CCHOHT Clinical Lead-PCN Advancement Social Prescribing

0.2 FTE (7.5 Hours Per Week)

Dates: ASAP to March 31st, 2025

Overview

The Clinical Lead for Social Prescribing and Primary Care Network (PCN) Development plays a pivotal role within the Connected Care Halton Ontario Health Team (CCHOHT) by bringing clinical leadership to advance and integrate social prescribing into local PCNs. This role focuses on enhancing patient care by addressing social determinants of health, fostering community connections, and building innovative care pathways that combine clinical and non-clinical support.

This position involves delivering exceptional leadership to build knowledge within primary care on the patient benefits and best practices within emerging social prescribing strategies that improve patient outcomes, reduce healthcare utilization, and create sustainable care models. The Clinical Lead will work collaboratively with primary care providers, healthcare organizations, Indigenous Partner and community agencies to drive change and achieve the goals of the developing PCNs.

About the Connected Care Ontario Health Team and the Primary Care Working Group (PCNWG)

As a key deliverable of the Operating Plan for 2024/25, the CCHOHT and the Halton Physician Association has collaborated on establishing a Primary Care Working Group (PCNWG) inclusive of Physician, Nurse Practitioner, Patient, Family and Caregiver Chair and Halton Healthcare Administrative Leaders. The purpose of this working group is to identify and expand upon the foundations of the HPA membership to inter-professional primary care teams to support improving patient attachment, timely access to care and build impactful population health interventions. Social prescribing has been identified as a new key strategy to connect patients to community resources and address unmet social needs.

Key Responsibilities & Deliverables

Leadership in Social Prescribing:

- Lead the adoption of paRX social prescription program across primary care to increase knowledge and adoption.
- Lead the design, implementation, and evaluation of social prescribing programs within the emerging PCN.
- Serve as the clinical champion for local existing social prescribing, advocating for its integration into care models across the CCHOHT.
- Collaborate with the PCNWG to align social prescribing initiatives with overall PCN goals.
- Provide strategic guidance on leveraging social prescribing to improve access to care and reduce inequities.

Program Development and Integration:

- Work with community organizations to scale and spread existing partnerships that support social prescribing initiatives.
- Collaborate on advancing integrated care pathways that include social prescribing for chronic disease management, mental health, and preventive care and community based screening practices.
- Train and support primary care teams in adopting social prescribing practices.
- Encourage the integration of social prescribing with team-based care models to optimize patient outcomes.

Partner Engagement:

- Facilitate collaboration between primary care providers, community organizations, and healthcare leaders to build a shared vision for social prescribing.
- Engage with patients and caregivers to ensure social prescribing strategies are patient-centered and culturally appropriate.
- Represent the CCHOHT in regional and provincial committees to share insights and influence policies related to social prescribing.

Performance Measurement and Reporting:

- Develop a basic set of key performance indicators to assess the impact of social prescribing, including patient satisfaction, improved health outcomes, and reduced healthcare utilization.

- Prepare regular reports for the CCHOHT and PCNWG to track progress and demonstrate value.
- Identify opportunities for continuous improvement in social prescribing practices.

Equity, Diversity, and Inclusion:

- Prioritize equity in the design and implementation of social prescribing programs, ensuring accessibility for marginalized populations.
- Advocate for the use of social prescribing to address systemic barriers to health and wellness.

Key Competencies

- **Collaborative Leadership:** Builds and leads interprofessional teams to achieve shared goals in social prescribing and primary care.
- **System Thinker:** Understands the intersection of clinical care, community resources, and social determinants of health.
- **Patient-Centered:** Ensures that social prescribing initiatives prioritize the needs and voices of patients and caregivers.
- **Innovative Problem Solver:** Identifies and implements creative solutions to integrate social prescribing into clinical care.
- **Equity Advocate:** Demonstrates a commitment to reducing health disparities through inclusive and accessible care models.
- **Effective Communicator:** Clearly articulates the value of social prescribing to diverse stakeholders and inspires action.

Qualifications and Experience

- **Medical License:** Holds a valid certificate of registration as a physician in good standing with the College of Physicians and Surgeons of Ontario.
- **Member of the College of Family Physicians of Canada** is an asset.
- **Active Practice:** Currently has an active practice in Oakville, Milton, or Halton Hills within the community or hospital as a Primary Care Physician or Specialist.
- **Experience in Social Prescribing:** Demonstrated expertise or interest in developing and implementing social prescribing initiatives.
- **Leadership Training:** Formal education in change management, leadership, or health administration is considered an asset.
- **Community Engagement:** Proven ability to collaborate with community organizations and system stakeholders.

Clinical Lead Compensation

The compensation for the Clinical Lead role aligns with recommended OMA and Ontario Health Team (OHT) physician leadership rates. This position operates 7.5 hours per week (0.2 FTE) at a rate of $165/hour.

TERM: Position begins ASAP following the selection process and is funded until March 31, 2025, with the opportunity to be extended subject to funding and performance on above deliverables. The fiscal year runs from April 1st March 31st.

Reporting: The Clinical Lead -PCN advancement Social Prescribing will report to the Executive Director of the Connected Care Ontario Health Team.

Application and Selection Process

All resumes and cover letters are to be emailed to zdawe@haltonhealthcare.com with the subject line: **CCHOHT Clinical Lead PCN Advancement Social Prescribing Application.** The closing date for applications will be **Wednesday January 8th at 5:00pm**. Only selected applicants will be contacted for an interview.