

Improving Data Quality & Collaboration Through Standardized Social Prescribing Pathways

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From Fragmented Work to Connected Care

Today's Focus

- The previous documentation challenge
- Why it impacted care and outcomes
- How social needs are identified and supported
- A standardized approach to improve care
- What this means for practice and data

The Challenge: Work Happens, But Isn't Captured

- No consistent approach to documenting social supports
- Heavy reliance on informal communication:
 - Emails,
 - Sticky notes
 - Hallway conversations
- Client records were often incomplete or fragmented
- Limited visibility across teams



Key Issue: Important work was happening – but it was not being consistently recorded or shared.

Why This Matters for Client Care

- Incomplete understanding of client needs
- Missed or delayed follow-ups
- Reduced coordination across providers
- Limited ability to track outcomes and trends



Impact: We lost opportunities to deliver fully coordinated, client-centred care.

Understanding Socially Driven Needs

Common needs we **see** in clients:

- Housing instability
- Food insecurity
- Social isolation
- Financial challenges
- Access to community resources

How we **identify** them:

- Screening tools
- Targeted conversations
- Client disclosure
- Ongoing provider insight

How We Support Clients Today

Support can include:

- Referrals to community connectors or link workers
- Connecting clients with community organizations
- Providing resources and information (e.g., pamphlets, contacts)
- Supporting access to programs (e.g., food, classes)
- Addressing barriers (e.g., transportation, technology, forms)



Key Point: Support is already happening – across many roles and touchpoints.

The Missing Link: Consistent Documentation

When to Document

- When a need is identified **and** support is provided or facilitated (e.g., providing program info, referring to community agencies)

What to Document

- Actions taken
- Referrals made
- Follow-up plans

How to Document

- Use standardized encodes
- Select “**Social Prescription**” under services
- Record follow-up clearly



Goal: Capture meaningful actions – not just conversations.

Our Approach: From Informal to Standardized

Making existing work visible and trackable.

We introduced:

- A standardized referral pathway
- A consistent documentation workflow
- A structured EMR (PSS) custom form
- Integrated internal communication



This is not extra work – it's better visibility of the work already happening.

The Referral Pathway: Clear and Consistent

How it works:

1. Provider identifies a social need
2. Referral pathway is activated
3. Support is provided directly by the provider **OR** a referral is initiative to the Social Prescribing Team
4. Connection to a Community Connector
5. Follow-up is documented

Built collaboratively across teams

- Provider input, feedback, training, committee work

Making It Visible: The PSS Custom Form

Captures:

- Client needs and priorities
- Actions taken by providers or teams
- Referrals (internal & external)
- Wraparound supports provided
- Barriers and how they're addressed
- Follow-up actions and ongoing engagement



Outcome: A complete, structured view of the client journey.

Date (New Referral)

- Info & Navigation Support**
Help finding community services (e.g., income taxes, house cleaning, transportation, etc.)
- Outdoor Activities**
Garden programs, walking groups, Gnaraska Trails, Tree Top Trekking, fishing, etc.
- Wellness Programs**
Assistance connecting to support groups, friendly callers, mental health workshops, etc.
- Digital Equity**
iPad loaning, device assistance, assistance connecting with virtual program or appointment
- Arts and Culture**
Assistance connecting to art and culture programs & activities (e.g., pottery, painting)
- Exercise Programs**
Physical activities or assistance connecting with external agencies (e.g., YMCA, SALCs, etc.)
- Social Programs**
Assistant connecting to social groups (e.g. teas, book clubs) or SALCs.
- Food Support**
Assistance connecting to food bank, community meals, cooking programs, etc.
- Volunteering**
For clients interested in volunteering at CHCN, or other community volunteer opportunities
- Other**
Please specify in "Provider Notes" section below.

Actions taken by providers or teams

Provider Notes
(e.g., support required, interest, goals, barriers, etc.)

← Hide

Service/Program Location

- ☐ CHCN (Internal)
☐ Community (External)
☐ SALC
☐ Other (please specify)

Wraparound Supports

- ☐ None
- ☐ Transportation
- ☐ Financial Supports
- ☐ Food Security
- ☐ System Navigation
- ☐ Digital Equity
- ☐ Other (please specify)

Referrals

(internal & external)

Wraparound supports provided

Why Standardization Matters

- Creates a shared language across teams
- Reduces gaps and miscommunication
- Improves continuity of care
- Enables real-time collaboration through EMR messaging



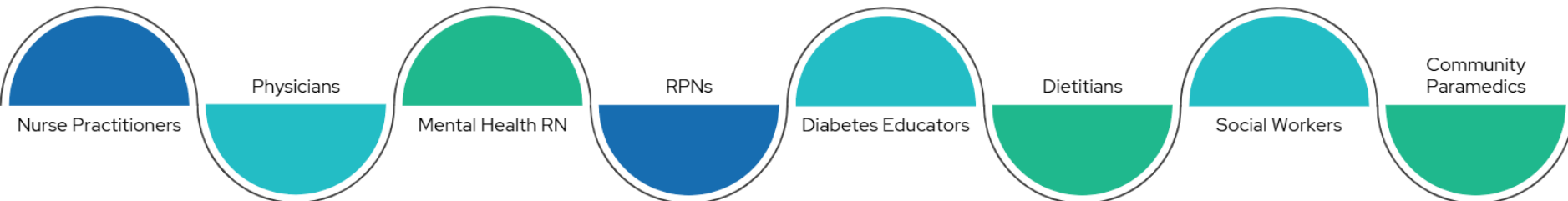
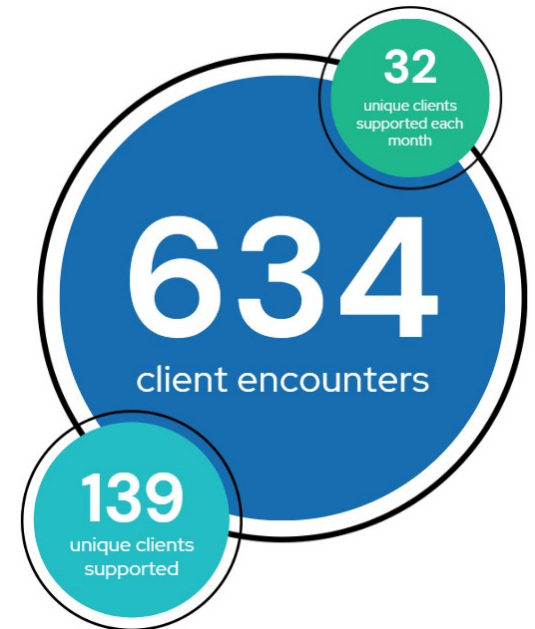
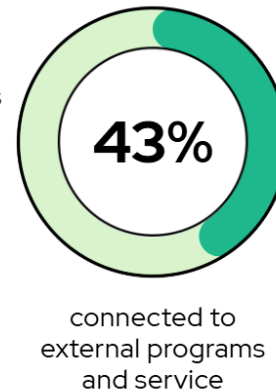
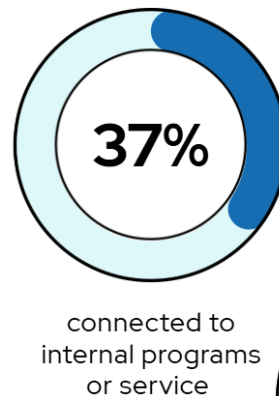
Result: Stronger coordination and more efficient care delivery.

From Documentation to Insight

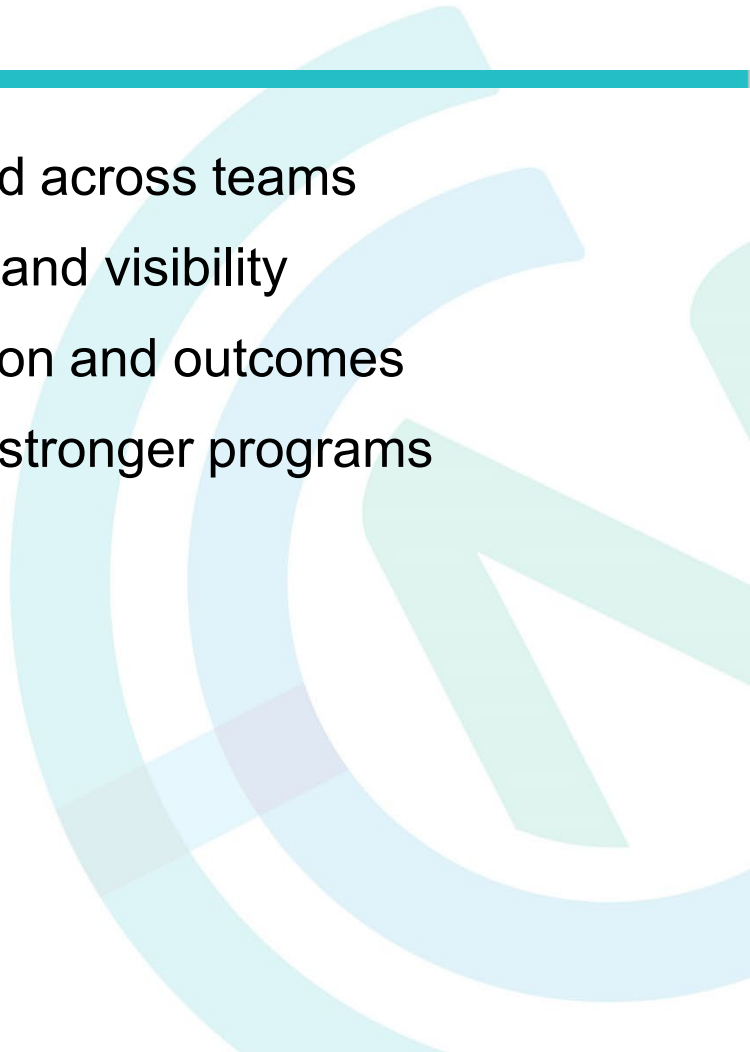
What better data enables:

- Tracking client needs and service use
 - Identifying trends across populations
 - Measuring program impact
 - Strengthening reporting and funding applications
- 
- A decorative graphic on the right side of the slide. It features several concentric, semi-transparent circles in shades of light blue and teal. Overlaid on these circles is a stylized, thick arrow pointing towards the bottom right. The arrow is composed of several segments in different shades of blue and teal, creating a sense of motion and direction.

From Documentation to Insight



Key Takeaways



- Social needs are already being addressed across teams
- Inconsistent documentation limits impact and visibility
- Standardization improves care coordination and outcomes
- Better data leads to better decisions and stronger programs

Thank You

Questions?

