FAQ for Healthcare Providers

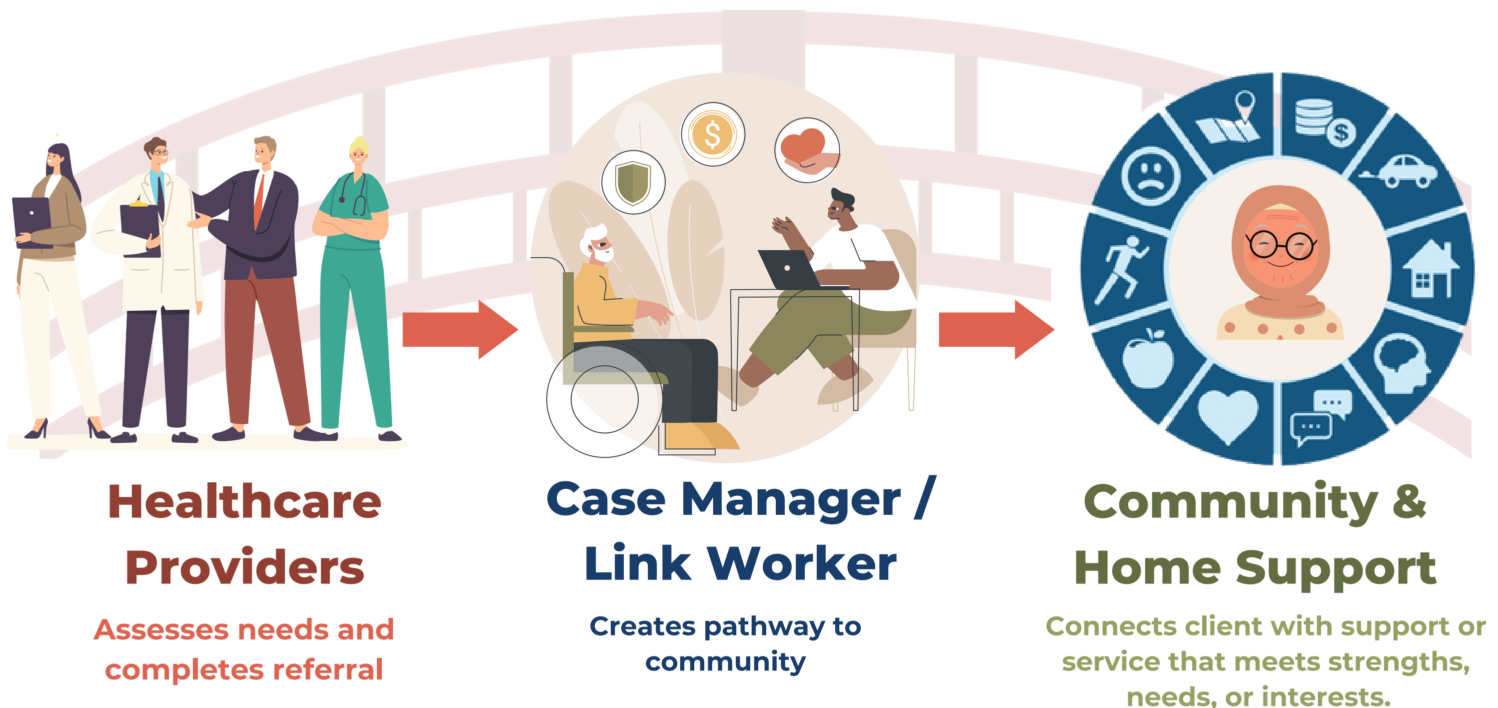
Social Prescribing Edmonton: Seniors 55+

This Pilot Project aims to support Healthcare Providers by connecting you and your patients to community-based seniors organizations that:

- Provide pro-active interventions to improve heathy aging for patients.
- Address unmet non-medical needs outside of the physician's office/ clinics.
- Increase capacity of primary care, improve patient experience.
- Aims to alleviate workload pressures on existing staff.

Social Prescribing Edmonton 55+ : Holistic Integrated Care Model

The social prescribing approach can reduce the demand on professional health providers and promote seniors' resilience in their communities.



Healthcare Providers

Assesses needs and completes referral

Case Manager / Link Worker

Creates pathway to community

Community & Home Support

Connects client with support or service that meets strengths, needs, or interests.

Program Eligibility

The Social Prescribing Project is designed to support older adults ages 55+ with limited support, multiple complex care needs, and who may require community-based services.

For Further Information on Social Prescribing, contact the Edmonton Seniors Coordinating Council at socialprescribing@seniorscouncil.net or call 587-635-1575.

Project Background:

The social prescribing collaborative aims to purposefully link the health care system with community-based senior serving (CBSS) organizations by establishing a formal referral pathways and mechanisms for ongoing collaborative service delivery. The project also expands and extends the Aging in Community Supports Program (Alberta In-Home Supports Demonstration Project) supported by the Ministry of Seniors and Housing and Alberta Health to reduce the pressure on Alberta's health care system.

What is Social Prescribing?

Social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections."

What happens after a referral is made?

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

What are the key outcomes of Social Prescribing in Edmonton?

Social prescribing aims to address the social determinants of health and this pilot project will aim to:

- Improve physical and mental health,
- Increase seniors' confidence living at home,
- Increase social/ community connection.
- Reduce length/ frequency of hospitalization and emergency room visits.
- Measure outcomes to evaluate individual and initiative-wide success.

What is a Link Worker?

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

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

How does it work?

Healthcare Providers can complete the Edmonton Social Prescribing 55 + Referral Form and submit to the Central Intake (SAGE) at aic@mysage.ca and by Fax (780) 426-5175, attention: Social Prescribing. The Healthcare Provider will receive confirmation once a referral is received. Please ensure consent to disclose health information is given prior to submission.