Identifying Barriers to Accessing Community-Based Services for Clients of Fraser Health's Social Prescribing Program

By

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B.A.Soc., Thompson Rivers University, 2016

A Master's Project Submitted in Partial Fulfillment of the Requirements for the Degree of

MASTER OF ARTS IN COMMUNITY DEVELOPMENT

In the School of Public Administration

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Acknowledgements

I am grateful to have researched and written this project on traditional and unceded territories of the Coast Salish peoples, including the Musqueam, Squamish, Tsleil-Waututh and Qayqayt First Nations.

This is for Kindra and Matilda. You made it possible. Thank you.

Thank you to Dr. Grace Park for inviting me into the social prescribing program, and to its seniors' community connectors for participating in my research. You're doing important work and I hope this project helps you. I am also grateful to Linda Dempster for connecting me with the program and Christina Krause for her overall support and helping me find the MACD program.

Thank you to Dr. Bart Cunningham for coaching and supporting me through this project, and to Dr. Lynne Siemens whose feedback bookended its work.

And thank you to my classmates in the MACD program. I learned so much from you.

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Executive Summary

Social prescribing is a practice which addresses people's social determinants of health by connecting them with non-medical services in their communities. Models vary but, commonly, general practitioners refer patients to a program which partners with them to co-develop wellness goals and finds community- or volunteer-based services which can help them achieve those goals. Social prescribing has been in place primarily within the United Kingdom for roughly three decades but is beginning to gain in popularity as governments seek to ease dependencies on medical systems.

In 2019, Fraser Health launched a social prescribing program – one of the first in Canada. It features a three-year funding commitment from United Way and currently operates in three communities with another six joining soon. The program focuses on supporting a specific population: frail seniors.

A frail individual has many health issues, such as unintentional weight loss, muscle loss, muscle weakness, fatigue and slow walking speed, that combine to reduce their function and health (Canadian Frailty Network, n.d.a). More than 1.5 million Canadians are frail (Canadian Frailty Network, n.d.b).

Social prescribing program staff – titled senior's community connectors – are responsible for supporting its clients and connecting them with community-based services which could improve their physical activity, social engagement and nutrition. What the connectors have found, however, is that their clients often face barriers that affect their abilities to access those services. Instead of quickly connecting clients with service providers and supporting them to self-manage their health, the connectors are spending significant time addressing clients' barriers. This substantially reduces the number of clients they are able to connect with services as well as the overall number of clients they are able to support.

This project identifies barriers which prevent the clients of Fraser Health's social prescribing program from accessing community-based services, as well as facilitators which help them to do so. It concludes with recommendations for how the program can resolve or mitigate barriers as well as enhance facilitators.

The primary research question answered by this project is:

- What barriers are preventing clients in the social prescribing program from accessing community-based services?

As well, the following secondary research questions are answered:

- What are barriers which prevent frail seniors from accessing community-based services?
- What facilitators are supporting clients to access community-based services?
- How do these barriers and facilitators inform future practices of the social prescribing program?

Methodology

Following an extensive literature review which identified more than 240 barriers and facilitators potentially experienced by the social prescribing program's clients, an online survey enabled three seniors' community connectors to identify how many of their clients actually experience each barrier and facilitator. Barriers and facilitators are sorted into four categories: cultural, financial, physical and psychological.

A focus group was then facilitated so that the seniors' community connectors could contextualize and expand upon the survey data. A force field analysis was also led where they identified prominent barriers and facilitators which would have the greatest impact on improving the accessibility of services if they were to be resolved or mitigated, or enhanced, respectively.

Findings

The data shows a significant number of barriers and facilitators which are experienced by the social prescribing program's clients. More clients are affected by psychological barriers than any other category; prevalent barriers in the physical and psychological categories tend to be individual in nature whereas prevalent ones in the cultural and financial categories often have roots at the program and system levels.

These relationships are almost reversed when considering facilitators – those in the cultural and psychological categories often relate to things which can be influenced by clients and other individual program stakeholders, whereas physical and financial facilitators are commonly impacted by program- and system-level partners or factors.

Prevalent barriers experienced by the social prescribing program's clients, and which are focused upon in this report's recommendations, often concern stigma and stereotypes, information exchange and communication, and the involvement of general practitioners. Prevalent facilitators, which also influenced recommendations, often concern relationships between stakeholders, providing client-centred services, awareness of the program and its benefits, and the support provided to clients by seniors' community connectors.

Recommendations

Twelve recommendations are detailed in this report:

- Utilize peer volunteers strategically
- Assess the program's concentration of high-needs clients
- Expand who can submit referrals
- Embed seniors' community connectors within clinical practices
- Designate funding for resolving accessibility issues
- Implement steering committees
- Send regular updates to general practitioners
- Establish partnership agreements with general practitioners
- Invest in educating general practitioners
- Facilitate person-centred services
- Market the program to seniors
- Create new marketing materials

Conclusion

The challenges experienced by Fraser Health's social prescribing program are not unique to its model. A comprehensive review of the barriers and facilitators which its clients are encountering as they access community-based services has led to a series of recommendations which can enable the program and its seniors' community connectors to resolve, mitigate or enhance those barriers and facilitators. As a result, the connectors can gain capacity to accept new clients and support their clients in accessing services so they can improve their health.

Introduction

Frailty

Frailty is a medical condition where an older individual has health deficits in multiple systems (Kojima, Liljas & Iliffe, 2019) such as unintentional weight loss, muscle loss, muscle weakness, fatigue and slow walking speed which combine to reduce their function and health (Canadian Frailty Network, n.d.a). When an individual is frail, their body cannot cope with minor illnesses, which then leads to rapid and dramatic deterioration in their health (Canadian Frailty Network, n.d.a). More than 1.5 million Canadians are frail – a figure which is estimated to grow to 2 million within a decade (Canadian Frailty Network, n.d.b).

The impacts of frailty are diverse and profound. Frailty can be a better predictor of death than age; frail surgical patients are more likely to develop postoperative complications, and die from those complications, than patients who are not frail; and people who are frail face increased risk of fractures, recurrent falls and disability (Lee, Heckman & Molnar, 2015). People who are frail are also more likely to visit emergency departments, be hospitalized and re-hospitalized, and die in hospital (Lee, Heckman & Molnar, 2015). These figures, though concerning on their own, become more alarming when considering Canada's aging population and already stressed health care system.

Project Client

Fraser Health, a regional health authority which provides services for communities stretching from Burnaby to Hope, has a Community Action and Resources Empowering Seniors (CARES) initiative which is helping seniors reduce or avoid frailty and self-manage their health. The initiative recently started a social prescribing program aimed at helping frail seniors delay the progression of their syndrome (Garm & Park, 2019) by connecting them with community-based services which can help them increase their physical activity, increase their social engagement and/or improve their nutrition (Canadian Foundation for Healthcare Improvement [CFHI], n.d.). Examples of community-based services include walking groups, bridge clubs and cooking classes (Seniors Come Share Society, 2019a).

Within the social prescribing program, three staff members – titled seniors' community connectors – introduce frail seniors ("clients") to community-based services and then support them to stay engaged with those services (CFHI, n.d.). The connectors are funded by the United Way and situated within community-based organizations in Mission, White Rock/South Surrey and Delta (with additional communities joining the program in the near future).

General Problem

When the social prescribing program was launched in fall 2019 the seniors' community connectors planned on quickly moving clients from an intake stage (which includes meeting with them and setting wellness goals) to actively and independently participating in community-based services (Seniors Come Share Society, 2019b). This process would help clients swiftly access resources, and build their confidence and capacity to do so, without requiring ongoing support; it would also help the connectors support as many clients as possible during the program's three-year funding period.

However, the seniors' community connectors often discover barriers which require significant time to understand and address before their clients can even access community-based services. Instead of quickly connecting clients with services and supporting them to stay engaged with those services independently, as the program originally envisioned, the connectors are unexpectantly spending

significant time identifying and addressing barriers such as social determinants of health, medical issues and lack of confidence/self-efficacy.

The barriers faced by clients are varied and often intensely personal. For example, a client wants to participate in services that could improve their health, but they do not have transportation to reach those services. Another client wants to visit a facility in their community but needs help building their confidence to do so because they once experienced an accident there. Others may require frequent, unscheduled medical appointments which disrupt any work they had planned with their seniors' community connectors.

Unless clients can access services and reach a point where they no longer require support from the social prescribing program, the seniors' community connectors will be very limited in the number of clients they are ultimately able to support. As well, clients who enter the program will be less likely to reduce or avoid frailty. The program's evaluation relies upon demonstrating clients' positive outcomes and supporting a low number of clients could jeopardize applications for funding beyond March 2022.

Research Questions and Project Objectives

This project aimed to identify barriers which prevent clients within Fraser Health's social prescribing program from accessing community-based services. It also identified facilitators which support clients to access services and concludes with recommendations for how the program can mitigate or resolve barriers, and enhance facilitators.

Primary research question:

- What barriers are preventing clients in the social prescribing program from accessing community-based services?

Secondary research questions:

- What are barriers which prevent frail seniors from accessing community-based services?
- What facilitators are supporting clients to access community-based services?
- How do these barriers and facilitators inform future practices of the social prescribing program?

As Huot and colleagues (2019) note, a project of this nature tends to focus on the needs and deficits of an individual or community. The secondary research question related to identifying facilitators which support clients to access services aims to counter this inclination by informing the social prescribing program of strengths and resources that can be enhanced to improve or maintain access for clients (Huot et al., 2019).

Background

Challenges in Caring for Frailty

Health care systems do not deal well with frailty because they are not organized to manage complex problems, health professionals have low awareness of frailty and there is a lack of expertise in caring for older adults living with the syndrome (Canadian Frailty Network, n.d.b). Since patients with frailty have multiple illnesses, they often end up dealing with numerous care providers such as general practitioners and specialists throughout their health journeys (Hansson et al., 2018). Those providers often work in a siloed manner, existing alongside but isolated from each other, which leads to delayed diagnoses,

medication errors and unhappy patients (Buchman et al., 2018). This fragmented approach also limits patients' abilities to be active participants in their care (Robben et al, 2012).

Furthermore, little research exists to guide care for frail seniors and evaluate current therapies (Canadian Frailty Network, n.d.b). This could change, however, as in June 2019 the Canadian Foundation for Healthcare Improvement launched a collaborative of 17 teams across the country who are working together to improve care for frail seniors in the community (CFHI, 2020). Fraser Health's CARES initiative is one of the participating teams.

Further complicating matters is a lack of consensus regarding how clinicians can and should identify if a patient is frail (National Institute on Ageing, 2018). To establish consistency among its referring general practitioners, Fraser Health's social prescribing program asks them to assess patients' frailty by using the Rockwood Clinical Frailty Scale, an assessment tool developed in Canada that has shown to predict the condition with reliability and accuracy (O'Caoimh et al., 2019)[1]. The scale uses a nine-point scoring system (one equals very fit and nine equals terminally ill); patients who score four are considered pre-frail and those who score from five to eight are considered frail.

Social Prescribing

It is likely widely assumed that as people age they become more likely to develop health issues. What may be less considered, though, is that as people age they also become more vulnerable to social determinants of health such as social support, financial limitations and housing (Ruikes et al., 2012). Social determinants of health are responsible for between 80 and 90 percent of people's health outcomes; they can also impact an individual's ability to access health care as well as the quality of care they receive (Magnan, 2017). As well, social factors can influence an individual's ability to recover from and cope with frailty (National Institute on Ageing, 2018).

At an individual care provider level, attention to the social determinants, given the important role they play in people's health, is low. Only 60% of British Columbian family doctors screen their patients for social needs, 47% frequently coordinate care with social services and 46% are unaware of social services in their communities (Canadian Institute for Health Information, 2020). Fortunately, health systems and governments are increasingly focusing on addressing social determinants, in recognition that doing so can improve people's health while reducing their dependency on medical systems (Alliance for Healthier Communities, 2020a). Implementing social prescribing programs is one way they are doing so.

Although definitions and delivery models of social prescribing vary (Elston et al., 2019), the practice has been in place, primarily within the United Kingdom, for almost three decades. Commonly, a general practitioner or other frontline care provider will refer a patient who has non-medical needs to a non-clinically trained person who then partners with the patient to co-design a wellness plan to improve their health and wellness (Polley et al., 2017).

The patient is then connected with a community- or volunteer-based organization or social enterprise that provides services and activities which could help the patient achieve their wellness plan (Brandling & House, 2009). These service providers include arts and culture organizations, senior services and nature groups (Alliance for Healthier Communities, 2020a), walking groups and bridge clubs (Seniors Come Share Society, 2019a) as well as exercise venues and community kitchens (Garm, 2019). This

[1]Still, the tool requires a degree of subjectivity and may be best applied when a clinician has some familiarity with a patient (O'Caoimh et al., 2019).

approach provides individualized care that supports people to address social factors which are negatively impacting their health (Polley et al., 2017), and to take a more active role in managing their health and wellness (Alliance for Healthier Communities, 2020a).

As the Alliance for Healthier Communities (2020a) explained following a pilot program in Ontario, social prescribing is as much about shifting health care culture as it is about shifting health care practice:

> Social prescribing is more than just overlaying a structure over existing processes, providing a set of new guidelines, or collecting more information. It is about fundamentally shifting the culture of the healthcare system. Social prescribing requires us to view healthcare from a strengths-based instead of illness-based perspective, to shift our perception of individuals from 'patient with needs' to 'person with gifts,' and to make collaboration and co-creation between clinical and social care the norm rather than the exception. (p. 42)

Despite the uptake of social prescribing since the 1990s, few high-quality studies have examined programs' effectiveness (Clements-Cortes & Yip, 2019; Polley et al., 2017b). As well, studies tend to focus on small-scale pilot projects and therefore have limited ability to comprehensively evaluate their effectiveness and value (Centre for Reviews and Dissemination, 2015). The diversity of social prescribing models also makes it challenging to compare or group them (Moffatt et al., 2017; Centre for Reviews and Dissemination, 2015).

When research on social prescribing is published, it often features poor design or reporting (Bickerdike et al., 2016) or weak research methodology (Pescheny, Pappas & Randhawa, 2018; Chatterjee et al., 2018). A recent review of more than 1,000 studies and reports on social prescribing programs, as well as programs strongly related to social prescribing, determined that none could claim evidence-based health, social or economic outcomes such as improvements in frailty, psychosocial wellness, social support and health-related quality of life for the frail and pre-frail seniors which they served (Smith et al., 2019).

Still, examples of social prescribing programs' positive outcomes found in this less-rigorous research include reducing participants' social isolation and building their resilience (Moffatt et al., 2017), improving participants' health and wellness (Elston et al., 2019), and generating positive behaviour changes (Friedli, Themessl-Huber & Butchart, 2012). Further (weak) evidence suggests that social prescribing can reduce demand on primary and secondary health care systems which have limited capacity to address issues that are rooted in social determinants (Polley et al., 2017b).

There is, however, some solid research to draw from. Elston and colleagues (2019) compared health outcomes data for 126 social prescribing program participants – roughly half of whom were mildly or moderately frail – before and after their 12-week intervention periods. The authors concluded that most participants achieved their wellness goals, more than half improved their abilities to self-manage their conditions, a third improved their frailty levels and almost half saw a decrease or no change in their health and social care costs (Elston et al., 2019). As well, a randomized control trial which evaluated a social prescribing-type model found that participants enrolled in the program experienced greater improvements in their anxiety and other "emotional problems," and felt more positively about their health, than patients who continued receiving routine care from their general practitioners (Grant et al., 2000).

Additionally, a robust evaluation of a social prescribing pilot program in Ontario was published last year. After reviewing the experiences of more than 1,100 clients who received almost 3,300 social prescriptions at 11 sites, evaluators determined that clients' health and wellness improved in numerous areas, repeat visits to primary care providers decreased and integration between health and social care providers improved (Alliance for Healthier Communities, 2020a). The program generated significant attention from media as well as governments and organizations within the health and social sectors; it has already shared learnings that will guide similar programs implemented in Canada (Alliance for Healthier Communities, 2020a) – including Fraser Health's initiative.

Ultimately, the potential likelihood of social prescribing to achieve cost-effective improvements in health outcomes, especially for patient populations who face barriers or challenges in achieving or maintaining health and wellness, has outweighed the need for their existence to be supported by rigorous evaluation. As well, even though previous research may lack quantitative data or findings with statistical significance, in general social prescribing program stakeholders believe that the practice improves participants' mental wellness and reduces demand on health care services (Kilgarriff-Foster & O'Cathain, 2015).

Opportunities to bridge the health and third/volunteer/community service sectors, mitigate social determinants which negatively impact people's health, and improve physical and mental health have already led social prescribing to become entrenched in health policies and priorities throughout the United Kingdom (Chatterjee et al., 2018). Although uptake of social prescribing has been slower in Canada compared to its Commonwealth counterpart, the practice is now beginning to receive more attention and resources.

Social Prescribing in Fraser Health

Fraser Health is one of the first organizations in Canada to implement a social prescribing initiative. Its program borrows heavily from United Kingdom-based models and focuses on a specific patient population: frail seniors. General practitioners in three communities are identifying patients with frailty and then developing care plans to mitigate the health deficits which are contributing to their frailty. This includes referring patients to one of the program's seniors' community connectors who then supports their non-clinical social concerns.

Currently seniors' community connectors are operating out of non-government organizations in White Rock/South Surrey, Mission and Tsawwassen. An additional six positions are set to join the program and serve other communities throughout the Lower Mainland and Fraser Valley. The United Way provides funding for the positions, which expires in March 2022, and chairs a community of practice for the connectors. Fraser Health provides overall coordination for the program, which includes partnering with the non-government organizations to hire connectors, advising on physician engagement and participating in the community of practice.

After receiving referrals from general practitioners, the seniors' community connectors assess patients' suitability for the program and then utilize motivational interviewing to learn about their challenges and co-develop wellness goals. They then connect these clients with community-based services that can help them achieve those goals. Connectors also provide close support and motivation as they build clients' capabilities and capacities to self-manage their health and social issues in order to delay frailty and loss of independence for as long as possible.

As clients utilize the community-based services, seniors' community connectors stay in regular contact with them in order to assess if they are continuing to pursue their wellness goals and, if so, identify any positive outcomes.

The program began receiving referrals in fall 2019 and seniors' community connectors have been struck by the barriers hindering their clients' abilities to access community-based services. This has resulted in more time than anticipated being spent identifying and addressing these barriers as opposed to connecting clients with community-based services, helping build the skills and confidence they need to self-manage their health and social issues, and ensuring they have the capacity to continue with their wellness plans without receiving support from the program.

Defining Access

The BC Patient Safety & Quality Council is mandated by the province's Minister of Health to "promote and inform provincially coordinated, innovative, and patient-centred approaches to patient safety and quality in British Columbia" (BCPSQC, n.d.). Fulfilment of this mandate includes establishing a common language and understanding around what it means to provide quality care within BC's health care system. This definition is encapsulated as the BC Health Quality Matrix, which describes quality through seven dimensions: respect, safety, appropriateness, effectiveness, equity, efficiency and accessibility (BCPSQC, 2020).

The BC Health Quality Matrix views accessibility as the "ease with which health and wellness services are reached" (Kelley & Hurst, 2006). It proceeds to note that:

> Accessibility is the extent to which people can readily obtain care when and where they need it. This dimension aims to overcome physical, financial, cultural and psychological barriers to receiving information and care. It includes a welcoming entry and seamless transitions between and within services. (BCPSQC, 2020, p. 5)

This report organizes barriers which prevent clients of Fraser Health's social prescribing program from accessing community-based services into categories identified by the BC Health Quality Matrix in its description of accessibility: physical, financial, cultural or psychological (BCPSQC, 2020). Facilitators which support clients in accessing community-based services are also categorized in this manner.

This categorization also aligns with previous research related to this report. For example, Minear and Crose (1997) grouped barriers to care faced by low-income frail seniors into five themes: emotional, economic, physical, knowledge and communication. Although not as concise, other barrier themes used by research cited within this report include physical and mental health status (Avgerinou et al., 2018), urban environmental (Clarke & Gallagher, 2013), barriers in interdisciplinary cooperation (Amacher et al., 2016) and responding to frail seniors' preferences and care needs with limited resources (Chapman, Keating & Eales, 2003).

The process of categorizing barriers into the four themes was carried out with as much accuracy and logic as possible, however some barriers and facilitators may not seem to naturally fit within their categories. The BC Patient Safety & Quality Council intentionally did not provide criteria which could be used to identify something as, for example, a financial barrier versus a physical barrier. This was done in an attempt to ensure that users of the BC Health Quality Matrix would focus on identifying and understanding barriers within their contexts as opposed to finding a predetermined fit within the categories (C. Hochfilzer, personal communication, January 14, 2021).

Terminology

Social prescribing programs are in place in health jurisdictions around the world, and their reports and documents cited throughout this report contain many synonymous terms for program components. This report has addressed that variance by consistently using terms which are utilized by Fraser Health's program:

- Program staff who "connect" people to service providers are called link workers, navigators, social prescribing navigators, community navigators and community connectors. This report calls them seniors' community connectors.

- Similarly, multiple terms are used to describe people who receive services, including participants, patients and clients. This report calls them clients.

- As well, the services which clients are connected to vary in nature and sector, and are described via numerous synonymous terms. This report calls them community-based services, and it uses the term service providers to describe organizations which provide the services.

Research Framework

A broad literature review, which considered a range of research populations, programs, services and regions, built the foundation of this project's research framework and an initial understanding of the challenges faced by the social prescribing program and its clients. It identified potential barriers experienced by clients of Fraser Health's social prescribing program as they access services, as well as potential facilitators which help them do so.

The quality, methodologies and styles of the studies which were reviewed varied immensely and the BC Health Quality Matrix, which is a framework for defining high-quality health and wellness care and services in British Columbia, provided a way to structure the early stages of this report's research framework. The Matrix's accessibility dimension specifies four types of barriers which can hinder people's abilities to obtain care when and where they need it: cultural, financial, physical and psychological (BCPSQC, 2020).

The Matrix's four access categories also update previous frameworks so they align with current paradigms concerning accessing health and social services. For example, research by Minear and colleagues (1997) was perhaps the most relevant to this project, however its structure and many of its barriers have not held up over the three decades since it was published, in particular those concerning culture. This applies especially to barriers related to the principles of person-centred care, such as shared decision-making, which have been prioritized within British Columbia's health care system for many years now (BC Ministry of Health, 2015).

Through this project's survey, the social prescribing program's seniors' community connectors identified how many of its past and current clients were affected by each of 147 potential barriers and 95 potential facilitators. This aggregate-level data established prominent barriers and facilitators and, conversely, those which affected few (if any) clients. For examples, the seniors' community connectors reported that stereotypes held by clients about themselves prevented 17 of them from accessing services; 17 clients encountered health care system bureaucracy such as red tape or complicated forms; and zero clients were held back because they felt that sustained behaviour change was too hard.

This level of data analysis could be helpful in itself. Broadly speaking, recommendations could be designed to resolve, mitigate or enhance any and all of the barriers and facilitators. This project, however, seeks to have the greatest impact for clients by resolving or mitigating, or enhancing, those which a) it can realistically address, and b) can be addressed quickly (Table 1). So while it is helpful for the program to now know that health care system bureaucracy is negatively affecting one out every five of its clients, the scale of interventions required to achieve change within such a complex system falls outside the scope of this project in terms of both time required and likelihood of success.

Table 1

Determining Potential Impact of Recommendations

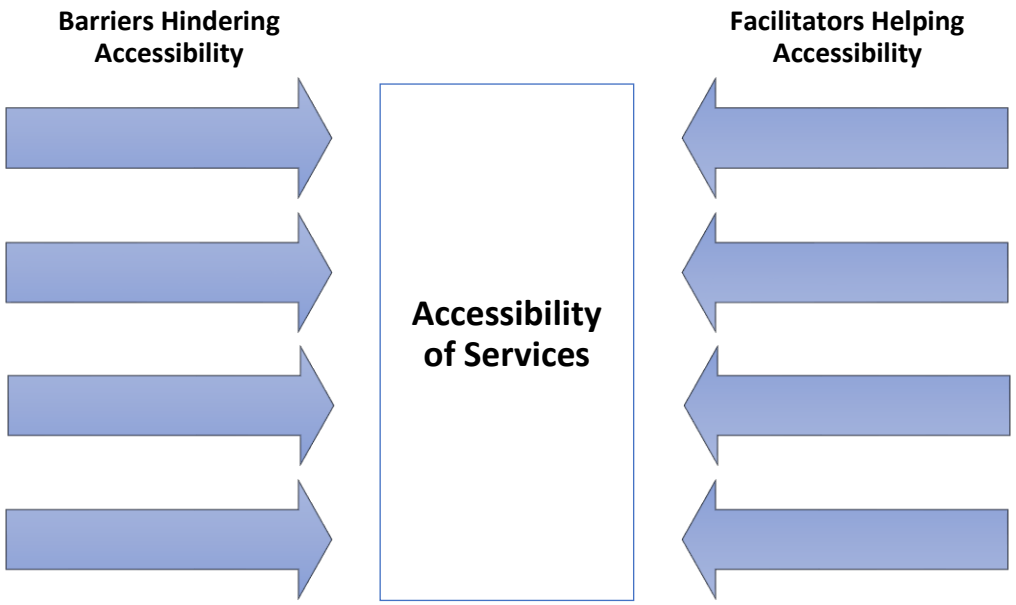
Likelihood of Impact			
	High		Example of barrier addressed: stereotypes held by seniors about themselves
	Low	Example of barrier addressed: health care system bureaucracy	
		Low	**High**

Potential Speed in Which Impact Could be Delivered

This project, therefore, used a force field analysis to identify prevalent barriers and facilitators which can be realistically and quickly resolved or mitigated, or enhanced, respectively, so that it could have the greatest potential impact. Force field analysis stems from field theory, an approach useful for planning change which sees situations as equilibriums maintained by various forces (Burnes, 2004). By identifying those forces, and understanding how they support that equilibrium, one can plan efforts to change equilibriums by removing negative forces and enhancing positive ones (Schwering, 2003). Often a diagram is used to visualize these forces: with hindering and helping forces placed on either side of a line, stakeholders identify those which can have the biggest impact on the change efforts by resolving or mitigating, or enhancing them, respectively (Schwering, 2003). See Figure 1 for an example.

Figure 1

Force Field Analysis as Applied to the Social Prescribing Program



Field theory is commonly associated with organizational change however it can be applied in a variety of contexts – for example, to understanding group behaviour or resolving social conflict within society (Burnes, 2004). In adapting and applying force field analysis to this project, barriers impeding the social prescribing program's clients from accessing services are considered hindering forces, and facilitators which support clients to access services are considered helping forces. Segmenting the 147 barriers and 95 facilitators assessed by research participants into the four categories provided by the BC Health Quality Matrix also served to establish boundaries for the force field analysis which led to a focused analysis and discussion of the ones most likely to have an impact on service accessibility if they were to be resolved, mitigated or enhanced.

When examining the complex issue of service inaccessibility for the social prescribing program's clients, it is apparent how many barriers are influenced in some way by the program's numerous stakeholders, by communication, funding and health issues, and by processes entrenched in bureaucracy, hierarchy and culture. Understanding how these issues come together to affect the accessibility of community-based services is aided by viewing them through the lens of system thinking.

Three elements form the core of any system: components, interconnectedness and purpose (Meadows, 2009). Systems thinking helps illuminate the degree to which components are working together to achieve their purpose (Meadows, 2009) – in other words, how components are creating the equilibrium which is a system's performance. It enables the social prescribing program to be viewed as an open system constantly within a state of dynamic equilibrium as it exchanges inputs and outputs with its environment (Kast & Rosenzweig, 1972), similarly to how force field theory enables the program to be viewed as an equilibrium maintained by helping and hindering forces.

Looking more closely at the social prescribing program, one sees how it features a multitude of stakeholders, issues and processes; how it is nested within suprasystems (health and social care); how it features information pathways, behaviour patterns and communication flows; and how its components emerge and grow in complexity over time. These are all characteristics of systems (Morgan, 2008), and they are often at the root of the barriers which are hindering the social prescribing program's clients' abilities to access services.

Furthermore, when considering change, systems thinking emphasizes change management and understanding risks (Morgan, 2005). Successful change interventions within systems often rely on holistic and strategic approaches which address many issues within a system and affect multiple stakeholders and areas of activity (Auspos & Cabaj, 2014). Force field analysis values understanding the system within which a change is desired before interventions are implemented (Burnes, 2004). This strategy of planned change is effective for "improving the operation and effectiveness of the human side of the organization" (Burnes, 2005) – a description which aptly summarizes many areas of the social prescribing program's system in which changes will be needed if barriers to services are to be resolved or mitigated.

This project's force field analysis served to identify where this project's recommendations could be most impactful. Resolving or mitigating hindering forces is more effective than enhancing helping forces, because if hindering forces are not removed they can continue to restrain performance (Cunningham, 2016). As such, the primary focus of this report is on resolving or mitigating barriers faced by the social prescribing program's clients. Many recommendations aimed at doing so rely on identifying strategies which have proven successful elsewhere and adapting them for the program's unique context – another strategy used within systems thinking (Morgan, 2005).

In summary, this report's research framework (Figure 2) functioned in four ways:

1. Organizing potential barriers and facilitators experienced by social prescribing program clients
2. Identifying actual barriers and facilitators experienced by social prescribing program clients

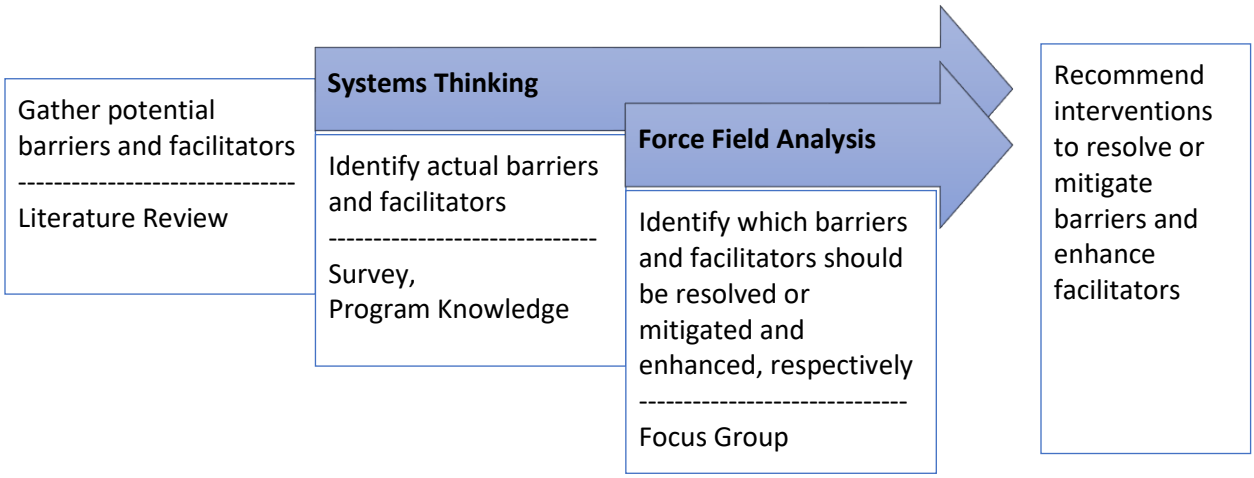
3A. Identifying barriers which, if resolved or mitigated, would have the greatest impact in improving the accessibility of services for clients of the social prescribing program.

3B. Identifying facilitators which, if enhanced, would have the greatest impact in improving the accessibility of services for clients of the social prescribing program.

4. Informing recommendations aimed at resolving or mitigating barriers and enhancing facilitators.

Figure 2

Research Framework



Literature Review

The purpose of this literature review was to generate a list of barriers to accessing community-based services which may be faced by the social prescribing program's clients, as well as facilitators which may support them in doing so. This was completed by utilizing the University of Victoria's Summon 2.0, Google Scholar, MEDLINE as well as the Cumulative Index of Nursing and Allied Health Literature. Included publications often focused on social care, seniors care, community care, health services and social services. The review also included grey literature published by social prescribing programs, or the organizations which operate them, as well as other community-based services which engage frail seniors. This research was supported by a Fraser Health librarian.

To date there has not been much research into caring for frail seniors (Canadian Frailty Network, n.d.b), which is likely connected to how health systems around the world have only recently begun prioritizing it as a public health issue (Kojima, Liljas & Iliffe, 2019). As well, research which has been conducted often focuses on a specific attribute of frail seniors or other patient populations. For example, studies by Minear and Crose (1997) as well as Chapman, Keating and Eales (2003) focused on frail seniors who have low incomes or are living in residential care, respectively.

Furthermore, it is common for literature to report on the number of clients who progress through a social prescribing program without analyzing why other clients were unable to start or complete the program – even when they are near in number or exceed the number of clients who finished (see Elston et al., 2019; Dinan et al., 2006; Bird, Biddle & Powell, 2019). Such research could illuminate barriers which prevented clients from starting programs or sustaining their participation.

Given this, as well as the lack of quality research into social prescribing programs identified previously in this report, the focus of this literature review was expanded to include research on similar client/patient populations, care settings and regions. For example, studies included in this review have focused on seniors who belong to specific ethnic groups, or who have specific health issues such as chronic

obstructive pulmonary disease. Their data has been reported by clients, their family members and/or service providers through a variety of research methods. Some are grounded in health care, others in social care.

The result is a robust examination of barriers which may be faced by frail seniors when accessing community-based services, as well as facilitators which may support them in doing so. In doing so, the challenges and issues faced by the social prescribing program and its clients begin to take shape and the foundation of this project's research framework was formed.

Barriers

Cultural Barriers

Historically, health care systems have prioritized and valued the experiences and needs of health care providers while ignoring those of the patients for whom they care (Baker, Judd, Fancott & Maika, 2016). Over the past decade or so, however, there has been a shift as organizations have recognized many benefits provided by designing service delivery with patients, not for them (Baker, Judd, Fancott & Maika, 2016). This new approach, termed person- and family-centred care[2], represents a systemic culture that honours the needs, interests and values of those who receive care as well as those of their loved ones (Institute for Healthcare Improvement, n.d.).

It is within this understanding that many cultural barriers to accessing care are grounded. If clients' cultural attributes were not considered when services were designed, those services may not be sufficient nor appropriate for that population (Carlton-LaNey, 1991). Furthermore, service providers' staff may lack the cultural competency necessary to communicate or build relationships with clients from other cultural groups (Shepherd et al., 2019).

For example, Minear and Crose (1997) found that low-income frail seniors may encounter rude or unhelpful service providers and stereotypes. There can be disconnects between clients' preferences and their service providers' priorities (Chapman, Keating & Eales, 2003); clients may feel that service providers are not listening to them (Pass, Kennelty & Carter, 2019) or are unresponsive to their needs (Farenden et al., 2015).

Barriers related to communication are common in research. These could include the limited English proficiency of service providers (Casado & Lee, 2012) as well as clients (Smedley et al., 2003). They also relate to the quality of a service provider's communication, both in the methods used (Pass, Kennelty & Carter, 2019) as well as the style used, such as impersonal or one-way approaches (Ligthart et al., 2014; Wang et al., 2018).

This category also includes the culture of the system within which services are being provided. System bureaucracy could manifest via red tape or complicated forms that clients have difficulty navigating (Minear & Crose, 1997). Poor coordination or communication between health care professionals could lead to fragmented service delivery (Muntinga et al., 2012). There could be a lack or trust or relationships between the social prescribing program's seniors' community connectors and general practitioners who refer clients to the program (Pescheny, Pappas & Randhawa, 2018).

[2] Synonyms include person-centred care, patient-centred care as well as patient- and family-centred care. The term person-centred is used throughout this report as family involvement in supporting loved ones' participation in social prescribing programs is not a common practice.

Finally, clients may be less likely to seek help because of their attitudes, preferences or values. For example, they may prefer faith- or medical-based services (Solway et al., 2010). They may also attach a stigma to frailty or using some of the services which may help them reduce their frailty (Biegal, Shore & Silverman, 1989; Solway et al., 2010; Pescheny, Pappas & Randhawa, 2018).

Financial Barriers

Unlike cultural barriers which may be intangible or very unique to every individual, financial barriers which the social prescribing program's clients may encounter are often universally applicable to seniors or service providers.

Clients' low incomes could impact their ability to access services (Minear & Crose, 1997). Relatedly, the costs associated with getting to services (Meshe, Bungay & Clayton, 2019) or participating in them (Amacher et al., 2019) may be too high. There could also be hidden expenses or rising costs associated with accessing services (Minear & Crose, 1997).

The social prescribing program may also create barriers for clients. Its seniors' community connectors could reach their capacity and be unable to accept new clients (Wang et al., 2018). The program may lack the staff or volunteer resources needed to effectively operate, or face high turnover among them (Pescheny, Pappas & Randhawa, 2018).

Service providers, on the other hand, may reach their own capacity and be unable to accept new clients or commit appropriate time to existing ones (Wang et al., 2018; Chapman, Keating & Eales, 2003). They may need to utilize wait lists (van Bilsen et al., 2008; Minear & Crose, 1997; Pescheny, Pappas & Randhawa, 2018) or clients may face wait times when theoretically able to access their services (Pass, Kennelty & Carter, 2019). How providers schedule services may not align well with clients' availability (Wildman et al., 2019).

Financial limitations could lead to a lack of continuity among service providers' activities (Valaitis et al., 2020; Minear & Crose, 1997) or staff (Ligthart et al., 2014). They may be unable to offer a range of activities for clients (Heatwole Shank et al., 2020), or activities for women only (Wildman et al., 2019). Systemically, a lack of funding overall could lead to services distributed unevenly throughout a region, leaving some areas uncovered (Huot et al., 2019).

Physical Barriers

This category encompasses a wide range of barriers which may hinder clients' abilities to access services. While the barriers are not limited to clients' physical health, it is clear that their ages and health issues can lead them to encounter personal and community-based obstacles.

On an individual level, clients may be unable to do assessments or engage in exercises (Amacher et al., 2016). The level of support they require for their physical health (Nagaya and Dawson, 2014) may prevent them from accessing services; so too might living alone, according to Wang and colleagues (2018), who examined barriers faced by frail seniors who have depression.

Clients' functional status – their ability to perform basic daily activities (Brown et al., 2017) – may impact how well they are able to access or participate in service providers' activities (Clarke & Gallagher, 2013; Wang et al., 2018). They may lack the strength needed to access services, or have hearing, eyesight or speech difficulties (Minear & Crose, 1997). Fatigue or medical appointments may also stand in their way (Meshe, Bungay & Claydon, 2019), as may sleep disorders (Ribeiro et al., 2015).

Medication side effects (such as dizziness) could impact clients' abilities to participate in activities (Ribeiro et al., 2015) and, as Ribeiro and colleagues (2015) note, previous research has found a relationship between taking multiple medications and lower physical activity levels. Relatedly, difficulty obtaining medications which could help clients access services is another potential barrier they may face (Minear & Crose, 1997).

Although 90 percent of seniors in British Columbia between the ages of 65-69 have a drivers licence, this figure steadily decreases as people age and it drops to just 61 percent for those aged 80-84 (Office of the Seniors Advocate, 2018). This often forces seniors to rely on public transportation, and there are many barriers associated with doing so which clients of the social prescribing program may encounter. Transit could be difficult to access (Valaitis et al., 2020; Clarke & Gallagher, 2013) or be unreliable (Meshe, Bungay & Claydon, 2019; Valaitis et al., 2020), and it could be inefficient or feature long wait times (Meshe, Bungay & Claydon, 2019).

At the service provider level, activities may be designed for people who are older than the clients (Wildman et al., 2019). Service providers' premises may not be wheelchair accessible (Minear & Crose, 1997), and clients who are advised to manage their own activities may face hazards in their home (Clarke & Gallagher, 2013) or lack the space or equipment to do so (Vernon & Ross, 2008).

In considering clients' communities, service providers may be based in areas perceived by clients as unsafe (Wildman et al., 2019). The distance which service providers are located from clients could be a barrier, as could the time required to traverse that distance (Meshe, Bungay & Claydon, 2019). A study of seniors who stay in their homes or communities as they age found that they can encounter inadequate lighting, excessive noise, heavy traffic or poor curbs, sidewalks or streets (Clarke & Gallagher, 2013).

Psychological Barriers

The final category, psychological, features the highest number of barriers identified through the literature review. The range of factors encompassed within the category are also extraordinarily complex and include a variety of elements grounded in emotions, knowledge, psychosocial responses and mental health.

There are a range of emotions, feelings and thoughts which may prevent clients from accessing services. Minear and Crose (1997) identified numerous psychological barriers (which they termed emotional) experienced by low-income frail seniors: clients may feel discouraged by, and lack trust in, systems; they may feel frustrated or impatient; they may be too prideful in caring for themselves and feel shame in asking for help or too stubborn to do so; and they may feel confused by, rejected by and weary of services. Furthermore, the authors identified numerous fears which were barriers, including fear of strangers, losing control of their affairs or losing their homes (Minear & Crose, 1997) as well as being harmed, losing independence or losing privacy (Minear & Crose, 1997).

Clients may also feel anxiety over being considered annoying or a bother/nuisance (Smith & Carragher, 2019), or over what others may think or say (Nagaya & Dawson, 2014). Feelings of alienation may dissuade them from participating, or they may be suspicious of unknown "people who come to help" (Carlton-LaNey, 1991). They may lack motivation (Bleijenberg et al., 2013), a sufficient understanding of frailty (Minear & Crose, 1997) or the self-efficacy to make necessary changes (Clarke & Gallagher, 2013). Multiple studies identified low health literacy as a barrier which prevented seniors from effectively

communicating about and understanding health information (Valaitis et al., 2020; Pass, Kennelty & Carter, 2019).

Mental health issues may also block clients from accessing services (Minear & Crose, 1997); more specifically, this could include depression or depressive symptoms (Ribeiro et al., 2015) or psychological affects of living with long-term conditions (Wildman et al, 2019). Perhaps clients are unable to set goals and keep to a plan, or remember appointments (Avgerinou et al., 2018). They may lack the social skills required to participate in service providers' activities (Wang et al., 2018) or a social support system that may aide their participation (Minear & Crose, 1997).

Once clients begin interacting with service providers, they may feel judged, disrespected or disregarded (Ligthart et al., 2015), or find that providers' advice or instructions are patronizing (Ligthart et al., 2015). They may feel unwelcomed (Farenden et al., 2015), intimidated (Meshe, Bungay & Claydon, 2019) or reluctant to discuss their current behaviours (Harris et al., 2019). In their study of UK-based social prescribing programs, Pescheny, Pappas and Randhawa (2018) note that clients may be skeptical of activities' potential benefits. Clients may be worried about being taken seriously (Smith & Carragher, 2019) or service providers' abilities to maintain confidentiality (Biegal, Shore & Silverman, 1989).

Over time, clients may de-prioritize accessing services or not wish to make changes at the expense of "style" (Mohler, Neufeld & Perlmutter, 2015). They may ultimately feel that sustained behaviour change is too difficult (Wildman et al., 2019) or the required time investment is off-putting (Harris et al., 2019). They may have concerns about their health and safety (Heatwole Shank et al., 2020) or worsening their current health issues (Bird et al., 2019). Clients may have difficulty establishing long-term relationships with service providers (Pass et al., 2019); so too may their family members, which can be important if they are relied on to support their frail loved ones (Chapman, Keating & Eales, 2002).

There are also psychological barriers that may lie with service providers, such as a lack of relevant knowledge or training (Wang et al., 2018; Britton, 2017). They may be skeptical of information from others, such as general practitioners (Amacher et al., 2016), the information they give to clients may be misleading (Minear & Crose, 1997) or activities they recommend may encourage a dependency on them that prevents clients from self-managing their health or care, which was a barrier identified by Frost and colleagues (2017) in a study of seniors with mild frailty. Providers' staff may not provide the social prescribing program's seniors' community connectors with needed or sufficient information for them to effectively connect clients with service providers (Minear & Crose, 1997).

Finally, at a program level, the social prescribing program itself may lack a process for identifying and responding to barriers faced by its clients (Pescheny, Pappas & Randhawa, 2018). General practitioners may not be familiar enough with the program to accurately explain it to their patients, provide appropriate referrals or set realistic expectations with referred patients (Pescheny, Pappas & Randhawa, 2018).

Facilitators

Cultural Facilitators

Similarly to cultural barriers, many culture-based facilitators reported in previous research relate to how service providers respect the needs, values and preferences of the social prescribing program's clients. Effective relationships between all stakeholders, which are based on elements such as trust and strong rapport, may also support clients in accessing services.

For example, factors which may support clients in accessing services include providers' empathy (Ramsay et al., 2019), caring demeanour (Marlow, White & Chesla, 2010), one-on-one attention (Blonski et al., 2014) and ability to recognize and reinforce clients' efforts (Ligthart et al., 2015). It can be beneficial when they ask clients questions, listen to their answers and then develop individualized plans with them (Ligthart et al., 2015), or when they assess activities and modify them for clients' abilities (Blonski et al., 2014).

In a study of health promotion facilitators which help frail seniors engage in behaviour change, the importance of reflective listening was highlighted (Avgerinou et al., 2019). Effective communication skills (Ramsay et al., 2019) and methods (Valaitis et al., 2020) were also cited in previous research. Clear, simple instructions could help clients follow service providers' instructions (Blonski et al., 2014) and ensuring that clients do not feel judged could go a long way towards helping them have positive experiences and relationships with service providers (Ramsay et al., 2019).

Additional facilitators which could support clients to access services include respecting their autonomy, ensuring they feel heard and respected, and providing space for them to discuss issues as equal partners (Ligthart et al., 2015). Establishing positive goals with clients[3] may help clients overcome things like stigma or negative stereotypes which they hold (Amacher et al., 2016). In a review of a social prescribing program for people with long-term conditions, Moffatt and colleagues (2017) concluded that rapport and a high-quality relationship between clients and seniors' community connectors was integral to clients achieving their wellness goals.

At the program level, facilitators may include clients' longstanding relationships with seniors' community connectors (Ligthart et al., 2015). Strong relationships based on elements such as trust, respect and shared understanding between all social prescribing program stakeholders has been shown to support clients in accessing and benefitting from services (Farenden, 2015). Trust was a theme in other research as well, whether it be between seniors' community connectors and clients (Wildman et al., 2019), clients and service providers (Ligthart et al., 2015) or service providers and general practitioners (Valaitis et al., 2020). Furthermore, in a review of eight studies of social prescribing programs in the United Kingdom, Pescheny, Pappas and Randhawa (2018) concluded that structured contact and regular communication between connectors and practitioners as well as between connectors and service providers impacted numerous areas related not only to facilitating clients' access to services, but to removing barriers as well.

In a study of primary care and community-based health and social services which care for seniors, Valaitis and colleagues (2020) found that effective case coordination and adapting services to address access barriers or gaps for clients' needs facilitated access. Furthermore, they found that advocating on behalf of clients for improved program access was key because they have challenges doing so for themselves (Valaitis et al., 2020).

Financial Facilitators

Financial facilitators identified in previous related research are relatively straightforward, however there is little space devoted to supporting clients who may not have the means to participate in service providers' activities. This is key, given that a senior's socioeconomic status – often measured as a combination of education, income and occupation (American Psychological Association, n.d.) – could be linked to increased participation in activities that promote physical activity (Ribeiro et al., 2015).

[3] For example, goals focused on what to do as opposed to what to avoid doing.

Access to a vehicle could help clients travel farther distances to services while reducing their reliance on others, public transportation or taxis (Heatwole Shank et al., 2020). To that end, seniors with mild frailty in the United Kingdom reported that travel subsidies for taxis helped them access services if they had difficulty using public or private transportation (Avgerinou et al., 2019). On a related note, service providers able to perform outreach to clients could improve access for those who have transportation challenges (Ramsay et al., 2019).

Program funding was a common theme among financial facilitators described by previous related research. It can enable service providers to provide regular support and supervision (Meshe, Bungay & Claydon, 2019; Pescheny, Pappas & Randhawa, 2018), as well as improve the overall diversity of providers in an area (Pescheny, Pappas & Randhawa, 2018).

Physical Facilitators

A person's symptoms of frailty often impact their physical health, so it is unsurprising that this literature review found numerous facilitators related to clients' physical abilities to travel to and participate in services providers' activities.

Convenience is an important factor – services' proximity to participants and duration, as well as the time of day and day of week during which they take place, have all shown to increase seniors' abilities to access them (Meshe, Bungay & Claydon, 2019). Integrating participation into consistent routines could also help (Blonski et al., 2014); so too could the ability of clients to commit appropriate time to engaging in activities (Meshe, Bungay & Claydon, 2019).

Co-designing individualized home-based activities has been identified by seniors with mild frailty as potentially improving their participation in activities (Frost et al., 2017). Relatedly, giving seniors with mild frailty equipment and instructions to take home has shown to help them change behaviours (Avgerinou et al., 2019).

Since clients may face challenges travelling to service providers, previous related research has shown that locating providers in locations which are familiar to clients, or which feature transportation routes familiar to clients, can improve their accessibility (Heatwole Shank et al., 2020). Centralizing multiple service providers' locations could also help clients access them (Ramsay et al., 2019). Meshe and colleagues (2019) found that seniors with chronic obstructive pulmonary disease, which is associated with frailty (Marengoni et al., 2014), recommended that service providers avoid overcrowding in their spaces and provide proper equipment.

To that end, additional transportation-related facilitators identified by this review include seniors' abilities to drive (Heatwole Shank et al., 2020) or to leverage a family member or friend who could do so (Frost et al., 2017). In one study, seniors with mild frailty were better able to engage in activities when service providers' locations were easily accessible by foot or public transportation (Frost et al, 2017). Good weather is also a factor which has been shown to positively impact seniors' abilities to travel to service providers (Meshe, Bungay & Claydon, 2019).

Additional physical facilitators identified in previous research include the ability of seniors with mild frailty to complete forms (Frost et al, 2017) and the value provided by participating in activities alongside others with similar health issues (Blonski et al., 2014).

Psychological Facilitators

Psychological facilitators identified by related studies tend to focus on factors which affect clients' motivation to continue accessing service provider's activities and how well they are supported in doing so.

Strong social networks (Casado & Lee, 2012; Frost et al., 2017; Mohler, Neufeld & Perlmutter, 2015) was a common theme. In researching how to drive behaviour change among frail seniors, Avgerinou and colleagues (2019) determined that social, practical and emotional support was important. Meshe, Bungay and Claydon (2019) found this as well in their study of seniors with chronic obstructive pulmonary disease, in addition to support from family members and peers. Indeed, having role models (Rice et al., 2018) and help from family or others at home (Nagaya & Dawson, 2014) were facilitators identified in related research.

Many studies related to this project have connected seniors' experiences with service providers, and results from engaging in activities, with their continued engagement and motivation. High levels of self-esteem and self-efficacy have been shown to help seniors complete activities (Ribeiro et al., 2015), as have positive attitudes (i.e., determination and willingness to accept their situations) and desire to maintain or regain their independence (Mohler, Neufeld & Perlmutter, 2015).

Positive first experiences with service providers have shown to help (Rice et al., 2017). Seniors with chronic obstructive pulmonary disease have explained that it helps when they feel safe performing physical activities, either through service providers' support or learning to take personal responsibility for their safety, and when the activities are fun and less daunting (Meshe, Bungay & Claydon, 2019).

In previous research, seniors with mild frailty identified numerous characteristics of service providers which supported them in accessing services, including when providers' staff are "lively" young people or mature people whose life experiences may help them understand seniors' concerns (Frost et al, 2017), and when they use goal-setting approaches (Avgerinou et al., 2019). The genders of service providers' staff members could also influence whether or not clients continue accessing services (Rice et al., 2018).

Motivation is another theme which emerged across multiple related studies, where it has been created by the perception of being monitored (Ligthart, et al., 2015) as well as through actual monitoring of performance, including self-monitoring (Avgerinou et al., 2019). It has also been generated when seniors see themselves benefitting from their participation in activities (Meshe, Bungay & Claydon, 2019), receive positive feedback from service providers (Avgerinou et al., 2019) and know if they are doing well (Ligthart, et al., 2015).

Finally, in their review of eight UK-based social prescribing programs, Pescheny and colleagues (2018) found that when all stakeholders have shared understanding, attitudes and perspectives, expectations can be managed, tensions and disappointment can be prevented and stronger partnerships are developed.

Conclusion

There is very little previously published research which is directly relevant to this project so its literature review was supplemented by considering research related to social prescribing programs and/or frail seniors. The number of studies which identified barriers to accessing services is much greater than the number which identified facilitators, indicating a pattern within evaluation of analyzing what is hindering the effectiveness of programs as opposed to supporting their effectiveness.

More than 40 studies, reports and pieces of grey literature were included within the literature review. In total, 147 barriers and 95 facilitators potentially experienced by the social prescribing program's clients were identified, providing an initial, foundational awareness of the issues which this project seeks to identify, understand and then address through its recommendations. As this project's research framework outlined, that foundation enabled the program's seniors' community connectors to identify the barriers and facilitators which are indeed experienced by the program's clients and, in doing so, illuminate the path which this project followed.

Methodology & Methods

Methodology

This project employed a mixed methods methodology, gathering both qualitative and quantitative data in order to identify barriers that frail seniors in the social prescribing program face in accessing community-based services, as well as facilitators which help them access services. A sequential approach enabled each research method, as completed, to inform the next. This methodology was chosen in order to develop a full understanding of the barriers and facilitators as well as their impact on the program's clients, especially if the barriers were complex and/or not easily identifiable, and to maximize the potential impact of recommendations.

Survey

An electronic survey (Appendix 1) was sent to the social prescribing program's three seniors' community connectors. Comprehensive lists of potential barriers and facilitators, which were identified through the literature review, were included so that the connectors could identify any which their clients experience. Additional potential barriers and facilitators which were identified outside of the literature review (e.g., in conversations with this project's client) were also included.

The seniors' community connectors identified how many of their past and current clients experienced each barrier and facilitator that was listed; they were also able to add barriers and facilitators which were not contained within the survey. Additional open-ended questions allowed the connectors to provide additional context which informed their answers as well as details about how the COVID-19 pandemic affected the barriers and facilitators. This research did not collect any information which could identify a client.

Questions relating to clients' demographics were also included to help identify potential relationships between their personal characteristics and the barriers and facilitators they experience (Allen, 2017).

Focus Group

Next, a focus group was facilitated with the seniors' community connectors over Zoom, during which they were invited to discuss their aggregate-level survey data and its implications for the social prescribing program. The discussion gave them an opportunity to share comprehensive explanations and anecdotes which provided a richer understanding of the impact that barriers and facilitators have on clients.

The seniors' community connectors were asked open-ended questions which explored themes found within their data, relationships between barriers and/or facilitators, new barriers and facilitators identified by the connectors as well as how COVID-19 has affected services' accessibility.

A force field analysis was also facilitated during the focus group in order to identify barriers and facilitators which can be quickly and realistically resolved or mitigated, or enhanced, respectively. The seniors' community connectors were led through a series of exercises where, for each category (cultural, financial, physical and psychological), the five most prevalent barriers and facilitators (plus ties) were displayed. The connectors were then asked to score each barrier and facilitator from one to five, with one being weak and five being strong – by considering two factors: the likelihood that change could be achieved by resolving or mitigating that barrier or enhancing that facilitator, and the ability to achieve that change quickly. Their scores were then averaged (figures three through six) to determine the barriers and facilitators which this project's recommendations should focus on in order to have the greatest impact. This approach also enabled the connectors to validate data they provided through the survey.

Analysis: Survey Data

Quantitative data from the survey's close-ended questions was aggregated in order to provide a view of the total number of social prescribing program clients who experienced barriers and facilitators to accessing community-based services. This approach also maintained the anonymity of clients whose identities may have been inferred if region-level data was reported, given the relatively small number of clients served by each seniors' community connector.

An initial review of the aggregated data removed barriers and facilitators which no clients experienced; barriers and facilitators which were experienced by clients were then reviewed to identify themes. This was completed by using a general inductive approach common to health and social science research which allows findings to emerge from themes in the data (Thomas, 2006). This approach also allows data analysis to be shaped by the researcher's decisions about what is and is not important (Thomas, 2006) – which was relevant to this project because focus needed to be applied to some barriers and facilitators at the expense of others.

Responses to the survey's open-ended questions were analyzed to identify similar experiences reported by the seniors' community connectors, unique situations and other topics which warranted exploration and deeper discussion in the focus group. Anecdotes and anonymized quotes which represent the themes and provide examples of how barriers and facilitators affect clients were selected and included in this report; they do not include information which could infer the identities of any social prescribing program clients.

The aggregate survey data and initial analysis were provided to the seniors' community connectors in advance of their focus group so that they could review and reflect on it before discussing it together.

Analysis: Focus Group Data

The focus group was digitally recorded, transcribed verbatim and annotated with notes taken contemporaneously during the conversation by the researcher. The data was checked against the recording for accuracy and analyzed to validate and improve findings generated by the general inductive approach used when reviewing the survey data.

Anecdotes and quotes which illustrate themes and provide examples of how barriers and facilitators affect clients were selected and included in this report. Again, they do not include information which could infer the identities of any program clients.

Limitations and Delimitations

A central limitation to this project is the small the number of clients (53) being served by the social prescribing program. This number was expected to be higher but the COVID-19 pandemic significantly impacted the program's operations – it went on hold when initial safety measures were put in place, preventing the seniors' community connectors from enrolling new clients. As the number of clients served continues to grow over time, it will remain to be seen how representative this initial snapshot remains.

Additionally, as noted in the literature review section, this project is focusing on the experiences of a specific segment of the population (frail seniors) in accessing a specific type of service (community-based). As such, existing literature on the topic was limited and needed to be supplemented by research on related client populations, care settings, programs and jurisdictions.

A further limitation is how the social prescribing program's clients are not interviewed. Asking seniors' community connectors to provide data about clients means that only one perspective is provided about how barriers and facilitators are experienced – and it is not the perspective of the people who are experiencing them. The decision to interview connectors and not clients was based on a few factors. First and foremost was the recognition that connectors are deeply familiar with their clients. They have met with their clients, often multiple times, and this relationship-building has likely uncovered barriers and facilitators that a single visit or conversation would not. As Chapman, Keating and Eales (2003) note, getting to know clients on a deep level may be the most valuable way to fully understand their preferences, decision-making and needs.

The seniors' community connectors' backgrounds and experience better equipped them to identify barriers and facilitators. This includes years if not decades working in social services, social work and with seniors, providing them with in-depth knowledge of how seniors access services in their communities. This undoubtedly helped the connectors identify barriers and facilitators faced by their clients.

As previously noted, barriers faced by clients can be very unique to them individually and often very personal. Their existence may not emerge within a single conversation or, in the case of physical barriers, without visiting clients in person or in their "natural environments" as the seniors' community connectors have done with most of their clients. Furthermore, due to COVID-19 precautions, it was impossible or unsafe for the researcher to visit clients – seniors with multiple health issues.

This tactic was also chosen so as to not reduce an already small population of clients being considered by this project. If the researcher would have been unsuccessful in contacting some clients due to illness, death, moving, technology barriers, COVID-19 or other reasons, the representativeness of this data would have further eroded as the program expands and accepts additional clients.

Conclusion

Results from this literature review painted a picture of potential barriers and facilitators experienced by clients of Fraser Health's social prescribing program as they access community-based services. Next, a survey established the current state – that is, the actual barriers and facilitators experienced by clients. Finally, following an analysis of those barriers and facilitators, a focus group allowed for a deeper exploration and more comprehensive understanding of them as well as how they affect the clients.

Findings

This section contains findings from the project's survey and focus group. Both subsections are organized according to the cultural, financial, physical and psychological categories, with the survey subsection doing so twice, once for barriers and once for facilitators.

Survey Data

All three of the program's seniors' community connectors completed an online survey in October 2020. Only aggregate-level numerical data is reported so that, even if a connector has a small number of clients, connections cannot be made or inferred between their answer to a numerical question (e.g., "How many clients…") and the individuals whom that answer could include. This is also why the connectors are kept anonymous when their quotes are included.

The survey began by gathering data about the number of past and current clients in the social prescribing program. Next, the seniors' community connectors progressed through eight sections which asked them to identify how many of their clients experienced all potential barriers and facilitators to accessing services which were identified through the literature review, interviews with the client and program knowledge. Each section also invited the connectors to answer open-ended questions. The survey ended by asking the connectors questions about various characteristics of their clients.

It is clear through survey data as well as feedback provided by the seniors' community connectors that they faced limitations both in terms of information they know about their clients as well as their ability to accurately report it at an aggregate level. For example, although the seniors' community connectors report serving 53 past and current clients, they provided data for 57 clients when answering a question about clients' living situations. As a result, percentages are only included to emphasize when a particularly high number of clients have experienced a barrier or facilitator and, when they are included, it is noted that they are rough percentages.

Number of Clients

The seniors' community connectors reported a total of 53 past and current social prescribing program clients. Of those 53 clients, 32 were being served by the seniors' community connectors at the time of data collection. As well, the connectors reported that six of their past clients exited the social prescribing program because they became able to self-manage their participation in services – which is the program's primary goal for its clients.

The seniors' community connectors also reported that five past clients had exited the social prescribing program because barriers prevented them from accessing services. A further 10 clients had exited the program for reasons unrelated to barriers or their abilities to self-manage their participation in services[4].

Cultural Barriers

The survey began by identifying how many clients experience barriers to accessing community-based services. The first section featured 20 potential cultural barriers and the seniors' community connectors provided data on how many of the clients actually experienced each one (Table 2). They were also invited to also answer open-ended questions related to the category so that they could provide context and add barriers which were not included in the survey's list.

[4]Reasons cited by one seniors' community connector include moving to be closer to family, memory loss, cognitive decline and the COVID-19 pandemic.

Table 2

Cultural Barriers Experienced by Past and Current Clients

Barrier[5]	# of Clients
Beliefs	
Client: stereotypes about seniors	14
Stigma attached to frailty	8
Client: stereotypes about frailty	8
Client is less likely to seek help because of cultural reasons or values	2
Service provider: stereotypes about frailty	0
Service provider: stereotypes about seniors	0
Systems	
Lack of structures/processes to guide collaboration between seniors' community connectors and GPs	14
Health care system bureaucracy (e.g., red tape, complicated forms)	8
Lack of coordination and information exchange between health care professionals	8
Limited availability of culturally competent services	2
Behaviours	
Care is not client-centred (clients are not considered partners; their needs and desired health outcomes are not the driving force behind decisions)	6
Disconnect between client's preferences and service provider's priorities	5
Communication: poor methods used	5
Communication: poor quality (impersonal, one-way)	4
Communication: rude or unhelpful service providers	4
Communication: service provider "doesn't listen" or is unresponsive	4
Lack of trust or relationships between seniors' community connectors and GPs	2
Communication: client's limited English proficiency	1
Communication: service provider's limited English proficiency	0
Lack of trust or relationships between seniors' community connectors and service providers	0

Sixteen of the 20 potential cultural barriers assessed by the seniors' community connectors in the survey have been experienced by at least one of the social prescribing program's clients. Under the beliefs theme, clients' stereotypes about seniors tied for the most prevalent barrier they experience. Their stigma and stereotypes about frailty also ranked highly while, conversely, the seniors' community connectors did not report any instances of service providers holding stereotypes about frailty or seniors.

Within the systems theme, "lack of structures/processes to guide collaboration between seniors' community connectors and general practitioners" was the other most-prevalent barrier, followed by "health care system bureaucracy" and the "lack of coordination and information exchange between health care professionals."

[5] Barriers are grouped according to three themes adapted from those used for recommendations within a recently published report which are aimed at eliminating Indigenous-specific racism within British Columbia's health care system. "Beliefs" refers to attitudes and understandings; "systems" encompasses structures, processes and contexts; and "behaviours" includes norms and actions (Turpel-Lafond, 2020).

In responses to open-ended questions, the seniors' community connectors described how complicated processes and paperwork as well as back-and-forth between services create access barriers. Feedback from one connector illustrated how general practitioners' heavy workloads affect their abilities to learn about the program and remain engaged after submitting initial referrals:

> Difficult to gain access to doctors to promote the program. Medical offices are very busy. Doctors usually have 10 minutes with patient[s] to discuss multiple health issues so social prescribing is not top of mind, even though [clients accessing] the program would alleviate pressure on the health system.

One seniors' community connector noted that she was able to help resolve clients' barriers pertaining to paperwork and another mentioned that COIVD-19 has worsened the isolation faced by seniors.

Financial Barriers

Next, the seniors' community connectors answered how many of their clients experienced each of 23 potential financial barriers (Table 3) as well as open-ended questions about the barriers.

Table 3

Financial Barriers Experienced by Past and Current Clients

Barrier	# of Clients
Clients' Finances	
Low income	26
Costs associated with getting to services	12
Hidden expenses	10
Rising costs related to accessing services	9
Not accessing relevant subsidies/financial benefits	8
Costs associated with participating in services	3
Program's & Service Providers' Finances	
Services are unavailable (wait lists)	8
Service provider: unable to accept new clients	6
Service provider: lack of options for services/activities	5
Services are delayed (wait times)	3
Seniors' community connectors: unable to accept new clients	0
Seniors' community connectors: unable to commit appropriate time to clients	0
Service provider: unable to commit appropriate time to clients	0
Service provider: lack of continuity among services	0
Service provider: lack of services for women only	0
Service provider: lack of services for men only	0
Turnover in service provider's staff	0
Social prescribing program lacks staff or volunteers	0
Turnover in social prescribing program's staff or volunteers	0
Unsuitable scheduling of services	0
System Funding	
Insufficient diversity of services available	17
Uneven distribution of services within region	7
Insufficient number of service providers	6

Low income was, by far, the most prevalent financial barrier cited by seniors' community connectors as hindering clients' abilities to access services. Costs associated with travelling to and participating in services also ranked highly. This was elaborated upon within the connectors' comments, as one cited clients' difficulties controlling their spending, managing finances and covering expenses.

Many of the social prescribing program's clients are affected by the financial impact of joining the program as well as barriers related to system-level funding. Seventeen past and current clients were challenged by the lack of diversity of services which were available to them. Indeed, in comments, one seniors' community connector noted a disparity in the programs available across the communities which they serve.

Another seniors' community connector mentioned how some clients cannot afford the fees charged by recreation centres and how she has argued on behalf of clients to have the fees waived. Clients also often do not access subsidies or financial barriers which are available to them – barriers resolved by one connector by signing clients up for homeless prevention programs, food banks and food centres.

Regarding COVID-19, seniors' community connectors mentioned that financial barriers which were already affecting clients' abilities to access services have persisted through the pandemic. Some have been worsened, such as how service providers have restricted the number of people who are able to attend programs at one time.

Physical Barriers

Thirty-seven potential physical barriers were assessed by the senior's community connectors (Table 4). They were also invited to answer open-ended questions about the barriers.

Table 4

Physical Barriers Experienced by Past and Current Clients

Barrier	# of Clients
Clients' Homes & Environments	
Client's physical isolation	29
Client's home: hazards	4
Client's home: lack of space/equipment	2
Clients' Health	
Client's health: fatigue, lack of strength	26
Client's health: functional status (difficulty doing basic daily activities)	20
Client is unable to engage in exercises	17
Client's health: too frail	14
Client's health: sleep disorder	13
Client's health: medication side effects	10
Client's health: medical appointments	7
Client's health: multiple medications	7
Client's high level of care needed: physical health	6
Client's health: hearing difficulties	6
Client's health: eyesight difficulties	5
Client's health: addiction or substance use	4
Client's health: difficulty obtaining medications	2
Client's health: speech difficulties	2
Client is unable to do assessments	1
Transportation	
Distance to travel to reach services	7
Public transportation: difficult to access	5
Public transportation: inefficient	2
Public transportation: long wait times	0
Public transportation: unreliable	0
Time to travel to reach services	3
Difficulty accessing health care	2
Bad weather	0
Safety & Accessibility	
Client's age: services are geared towards younger participants	2
External environment: conditions of curbs, sidewalks, streets	1
External environment: excessive noise	1
External environment: heavy traffic	1
Client's age: services are geared towards older participants	0
External environment: inadequate lighting	0
Service provider: location is unsafe	0
Service provider: location is not wheelchair accessible	0
Other	
Appointments/meetings are often rescheduled by client	4
Client has a job	3
Client lacks time	3

Although barriers related to clients' physical health are most of the highest-ranked barriers within the category, "physical isolation" is the most prevalent barrier, with roughly 55% of the social prescribing program's past and current clients experiencing it. Conversely, few, if any, clients experienced barriers related to external environments and public transportation.

Comments provided by the seniors' community connectors made clear the connections between physical barriers and the social determinants of health. For example, one client's cluttered home was filled with fruit flies, another's social isolation made it difficult for them to manage a routine, and a third client's depression prevented them from taking steps to address barriers they were facing. Some barriers have also been exacerbated by COVID-19 – it has worsened the isolation for one client who cannot get out of their house and clients dealing with depression have found the extra steps needed to access services during a pandemic to be overwhelming.

Psychological Barriers

For the final barrier category, the seniors' community connectors provided data on how many of the clients experienced 68 potential psychological barriers (Table 5) and answered open-ended questions about the barriers.

Table 5

Psychological Barriers Experienced by Past and Current Clients

Barrier[6]	# of Clients
Feelings & Reactions	
Frustration	45
Discouragement	30
Lack of motivation	30
Pride	21
Stubbornness	20
Weariness	14
Confusion	9
Impatience	1
Mental Health	
Depression or depressive symptoms	40
Previous trauma	25
Psychological burden of living with a long-term condition	21
Mental health issues	17
Dementia	8
Knowledge	
Lack of understanding of frailty	33
GPs have difficulty explaining the social prescribing program to patients	22
Service provider: lack of knowledge about frailty	1
GPs' referrals to the social prescribing program are inaccurate	1
Seniors' community connectors' lack of awareness of services	0
Service provider: lack knowledge and training	0
Service provider: information given to clients is misleading	0
GPs give patients inaccurate information, leading to unrealistic expectations	0
Social & Emotional Support	
Lack of social support system	31
Social isolation	22
High level of emotional support needed	16
Lack of social skills	7
Alienation	0
Negative Beliefs, Attitudes or Fears	
Anxiety about being "a bother," "a nuisance" or "annoying people"	25
Client fears losing their independence	20
Shame	18
Client is skeptical of service's benefits	14
Client fears losing their privacy	13
Self-efficacy	11
Suspicion of unknown "people who come to help"	10
Distrust	9
Doesn't expect to benefit	7

[6] These barriers' themes have been adapted from Soundy et al. (2014)

Concerns about what others may think or say	6
Client is reluctant to reveal current behaviour	4
Concerns about health and safety	3
Client fears losing their home	3
Client is not willing to receive help	2
Concerns about potential for exacerbating existing health issues	2
Client is worried about being taken seriously	0
Client fears being harmed	0
Support from Service Providers	
Service provider: activities encourage dependency	14
Service provider: technology is inaccessible or intimidating	12
Patronizing advice or instructions	9
Service provider: staff discouraged by client's lack of interest	3
Service provider: skeptical of information from others (e.g., primary care doctors)	2
Client does not feel welcomed by service	0
Difficult to engage and motivate service provider	0
Responses to Support	
Feel disrespected or disregarded	13
Feel judged	12
Activity became less important or interesting to the client	10
Rejection	5
Intimidation	4
Maintaining style preferences was more important than making a change	0
Client is unsatisfied with progress	0
Required time is off-putting	0
Client feels that sustained behaviour change is too hard	0
Support from Seniors' Community Connectors or Social Prescribing Program	
Social prescribing program lacks process for identifying and responding to barriers	7
Other	
Low health literacy	24
Unable to set goals and keep to a plan	16
Lack of confidentiality	14
Unable to remember appointments	8
Client has difficulty establishing long-term relationships with service provider	0
Client's family members have difficulty establishing long-term relationships with service provider	0
Service provider has difficulty establishing long-term relationships with clients	0

Roughly 75% of all past and present clients have experienced "frustration," a "lack of information regarding services" and/or "depression or depressive symptoms" which have hindered their ability to access services. Additional prevalent barriers include clients feeling discouraged or lacking an understanding of frailty, a social support system or motivation.

In answers to open-ended questions, seniors' community connectors highlighted the impact of clients' depression, memory loss as well as "an overwhelming feeling that their lives would change dramatically and they would lose their independence" if they began accessing services.

When invited to add barriers which were not included in the survey's options, one seniors' community connector remarked:

> The effects of social isolation are debilitating and in this community there is a lack of understanding of social isolation and the programs required to address the isolation. The myth is that socially isolated people need social programs but this is not the case.

Seniors' community connectors did not report seeing any of these barriers successfully resolved for clients in the past. They reported that COVID-19 had worsened clients' anxiety and interrupted recent breakthroughs three clients had recently accomplished in overcoming depression, social isolation and memory loss.

Cultural Facilitators

In the second half of the survey, seniors' community connectors were asked to answer how many of their clients experienced a list of facilitators which potentially support them to access services, beginning with 33 cultural facilitators (Table 6). The connectors were also invited to answer open-ended questions so that they could provide additional context and facilitators which were not featured in the survey's list.

Table 6

Cultural Facilitators Experienced by Past and Current Clients

Facilitator	# of Clients
Systems	
Structured contact and regular communication between seniors' community connectors and GP	21
Adapting services to address access barriers	19
Adapting services to fill gaps for clients' needs	19
Services meet client's needs	16
Effective case coordination	14
Structured contact and regular communication between seniors' community connectors and service provider	14
Behaviours	
Strong relationship[a] between seniors' community connector and client	21
Service provider supports the social prescribing program	14
Longstanding relationship between client and seniors' community connector	14
Clear, simple instructions	14
Client is able to discuss issues with the service provider as an equal partner	14
Service provider asks questions and listens	14
Service provider recognizes and reinforces efforts that the client makes	14
Service provider discusses tangible, personalized plans with the client	14
Service provider's effective communication skills	14
Service provider's effective communication methods	14
Service provider’s reflective listening	14
Service providers' empathy	14
Service provider's caring demeanour	14
Service provider gives one-on-one attention	14
Service provider modifies exercises to fit client's needs	14
Service provider sets positive goals (e.g., what to do, not what to avoid)	14
Service provider’s reflective listening	14
Strong relationship[a] between seniors' community connector and GP	14
Strong relationship[a] between seniors' community connector and service provider	14
Strong relationship[a] between client and GP	7
Strong relationship[a] between client and service provider	7
Advocating for improved program access for clients	1
Strong relationship[a] between GP and service provider	0
Beliefs	
Diverse perspectives/backgrounds among everyone involved	14
Client does not feel judged	14
Client's autonomy is respected	14
Client feels heard and respected	14

[a]For example, trust, respect, shared understanding

Cultural facilitators related to how social prescribing program stakeholders work together affected the most clients, with strong relationships between seniors' community connectors and their clients, as well as structured contact and regular communication between connectors and general practitioners, each helping 21 people to access services.

One seniors' community connector was unaware of any programs designed for participants who use walkers or wheelchairs, or who have mild memory loss. She also mentioned that recreation centres in particular lack programs which are designed for participants with frailty or who are socially isolated, and that few programs exist which are participatory and flexible while meeting the needs of clients with physical and mental health barriers. She further explained how recreation centres could better facilitate clients' access to programs:

> Each centre would benefit from an ambassador to make the newcomers feel welcome. It is difficult to enter a centre for programs where so many people know each other. The first step is signing up for a membership which in itself is exclusionary. Volunteers who manage the front desk are not always well-versed in their knowledge about the centre.

Financial Facilitators

Next, the seniors' community connectors were asked to consider how many of their clients experience potential financial facilitators (Table 7).

Table 7

Financial Facilitators Experienced by Past and Current Clients

Facilitator	# of Clients
Program's & Service Providers' Finances	
Seniors' community connector is able to coordinate access to services	21
Regular support and supervision from service provider	14
Service providers are able to perform outreach to clients (e.g., travels to them)	14
System Funding	
Diversity of services available	14
Number of service providers	14
Financial support from social prescribing program	14
Service provider supplies equipment	14
Service provider supplies handouts with instructions	14
Clients' Finances	
Support finding and accessing subsidies, financial support	3
Meal programs	2
High socio-economic status (social standing or class, often measured as a combination of education, income and occupation)	1
Travel subsidies	0

Within the financial facilitators category, seniors' community connectors identified their ability to support clients as important to helping them access services. Many facilitators related to system and service provider funding also ranked highly, including the ability to provide regular support and

supervision, to travel to clients and to ensure many, diverse service providers are available for clients to access.

Physical Facilitators

Twenty potential physical facilitators were assessed by the seniors' community connectors (Table 8).

Table 8

Physical Facilitators Experienced by Past and Current Clients

Facilitator	# of Clients
Safety & Accessibility	
Access to locations (service providers or other) that have the correct equipment	19
Convenience - services' time of day	18
Convenience - services' day of week	18
Convenience - duration of services/activities	18
Convenience - service providers are close to where clients live	15
Service provider's location is accessible	14
Service provider's location is familiar	14
Access to locations (service providers or other) that are not crowded	11
Other	
Consistent routines	18
Client has the time to participate	18
Client has skills such as those needed to fill out forms	16
Multiple service providers are centralized/integrated	14
Presence of other individuals with frailty or similar health issues	14
Transportation	
Routes taken to go to service providers are familiar	16
Good weather	14
Client can drive	13
Family member or friend can drive the client	1
Client is able to access services by foot	1
Client is able to access services by public transportation	0
Clients' Homes & Environments	
Services/activities can take place in client's home	14

The seniors' community connectors identified the ability of clients to access service providers or other locations which have the equipment they need as the most important facilitators. This was closely followed by a range of facilitators related to the convenience of service providers' locations and activities. Connectors also reported that clients are helped by being able to establish consistent routines, having skills such as the ability to fill out forms, and being able to take familiar routes to accessible, familiar locations.

Psychological Facilitators

Finally, the seniors' community connectors assessed how many of their past and present clients had experienced a range of potential psychological facilitators (Table 9).

Table 9

Psychological Facilitators Experienced by Past and Current Clients

Facilitator	# of Clients
Knowledge	
Seniors' community connector is aware of service providers	48
Appropriate referrals from GPs	31
Support from Seniors' Community Connectors or Social Prescribing Program	
Support from seniors' community connector	48
Positive feedback from seniors' community connector	45
Social prescribing program's clear leadership	35
Responses to Support	
Client has experienced benefits of accessing services	42
Liked to know whether they were doing well	27
Perception of being "checked up on"	22
Monitoring of performance, including self-monitoring	21
Learnt to take personal responsibility for own safety	16
Positive Beliefs or Attitudes	
Positive attitude - determination and willingness to accept their situation	31
Perception of safety	28
Desire to maintain or regain independence	20
Everyone involved has a shared understanding, attitudes and perspectives	14
Client's self-efficacy	13
High self-esteem	4
High confidence	4
Support from Service Providers	
Service provider's goal-setting approach	16
Service provider is a "lively" young person	14
Client's first experience with service provider was positive	14
Positive feedback from service provider	14
Service provider is a mature person with life experience who client thinks could more easily understand their concerns	10
Support from service provider	5
Physical exercises are fun and less daunting	5
Female service provider staff	1
Male service provider staff	0
Social & Emotional Support	
Support from family members	13
Help from family or others at home	13
Strong social network	8
Support from peers	1
Other	
High level of independence	12
Role models	1

Similarly to how more social prescribing program clients are affected by psychological barriers than any other type of barrier, psychological facilitators help the greatest number of clients access services. The data is much more stratified than other facilitator categories, with clear groupings of facilitators which are experienced by high and low percentages of clients.

A seniors' community connector added four psychological facilitators which have helped her clients access services: resilience; general senses of purpose and belonging, which can decrease fear as a barrier; and mental health stability when faced with situational challenges which create mental health issues.

A connector also elaborated on how COVID-19 has affected how she works with clients who have mental health issues:

> I use goal-based approach[es] with clients who are engaged in the social prescribing program and it is the most beneficial. Clients with mental health issues often require goals that don't put them in contact with other service providers since COVID [began spreading]. They use me (seniors' community connector) as their point of contact and there are little resources where they can be redirected.

Although facilitators related to social support systems did not score highly in the survey, a seniors' community connector explained their value, and complexity:

> Most participants are supported by family members but in most cases the family dynamics are complex. Though well intended, decisions are being made for the senior, thus impacting [their] right to self determination.

Clients' Characteristics

The seniors' community connectors were also asked to provide basic demographic information about their clients (Table 10).

Table 10

Characteristics of Clients

Characteristic	Number of clients
Age, years	
< 60	4
61-65	4
66-70	5
71-75	5
76-80	10
81-85	8
86-90	13
> 90	5
Gender	
Men	20
Women	35
Two spirit	0
Non-binary	0
None of the above	0
I don't know	0
Prefer not to answer	0
Clients' Co-Habitation	
Alone	38
With one other person	15
With more than one other person	4
Clients' Homes	
In a house	15
In an apartment or condominium development	15
In a residence for senior citizens	7
In a long-term care home	0
Other (Please explain)	2
Clients' Locations	
In an urban setting	51
In a rural setting	4

Most of the social prescribing's clients are at least 76 years old, and roughly 20% of them are at least 86 years old. Women outnumber men by an almost 2:1 margin. Most clients live alone, in a house or apartment/condominium, and in an urban setting.

Focus Group Data

Following the survey, the five most prevalent barriers and facilitators (plus ties) experienced by the social prescribing program's clients in each category (cultural, financial, physical and psychological), were assessed by the seniors' community connectors in a force field analysis. The barriers and facilitators in each category were visually displayed against each other, depicting them as maintaining the equilibrium of services' accessibility. All three connectors participated, although one had recently left her job.

The connectors were asked to give each barrier and facilitator a score from one to five, with one being weak and five being strong, by considering two factors: the likelihood that accessibility could be improved by resolving or mitigating a barrier or enhancing a facilitator, and the ability to achieve that change quickly.

Afterwards, their scores were averaged and depicted visually via the figures which are displayed within this section. The scores also informed this project's recommendations so that, as often as possible, the barriers and facilitators they address could reside in the upper-right quadrant of Table 1. This means that the recommendations would have a high likelihood of improving accessibility for the social prescribing program's clients.

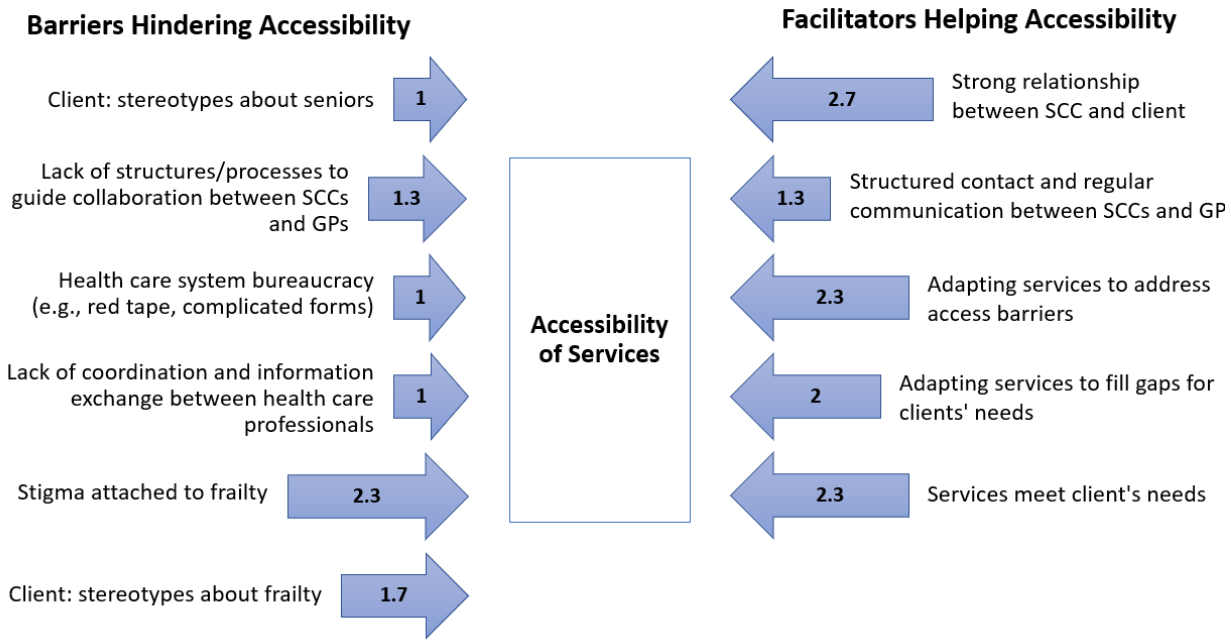
The value provided by this force field analysis is in how it enabled the senior's community connectors to identify where this project could have the greatest impact, in terms of prevalent barriers which it attempts to resolve or mitigate as well as prevalent facilitators which it attempts to enhance. The connectors know better than anyone what types of changes are both needed and realistic. This takes the intent of the project's recommendations beyond simply addressing prevalent barriers and facilitators, to addressing ones which, if resolved, mitigated or enhanced, would generate the greatest improvement in the ability of clients to access services

Cultural

The seniors' community connectors began by scoring the five most prevalent barriers and facilitators (plus ties) in the cultural category (Figure 3). Regarding barriers, all of the forces listed had similar average scores, except for "stigma attached to frailty" (2.3). On the facilitators side, "strong relationship between seniors' community connector and client" (2.7) scored highest, followed by "adapting services to address access barriers" (2.3) as well as "services meet clients' needs" (2).

Figure 3

Force Field Analysis: Cultural Barriers & Facilitators



In comments shared during the exercise, the seniors' community connectors provided context and explanations which informed their scores. Their comments also illuminated why certain barriers exist, or how certain facilitators may be difficult to enhance. For example, in response to the barrier "lack of coordination and information exchange between health care professionals," one connector replied, "Overall I'd have to say 'one' and that's why our roles or people like us who help navigate are so essential" (SCC3[7]).

As well, the seniors' community connectors were pessimistic when discussing the quality of their communication with general practitioners. When asked if the connectors provide general practitioners with updates about their patients, the connectors replied that they do, but they often do not hear back. One connector noted her belief that practitioners' busy schedules do not allow them much time to read her communications.

The seniors' community connectors explained that stigma and stereotypes can show up in numerous ways, including believing that seniors have trouble learning new things and frailty limits a person's ability to do things. They believe that community-held stigma about frailty has impacted the type of programming that is available – for example, they see a lack of non-medical programs for seniors with frailty.

[7] Seniors' Community Connector

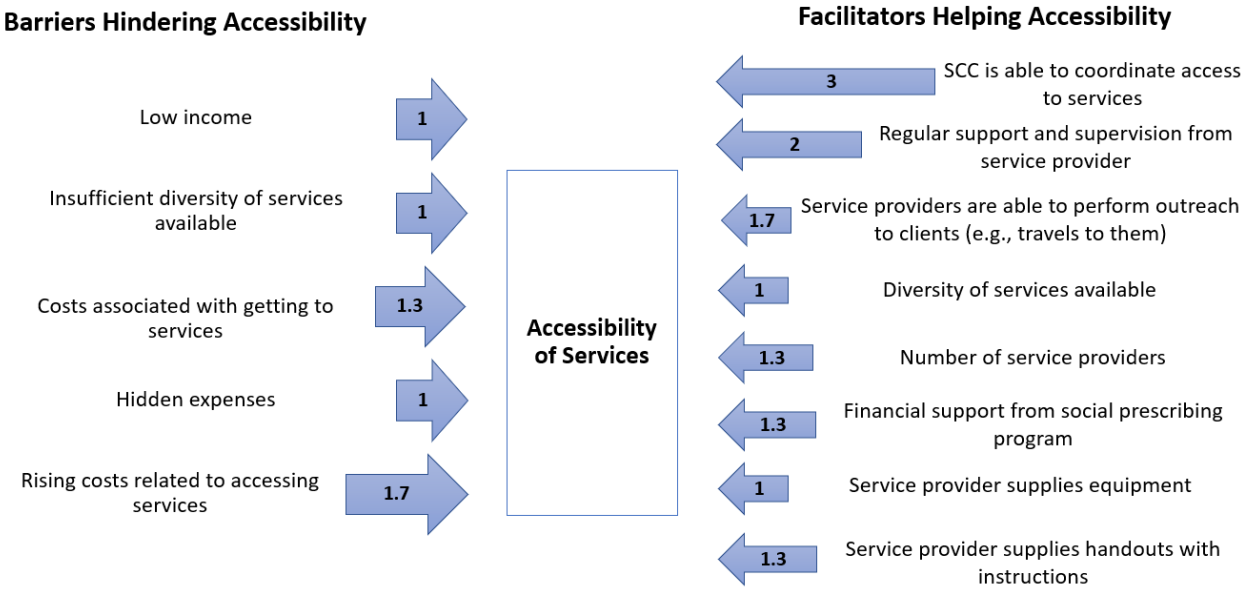
Financial

In the financial category (Figure 4), barriers' average scores ended up low and grouped very closely together. "Rising costs related to accessing services" received the highest score (1.7) and "costs associated with getting to services" (1.3) was the only other barrier which scored above one.

On the facilitators side, "seniors' community connector is able to coordinate access to services" (3) received the highest score by far; "regular support and supervision from service provider" (2) and "service providers are able to perform outreach to clients" (1.7) also stood out within the group.

Figure 4

Force Field Analysis: Financial Barriers & Facilitators



When asked to identify the types of funding provided to clients by the social prescribing program, one seniors' community connector responded, "Whatever we can work into our own budgets" (SCC3). Examples listed by the group included taking clients to classes, transportation as well as buying meals for clients with low incomes in order to build connections and give them food.

The seniors' community connectors acknowledged that these expenditures are not necessarily what their funding is meant for but that they either have the leeway to do so or easily obtain permission from their managers. One connector also expressed concern for clients who would lose access to this support should the social prescribing program's funding not be renewed.

The seniors' community connectors were also asked to provide examples of hidden expenses faced by their clients. They included meal programs, postage needed to mail applications, transportation, exercise class fees and exercise clothing such as shoes.

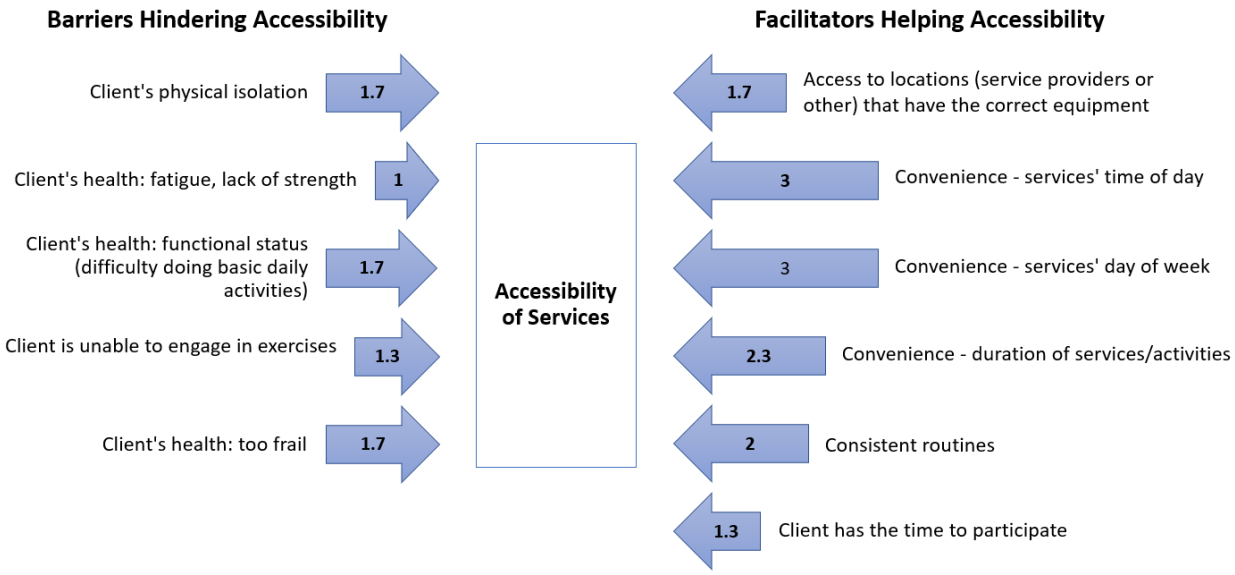
Physical

Following a trend established in the cultural and financial categories, barriers within the physical category (Figure 5) ended up with consolidated and low scores. Three tied with a score of 1.7: “client’s physical isolation,” “client’s health: functional status,” and “client’s health: too frail.”

Conversely, facilitators related to convenience scored highly. The time of day and day of the week during which services are scheduled tied for the highest score within the category (3), while the duration of services/activities followed closely behind at 2.3.

Figure 5

Force Field Analysis: Physical Barriers & Facilitators



Comments in response to this category’s barriers and facilitators shed light on the challenges faced by the seniors’ community connectors. One connector who joined the program over a year before the focus group took place did not have a client who had progressed to accessing services. While she noted that COVID-19 has affected her clients’ abilities to engage in activities, she also explained that the barriers listed were in place before the pandemic arrived – a point which was echoed by a second connector.

Clients’ proximities to service providers are key to their abilities to access activities. As one seniors’ community connector described in the focus group: “I was driving 20 to 30 minutes out...into a remote area, taking them to [an activity] and then driving them back and driving back to work. It took like three to four hours” (SCC1). She later explained that Handydart does not provide service so far outside of her community’s core. Another connector noted that her community features a free transportation service for seniors but bookings can only be made one day in advance, limiting the convenience and scheduling flexibility which this project’s research has shown to be key facilitators to accessing services.

The seniors' community connectors also noted that service providers' scheduling flexibility, as illustrated by facilitators representing convenience, is important because clients' many doctors appointments and medical tests make it difficult for them to schedule activities.

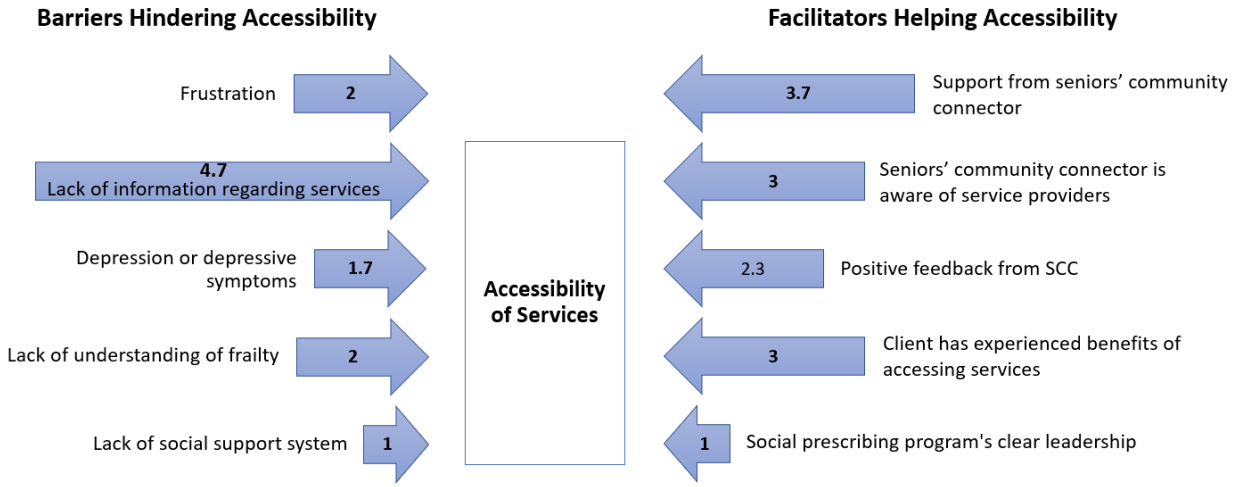
Psychological

One barrier within the psychological category (Figure 6), "lack of information regarding services," received the highest score (4.7) of any force assessed within the analysis. "Frustration" and "lack of understanding of frailty" received the next highest score (2).

This category also featured the highest-scoring facilitator among all of the facilitating forces in the analysis. "Support from seniors' community connector" received an average score of 3.7 while "seniors' community connector is aware of service providers" and "client has experienced benefits of accessing services" also scored highly (3).

Figure 6

Force Field Analysis: Psychological Barriers & Facilitators



Although "social prescribing program's clear leadership" was identified in the survey data as a facilitator which has supported 35 clients to access services, it received the lowest score possible in the force field analysis. The connectors noted that while the United Way, the program's funder, has been very helpful in providing relevant educational materials and programs, there has been a lack of top-down leadership to aide the onboarding of new connectors and provide avenues for connectors who are working with clients to develop skills and have discussions which could help them remove clients' barriers. The connectors have created many of the resources, such as intake forms, used by the program and ultimately work very independently.

Barriers related to clients' mental health featured prevalently in the focus group discussion. As one seniors' community connector noted, "…Most of the people that I'm dealing with have depression, some with very deep depression and memory loss" (SCC2). Another connector described a client whose early-stage dementia impacted his ability to travel to service providers. One spent a year working with a client, helping "with day-to-day stuff, setting a routine, those small things that might make a difference"

(SCC1) when the social prescribing program's original objective was to have clients be able to manage their own health and wellness after six to 12 weeks.

The seniors' community connectors reported that regularly visiting general practitioners is key so that they remember the program and will continue referring patients. One connector mentioned that practitioners have expressed concern that their patients may lack motivation needed to participate in the social prescribing program.

Connecting with Clients' General Practitioners

With so many barriers and facilitators related to communication between seniors' community connectors and their clients' general practitioners, the connectors were asked to describe how they introduce and describe the social prescribing program. The connectors explained that they provide case studies and take a variety of materials, which they have designed themselves and which include referral and intake forms as well as promotional cards and brochures, to one-on-one meetings.

Connecting with general practitioners through their Divisions of Family Practice, which are groups of physicians collaborating with others in their area to address local health care issues, has been relatively effective at generating client referrals. One seniors' community connector attended a breakfast meeting and received five referrals shortly thereafter; another was able to provide a write-up that was distributed to all of her community's clinics. Although this strategy has been successful, it is not necessarily a reliable means of marketing the program, as Divisions have insisted on communicating about the program in their own ways and, in one instance, accepted a customized promotional poster only to not follow through on a pledge to distribute it.

Peer Support Volunteers

An original concept of the social prescribing program included peer volunteers who would be able to step in and support clients roughly six weeks after they join the program. This additional support could help clients who are struggling to achieve their wellness goals while enabling the seniors' community connectors to accept new clients and connect them with services.

The seniors community connectors reported that, although the intent of having peer volunteers is solid in theory, in reality it has been difficult to achieve. This is due to a number of reasons, including how clients do not want to work with someone else after establishing strong relationships with connectors, and how volunteers may not have skillsets and experience which match those needed from the position.

> If a [client] is dealing with depression it's really difficult to say, 'Hey, I'm going to pass you on to a volunteer.' They either feel like, 'Oh, you're abandoning me,' or…the volunteer might not have the skillset to deal with someone with depression and then I'm being contacted by the volunteer and then the participant and then it becomes a lot bigger issue than it necessarily needs to be. (SCC1)

If peer support volunteers were to provide effective support, the seniors' community connectors noted that establishing very defined roles for them could help. This includes providing transportation, leading goal-oriented tasks with clients and doing weekly welfare checks with clients who have low needs. One connector had a meeting scheduled for the day following the focus group with two prospective peer volunteers who would perform specific tasks such as using provided templates to help clients with practical goals.

COVID-19

The focus group allowed the seniors' community connectors to further elaborate on how COVID-19 has affected their clients' abilities to access community-based services. The pandemic has worsened many of the barriers related to clients' mental health, as one connector explained:

> All of those referrals I'm getting are struggling with mental health now because of isolation and struggling with cognitive decline because of the lack of activity and lack of social interaction…I don't have one client who doesn't express anxiety of have challenges with anxiety and depression right now, lacking motivation… (SCC3)

Many service providers implemented safety measures in response to COVID-19, including switching activities to online formats or stopping them altogether, which affected the social prescribing program's clients. This includes losing transportation services being placed on waitlists. The availability of virtual activities varies across communities and organizations, and is dependent on clients' abilities to use required technology. One seniors' community connector noted there is a "huge lack" of virtual services in her community and another explained why virtual solutions are not barrier-free:

> We started doing chair yoga over Microsoft Teams but none of my clients were involved…the issue was that a lot of them have dementia, or do not have access to a tablet or a laptop, or they didn't know how to use technology or they weren't interested in using technology at all. That was a barrier I found – the use of technology. (SCC1)

The seniors' community connecters are employed by non-profit organizations and, similarly to how there is variation among service providers' activities, there is variation in the types of services provided by the connectors' organizations. One organization in particular was praised for how it tried to maintain activities' accessibility during the COVID-19 pandemic. According to the connector who works there:

> …They created a virtual website for the exercise and recreation [programs], the meal program, they'll drop off food and do cooking over Zoom…The volunteer services coordinator does painting parties and Zoom bingo. They bought and provide tablets with data and I've taught three of my social prescribing program [clients] how to use them, so I'm fortunate – but the rest of the community? I don't know... (SCC3)

Looking ahead to their work after COVID-19, one seniors' community connector noted that the pandemic may affect her clients for some time, "…Because the decline is so significant and notable, particularly with mobility, cognition – everything – so even post-COVID, post-vaccine, our job is going to be exponentially more challenging" (SCC3). She later explained that a goal-oriented approach to supporting clients, coupled with empathetic listening, will be key to supporting clients to access services.

Conclusion

Although the survey data in this section is less than scientific, it effectively identifies the most prevalent barriers and facilitators experienced by the social prescribing program's clients when accessing services, as well as those which are experienced by few if any clients. Of the 147 potential barriers which seniors' community connectors responded to, 110 were experienced by at least one client; of the 95 potential facilitators, 91 were experienced by at least one client.

This data enabled the seniors' community connectors to identify, through a force field analysis, the prevalent barriers and facilitators which would have the greatest impact in improving the accessibility of

services if they were mitigated or enhanced, respectively. They include barriers such as stigma and stereotypes attached to frailty, rising costs, lack of information regarding services and a lack of understanding of frailty, as well as facilitators such as strong relationships between seniors' community connectors and their clients, services meeting clients' needs and the connectors' abilities to maintain awareness of services and coordinate clients' access to them. The step was critical in ensuring this project's recommendations focus on barriers and facilitators which can be addressed quickly and realistically, per Table 1.

Discussion

The purpose of this section is to summarize the project's research findings and interpret the data in order to inform recommendations aimed at improving service accessibility for the social prescribing program's clients. It is organized according to three of the project's primary and secondary research questions as well as additional topics which emerged.

What Are Barriers Which Prevent Frail Seniors from Accessing Community-Based Services?
This project's literature review revealed a lack of existing information which reports on and analyzes barriers experienced by frail seniors when attempting to access community-based services. Many studies which contributed potential barriers to this report included research participants who are frail and face additional challenges (e.g., low incomes) or are frail and attempting to access services which are similar to community-based services or have similar goals (e.g., health promotion activities).

Forty-three such potential barriers were identified. Many cultural barriers were based in communication and reflect negatively on how service providers might interact and approach relationships with the social prescribing program's clients. Only three financial barriers were identified; they concerned clients' income and costs associated with accessing services. All but one of the physical barriers identified concerned clients' health. Finally, psychological barriers, which formed the majority of all the barriers identified, almost entirely focused on clients' feelings, fears, emotions and mental health.

It is likely that many of the 43 barriers could be experienced by any patient or client in any health care system or program. While this universality, in theory, means that there may also be a wealth of published solutions for resolving or mitigating those barriers, it also means that the social prescribing program may face difficultly adapting those solutions for its very unique context. This challenge illuminated the need for the project's focus group to allow the program's seniors' community connectors to provide context and examples of how barriers are experienced by their clients. It also catalyzed a broader, second stage of the literature review.

Although the 43 barriers represent 30% of the total potential barriers which were considered by the seniors' community connectors, they were fairly relevant, with many having been experienced by a significant number of the social prescribing program's clients when compared to other barriers. This can be seen by examining how the 43 barriers ranked within their categories (Table 11) – for example, the "health care system bureaucracy" barrier was experienced by the second-highest number of clients within the cultural barrier category, so it ranked second within that category.

Table 11

Barriers Which Prevent Frail Seniors from Accessing Community-Based Services, Ranked by Prevalence within Category

Barriers	Rank within Category[a]
Cultural	
Health care system bureaucracy (e.g., red tape, complicated forms)	2
Lack of coordination and information exchange between health care professionals	2
Disconnect between client's preferences and service provider's priorities	4
Communication: rude or unhelpful service providers	5
Financial	
Low income	1
Hidden expenses	4
Rising costs related to accessing services	5
Physical	
Client's health: fatigue, lack of strength	2
Psychological	
Frustration	1
Lack of information regarding services	2
Lack of understanding of frailty	4
Lack of social support system	5

[a]Only barriers which ranked within the top 5 overall in their categories are included

Communication is a primary theme among most of the barriers identified in Table 11, impacting the degree to which social prescribing program stakeholders interact with each other and share key information. It also becomes apparent when reviewing the barriers how vulnerable clients are to experiencing them, and how little they can likely do on their own to resolve or mitigate barriers such as systemic bureaucracy, rude or unhelpful service providers, low income or the lack of a social support system. While this type of support is often within the seniors' community connectors' scope of work, the amount of time they spend helping their clients overcome these barriers is far greater than originally planned. One connector explained that her role has shifted from providing a short-term (six to 12 weeks) supportive role, as originally planned, connecting clients with services to a long-term role which involves providing individual support on an ongoing basis.

As mentioned earlier, initially focusing this project's literature review on research limited to client populations which have frailty led to the identification of only 43 potential barriers which may be experienced by the social prescribing program's clients. The resulting database was neither comprehensive nor diverse – for example, 33 barriers were contained within one study (published by Minear and Crose in 1997), and 27 of them were categorized by this project within the psychological category. The project's literature review was thereby expanded in order to generate a more substantive list by including client populations, service types, health issues and jurisdictions which may be similar to the social prescribing program and its clients.

What Barriers Are Preventing Clients in the Social Prescribing Program from Accessing Community-Based Services?

After expanding the literature review, a total of 147 potential barriers were identified and provided to the program's seniors' community connectors who, through an online survey, noted how many of their past and current clients have experienced each one (tables two through five). The connectors were also invited to submit additional barriers which were not identified within the survey.

Cultural Barriers

The data shows that inadequate communication among stakeholders is creating barriers for clients, who are affected by poor communication methods, rude or unhelpful service providers, service providers who do not listen or are unresponsive, and issues such as impersonal or one-way communication. This theme is also an area where, during the focus group, the seniors' community connectors expressed pessimism that it could be improved through this project, if at all.

A second theme which emerged from the data is how clients are affected by the inability of social prescribing program stakeholders to work together. This is evident by how many clients experience barriers related to poor collaboration and coordination, as well as clear disconnects between the decision-making and priorities of service providers and the preferences and needs of clients. The systemic nature of this theme becomes apparent when considering how only two clients have been affected by a lack of trust or relationships between seniors' community connectors and clients' general practitioners, but 14 clients have experienced barriers because connectors and practitioners lack formal structures and processes to guide their collaboration. The connectors have identified a handful of novel ways to introduce the social prescribing program to practitioners which are not reliant on meeting with them, however after practitioners make referrals it is a challenge to maintain connections with them.

Thirdly, clients' views of themselves and their frailty are creating barriers. Many have stereotypes about seniors and frailty, and hold stigma attached to their health condition, which are hindering their abilities to access services they need. This theme is related to many barriers and facilitators within the psychological category which concern stakeholders' knowledge and information available about these topics (or lack thereof). Recommendations aimed at addressing these issues, therefore, may be able to generate improvement across a range of barriers.

Financial Barriers

The seniors' community connectors' responses suggest that system-level funding is affecting their clients' abilities to access services. They feel that service providers are unevenly distributed throughout their communities and that many clients are also affected by an insufficient number of service providers available to them. Through the survey, they also reported that the services available to almost a third of their clients are not diverse enough; this was explained later by one of the connectors, who noted that the social prescribing program would benefit from being able to access programs such as philosophers' cafés, discussions on current affairs, art programs and men's sheds which are currently not available for seniors in her community.

Although the survey data indicated that service providers often feature wait lists, in the focus group a senior's community connector clarified that her clients have not experienced waits for services related to the social prescribing program's areas of focus: physical activity, social engagement and nutrition. This is another area that varies by region as a different coordinator pinpointed a specific program with a lengthy waitlist.

Roughly 10 percent of clients have been affected by service providers' inabilities to accept new clients or provide suitable activity options. Once clients are able to access activities, few barriers related to how service providers provide activities were identified as an issue. For example, the seniors' community connectors reported that zero clients have experienced service providers which are unable to commit appropriate time to clients, lack gender-specific services or have high levels of staff turnover.

Unfortunately, many clients experience barriers related to costs associated with participating in services, including those required to get to providers as well as hidden expenses such as exercise clothing and postage needed to mail applications.

Roughly half of all the social prescribing program's clients have low incomes. The data also shows that these barriers could be at least partially mitigated for many clients if they were also accessing relevant subsidies or financial benefits available to them.

Additionally, no program-level financial barriers were identified, as the seniors' community connectors reported that their abilities to accept new clients and commit appropriate time to clients have not been issues. Nor have the social prescribing program's staff/volunteer levels.

Physical Barriers

The survey and focus group data clearly indicate that clients' physical health creates barriers to accessing services. Given how health deficits combine to reduce the function and health of people who are frail (Canadian Frailty Network, n.d.a), it is logical that barriers such as clients' fatigue, lack of strength, difficulty doing basic daily activities and inability to engage in exercises rank highly in this category.

Collectively, physical barriers experienced by the social prescribing clients reveal the difficulty many may have in being able to participate in and benefit from service providers' activities. For example, the seniors community connectors report that roughly one-third of their clients are unable to engage in exercises, and about a quarter of them are too frail. This suggests that improvements could be made in the appropriateness of clients who are referred to the program by general practitioners as well as how the program assesses whether or not it is suitable for a referred client.

> …I've had the one [client] say to me, 'Please don't give up on me.' So you know, having those referrals and having the option to say, 'This referral is not appropriate' when you do the feedback form, it's very difficult to do that because at the time you're that only person that that person is talking to. And so I'm finding that getting those referrals that are not appropriate puts us at a very difficult situation when [they're] so high needs and you know that you're the only person that they're talking to. (SCC2)

Although health-related barriers were most prevalent within this category, physical isolation was identified by the seniors' community connectors as the barrier experienced by the most clients. Physical isolation illustrates the interconnectedness that can occur across the cultural, financial and psychological categories. For example, a client who faces physical isolation may also lack a social support system, experience social isolation and face challenges accessing other care and services which could improve their health and wellness.

Psychological Barriers

Psychological barriers affect more clients of the social prescribing program than any other category of barriers. Twenty-six barriers have been experienced by roughly 25 percent of the program's clients, indicating a significant need to identify and then resolve or mitigate their psychological obstacles.

It is apparent that clients need more information about frailty, the social prescribing program and the benefits they may receive from accessing services. Clients' health literacy is a barrier potentially correlated to skepticism many of them have about accessing services and how they might benefit from doing so, as well as fear they may have about losing their independence. Improved health literacy may also help break down some the stigma and stereotypes clients hold about themselves and frailty.

According to the survey data, general practitioners for roughly 40 percent of the program's clients had difficulty explaining the social prescribing program to them, but only one client was considered by the seniors' community connectors to have been an inaccurate referral. This disconnect may be attributable to the seniors' community connectors feeling a responsibility to help clients who are not getting the care they need through other systems. Indeed, as one connector remarked in the focus group, "I would say that probably upwards of 80% of the referrals I've received are people that need trauma-informed care and have often not had those issues addressed…" (SCC3).

That seniors' community connector also remarked:

> I feel like we fill in all the other gaps in service…there's no one to pick up your stuff from the Red Cross and install your adaptive equipment. Even though we're not (occupational therapists), we do it. There's no one to encourage your mobility. There's no one to get your ID. That's been a huge one. There's no one to fill out your pension forms. Every little thing, we do, and it's awesome, but not what was intended. (SCC3)

An additional theme is the level and type of support required by clients. For example, significant numbers of clients lack a social support system, experience social isolation and/or require high levels of emotional support. These are complex barriers that reveal the degree to which barriers which are not directly linked to frailty or accessing services can affect clients' health and wellness. It is also a significant gap in health and social care that is often filled by the seniors' community connectors even though they were not originally intended to do so. As one connector remarked in the focus group, "We become a social support system and it's not entirely appropriate but anyhow, it's what happens" (SCC3). On the other hand, resolving clients' inabilities to set goals and keep to plans is a role within the connectors' scope of work and experienced by a significant number of their clients.

Many barriers provide insight into how clients' mindsets, emotions and feelings create barriers. For example, feelings of frustration and discouragement ranked highly; as did anxiety over annoying people or being a bother or nuisance. Many clients' pride, shame, distrust and perceived judgement from others also prevent them from accessing services. This data illuminates the need for sufficient psychological support to be available alongside services intended to help clients reduce or avoid frailty.

Very few of the psychological barriers experienced by the social prescribing program's clients lie at the service provider level. Given the one-to-one nature of relationships between seniors' community connectors and clients, as well as general practitioners and clients, however, it could be that clients' fears of losing privacy and confidentiality concern their experiences accessing services.

What Facilitators are Supporting Clients to Access Community-based Services?
Although it was not an independent research question, identifying facilitators which help frail seniors access community-based services was a first step in identifying those experienced by the social prescribing program's clients specifically. This followed the same process used to identify potential barriers, and began by reviewing previous research which focused on frail seniors.

Initial Literature Review
At this stage, 18 facilitators were identified. Cultural facilitators focused on how service providers communicate with and adapt activities for clients. Travel subsidies was the only financial facilitator identified. Whereas physical barriers were primarily related to clients' health, physical facilitators tended to concern how clients get to service providers and what they need in order to participate in activities. Psychological facilitators were wide-ranging and touched on how service providers set goals with and motivate clients as well as demographics of service providers' staff.

The 18 potential facilitators identified at this stage of the research comprised 19% of the total potential facilitators which were considered by the seniors' community connectors. Generally, they were less relevant than the barriers identified in the first stage of the literature review, as they ranked lower within their categories and no facilitators finished within the top five in the financial category (Table 12).

Table 12

Facilitators Which Support Frail Seniors in Accessing Community-Based Services, Ranked by Prevalence within Category

Facilitators	Rank within Category[a]
Cultural	
Service provider gives one-on-one attention	4
Service provider modifies exercises to fit client's needs	4
Clear, simple instructions	4
Service providers' reflective listening	4
Physical	
Consistent routines	2
Client has skills such as those needed to fill out forms	3
Services/activities can take place in client's home	5
Presence of other individuals with frailty or similar health issues	5
Psychological	
Positive feedback from service provider	2

[a]Only facilitators which ranked within the top 5 overall in their categories are included

In reviewing the nine facilitators which were identified via the initial literature review and ranked within the top five facilitators within their categories, two themes stand out: the importance of how service providers communicate with their clients as well as adapting activities for clients' needs and abilities.

Expanded Literature Review
Similarly to the process of identifying potential barriers experienced by the social prescribing program's clients, the literature review was expanded in order to generate a larger list of potential facilitators which support them to access services. This was accomplished by again including client populations,

service types, health issues and jurisdictions which may be similar to the social prescribing program and its clients.

In total, 95 potential facilitators were included in the survey which was completed by the seniors' community connectors. They identified ones experienced by their clients (tables six through nine) and were also invited to submit additional facilitators which the survey did not include. Generally, facilitators ended up grouped much more closely together within their categories than was seen with barriers. This means that there was less variation among the number of clients who experienced each individual facilitator and made themes more difficult to identify.

Cultural Facilitators

The data shows that the strength of the relationships which seniors' community connectors have with other social prescribing program stakeholders is critical in supporting clients to access services. "Strong relationships with clients" tied for the most prevalent facilitator, and longstanding relationships with them ranked high as well. Strong relationships with service providers and clients' general practitioners also ranked highly. These results contrast with relationships between any other combination of program stakeholders – all of which were experienced by, at most, half as many clients (if any).

"Structured contact and regular communication between seniors' community connectors and clients' general practitioners" was experienced by the most clients in the cultural facilitators category. This aligns with how a lack of structured contact was identified by the connectors as the most prevalent cultural barrier experienced by their clients[8]. These findings emphasize the importance of establishing ongoing and routine communications channels between these two stakeholders.

As mentioned previously in this report, there has been a recent shift in health care systems towards providing person-centred care, an approach which respects the needs, interests and values of those who receive care (Institute for Healthcare Improvement, n.d.). This shift can also be seen in facilitators which were identified in the expanded literature review, which often included research published more recently than what was included in the initial review. As a result, facilitators identified in the expanded review were more likely to align with principles of person-centred care; they also tended to rank very highly in terms of how many social prescribing program clients experienced them.

This is very evident in the cultural facilitators category, where facilitators such as "adapting services to address access barriers," "adapting services to fill gaps for clients' needs," and "services meeting client's needs" were all experienced by at least 30 percent of clients. Additional prevalent facilitators included "respecting clients' autonomy," "clients feeling heard and respected," "clients discussing issues with service providers as equal partners" as well as many more related to the quality of service providers' communication.

Financial Facilitators

Within the financial facilitators category, the ability of seniors' community connectors to coordinate clients' access to services was experienced by seven more clients than any other facilitator. This indicates the importance of ensuring they have capacity to do so, as opposed to how they are currently committing significant time to resolving and mitigating barriers experienced by their clients.

[8] Tied with stereotypes held by clients about seniors.

A system-level theme which emerged from this category's data was the importance of ensuring that the social prescribing program and service providers are sufficiently funded. Specifically, this means that the program is able to provide clients with financial support when needed, even though doing so is not explicitly accounted for within seniors' community connectors' budgets, and service providers are able to supply social prescribing program clients with sufficient support, supervision and instructions, as well as the necessary equipment. It also helps if they are able to perform outreach to clients. In connection with the financial barriers section, sufficient quantities and diversities of service providers were high-ranking facilitators.

Physical Facilitators

The findings of this section indicate that service providers need to meet clients where they are, meaning that when and where they host activities is important to ensuring that clients are able to access them. This is seen within a number of high-ranking facilitators, including the duration of their services as well as the time of day and day of week during which they take place.

The previous section noted that having a sufficient number of service providers available for clients is an important facilitator, and the seniors' community connectors reported here that ensuring services are located close to clients as well as centralizing or integrating those services helps make them accessible.

A third theme is the comfort level that clients feel in accessing services. This is evidenced by high-ranking facilitators such as "consistent routines," familiar and convenient routes to service providers, "familiarity of service providers' locations" and the "presence of other individuals with frailty or similar health issues." Working with service providers to tailor the provision of services in ways that help clients feel comfortable accessing them (when feasible) is an example of providing person-centred care and could also be an effective way to mitigate some of the psychological barriers they experience. Flexibility is helpful, as clients' schedules are often complicated by their various medical appointments.

Psychological Facilitators

The seniors' community connectors' survey answers show that five barriers were experienced by at least two-thirds of the social prescribing program's clients. Overall, the high numbers of clients who have experienced many of the facilitators in this category indicates a need to ensure not only that psychological barriers are resolved or mitigated, but that many psychological facilitators are enhanced as well.

Seniors' community connectors reported that their support, as well as being aware of service providers available for their clients, has positively impacted roughly 90% of their clients. This data illustrates the opportunity available by re-allocating their time away from addressing clients' barriers (especially complex ones) and towards supporting them to access services and develop their self-management abilities.

Feedback loops have also impacted many clients, including in the forms of positive feedback from their seniors' community connector and experiencing services' benefits, provide insights into how to motivate clients. Relatedly, accountability emerged as a theme, as the connectors reported that clients' access is enhanced by "knowing whether they are doing well," "the perception of being 'checked up on'" and performance monitoring. Clients' desires to maintain or regain independence as well as learning to take responsibility for their own safety were additional facilitators related to their motivation which ranked highly.

Finally, the seniors' community connectors identified numerous traits which support clients in accessing services. These include having a positive attitude, determination and a willingness to accept their situations.

There are additional insights that service providers can take away from this data to enhance their accessibility. For example, utilizing goal-setting approaches, ensuring clients have positive first impressions with them, providing positive feedback and understanding if clients may prefer to work with a staff member who is young and "lively" or mature with relevant life experience were facilitators which deserve attention.

Clients' Characteristics

Roughly two-thirds of the social prescribing program's clients are at least 76 years old. Barriers which they experience may not be limited to their frailty – they can include common barriers generally faced by seniors related to their health, wealth and social support (Canadian Institute for Health Information, 2011). It also suggests that, similarly to this project's literature review, solutions to mitigating barriers and enhancing facilitators should not be limited to seeking successes and best practices from research which focused solely on people with frailty.

When asked about their clients' co-habitation arrangements, the seniors' community connectors answered that roughly two-thirds of them live alone. This helps explain the prevalence of barriers related to physical and social isolation as well as income and expenses. It also may illuminate why so many facilitators, across all four categories, related to providing support for clients.

Almost all of the program's clients live in an urban setting. Combined with survey results indicating that relatively few clients experience barriers related to travelling to community-based services, and how few of them live in seniors-specific accommodations, this suggests that services are well-located in communities.

The seniors' community connectors were less familiar with their clients' homes than they were with other characteristics. Within that context, they identified that equal numbers of clients live in a house or apartment/condominium, and half as many clients live in a residence for senior citizens. No clients live in a long-term care home. This suggests there is value in identifying or working more with service providers who are able to provide outreach so that they could connect with clients in groups where they live or in a central location.

COVID-19

COVID-19 emerged while this project was underway and significantly impacted the social prescribing program and many aspects of clients' lives as the health care system and their communities responded to the pandemic. This worsened barriers, created new ones and diminished facilitators. The imminent rollout of vaccines to high-risk populations, which presumably encompass a high percentage of the social prescribing program's clients[9], enabled the seniors' community connectors to think about "after COVID" when participating in the force field analysis.

The pandemic significantly impacted the social prescribing program's operations. The program initially went on hold in the early days, during which time it could not enrol new clients. As well, physical

[9] Given their health issues, ages and likelihood of living in a residence for seniors.

distancing and other measures intended to prevent the virus from spreading prevented current clients from participating in activities.

While some services were able to switch to a virtual delivery format (e.g., through Zoom or Microsoft Teams), the ability for this to be accomplished is dependent on each individual service provider's financial and other capabilities. As well, simply providing a service virtually does not mean it is accessible; the seniors' community connectors were clear that clients' abilities to use necessary technology is essential and many require training.

The seniors' community connectors raised concerns about the long-term impact that COVID-19 may have on their clients' mental health. The connectors are already providing unplanned support to address psychological barriers experienced by their clients, and an increase in this area of need would further diminish the time they have available to connect clients with services. This suggests a need to ensure that clients which are referred to and accepted by the program are effectively screened to identify if they are well enough to participate.

Conclusion

This project has contributed to limited literature related to frail seniors' experiences when accessing community-based services, and specifically when doing so through a social prescribing program.

Fraser Health's social prescribing program is providing services and support which are badly needed by its clients. Some of that support, however, is beyond the program's scope as its seniors' community connectors commit substantial time and resources to addressing barriers faced by their clients when accessing services. This creates a chain reaction: a client experiences an obstacle to accessing a service, the connector supports them in overcoming that obstacle, and then the connector has less ability to help other clients access services. As one seniors' community connector commented, "The idea of social prescription is a great idea…the reality is completely different" (SCC1).

This project has identified high-leverage barriers and facilitators that clients experience when accessing services which, if resolved or mitigated, or enhanced, respectively, could improve their abilities to access services. Prevalent barriers affecting clients at the individual level are typically within the physical and psychological categories, while barriers within the cultural and financial categories are often located at the program and system levels. Interestingly, this situation is almost reversed when considering facilitators – prevalent ones at the individual level often reside in the cultural and psychological categories whereas those at the program and system levels are in the financial and physical categories.

The next section of this report proposes recommendations aimed at resolving, mitigating and enhancing those barriers and facilitators.

Recommendations

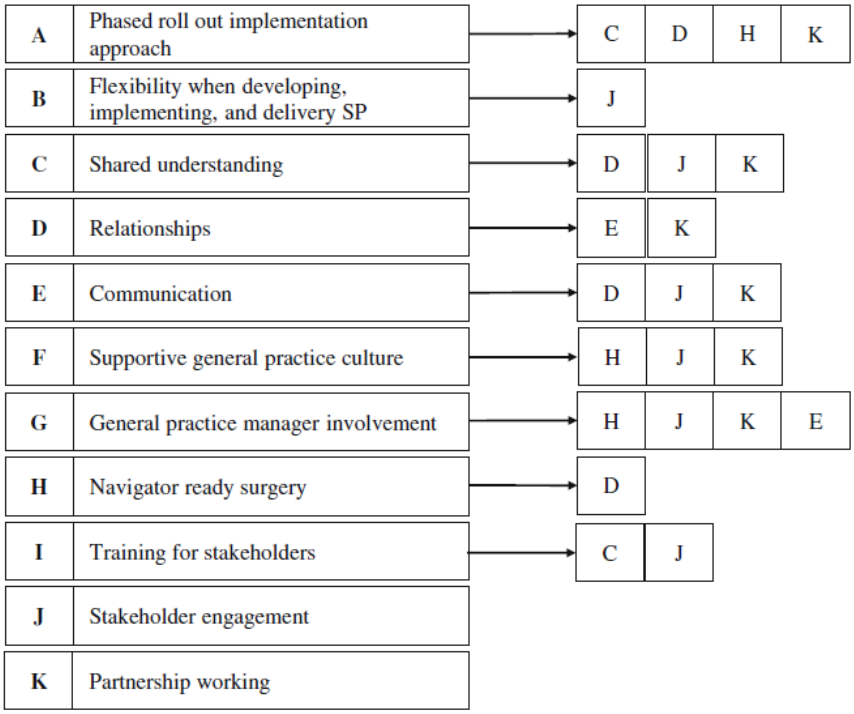
This section features a number of recommendations aimed at resolving or mitigating barriers which prevent the social prescribing program's clients from accessing community-based services, as well as ones aimed at enhancing facilitators which support clients to access services. Ultimately, the recommendations answer the research question, how do these barriers and facilitators inform future practices of the social prescribing program?

When possible, the recommendations align with strategies and tactics which have been successfully implemented by other social prescribing programs. A broad approach is taken, as these programs often feature different models and, therefore, their findings can be specific to their context and interventions (Pescheny et al., 2018). For example, models in the United Kingdom sometimes had their seniors' community connectors embedded within clinical practices, which is not an approach currently followed by Fraser Health's program.

The recommendations are often cross-cutting, impacting each other as well as multiple barriers and facilitators. Many barriers and facilitators are closely related to other, as data illustrates in tables two through nine. They can also affect each other. As an example, this was visualized well by Pescheny, Pappas and Randhawa (2018) who, in research regarding the implementation and delivery of social prescribing programs, identified facilitators which are connected to each other (Figure 7).

Figure 7

Interrelationship between Facilitators to the Implementation and Delivery of Social Prescribing Services



Note: Reprinted from "Facilitators and barriers of implementing and delivering social prescribing services: a systematic review," by J.V. Pescheny, Y. Pappas and G. Randhawa, 2018, BMC Health Services Research, 18(1), p. 11 (https://tinyurl.com/y8v6vh4).

These interrelationships illustrate the complexity of social prescribing (Pescheny et al., 2018) and help explain why a diverse range of solutions may have the greatest likelihood of resolving or mitigating barriers and enhancing facilitators experienced by clients in Fraser Health's program. For example, some recommendations may generate referrals to the program, and other recommendations provide seniors' community connectors with the capacity to accept and support many new clients. This leverages

research from Auspos and Cabaj (2014) who note that change interventions within systems require holistic and strategic approaches that impact multiple stakeholders and activity areas).

The recommendations address many of the prevalent barriers and facilitators which were reviewed by the seniors' community connectors during the force field analysis. They include barriers such as stigma, stereotypes and understanding of frailty, costs and lack of information regarding services, as well as facilitators such as strong relationships between seniors' community connectors and their clients, services meeting clients' needs and the connectors' abilities to maintain awareness of services and coordinate clients' access to them. Greater weight is given to solutions aimed at resolving or mitigating barriers, as opposed to enhancing facilitators, because removing obstacles is more likely to generate sustained changed (Cunningham, 2016).

There are some prevalent barriers and facilitators which are not addressed within the recommendations, such as health care system bureaucracy, as doing so through this project would be impractical due to their systemic nature or complexity. The recommendations also touch on other barriers and facilitators which, although they did not finish within the "top five" of their categories, were still experienced by a significant number of the social prescribing program's clients.

It is noted within recommendations' descriptions how they could be implemented with COVID-19 safety measures in mind. Most recommendations, however, can be acted upon during or after the pandemic.

Finally, as noted in this project's research framework, recommendations were selected based on the degree to which they can realistically and quickly resolve or mitigate prevalent barriers and enhance prevalent facilitators. As depicted in Table 1, and specifically the table's upper-right quadrant, this means that they have the greatest potential to improve social prescribing program clients' abilities to access services.

The Social Prescribing Program's Model

There are a number of potential changes which the social prescribing program could make to its model:

<u>Recommendation 1: Utilize peer volunteers strategically</u>

As noted earlier in this report, peer volunteers were originally envisioned by the social prescribing program as a source of support for its clients. Currently the seniors' community connectors do not utilize peer volunteers because their caseloads are not heavy enough and there are few areas where support would be appropriate given clients' high needs. Adding volunteer support early in the client intake process, however, could enable the connectors to provide more strategic support for their clients.

For example, peer volunteers could teach clients about the social prescribing program, frailty and other topics which could resolve or mitigate barriers related to their stereotypes and stigma. Volunteers could also complete initial intakes, including screening for barriers and facilitators identified through this project, show clients how to use iPads so they can participate in virtual activities during COVID-19 and support clients with barriers related to filling out forms and applications for things like financial subsidies, homeless prevention programs and food banks. In focus group data shared earlier in this report, the seniors' community connectors provided additional roles which could be filled by volunteers as well.

As a result, the seniors' community connectors could have increased capacity to enhance facilitators such as developing strong relationships with their clients, coordinating their access to services and providing them with more focused support that leverages connectors' unique competencies.

Recommendation 2: Assess the program's concentration of high-needs clients

It is clear that high-needs clients – those whose barriers to accessing services may involve significant mental or physical health issues, for example – are consuming an unexpectedly significant amount of the seniors' community connectors' time and support. This is not unique to Fraser Health's program (see Holding et al., 2020). Some of the barriers that its clients face in this respect include being too frail, being unable to participate in exercises and "depression or depressive symptoms."

The appropriateness of referrals to the social prescribing program for clients with high needs can often be debated, and connectors frequently feel responsibility to accept those clients into the program. Improving the appropriateness of referrals is covered by other recommendations in this section; accepting fewer high-needs clients could increase connectors' capacities to enhance facilitators, similarly to recommendation one, in areas such as strengthening relationships with general practitioners and staying current with the service providers in their regions.

It is recognized that this recommendation strays outside the scope of this project but now that the social prescribing program has been operational for roughly 18 months, it may be time to assess if supporting so many high-needs clients is a sustainable and effective model. Such a review could even provide affirmation that connectors *should* focus on high-needs clients – evaluators of the Ontario-based social prescribing program concluded that clients who may benefit the most from social prescribing are often those who require significant support before they begin accessing services (Alliance for Healthier Communities, 2020a). On the other hand, models in the United Kingdom typically focus on supporting clients' non-medical needs because their staff are not clinically trained (Polley et al., 2017).

Either way, it may be beneficial for the social prescribing program to partner with health care organizations and professionals who could provide support for clients' complex mental and physical health issues. Doing so would remove this responsibility from the seniors' community connectors while enabling them to focus on connecting clients with community-based service providers when they are ready for that step.

Recommendation 3: Expand who can submit referrals

If the seniors' community connectors began supporting fewer high-needs clients or providing less support for clients' complex barriers they would, theoretically, also have greater capacity to accept new clients. The social prescribing program could leverage this new capacity by enabling pharmacists, psychologists, counsellors, allied health professionals and even frail seniors themselves to submit referrals. This could also reduce the program's dependency on general practitioners, with whom it has been difficult to establish sustained engagement.

Broadening referral bases is a solution aimed at increasing referral numbers which was proposed by Bertotti and colleagues (2014) following the evaluation of their large social prescribing program in the United Kingdom. In fact, one seniors' community connector has already received inquiries from seniors who heard about the social prescribing program through word of mouth and were interested in enrolling (the connector received permission to contact their general practitioners with information about the program).

Recommendation 4: Embed seniors' community connectors within clinical practices

A social prescribing program in Ontario which featured seniors' community connectors who were employed by external organizations, as Fraser Health's program does, found that co-locating connectors with referrers, even just part time, generated stronger connections between the connectors and referrers as well as their colleagues (Alliance for Healthier Communities, 2020b). Doing so also reduced clients' participation barriers because they were already familiar with the setting within which the prescribing took place (Alliance for Healthier Communities, 2020b). This recommendation, while potentially more difficult to implement than others, could facilitate collaboration and communication between connectors and practitioners.

Recommendation 5: Designate funding for resolving accessibility issues

The social prescribing program is likely limited in its ability to resolve or mitigate many of its clients' financial barriers, such as their low incomes or the number of service providers within a region. There is potential, however, for it to formally support its clients to access community-based services.

As described earlier in this report, the seniors' community connectors utilize money available within their budgets to help their clients access services. This ability, however, is dependent upon space within their budgets as well as approval from their managers. Dedicating portions of budgets specifically to addressing clients' accessibility issues could ensure the availability of money and set a tone for refusing to allow financial barriers such as travel costs, "hidden expenses" and "rising costs" to impact the degree to which clients are able to access services. This could include the provision of iPads or similar devices so that clients can participate in virtual activities while COVID-19 safety measures are in place.

If seniors are going to participate in the social prescribing program, financial barriers (within reason) should not prevent them from both doing so, as well as realizing the full benefits of doing so. Additionally, clients should not bear costs because they are participating in the program, let alone ones which may place greater stress on financial situations which are already strained due to barriers such as low incomes.

Relationships and Communication with Stakeholders

The importance of strong relationships and communication between seniors' community connectors, clients, service providers and general practitioners was consistent throughout the literature and this project's research data. These relationships can take time to develop – one social prescribing program evaluation found that it took three to six months for connectors to develop solid relationships with referrers (Farenden et al, 2015).

Recommendation 6: Implement steering committees

Launching a steering committee in each of the communities within which the social prescribing program operates could engage stakeholders and resolve or mitigate barriers related to communication, collaboration and information exchange.

Committee members could include general practitioners, leaders within local Divisions of Family Practice, clients, service providers and other community stakeholders. In their review of a United Kingdom-based social prescribing program, Farenden and colleagues (2015) noted that this approach could resolve numerous issues it encountered. Many of the issues are shared by Fraser Health's program and create barriers for its clients, such as a lack of information regarding its services.

In influential research regarding how to generate change within complex systems, one approach identified by Meadows (1999) is "the power to add, change, evolve, or self-organize system structure." Creating steering committees would redistribute some control away from the social prescribing program however it could also enhance its innovativeness, ability to respond to emergent opportunities and issues, and its ability to evolve over time, including in ways that support its clients to access community-based services.

If steering committees are implemented, the social prescribing program should identify and invite general practitioners who regularly refer patients and understand how the program helps those patients' health and wellness. Engaging clinical champions has been shown to help identify barriers as well as solutions to them (Alliance for Healthier Communities, 2020b). These practitioners could also act as "champions" who testify to the program's value and generate buy-in, support and increased numbers of referrals from their colleagues (Alliance for Healthier Communities, 2020b; Farenden et al, 2015).

Additionally, engaging service providers in a steering committee could help ensure that their activities enhance accessibility facilitators such as ensuring their activities take place at convenient times and meet clients' needs, and that they are providing adequate support and supervision. As well, engaging clients would ensure that program leaders are engaging those most affected by its work, while enabling clients to contribute to solutions which could resolve or mitigate barriers, or enhance facilitators, in a range of areas, including communication.

<u>Recommendation 7: Send regular updates to general practitioners</u>

Good communication amongst stakeholders is critical to the success of a social prescribing program (Dayson, Bashir & Pearson, 2013), especially between the program and its referring health professionals (Age UK, n.d.). In an Ontario-based social prescribing program, regularly communicating results and lessons learned to stakeholders maintained their engagement as well as the program's momentum, while also providing a mechanism for learnings to fuel iterative improvements (Alliance for Healthier Communities, 2020b).

Indeed, numerous evaluations of social prescribing programs identify the benefits of sending regular updates regarding clients' progress to their general practitioners. Doing so has built practitioners' support of social prescribing programs (Bickerdike et al., 2017), which itself could mitigate numerous barriers and issues identified by this project, such as their ability to explain it and decreased engagement over time. It has led to more referrals as well as improved appropriateness of referrals (Farenden et al, 2015; Palmer & Sango, 2017), which is relevant to Fraser Health's program given how many of its clients have high needs (as discussed above).

Establishing and maintaining good relationships between seniors' community connectors and general practitioners is critical to ensuring that social prescribing program clients are able to access community-based services. While structured reports have proven successful (Pescheny, Pappas & Randhawa, 2018), prioritizing in-person updates in order to facilitate effective communication was recommended following the evaluation of a large social prescribing program in the United Kingdom (Dayson, Bashir & Pearson, 2013). Regardless of updates' formats, more communication between connectors and practitioners could lead to better collaboration and information exchange.

As Meadows (1999) notes, "Missing feedback is one of the most common causes of system malfunction." Establishing new information flows between the social prescribing program and general practitioners is another leverage point which could effectively maintain practitioners' engagement with

the program and improve both the number and appropriateness of their referrals. Reports can include the reasons for a client's referral and services which they have been connected to (Palmer et al., 2017) as well as the support which has been provided by their seniors' community connector and the client's progress.

Regular, aggregated reports could also be sent to other stakeholders such as local Divisions of Family Practice as well as steering committees' members if they were to be implemented. Doing so could have similar benefits as those outlined above for general practitioners.

Educational & Marketing Components

Recommendation 8: Establish partnership agreements with general practitioners

The foundation of a solid relationship between senior's community connectors and general practitioners is laid early. As the connectors reported, practitioners' referrals and awareness of the social prescribing program often decline shortly after they begin referring; establishing a partnership agreement at the outset could outline the scope of the program's services as well as what is expected from practitioners so that they could commit to referring patients on an ongoing basis (Farenden et al., 2015). Doing so could enhance collaboration while improving information exchange and potentially screening practitioners who may become inactive shortly after the connectors invest time in introducing them to the program. It could also improve practitioners' understanding of what constitutes an appropriate referral.

As well, there are benefits to ensuring practitioners remain engaged with the social prescribing program beyond ensuring that they continue sending referrals. Patients referred to the social prescribing program continue seeing their practitioners for their health issues; those practitioners, therefore, can provide important psychological support that resolves or mitigates clients' barriers such as lacking motivation or feeling discouraged, frustrated, anxious or shame.

Pescheny, Pappas and Randhawa (2018) point out that good relationships between social prescribing program stakeholders promote effective communication, and effective communication fuels good relationships. This shows up in numerous ways within social prescribing programs. For example, when reviewing how well the aging and mental health systems served seniors with mental health issues in the Commonwealth of Pennsylvania, researchers found that good relationships led to issues becoming resolved without the need for formal structures and were vital to increasing the probability of patients' successful transitions between the two systems (Biegal, Shore & Silverman, 1989).

Recommendation 9: Invest in educating general practitioners

According to the survey data, general practitioners for roughly 40 percent of the program's clients had difficulty explaining the social prescribing program to them. This is unsurprising - social prescribing is a relatively new practice and many potential referrers need to be taught about it (Bickerdike et al., 2017; Friedli, Themessl-Huber & Butchart, 2012). In addition, health professionals may not have much experience in looking outside of traditional medical models to improve their patients' health and wellness (Brandling & House, 2009).

It goes without saying that the better general practitioners know about the social prescribing program, the better they will be able to explain it to patients and resolve or mitigate barriers such as their suspicions of unknown people and skepticism of the program's benefits – both of which are experienced by roughly 20% of clients. Improved education could also redirect clients away from the social

prescribing program and towards other programs or sources of support for complex physical and mental health issues.

According to Farenden and colleagues (2015), who surveyed 38 referrers to a UK-based social prescribing program, information provided to the general practitioners should provide:

- Clarity on the background and skills of the seniors' community connector to whom they will refer patients;
- Information on the training and support which connectors receive;
- Regular reports on their patients' outcomes; and
- Testimonials from other practitioners who have referred patients to the social prescribing program.

Recommendation 10: Facilitate person-centred services

Person-centred care seeks, listens and responds to the needs, values and preferences of people who receive care. Many barriers and facilitators related to this approach are experienced by social prescribing program clients as they interact with community-based service providers[10]. This includes barriers such as disconnects between clients' preferences and service providers' priorities as well as facilitators such as helping them feel that they are not being judged, their autonomy is respected, that they are heard and respected and that they are able to discuss issues as equal partners.

Feedback from seniors' community connectors suggests that service providers can provide improved person-centred care. This may require an educational component, similarly to how many general practitioners need to be taught about the services and value of social prescribing. One way to do so is by sharing locally developed educational resources developed for an initiative in British Columbia titled "What Matters to You?"[11]. The initiative encourages care providers to have conversations with their patients about what matters so that their care and services align with their patients' preferences.

In an evaluation of a social prescribing program in the United Kingdom, participants praised seniors' community connectors' "person-centred and non-judgmental approach [which] facilitated trust, feelings of control and a readiness to reflect on current circumstances and implement positive changes" (Moffatt et al., 2017). Encouraging service providers to understand the needs, values and preferences of the social prescribing program's clients would help them adapt their activities to address clients' access barriers and ensure their activities meet clients' needs. This also extends to general practitioners, who may improve both their understanding of how their patients want to improve their health and wellness by participating in the social prescribing program as well as their decision-making around if referring patients to the program would be appropriate.

Recommendation 11: Market the program to seniors

Reviews of other social prescribing programs suggest that broad publicity campaigns as well as placing marketing materials in participating general practitioners' waiting rooms could increase patients' understanding of social prescribing and its interventions (Pescheny, Pappas & Randhawa, 2018). These materials are a first opportunity to provide information aimed at resolving or mitigating clients' barriers

[10] Although community-based service providers may not provide care in a literal sense, the tenets of person-centred care apply to service provision just as well.

[11] Disclosure: this researcher is employed by the organization which leads "What Matters to You?" in British Columbia.

regarding stigma and stereotypes which they hold about frailty and themselves, their understanding of the program and how participating in it could help them.

Instigating referrals by having patients approach their general practitioners about the social prescribing program could complement how seniors' community connectors introduce the program to practitioners and wait for them to refer patients. As well, it would be prudent not to rely solely on practitioners teaching their patients about the program and "selling" them on participating in it.

Recommendation 12: Create new marketing materials

Currently, the seniors' community connectors share and modify marketing materials which they created themselves. The social prescribing program could create a suite of materials that establish a new, consistent brand for the program while providing flexibility for region-specific information to be included (such as the local connector's name, their organization's logo and unique services or support they provide). This "brand consolidation" was recommended by Bertotti and colleagues (2015) following the evaluation of their social prescribing program in the United Kingdom.

In doing so, the social prescribing program could utilize graphic design support to create these materials, whether it be from United Way, Fraser Health or an independent contractor[12]. High-quality materials which clearly communicate information about the program, its benefits and the roles of various stakeholders could resolve or mitigate barriers related to stigma and stereotypes, information regarding services and skepticism about the program's benefits. They can also build prospective clients' and referrers' confidence in the program, its professionalism and its ability to deliver results (Hollerup, 2017).

One seniors' community connector reported challenges in promoting the social prescribing program. Her efforts to promote it in publications read by seniors have been denied, including by the publisher of a seniors recreation centre's newsletter who felt that its readers may confuse Fraser Health's program with a similar service that operates in the area. This challenge could be more difficult for the connector, according to one of her peers, because she works for a housing provider as opposed to the other two connectors whose employers are community-based organizations which are better-positioned to leverage their positions and reputations within their areas.

As noted above, marketing materials have potential to educate general practitioners and clients about the social prescribing program. These, and advertising tactics with broad distribution and audiences (such as newspaper advertisements and direct mail flyers) would be well served by leveraging the brands of the United Way, Fraser Health and local Divisions of Family Practice[13] and having those organizations also distribute the materials[14]. The credibility, name recognition and reputations of these key partner organizations would provide significant weight behind the seniors' community connectors' outreach efforts while giving seniors and practitioners confidence in the program's legitimacy and potential benefits.

[12] This is not a comment on the quality of the current materials, rather a recognition that creating them is pulling seniors' community connectors away from supporting clients and that graphic design is not their area of expertise.
[13] These organizations' logos are currently placed in the footers of promotional materials however they could have greater impact if moved to more prominent positions.
[14] The program has had mixed success in getting promotional support from local Divisions of Family Practice; this could be aided by implementing recommendations which aim to improve engagement and support of divisions' leaders such as steering committees and regular reports.

Conclusion
Data obtained through this project's research has significant potential to inform the social prescribing program's practices. It was used to develop recommendations which aim to resolve or mitigate prevalent barriers or enhance prevalent facilitators, so that they can have a high likelihood of impacting clients' abilities to access services (as depicted in Table 1).

Ultimately, the recommendations tend to focus on barriers' and facilitators' cultural and psychological categories. This is primarily attributable to the ability of the social prescribing program and its seniors' community connectors to implement changes in those areas. To that end, barriers and facilitators within the financial and physical categories are often too complex or systemic in nature for this project to address.

By no means does this suggest that data regarding the financial and physical categories cannot be acted upon. The program now has data which could be used to advocate for policy changes or funding which could improve the accessibility of community-based services or increase the support provided to clients by the program. As well, it now has a database of facilitators which are known to improve clients' access to and experiences with service providers which could be turned into a resource for those providers which explains the importance of, for example, practicing reflective listening when communicating with program clients.

Conclusion

Social prescribing is a model of health and social care provision gaining in popularity as governments seek non-medical approaches to improving populations' health and wellness. Although robust evidence of the effectiveness and impact of social prescribing is lacking, enough reporting exists to justify the model's implementation – including in ways such as Fraser Health's program.

Fraser Health's social prescribing program has been in place for roughly 18 months, allowing for a comprehensive review of the degree to which its clients – frail seniors – have been accessing community-based services. This project sought to first identify barriers and facilitators which are hindering and facilitating, respectively, clients' abilities to do so and then make recommendations aimed at resolving and mitigating barriers those barriers and/or enhancing those facilitators.

A broad literature review identified more than 240 barriers and facilitators potentially experienced by the social prescribing program's clients. The program's seniors' community connectors – staff who provide direct support to clients and help them access community-based services – then completed an online survey to identify how many of their clients experience each potential barrier and facilitator. A focus group enabled them to contextualize the survey data and, through a force field analysis, identify how this project's recommendations could have the greatest impact by focusing on prevalent barriers, and enhancing prevalent facilitators, which could be quickly and realistically resolved, mitigated or enhanced.

The data shows many of the social prescribing program's clients experience cultural, financial, physical and psychological barriers which require a high level of support from seniors' community connectors which was unplanned when the program was launched. These barriers often prevent clients from accessing services and/or consume significant amounts of the connectors' time and resources which, in

turn, prevents them from supporting other clients. These challenges are not unique to Fraser Health's social prescribing model but they risk the program's ability to achieve its mandate and objectives.

As well, this project identifies numerous facilitators which are experienced by the program's clients. Although fewer in number than barriers, the facilitators provide equally significant value; if enhanced, they can improve the degree to which clients are accessing services.

COVID-19 continues to affect the social prescribing program's operations, and safety measures within communities intended to reduce transmission of the virus are significantly affecting clients, including their mental health, social isolation and ability to participate in services. The pandemic also impacted this project's methodology, in particular making it impossible to meet with clients in person. This project's recommendations are mindful of COVID-19 safety measures and can be acted upon during or after the pandemic. Thankfully, vaccination rates at the time of this report's publishing indicate that the program and service providers may be able to operate "normally" again very soon.

Twelve recommendations are provided which identify ways to resolve or mitigate barriers and/or enhance facilitators. They are grounded in learnings and recommendations which have emerged from social prescribing programs elsewhere. For the most part, they can be implemented quickly and their objectives are realistic when considering the program's capabilities and the scope of this project. Five of the recommendations pertain to the social prescribing program's model; two seek to improve relationships and communication between the program's stakeholders; and five propose improvements to how the program markets and teaches stakeholders about itself. All of them are provided in the hope that, if implemented and successful, they can help frail seniors improve their health and wellness.

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Appendices

Appendix 1: Electronic Survey Questions

How many clients are you currently serving?

How many of your past clients exited the social prescribing program because they became able to self-manage their participation in services?

How many of your past clients exited the social prescribing program because barriers prevented them from accessing services?

How many of your past clients exited the social prescribing program for other reasons not related to barriers which prevented them from accessing services?

The next four sections ask you to note how many of your past and current clients experience a range of barriers to accessing services. The barriers are grouped according to categories identified within the BC Health Quality Matrix, a provincial framework for health and wellness to support people and their communities to thrive. Some barriers may not seem like a natural fit for the categories in which they appear; this is okay – it is more important to ensure that a barrier is considered than it is to find its perfect fit within the categories.

Cultural Barriers

How many of your past and current clients experience(d) each of the following barriers when attempting to access services?

- Care is not client-centred (clients are not considered partners; their needs and desired health outcomes are not the driving force behind decisions)
- Disconnect between client's preferences and service provider's priorities
- Client is less likely to seek help because of cultural reasons or values
- Communication: client's limited English proficiency
- Communication: poor methods
- Communication: poor quality (impersonal, one-way)
- Communication: rude or unhelpful service providers
- Communication: service provider "doesn't listen" or is unresponsive
- Health care system bureaucracy (e.g., red tape, complicated forms)
- Lack of coordination and information exchange between health care professionals
- Service provider: stereotypes about frailty
- Service provider: stereotypes about seniors
- Stigma attached to frailty
- Client: stereotypes about frailty
- Client: stereotypes about seniors
- Lack of trust or relationships between seniors' community connectors and GPs
- Lack of structures/processes to guide collaboration between seniors' community connectors and GPs
- Communication: service provider's limited English proficiency
- Limited availability of culturally competent services

- Lack of trust or relationships between seniors' community connectors and service providers

When answering the following questions, please maintain clients' privacy and anonymity. Do not include an example if you cannot maintain a client's privacy and anonymity.

How have any of these barriers prevented clients from accessing services?

Have you seen any of these barriers successfully removed for a client(s)? If yes, which one(s) and how?

Do you have any comments on how COVID-19 has affected these barriers?

Do you have any cultural barriers to add?

Financial Barriers

How many of your past and current clients experience(d) each of the following barriers when attempting to access services?

- Low income
- Not accessing relevant subsidies/financial benefits
- Costs associated with getting to services
- Costs associated with participating in services
- Rising costs related to accessing services
- Hidden expenses
- Insufficient diversity of services available
- Insufficient number of service providers
- Seniors' community connectors: unable to accept new clients
- Seniors' community connectors: unable to commit appropriate time to clients
- Service provider: unable to accept new clients
- Service provider: unable to commit appropriate time to clients
- Service provider: lack of continuity among services
- Service provider: lack of options for services/activities
- Service provider: lack of women-only services
- Services are delayed (wait times)
- Services are unavailable (wait lists)
- Turnover in service provider's staff
- Uneven distribution of services within region
- Unsuitable scheduling of services
- Social prescribing program lacks staff or volunteers
- Turnover in social prescribing program's staff or volunteers

When answering the following questions, please maintain clients' privacy and anonymity. Do not include an example if you cannot maintain a client's privacy and anonymity.

How have any of these barriers prevented clients from accessing services?

Have you seen any of these barriers successfully removed for a client(s)? If yes, which one(s) and how?

Do you have any comments on how COVID-19 has affected these barriers?

Do you have any financial barriers to add?

Physical Barriers

How many of your past and current clients experience(d) each of the following barriers when attempting to access services?

- Distance to travel to reach services
- Time to travel to reach services
- Client's age: services are geared towards younger participants
- Client's age: services are geared towards older participants
- Client has a job
- Client lacks time
- Client is unable to do assessments
- Client is unable to engage in exercises
- Client's high level of care needed: physical health
- Client's high level of support needed: dealing with logistics
- Client's physical isolation
- Client's diminished physical health causes them to de-prioritize accessing services
- Client lives alone
- Client's health: functional status (difficulty doing basic daily activities)
- Client's health: hearing difficulties
- Client's health: fatigue, lack of strength
- Client's health: addiction or substance use
- Client's health: too frail
- Client's health: medical appointments
- Client's health: medication side effects
- Client's health: multiple medications
- Client's health: difficulty obtaining medications
- Client's health: sleep disorder
- Client's home: hazards
- Client's home: lack of space/equipment
- External environment: conditions of curbs, sidewalks, streets
- External environment: excessive noise
- External environment: heavy traffic
- External environment: inadequate lighting
- Public transportation: difficult to access
- Public transportation: inefficient
- Public transportation: long wait times
- Public transportation: unreliable
- Service provider: location is unsafe
- Service provider: location is not wheelchair accessible
- System bureaucracy (applying for programs, subsidies, etc.)
- Difficulty accessing health care
- Appointments/meetings are often rescheduled by client
- Bad weather
- Client's health: eyesight difficulties
- Client's health: speech difficulties

When answering the following questions, please maintain clients' privacy and anonymity. Do not include an example if you cannot maintain a client's privacy and anonymity.

How have any of these barriers prevented clients from accessing services?

Have you seen any of these barriers successfully removed for a client(s)? If yes, which one(s) and how?

Do you have any comments on how COVID-19 has affected these barriers?

Do you have any physical barriers to add?

Psychological Barriers

How many of your past and current clients experience(d) each of the following barriers when attempting to access services?

- Alienation
- Anxiety about being "a bother," "a nuisance" or "annoying people"
- Confusion
- Discouragement
- Distrust
- Doesn't expect to benefit
- Feel judged
- Feel disrespected or disregarded
- Frustration
- Impatience
- Intimidation
- Lack of motivation
- Low health literacy
- Patronizing advice or instructions
- Pride
- Rejection
- GPs have difficulty explaining the social prescribing program to patients
- Self-efficacy
- Shame
- Stubbornness
- Social isolation
- Suspicion of unknown "people who come to help"
- Weariness
- Seniors' community connectors' lack of awareness of services
- Lack of confidentiality
- Lack of information regarding services
- Lack of social skills
- Lack of social support system
- Lack of understanding of frailty
- Unable to set goals and keep to a plan
- Unable to remember appointments
- Mental health issues
- Dementia
- Depression or depressive symptoms
- Previous trauma
- Psychological burden of living with a long-term condition
- High level of emotional support needed
- Activity became less important or interesting to the client
- Maintaining style preferences was more important than making a change
- Client is unsatisfied with progress
- Concerns about what others may think or say
- Social prescribing program lacks process for identifying and responding to barriers
- Concerns about health and safety
- "Concerns about potential for exacerbating
- existing health issues"
- Client has difficulty establishing long-term relationships with service provider
- Client's family members have difficulty establishing long-term relationships with service provider
- Service provider has difficulty establishing long-term relationships with clients
- Client fears being harmed
- Client fears losing their home
- Client fears losing their independence
- Client fears losing their privacy
- Client is reluctant to reveal current behaviour
- Client feels that sustained behaviour change is too hard
- Client is not willing to receive help
- Client is worried about being taken seriously
- Required time is off-putting
- Service provider: lack knowledge and training

- Service provider: lack of knowledge about frailty
- Service provider: staff discouraged by client's lack of interest
- Service provider: skeptical of information from others (e.g., primary care doctors)
- Service provider: information given to clients is misleading
- Service provider: technology is inaccessible or intimidating
- Service provider: activities encourage dependency
- Client is skeptical of service's benefits
- Client does not feel welcomed
- Client fears strangers
- GPs' referrals to the social prescribing program are inaccurate
- GPs give patients inaccurate information, leading to unrealistic expectations

When answering the following questions, please maintain clients' privacy and anonymity. Do not include an example if you cannot maintain a client's privacy and anonymity.

How have any of these barriers prevented clients from accessing services?

Have you seen any of these barriers successfully removed for a client(s)? If yes, which one(s) and how?

Do you have any comments on how COVID-19 has affected these barriers?

Do you have any psychological barriers to add?

The next four sections ask you to note how many of your past and current clients experience a range of facilitators which help them access services. Like the barriers, the facilitators are grouped according to categories identified within the BC Health Quality Matrix, a provincial framework for health and wellness to support people and their communities to thrive. Some facilitators may not seem like a natural fit for the categories in which they appear; this is okay – it is more important to ensure that a facilitator is considered than it is to find its perfect fit within the categories.

Cultural Facilitators

For how many of your past and current clients' access to services was helped because of the following facilitators?

- Diverse perspectives/backgrounds among everyone involved
- Service provider supports the social prescribing program
- Longstanding relationship between client and seniors' community connector
- Clear, simple instructions
- Effective case coordination
- Adapting services to address access barriers
- Adapting services to fill gaps for clients' needs
- Advocating for improved program access for clients
- Services meet client's needs
- Client does not feel judged
- Client's autonomy is respected
- Client feels heard and respected
- Client is able to discuss issues with the service provider as an equal partner

- Service provider asks questions and listens
- Service provider recognizes and reinforces efforts that the client makes
- Service provider discusses tangible, personalized plans with the client
- Service provider's effective communication skills
- Service provider's effective communication methods
- Service providers' empathy
- Service provider's caring demeanour
- Service provider gives one-on-one attention
- Service provider modifies exercises to fit client's needs
- Service provider sets positive goals (e.g., what to do, not what to avoid)Service provider's reflective listening
- Strong relationship (e.g., trust, respect, shared understanding) between seniors' community connector and GP
- Strong relationship (e.g., trust, respect, shared understanding) between seniors' community connector and client
- Strong relationship (e.g., trust, respect, shared understanding) between seniors' community connector and service provider
- Strong relationship (e.g., trust, respect, shared understanding) between GP and service provider
- Strong relationship (e.g., trust, respect, shared understanding) between client and GP
- Strong relationship (e.g., trust, respect, shared understanding) between client and service provider
- Structured contact and regular communication between seniors' community connectors and GP
- Structured contact and regular communication between seniors' community connectors and service provider

When answering the following questions, please maintain clients' privacy and anonymity. Do not include an example if you cannot maintain a client's privacy and anonymity.

How have any of these facilitators helped clients to access services?

Do you have any comments on how COVID-19 has affected these facilitators?

Do you have any cultural facilitators to add?

Financial Facilitators

For how many of your past and current clients' access to services was helped because of the following facilitators?

- Regular support and supervision from service provider
- High socio-economic status (social standing or class, often measured as a combination of education, income and occupation)
- Service providers are able to perform outreach to clients (e.g., travels to them)
-
- Seniors' community connector is able to coordinate access to services
- Travel subsidies
- Access to a vehicle

- Diversity of services available
- Number of service providers
- Support finding and accessing subsidies, financial support
- Meal programs
- Financial support from social prescribing program

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How have any of these facilitators helped clients to access services?

Do you have any comments on how COVID-19 has affected these facilitators?

Do you have any financial facilitators to add?

Physical Facilitators

For how many of your past and current clients' access to services was helped because of the following facilitators?

- Convenience - services' time of day
- Convenience - services' day of week
- Convenience - duration of services/activities
- Convenience - service providers are close to where clients live
- Consistent routines
- Client has the time to participate
- Client has skills such as those needed to fill out forms
- Client can drive
- Family member or friend can drive the client
- Client is able to access services by foot
- Client is able to access services by public transportation
- Good weather
- Access to locations (service providers or other) that are not crowded
- Access to locations (service providers or other) that have the correct equipment
- Service provider's location is accessible
- Service provider's location is familiar
- Routes taken to go to service providers are familiar
- Service provider supplies equipment
- Service provider supplies handouts with instructions
- Services/activities can take place in client's home
- Multiple service providers are centralized/integrated
- Presence of other individuals with frailty or similar health issues

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How have any of these facilitators helped clients to access services?

Do you have any comments on how COVID-19 has affected these facilitators?

Do you have any physical facilitators to add?

Psychological Facilitators

For how many of your past and current clients' access to services was helped because of the following facilitators?

- Support from family members
- Support from service provider
- Support from peers
- Support from seniors' community connector
- Role models
- Strong social network
- Help from family or others at home
- High self-esteem
- High self-efficacy
- High confidence
- High level of independence
- Perception of being "checked up on"
- Perception of safety
- Monitoring of performance, including self-monitoring
- Client has experienced benefits of accessing services
- Physical exercises are fun and less daunting
- Positive attitude - determination and willingness to accept their situation
- Desire to maintain or regain independence
- Learnt to take personal responsibility for own safety
- Liked to know whether they were doing well
- Service provider is a mature person with life experience who client thinks could more easily understand their concerns
- Service provider is a "lively" young person
- Service provider's goal-setting approach
- Client's first experience with service provider was positive
- Positive feedback from service provider
- Positive feedback from seniors' community connector
- Everyone involved has a shared understanding, attitudes and perspectives
- Social prescribing program's clear leadership
- Male service provider staff
- Female service provider staff
- Seniors' community connector is aware of service providers
- Appropriate referrals from GPs

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How have any of these facilitators helped clients to access services?

Do you have any comments on how COVID-19 has affected these facilitators?

Do you have any psychological facilitators to add?

Clients' Demographics

The following questions will help identify potential relationships between clients' barriers and personal characteristics:

How many of your past and current clients fall into these age ranges?

- < 60
- 60-65
- 66-70
- 71-75
- 76-80
- 81-85
- 86-90
- > 90

How many of your past and current clients are:

- Men
- Women
- Two spirit
- Non-binary
- None of the above
- I don't know
- Prefer not to answer

How many of your past and current clients live:

- Alone
- With one other person
- With more than one other person

How many of your past and current clients live:

- In a house
- In an apartment or condominium development
- In a residence for senior citizens
- In a long-term care home
- Other (Please explain)

How many of your past and current clients live:

- In an urban setting
- In a rural setting