPATE

An individual engages in activities with the assistance of a Volunteer Connector, utilizing community supports and resources to improve their well-being and overall health. If language barriers are present, a Volunteer Connector who speaks the individual's language will be assigned to the individual.



Participate

### 4. FOLLOW UP

The Health Care Navigator journeys along and follows up through check-ins to ensure the activities are appropriate, identify any barriers, and to observe and document health outcomes for their health care practitioner.



Follow Up

### 5. LEARN

Evaluation and learning continue to improve the pathway as individuals move on or re-enter the process.



Learn



## HOW CAN YOU REFER AN INDIVIDUAL OR YOURSELF TO SOCIAL PRESCRIBING?

To self-refer or refer someone to social prescribing, visit [burnabypcn.ca/social-prescribing/](https://burnabypcn.ca/social-prescribing/)

- Make a referral or refer yourself
- Submit the online form



Health Care Navigator will contact the individual to onboard and connect them with a Volunteer Connector.

# Broad Evidence

Social prescribing has significant potential to improve health systems within the dimensions of the Quintuple Aim.

The Quintuple Aim is a set of five interrelated and reinforcing goals for individual well-being, community health promotion and health systems improvement.

## The Five Goals of the Quintuple Aim

**Health Outcomes:** Promote positive physical, emotional, and mental health that addresses the social determinants of health.

**Patient Experience:** Enhance the experience of care navigation, support service access, and improve community connectedness.

**Promote Health Equity:** Build the capacity to address the social determinants of health.

**Clinician Experience:** Increase clinician engagement and job satisfaction, which in turn improves patient experience.

**Reduce Costs:** Decrease reliance on primary and acute care by emphasizing preventive and holistic health care and social support.



# Sample Evidence

## HEALTH OUTCOMES

A systematic review of seven global social prescribing studies revealed:

**48%** of participants reported more frequent physical activity;  
**20%** reported improvements in their health status;  
**23%** reported improvements in their health confidence.

## PATIENT EXPERIENCE

Results from *The Way In Network* in Calgary, A.B., have shown that:

**76%** of participants reported being less lonely and isolated;  
**83%** felt the program helped them access needed community services;  
**76%** reported the program helped them communicate and advocate with their medical team.

## REDUCE COSTS

The impact of the social prescribing initiative at Involve Kent CHC in the UK includes:

**5%** reduction in unplanned inpatient stays;  
**26%** reduction in ER visits among older adults.

## CLINICIAN EXPERIENCE

The Evaluation findings from the *Alliance for Healthier Communities' RxCommunity Pilot: Social Prescribing in Ontario* revealed:

**42%** of health providers reported social prescribing decreased the number of repeat visits by clients;  
**74%** of health providers reported an increase in collaboration and integration between interprofessional health providers

## PROMOTE HEALTH EQUITY

We've learned how social determinants of health—such as income, housing, food security, and more—play a major role on long term health and wellbeing. The COVID-19 pandemic further revealed how these challenges disproportionately affect low-income, underhoused, and racialized communities. In response, many social prescribing initiatives have emerged across Canada, along with ongoing research to better understand and address these community needs.