HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH | D-LAB

Design for Social Prescribing

Bridging Silos for Health Promotion

March 1, 2023

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Acknowledgment

This project was led by D-Lab's Builder Fellow, Reena Shukla, who had the vision to bring design to support the social prescribing movement. Her vision was made possible with the support of key collaborators, stakeholders who gave their time to be interviewed, and the 40 participants of the convening held in October 2022 as captured in this report.

A special thanks to David Andersson, Chris Appleton, Charlemya Erasme, Staci Jacin, Dan Morse, Jill Sonkie, Käthe Swaback, and Marete Wester for providing feedback on this report.

Key Collaborators

The project was led by the Design Laboratory at the Harvard T.H. Chan School of Public Health in collaboration with the Center for Arts in Medicine of the University of Florida and Social Prescribing USA.

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH | D-LAB

The D-Lab explores how design, public policy, and public health can work together on the well-being of people, organizations, and the natural environment. It conducts research and develops education and translation programs using an advanced set of design frameworks and methods that are pliant, flexible, and adaptable to fit the uncertainty and volatility of today's complex challenges.

Center for ARTS IN MEDICINE UNIVERSITY OF FLORIDA

The UF Center for Arts in Medicine is an academic and research unit in the University of Florida College of the Arts. It is committed to advancing research, education, and practice in arts in health, locally and globally. The Center facilitates research, education, and training in the use of the arts to enhance health in both health care and public health contexts.

social prescribing usa

Our mission is to make social prescribing available to every American by 2035. We aim to catalyze the social prescribing movement by building a community of practice, bridging sectors to collaborate, and supporting passionate health care leaders as they fundraise and implement social prescribing in their clinics and cities.

Additional Collaborators

World Health Organization

National Academy for Social Prescribing

Global Social Prescribing Alliance

On October 27 – 28, 2022, 40+ participants across diverse sectors and industries leveraged design knowledge to explore pathways for expanding and accelerating the adoption of social prescribing initiatives in the US.

The convening is part of a three-phase project led by the Design Laboratory at the Harvard T.H. Chan School of Public Health in collaboration with researchers and leaders from the Center for Arts in Medicine of the University of Florida and Social Prescribing USA.

This report outlines what emerged during the planning and implementation of a three-phase project to explore how design could help expand and accelerate a social prescribing agenda within the US.

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Executive Summary

Social prescribing refers patients to community and social services that support the individual's larger social needs and that can bolster their overall health and well-being. Social prescribing offers a promising approach to addressing widespread mental health issues, pervasive health inequity, aging population, and growing social isolation across all segments of society. While Social prescribing is integrated into the national health systems of countries such as the United Kingdom (UK), Canada, Australia, and Japan, it has only recently begun to take root in the United States (US) through pilots in at least six states.

"Design for Social Prescribing" is a project undertaken by the Design Lab's Builder Fellow, Reena Shukla, who identified the value that design can bring to the early stages of complex initiatives. The Design Lab's research, education, and translation programs are structured on the Whole View model.[1] This model is particularly useful in helping organizations navigate the uncertainty of complex new endeavors laden with not only technocratic factors driven by technology and economics, but also ambiguous behavioral factors driven by emotion and culture.

In this project, the Design Lab collaborated with Social Prescribing USA and the University of Florida's Center for Arts in Medicine to explore whether the Whole View could help expand and accelerate the social prescribing agenda within the US. At this moment, the project has advanced in three phases: Understanding Context, Broadening Perceptions, and Exploring Pathways. This document outlines learnings generated from activities undertaken during these three phases, and presents actions taken towards exploring next steps.

[1] Whitney and Nogueira, "Cutting Cubes Out of Fog: The Whole View of Design."

Phase I: Understanding Context

For six months, the team conducted secondary research and engaged with key stakeholders across academia, private health insurance, start-ups, policy, advocacy, and health service delivery to learn about interest, viability, and implementation of social prescribing initiatives in the US. This work surfaced six areas where action could be taken to overcome key challenges for adoption and gain momentum in the US. The action areas briefly described below informed activities in Phase II.

- **Broadening referral systems:** integrating social health screening metrics and referral links to community and social services.
- **Building capacity of social services systems:** strengthening social services ecosystems to include arts, nature, volunteerism, and other areas that foster human well-being and social connectivity.
- **Making the economic case:** utilizing financial and health outcomes data from pilots to build evidence on social prescribing's value for health, and create sustainable financing models.
- **Linking to parallel movements:** connecting with existing patient-centered care initiatives to fuel learning and bolster momentum for the movement.
- **Disseminating knowledge:** increasing dissemination and awareness to expand adoption and curiosity around the emerging practice.
- **Centering around the community:** co-creating initiatives with community members in response to their aspirations, needs, and available assets—including trusted partners.

Phase II: Broadening Perceptions

After engaging with a diverse set of key stakeholders and learning from these action areas, it became evident that no silver-bullet solution led by a single organization would promote the intended impact. While all stakeholders recognized the need to transform the current state of health care, none had a comprehensive understanding of the challenges and opportunities across all the possibilities for influence.

This complex and often conflicting understanding of best ways forward was used to design a convening of 40+ stakeholders across sectors and industries. Between October 27 and 28, 2022, people from the public, private, social, and academic sectors working in public health, health care, design, digital health, arts and culture, community development, environmental conservation, education, volunteerism, and philanthropy came together at Harvard's Innovation Lab to broaden their perspectives towards expanding and accelerating social prescribing efforts in the US.

Co-design activities were structured on the Whole View, helping participants consider the broader purpose of social prescribing from the viewpoints of users, offerings, value creation, and organizational strategy and operations. Participants were organized in cross-sector groups. Each group co-created a platform concept in response to the considered aspirations, needs, and related problems of a specific stakeholder group. Six platform concepts were developed:

- **Integrating Health:** connecting *health providers* with community assets to expand their medical practices beyond conventional one-to-one clinical interactions.

- **Collective Community Care:** enabling *patients* to access emotional, practical, financial, and social support services to create a culture of health.
- **Link Co-Creators:** building the capacity of *community members* to become anti-oppressive and trauma-informed links to community-based well-being services fit to individuals' needs and aspirations.
- **Interconnectivity:** supporting partnership formation across *community organizations* to increase access to resources, diversity, visibility and impact in the community.
- **Community-Based Ecosystems:** bridging silos across *government agencies* to increase efficiencies in resource allocation and create feedback loops in response to community priorities.
- **Neighbors in Health:** helping *insurance companies* justify coverage parity in service delivery through the rigorous use of data to design low-cost and culturally-sensitive social interventions.

Phase III: Exploring Pathways

The workshop revealed the diversity of perspectives present in the Social Prescribing movement. Not surprisingly, some perspectives complement each other. Others, however, are representative of social tensions briefly described below under the umbrella of four major themes:

Language

Locking in a definition ↔ **Agreeing on a meaning**

While some prioritize defining social prescribing in the US context, others argue for harnessing the momentum of the movement to broaden the notion of health, and promote a shift in care paradigms.

Governance

Control of the system ↔ **Autonomy of the parts**

While some seek to establish a common policy framework and control over various factors influencing success before intervening, others recognize the role of numerous multi-sectoral agents acting independently.

Process

Enabling bottom-up ↔ **Enforcing top-down**

While some strive to pull change from ongoing initiatives happening on the ground, others argue that change must be pushed through top-down mechanisms.

Evaluation

Prototyping futures ↔ **Benchmarking the past**

While many wait for evidence from pilots in existing systems before making decisions about future directions, others recognize that the novelty of this work requires exploration and experimentation.

Next Steps

"Design for Social Prescribing: Bridging Silos for Health Promotion" reflects an effort to promote paradigm shifts in the US health system to address some of our society's most pressing challenges. While this initial exploration was, of course, limited in providing a deep understanding of the complex challenges underlying social prescribing, it did accelerate learning across stakeholder groups about new opportunities in this space and the pathways forward.

Particularly, Phases I and II of this project have encouraged openness to explore unusual collaborations across diverse stakeholder groups—a critical condition for advancing the movement. Within a few months of the October 2022 convening, we heard from participants about several initiatives and strategic shifts that emerged from their involvement in this project. Examples include the prioritization of anti-racist principles to design program evaluations, introduction of social prescribing to state service commission executives and health insurance representatives, evidence-based primers on social prescribing, and new collaborations bridging technical and policy expertise to increase knowledge and awareness for health care practitioners on social health approaches.

In parallel to supporting these and other activities, collaborators are currently exploring ways to structure a long-term initiative, involving diverse stakeholders along with participants of the convening, to expand and accelerate the social prescribing movement in the US.

Find more resources on Social Prescribing here:
http://www.socialprescribingusa.com/resources

It is about asking "what matters to you" rather than "what is the matter with you."

Bogdan C. Giurca,
Clinical Champion Lead,
National Academy of Social Prescribing,UK

SOCIAL PRESCRIBING

Advancing an Audacious Idea

Social prescribing is a growing area of research and practice that aims to connect established health systems with existing community assets by providing a platform for health professionals to prescribe interventions that have not been conventionally considered in medical practice, but nevertheless influence people's health.

This may include ways to increase social connectivity, improve access to housing and education, and create linkages to arts, culture, and nature-based activities. Social prescribing takes a holistic, people-centered approach to addressing an individual's health-related social and psychological needs and improving their overall health and well-being outcomes.[2] It recognizes that health is not just a medical issue, but rather is affected by wider social determinants.[3,4]

Social prescribing has been implemented in several countries, including Australia, Canada, Ireland, Japan, New Zealand, Portugal, Singapore, the UK, and Northern Ireland.[5] In 2021, the Global Social Prescribing Alliance was established to support the development and growth of social prescribing worldwide.[6] This alliance currently involves partners from 23 countries working to upscale social prescribing implementation.

Social prescribing pilots were recently launched in at least six states in the US, including, "CultureRx: Social Prescription" in Massachusetts.[7] In this pilot, the Mass Cultural Council collaborated with arts, nature, and cultural organizations to increase support for patients within a variety of health care systems. One key takeaway from their work is the value of expanding concepts of health and healthcare by linking healthcare systems to additional community resources and assets that are capable of responding to a vast array of experiences, cultures, and backgrounds. This process recognizes the need for a holistic, yet pragmatic understanding of behavior that considers people's daily life experiences in relationship to environmental and social determinants of health.

Dealing with the Invisible

Understanding behavior is difficult because people are influenced by emotion, culture, and other powerful factors that are hard to measure or even see. People typically make everyday decisions and act accordingly by fitting together information, services, and other resources and assets readily available to them to achieve their health aspirations.

Terrains of daily life are a way to characterize people in the context of their aspirations, problems, and needs. While we cannot see the aspirations that define a terrain, we can observe the activities that result from everyday decisions people make to achieve their aspirations, including those related to working, playing, learning, and living with family and friends, among others.

For example, we cannot see the aspirations a parent has for their child's learning, but we can see them helping with homework. We cannot see the aspirations a doctor might have for advancing their job, but we can see what they do to learn new skills. Observing and understanding these activities not only gives deeper insight into terrains, but the patterns of behavior that we find also provide the context for designing offerings that shape the experience of diverse stakeholders participating in a system.

CASE STUDY: Advancements in the UK

In England, approximately 1 in 5 primary care appointments are related to unmet social needs, such as loneliness, financial stress, or poor housing.[8] In 2019, Social Prescribing was integrated into England's National Health Services (NHS) Long-term Plan, a 10-year roadmap for the health care system, as part of wider efforts to improve health outcomes and deliver universal, people-centered, tailored care.[9] The plan introduced a new stakeholder group into health ecosystems called "Social Prescribing link workers." This group became an integral part of multi-disciplinary teams in primary care, dedicating their time to working with and understanding people's aspirations, needs, and related problems. Together, they co-create a plan of action shaped by the user's preferences, which includes addressing loneliness by participating in local social activities to improve well-being.[10]

In 2019, England's Department of Health and Social Care established the National Academy for Social Prescribing (NASP) to champion, promote and advocate for Social Prescribing nationwide with key stakeholders from the health service and voluntary community sector.[11] In August 2022, NHS England announced the accelerated recruitment of 1,000 link workers to further supplement capacity and facilitate service delivery activities of the 2,600 link workers that were already supporting Social Prescribing in the country.[12] This fast adoption made Social Prescribing an important mechanism to help reduce pressures on the health system and tackle inequality in health outcomes.[13,14] Recent evidence suggests that the current NHS link worker program could lead to 4.5 million fewer GP appointments per year, with those patients receiving community-based social solutions to their unmet social needs.[15]

Written by: Bogdan C. Giurca, Clinical Champion Lead, National Academy of Social Prescribing, UK

Confronting Complexity

A broader lens is needed towards how people currently use community assets in their everyday activities. Without such a lens, medical professionals might inadvertently prescribe social interventions that reinforce the very aspects that underlie the problem, or become a new challenge influencing a person's health.

For example, doctors might prescribe visits to museums where people have been historically excluded, further intensifying intimidation, misrepresentation, and a lack of belonging; or they might prescribe experiences that people cannot understand due to language barriers; or even suggest visits to places that people cannot access due to lack of public transportation or financial constraints.

The underlying forces creating friction between people's activities and medical protocols are ubiquitous and can live in institutional blind spots, where people's aspirations and lived experiences are often overlooked by the application of rigorous scientific methods, rigid data schemes, and the stringent analysis of economic, demographic, environmental, and medical information underlying current practices in health systems.

This situation becomes even more complex upon recognizing that health systems might be limited in effectively supporting people's health. People interact with a wide range of stakeholders when trying to achieve their health aspirations. Examples might include art-related organizations, conservation institutions, faith-based institutions, among others. In turn, these stakeholders will also be challenged to change the way they currently work. They will have to create spaces that are more accessible, equitable, and welcoming for all, including supporting experiences for diverse patients where they can feel a sense of belonging.

Identifying opportunities for cooperation amid the complex and often conflicting interests between health care institutions, payers of health services, and social, conservation, and cultural organizations is critical for the successful implementation of social prescribing. So is understanding the systems and power structures that have created and continue to govern these organizations in the first place.

While pilots have highlighted innovative ways forward in cooperative models, it is not clear which organizational arrangements and business models would be needed to create and account for the value of social prescribing. It is also not clear which offerings these arrangements should create to achieve the intended impact.

Pathways forward through these challenges will not be created by single organizations, in disciplinary silos, or in research think tanks. Rather, it will require novel capabilities and organizational arrangements among diverse stakeholders committed to confronting the complexity that emerges when intervening in existing systems to promote better health outcomes.

Making progress

We are in a transformational moment, where the growing interest in proving the success of social prescribing initiatives in order to scale programs at the national level may also lead to the scaling of the frictions and uncertainties previously stated.

Indeed, it is important to generate evidence on successful implementation models and design programs upon which to scaffold this expanded view of health. Yet, we ought to simultaneously raise some other questions if we want to avoid replicating the mistakes of previous models that have gotten us here in the first place. For example,

- What constitutes evidence in social prescribing?
- How might health systems account for non-medical factors influencing a person's health when prescribing interventions?
- What value does social prescribing bring to the different stakeholders involved? How should cooperation be structured within and across industries and sectors?
- Is social prescribing a proper mechanism to transform health systems and spiral up a new culture of health in the US?

To make progress in light of the complex challenges underlying social prescribing, health professionals and others working in health systems will have to work with people from other disciplines, domains of practice, and sources of knowledge that influence people's health and well-being. "Design for Social Prescribing" is a project prototyping what collaboration across silos could look like, and how it could help accelerate the movement's efforts.

2 "What is Social Prescribing?"
3 Braveman and Gottlieb, "The Social Determinants of Health: It's Time to Consider the Causes of the Causes."
4 Hood et al., "County Health Rankings: Relationships Between Determinant Factors and Health Outcomes."
5 "About Us: Global Social Prescribing Alliance."
6 Torjesen, "Social prescribing could help alleviate pressure on GPs."
7 Heinen, "Study Unveils Benefits & Recommendations for Social Prescription –."
8 Foster et al., "Impact of Social Prescribing to address loneliness: A mixed methods evaluation of a national Social Prescribing programme. "
9 "About Us : National Academy for Social Prescribing UK."
10 "Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter"
11 Polley, Seers, and Fixsen, "Evaluation Report of the Social Prescribing Demonstrator Site in Shropshire -Final Report."
12 Kimberlee, "Developing a Social Prescribing approach for Bristol."
13 Fisher, "Social Prescribing Programme Could Lead to 4.5 Million Fewer GP Appointments per Year, according to New Analysis by NASP —."

WHY DESIGN NOW?

New and Unusual Applications

Recognizing that today's complex and ambiguous challenges require more than incremental steps to existing structures and cannot be adequately addressed by existing practices, organizations across industries and sectors are increasingly adopting design as a complementary approach to move forward in the face of uncertainty.

Design provides a structured approach with frameworks and methods that can help organizations navigate the uncertainty that stems from the early stages of complex projects, such as creating and implementing social prescribing interventions in the US.

Examples of design approaches include empathically observing people to understand their aspirations, needs, and related problems, finding patterns across individual experiences to inform population-level interventions, exploring early-stage prototypes that help discover new opportunities to create value for all stakeholders involved, utilizing abstraction to enable the exploration of the future rather than benchmarking the past, and visualizing complexity to make abstract ideas easier to understand and navigate.

Design is useful across the change spectrum ranging from incremental steps to transformative leaps. This project relies on the structured use of advanced design knowledge relevant for navigating complex contexts where different disciplines need to join forces to shift existing paradigms. A key aspect of this is understanding the multiple viewpoints that influence the purpose of an initiative early on.

The Whole View

When organizations venture into foggy initiatives like transforming the US health system, they can benefit from a structure to explore diverse options for making change. While organizations commonly start these initiatives with core frameworks from finance, technology, or marketing, we took a broader approach, using the Whole View as the main structure to guide our explorations.

Unlike most models of design that prescribe the steps in the design process, the Whole View is a conceptual model of connected frameworks and methods that show the relationships among various forces influencing the purpose for making change.[14]

By integrating viewpoints of strategy, value, operations, offerings, and users, the Whole View supports organizations in beginning exploratory initiatives with a broader understanding of problems—and opportunities—in a fraction of the time compared to traditional management processes. It can describe the current state of an offering or organization, prescribe changes, and speculate on futures.

The model is based upon four fundamental questions that have guided organizations through decisions over the years:

- What to make?
- Who is it for?
- Why does it create value?
- How to make it?

Today, these questions are central to how entrepreneurs work in new ventures and how entrepreneurs who work within large organizations seek transformative change within and across sectors. These questions may seem simple, but are often forgotten in the quest to create large-scale programs for diverse audiences. Rigorously applied, the Whole View surfaces various stakeholders' perspectives, making contradictory viewpoints explicit, debatable, and less abstract than what words alone can describe.

[14] Whitney and Nogueira, "Cutting Cubes Out of Fog: The Whole View of Design."

The **Whole View** is a conceptual model of connected frameworks and methods showing the relationships among various forces influencing the purpose for making change in complex contemporary problems.

Purpose

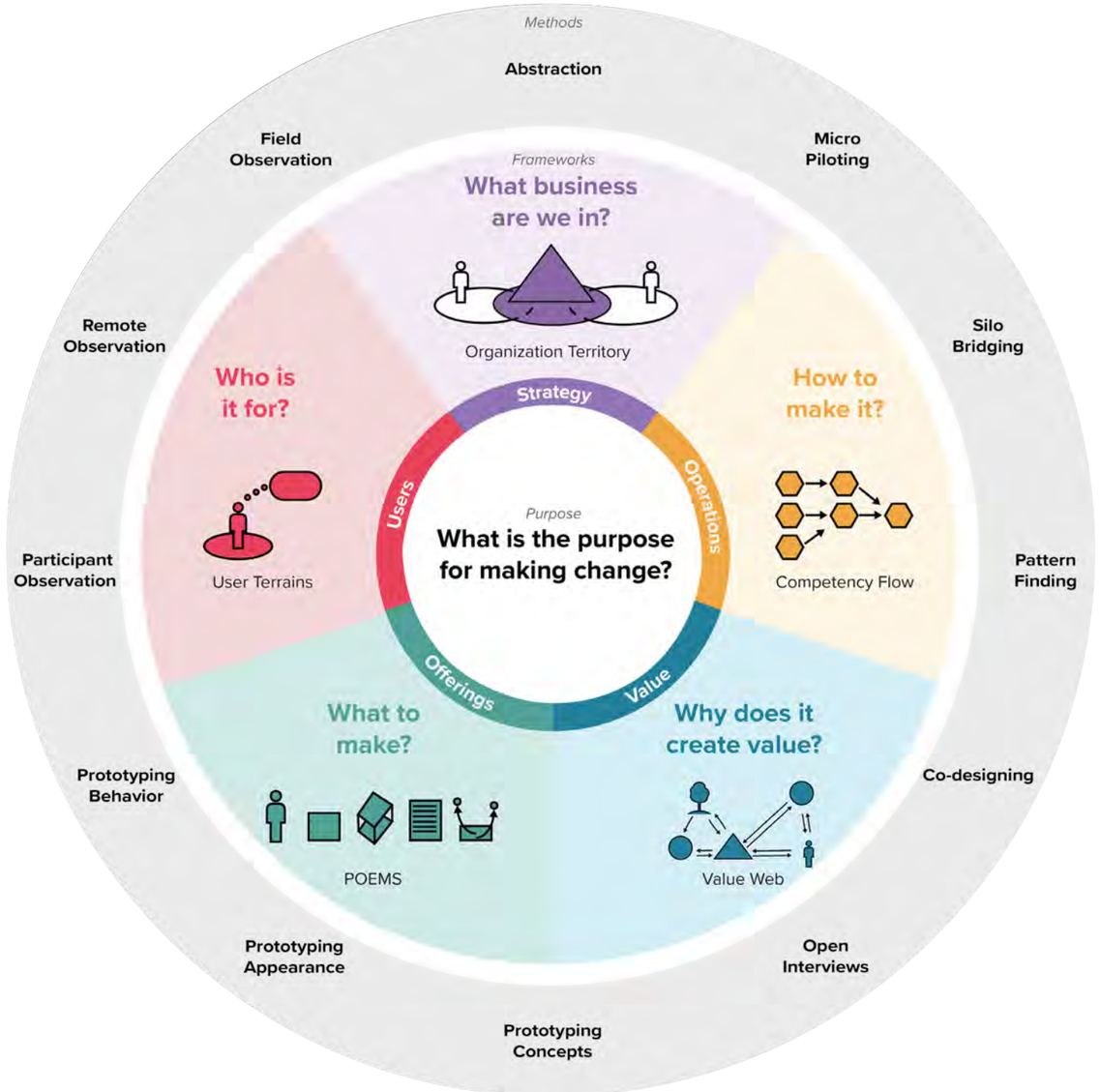
A statement describing an opportunity with content about strategy, users, offering, value, and operations.

Frameworks

A structure for organizing content and viewpoints about the context and purpose.

Methods

Actions taken to create and manipulate information that feeds the frameworks.



WHO IS IT FOR?

Rather than prescribing what the organization believes people want, or segmenting people using demographic and socio-economic factors, **User Terrains** is a framework that describes user groups in the context of individuals' aspirations and related problems.

WHAT TO MAKE?

POEMS is an acronym for the People, Objects, Environments, Messages and Services offered by organizations. It reminds us to think of offerings as systems composed of different elements that fit together.

WHY DOES IT CREATE VALUE?

Value Web describes the value exchanged between key stakeholders in the ecosystem. Examples of value include money, materials, reputation, loyalty, influence, among others.

HOW TO MAKE IT?

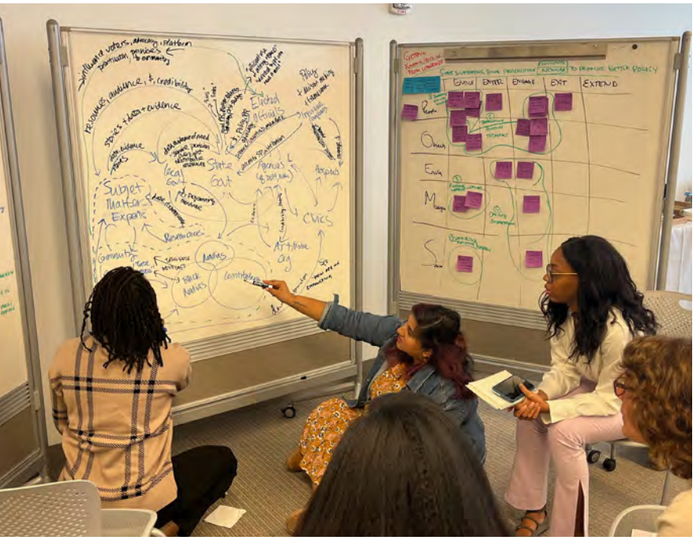
Competency Flow shows how the purpose of an initiative is supported by a system of core, primary, and supporting organizational competencies that differentiates it from the competitors and helps it collaborate with diverse stakeholders.

WHAT BUSINESS ARE WE IN?

A **Organization Territory** is a business area the organization enters with its core competency in response to user terrains. This framework helps organizations unveil collaborators and competitors who may operate in different sectors, but focus on the same terrains.

WHAT WE DID

The overall goal of this project is to explore whether design, and particularly the Whole View, can help diverse stakeholders working in Social Prescribing initiatives in the US expand and advance their efforts. As of November 2022, the collaborators of this project have organized their actions into three phases: **Understanding Context, Broadening Perceptions,** and **Exploring Pathways.** A brief description of methods and related activities undertaken in each phase are presented here.



Phase I: Understanding Context

We started this project by conducting open-ended interviews with key stakeholders to better understand the current challenges and opportunities for social prescribing in the US from various viewpoints.

These discussions involved a group of prominent stakeholders active across clinical practice, insurance, and public health policy, advocacy, and research. We then simultaneously conducted semi-structured interviews with representatives of these focus areas, explored social prescribing trends and models within and outside the US, and reviewed numerous mainstream media reports and peer-reviewed studies on the impact of nature and arts-based exposure on public health outcomes.

Next, we cleaned, structured, and analyzed all data collected, considering the viewpoints of users, offerings, operations, strategies, and value creation through frameworks from the Whole View. This multifaceted approach yielded insights into five areas where actions could be taken to expand and advance the social prescribing movement in the US. These areas are further explained on page 20.

Phase II: Broadening Perceptions

Phase II consisted of a two-and-a-half-day workshop that brought together 40+ participants across different sectors and industries in the US. Leading agents from the Canadian and UK Social prescribing movements and Harvard's Undergraduate Initiative for social prescribing, a student-led advocacy group, also participated in the event.

The workshop consisted of hands-on group activities utilizing design frameworks in the Whole View, following short presentations of related content and explanation. The convening started with all participants sharing questions they considered relevant to explore when making progress in the social prescribing movement within the US (Appendix III).

Then, participants were divided into small groups, each containing members across different sectors and industries. All groups received the same description of a complex, yet common action situation involving patient-health care provider interactions in the US health system (Appendix V). Each group centered their work around a different stakeholder involved in the action situation (Appendix VI) and ideated on concepts considering that stakeholder's aspirations, needs, and related problems. By the end of the workshop, a total of six platform concepts were developed, which are further described on page 54.

Phase III: Exploring Pathways

During Phase III, we structured data collected from Phase II with two focus areas: participants' use of design frameworks (field-focused analysis) and the results of each group (project-focused analysis). Phase III data sources included:

- **Observation:** photos and notes related to common questions and topics discussed across groups
- **Open interviews:** perspectives of participants on their experiences and on their thoughts on Social Prescribing captured during and after the workshop.
- **Concepts:** the evolution of each group's idea and discussions among participants were captured throughout the workshop in the form of photos, video, and audio recordings. All material was transcribed and digitized after the event.

All Phase III data were reviewed and compared against Phase I and II data. The results yielded four critical social tensions that key agents in the social prescribing movement must consider as they explore pathways to build momentum in the US. All social tensions are further described on pages 28 through 31.

WHAT WE LEARNED

Framing Action Areas

Social prescribing aims to tackle complex social challenges using the health system as an entry point. Social challenges are complex due to numerous factors, two of which we elaborate in this section.

Tackling social challenges requires the involvement of multiple stakeholders working in different industries and sectors. While each stakeholder has their own agenda based on their perception of the problems that need to be addressed and what to prioritize, all stakeholders work in parallel. Their actions influence situational conditions and contribute to the continually shifting nature of the context.

For example, actions taken by policymakers, public transportation companies, faith-based organizations, education institutions, and health professionals can all influence mental and physical health outcomes.

Another factor that contributes to the complexity underlying social challenges is that while an evidence-based understanding of the problem might be clear—such as depression leading to a reduced quality of life—defining users as "those suffering from depression" is insufficient. People have different aspirations, needs, and related problems that influence their ability to stay healthy. This suggests that a single "user group" with a set of predetermined needs to be addressed cannot be defined from the outset of an initiative. Similarly, the complexity and diversity of needs can make it hard to determine a clear set of "right partners" to work with in the early stages of an initiative.

For instance, an intervention for children struggling with depression might need to involve parents or caregivers in addition to engaging with the youth. To do so, health providers might need to engage with faith-based organizations or social workers to find the proper ways to understand and create value for parents. If social prescribing initiatives can understand the ways in which stakeholders are interconnected, they will have more contextually-appropriate approaches to address complex social challenges.

This open-ended way of working presents an alternative to conventional approaches that frame problems and solutions from the outset of an initiative.

Rather than simply listing problems to be addressed and expected solutions, if organizations leading social prescribing initiatives are interested in dealing with broader social challenges, they must learn to engage with diverse stakeholders currently focused on improving well-being outcomes in the context of change, further integrating their experiences into more holistic interventions.

Even though no single pattern on its own can summarize the complexity inherent in expanding and advancing the social prescribing movement in the US, our open-ended, broad, and shallow approach helped us uncover five action areas that diverse stakeholders have prioritized in their agendas.

While not extensive, these action areas present common intervention spaces where different stakeholders can continuously advance their own agendas while contributing to this shared purpose. In this section, we expand on each of these action areas with key insights and related descriptions.

Broadening referral systems
The digitalization of health systems can allow physicians to systematically screen patients and refer them for social services.

Core to social prescribing is integrating the social determinants of health into public health and clinical practices to improve health outcomes. Yet, physicians reported that current referral systems and electronic medical records lack proper mechanisms to integrate information about a range of social health factors influencing health, including loneliness and social isolation, in order to refer patients to the appropriate "social health" services. Moreover, existing systems have been predominantly designed without feedback mechanisms that allow health professionals to track and evaluate the progress of patients when engaged in social services provided by organizations outside of the conventional medical ecosystem.

To better support health care providers, therefore, electronic referral systems should integrate information about the "social" terrains of people's lives and incorporate feedback mechanisms about the quality, effectiveness, and acceptability of social health interventions for referred patients. When referral systems enable screening for different dimensions of the social determinants of health, such as isolation and loneliness, and establish continuous feedback mechanisms with social services organizations outside of traditional health systems, physicians not only have a supportive infrastructure to implement social prescribing interventions but are also incentivized to help address social challenges influencing their patients' health.

Building capacity of social services
Investing more in the social services ecosystem can strengthen overall capacity to promote better health outcomes.

Indeed, it is important to identify shared goals and metrics between social services organizations and the health care system to reinforce support for priority patient health outcomes. But none of these efforts can promote the intended impact if social services continue to be strained. Social services organizations and their workforce are key to ensuring quality patient follow-up, tracking, mental health support, and care in partnership with the clinical establishment.

There has been increased strain on social services organizations and the social services workforce, especially during the ongoing COVID-19 pandemic, which was not followed by commensurate levels of funding and staffing. Social prescribing interventions can help increase the capacity of social work professionals if resources from diverse sectors, not only health care, become activated and mobilized in alignment with their agenda.

Making the economic case
Analyzing financial and health outcomes data from social prescribing initiatives is key to informing sustainable financing models for future expansion.

Expanding and advancing social prescribing in the US requires sustainable financing models. A powerful pathway may involve leveraging Medicare, Medicaid, and the Department of Veterans Affairs' system when introducing pilots. These and other payers who are looking for alternative approaches to manage complex and costly issues have demonstrated interest in value-based care models, a structure that can help advance social prescribing efforts.

A relevant topic related to social prescribing that was widely recognized across stakeholders involved in this project was social connection. For them, creating interventions that promote the benefits of social connections and their relationships to counter loneliness, social isolation, and suicide is imperative to help overcome the contemporary mental health crisis in the US. Still, gathering evidence of ongoing interventions (or lack thereof) is critical for making an economic case for the broader promotion of social connection and adoption of other social prescribing initiatives. If leading stakeholders can demonstrate the health impact and cost-effectiveness of their social prescribing interventions, health providers, taxpayers, and administrators of health services will likely be able to justify the scale-up of social prescribing, and inform the design of alternative financing and partnership models. To do so, new structures will be required to help accelerate learning across the various initiatives.

Linking to parallel movements
Connecting to existing patient-centered care movements can fuel learning and bolster momentum for the social prescribing movement.

The social prescribing movement is not the first attempt to promote large-scale transformation in the US health system, and it is unlikely to be the last. An example of a past effort is the hospice care movement in the 1980s. The hospice care movement is notable for how it generated evidence for its impact to justify reimbursement and, therefore, widespread coverage by payers of health services. There are also lessons to be learned from other contemporary initiatives that, like social prescribing, are focused on promoting people-centered care, regardless of whether they are embedded or not within health systems.

A few examples are Age-Friendly Health Systems,[15] Choosing Wisely[16] (led by the American Board of Internal Medicine), Shared Decisionmaking,[17] Deprescribing Network,[18] Patient Priorities Care,[19] Embrace Race,[20] My Brother's Keeper Allicance,[21] Latinos Outdoors[22] and International Association for Dance Medicine and Science.[23] Learning from past transformations and connecting with parallel initiatives can build visibility and inform more effective paths forward.

Disseminating knowledge
Increased dissemination and awareness of social prescribing can bolster the practice and generate evidence for implementation.

Peer-reviewed publications that highlight improved health outcomes and financial savings from social prescribing are essential in order to advance this movement from a policy and resource allocation perspective. But social prescribing suffers from a knowledge and awareness gap within the public health and medical community as well as in adjacent disciplines, such as art, volunteerism, and environmental conservation.

Practitioners stressed the importance of leveraging information platforms and creating professional and social gatherings to bolster awareness and fuel a community of practice involving diverse stakeholders, including researchers, practitioners, policymakers, social workers, and community members. While evaluation of successful social prescribing implementation and partnership models is important for the movement to gain priority and visibility, the practice of social prescribing will only grow in the US with health and non-health organizations working together and building trustworthy relationships among their members.

15 Fulmer, Pelton, and Zhang, "Age-Friendly Health Systems: A Guide to Using the 4Ms While Caring for Older Adults."
16 "Website - Choosing Wisely."
17 Franklin and Zhang, "Cognitive Considerations for Health Information Technology."
18 "Home: US Deprescribing Research Network."
19 "Home: Patient Priorities Care."
20 Website - Embrace Race.
21 Website - My Brother's Keeper Alliance.
22 Website - Latino Outdoors.
23 Website - International Association for Dance Medicine & Science.

Centering around the community
Social prescribing needs customization based on community assets and sociocultural characteristics across diverse communities.

Social prescribing is highly dependent on strong partnerships between community stakeholders and agents within health systems. For social prescribing to gain traction in the US, it is critical to identify health organizations interested in challenging the pervasive paradigms built on an individualistic notion of health, and strengthening partnerships with trusted community partners that can improve well-being. Health organizations that have developed social prescribing initiatives centered on the aspirations and needs of community members have explored interventions tailored to the unique assets present in the community. These interventions, in turn, have demonstrated potential to strengthen trusted partnerships between community organizations and health systems that are responsive to local needs, consequently increasing the chances for acceptance, shared ownership, and success of social prescribing initiatives.

Exploring Platforms

Conventional problem-solving approaches have evolved to deal with challenges by splitting them up into sub-parts, often determined by a particular stakeholder's disciplinary, sectoral, or industry focus. For example, it's not uncommon to have government offerings, such as micro-loans, food stamps, and insurance programs, created by different sectors, such as finance, food, health, that work as vertical silos in government operations. While this way of working favors the organization making the offering by improving its operational efficiency to focus on specific needs, it increases complexity for the users as they try to connect disjointed offerings in their everyday lives.

This situation presents a new demand—and opportunity—for multiple ad-hoc offerings to be assembled into a more integrated, coherent whole.

Platforms offer a response to this need. Organizations adopt a platform approach when they see value in setting core standards to create a variety of offerings for diverse stakeholders that are or can be connected to each other. Unlike conventional approaches that treat users as recipients of offerings, a key value-add of a platform approach is that it engages all stakeholders as users, and vice-versa, enabling all to create and receive value in different ways.

Accordingly, a platform's core standards must allow stakeholders to see the relationships between themselves and the various offerings they use. In the context of social challenges, this approach can help organizations create an integrated system of offerings to improve people's experiences and uptake of essential services, while increasing the capacity of various stakeholders to create value.

For example, a farmer's market has a set of standards for its vendor selection, space distribution, and frequency of assemblage. As a platform, farmer's markets are then used by vendors, market managers, residents of surrounding neighborhoods, and other different user groups in a variety of ways: to buy and consume food, share practices, meet with friends, learn new recipes, support local businesses, etc. The same group may also conduct different activities and a diverse range of groups might join forces to create new offerings, such as a live concert.

Taking a platform approach is particularly relevant to expanding and advancing the social prescribing movement in the US because progress will require leading agents to connect and manage multiple stakeholders when framing problems as well as when creating solutions for the well-being needs of diverse populations. Hence, creating platform-based structures to

advance this movement can help multiple stakeholders combine their expertise, including, but not limited to, medical knowledge from health professionals, everyday knowledge from patients, and social knowledge from community partners, to design various offerings that create value for themselves, and for other stakeholders involved in the context they are working in.

On the following page, we present a brief description of all the platform concepts developed by the six groups that participants were divided into during the "Design for Social Prescribing" workshop (see appendix VII for further detail on the work developed by each group). While all groups received a description of a common action situation as context for their co-design process (appendix V), each group centered their efforts on the aspirations, needs, and related problems of a specific stakeholder (appendix VI).

An action situation reveals a pattern of interactions expected to occur in a given situation. For example, a doctor trying to explain a treatment protocol to a patient. Depending on the activities undertaken by the key stakeholders involved in this situation—for instance, the patient, the doctor, insurance company, treatment supporters, among others—multiple scenarios can unfold.

For this workshop, participants relied on an action situation concerning a patient-health organization interaction of scheduling and attending a medical appointment.

Throughout the workshop, groups rapidly prototyped and iterated on their platform concepts by engaging with participants in the room, many of whom represented "users" that their platforms were being conceptualized to serve. Although the event lasted only two days, these exchanges helped all groups to co-create concepts that could support not only their respective stakeholder, but also others involved in the action situation.

All groups discussed and, when relevant, leveraged digital health capabilities to strengthen their concepts. Expectedly, a few concepts promoted digital interactions. Others gave priority to physical interventions. Most were conceived to support hybrid digital-physical experiences for diverse stakeholders.

Platform Ideas Generated by Participant Teams

PATIENT

Collective Community Care: enabling patients to access emotional, practical, financial, and social support services to create a culture of health.

For individuals from marginalized and vulnerable populations that can benefit the most from biopsychosocial health services, Collective Community Care is a platform offering trauma-informed and anti-racist interventions where users co-create the emotional, practical, financial, and social support services for their well-being.

GOVERNMENT AGENCY

Community-Based Ecosystems: bridging silos in state government agencies to increase efficiencies in resource allocation and create feedback loops to respond to community priorities.

For state government agencies who want bipartisan support from elected officials, Community-Based Ecosystems provides equitable access to community-based data to support policy design and demonstrate the benefits of centering programs on historically and currently marginalized and excluded communities.

HEALTH PROVIDER

Integrating Health: connecting health providers with community assets to expand their medical practices beyond conventional one-to-one clinical interactions.

For physicians who wish to provide care effectively, be trusted, culturally competent and also prioritize their own well-being, Integrating Health is a platform that connects health providers with a network of diverse stakeholders, community assets, and evidence-based services that expand medical practices beyond conventional one-to-one clinical interactions.

COMMUNITY ORGANIZATION

Interconnectivity: supporting partnership formation across community organizations to increase access to resources, visibility, diversity, and impact in the community.

For community organizations who wish to expand their presence and influence, Interconnected offers a platform for partnership formation and resource support across community organizations that builds their capacity to act together as caregivers in the community.

SOCIAL/HEALTH WORKER

Link Co-Creators: building capacity of community members to become anti-oppressive and trauma-informed links to community-based well-being services fit to individual's needs and aspirations.

For community members who wish to build their capacity to co-create equitable wellness plans to fit people's needs and aspirations, Link Co-Creators offers trauma-informed and anti-oppressive capacity building trainings and ways to learn and access their community's resources and needs.

HEALTH INSURANCE

Neighbors in Health: helping insurance companies justify coverage parity in service delivery through the rigorous use of data to design low cost and culturally sensitive social interventions.

For insurance providers who want to address health inequality, Neighbors in Health creates low-cost and culturally-sensitive pilots of social interventions that helps inurance companies helps them justify coverage parity in service delivery through rigorous collection and analysis of data collected in the pilots.

Building New Paradigms

The 21st century health crisis in the US highlights friction related to addressing the high demand for tailored systems that respond to the needs of diverse populations. While no solution was created during the workshop, the resulting six platform concepts reflect a collective intention to build new care paradigms in the US. They are united by the recognition that doctors, patients, health workers, policy makers, and academics all influence the success of health promotion interventions based on how they perceive problems and solutions. Additionally, and perhaps more importantly, these concepts advocate for a care paradigm where family members, friends, social service providers, employers, artists, conservationists, and many other agents operating outside of conventional medical institutions are also involved in determining health outcomes.

Using frameworks from the Whole View, we integrated workshop results—including conceptual prototypes, audio recordings, participants interviews, and direct observations—with data collected from the preliminary research. Our analysis helped us surface four social tensions that underlie social prescribing debates in the US. Social tensions in systems design are forces that influence the dynamics and outcomes of a system in different directions. Rather than being exhaustive, the tensions presented in this section are intended to demonstrate and question existing norms and social contracts in current health systems and unleash proactive solutions towards building new care paradigms. These tensions also represent the diverse stakeholder perspectives participating in social prescribing initiatives or influencing health outcomes.

By surfacing these tensions, this report becomes a powerful tool to support the engagement of diverse stakeholders interested in further taking platform approaches to promote leap transformations in US health systems. The four tensions are presented here as paradoxes to be considered when designing platform-based interventions. Paradoxes are self-contradictory statements that—when investigated—can be proved to be true. In complex social challenges, interventions are likely to have a greater chance of success if they integrate both sides of a paradox. This type of paradox thinking can help leading agents devise offerings to reach and engage with diverse stakeholders. While these paradoxes may seem like common sense at first glance, and can represent decades of work for some, the way they relate to each other is intended to help expand the frame of thinking and scope of possibilities for stakeholders to build new care paradigms.

Of course, not every situation will confront all paradoxical tensions, and any single paradox can present itself through various manifestations depending on the context. When exploring social prescribing interventions, leading agents should understand if and how these tensions are present in their work, and whether they might influence the intended outcomes.

Language

Locking in a definition ↔ **Agreeing on a meaning**

Prescribing in the US has been implemented by stakeholders across sectors under the umbrella of various names, programs, and services. For example, the Boston Medical Center recently launched the Health Equity Accelerator to expand a decade-long agenda to tackle the social determinants of health. While this endeavor does not explicitly reference social prescribing, its impact certainly contributes to and benefits from the social prescribing movement. Each stakeholder has emphasized distinct aspects of health, well-being, and their intersection with broader community systems. This diversity of perspectives gave rise to different views towards problems and solutions, many of which presented strong resistance to the term “social prescribing”; most participants recognize that it is still an abstract concept, even for those who are already engaged in related initiatives.

When working in abstraction, team members attributed different meanings to the same aspects of health (for example, maintaining a healthy body being important for performing well at work, taking care of children, traveling the world, or making life-long plans with a partner). Likewise, the same meaning was attributed to distinct aspects of health (for instance, the problems and solutions of social isolation were variously attributed to aging, racial segregation, and lack of support for maternity care). Rather than spending time seeking agreement on a single definition, groups that focused on their purpose and recognized common meanings behind diverse viewpoints, identities, and types of expertise in their activities were able to move forward with integrative concepts.

This same tension shaped discussions among global agents supporting the roll-out of social prescribing in different countries, because each has adopted distinct terminology to fit their context. For example, in the UK, the agents that serve as a link between health systems and social services are called “social prescribing link workers”. In Canada, they are addressed as “community connectors.” They can also be called “well-being coaches” in the Netherlands, or “well-being coordinators” in Singapore. While they have different names, all of them represent a new capability to assess patients’ needs and facilitate community-based social support to improve people’s health and well-being.

Governance

Control of the system ↔ **Autonomy of the parts**

Transforming the US health system to broaden current perceptions of health and embrace well-being raises fundamental questions about leadership and accountability. In the US, government, private companies, academia, NGOs, foundations, and other agents within and outside the health sector are involved in influencing whether and how to shift modern care paradigms. These stakeholders have autonomy, acting and organizing themselves to delegate power and agency. Yet, no one entity has full control over the required interventions, and singlehandedly establishing and operating social prescribing systems does not fall within any individual mandate.

These complex debates can only be structured with consideration to a diverse range of perspectives, expertise, institutions, and experiences. During the workshop, critical discussions resulted from different groups sharing their unique ideas and platform concepts. Because each group prioritized a different stakeholder, the discussions helped surface relevant governance topics, such as leadership, responsibility, and accountability for broader health promotion in the US. While some participants questioned whether tackling social challenges was beyond the health sector's purview, and suggested that health organizations needed to recognize the power and influence of other industries influencing health, others argued for radical transformation of existing health systems. In many instances, however, participants voiced that most medical professionals working in the US do not see it as their role—nor are they incentivized to promote broader well-being. Regardless of these paradoxical viewpoints, contention regarding which sector and institutions could lead such a multi-dimensional endeavor was acknowledged to be a notable obstacle.

Process

Enabling bottom-up ↔ **Enforcing top-down**

Groups presented different suggestions for how their platforms could be implemented based on their respective stakeholder description. In general, groups took two distinct pathways to change: either bottom-up or top-down.

Groups proposing the former argued that the voices, processes, and assets of communities should be prioritized in decision-making, enabling the work of organizations operating with community members to pull changes in higher levels of governance. Proponents of the latter relied on authority figures to define broader goals and design related interventions to push the desirable impact in the context.

During conversations, participants indicated that the two approaches are not mutually exclusive, but rather play complementary roles. Indeed, working with stakeholders leading bottom-up efforts can reveal new insights about local contextual dynamics, and promote increased equity for resource management.

However, a broader understanding of the whole system's deficiencies can typically be found at the macro level, and is equally necessary for creating transformative interventions. In fact, most participants agreed that progress in the social prescribing movement depends on trustworthy and effective partnerships across the local, state, and national levels.

This tension was also expressed in the learnings from several pilots in the US, UK, and Canada, suggesting that social prescribing initiatives in the US will likely involve a combination of stakeholders leading bottom-up work and authority figures operating in different sectors, including politicians interested in impacting their sphere of influence. Without a more holistic and integrative approach that allows for diverse stakeholders to build circles of change and possibilities, agents interested in leading the social prescribing movement in the US will likely face significant resistance.

Evaluation

Prototyping futures ↔ **Benchmarking the past**

US health systems have relied on evidence-based practices from clinical, scientific, and social science methodologies that use documented peer-reviewed evidence to avoid replicating known errors. But what happens when there is limited evidence generated from these methodologies?

The lingering effects of institutional racism and historical social inequities—challenges explicitly explored during the workshop—suggest that interventions to transform existing health systems cannot rely solely on existing approaches. They have been insufficient in addressing these and other complex social challenges in ways that improve future well-being outcomes for all. For example, a recent study showed that over the last 30 years, less than 1% of articles published in the top 4 medical journals included the word "racism."[24]

A key aspect surfaced by participants was that racism and many other historically rooted systemic and structural challenges are influenced by emotional ties, cultural values, or behavioral habits. Not only are these dimensions hard to measure, but they often prevent people and

[24] Krieger et al., "Medicine's Privileged Gatekeepers: Producing Harmful Ignorance About Racism And Health."

organizations from changing, even when it is apparent that the surrounding context has completely changed. Faced with complex, seemingly intractable challenges, participants recognized that it was no longer certain that previous approaches could inform future decisions.

So, a convening that started with many asking questions related to evidence gathered on past successes to improve existing systems soon gave way to more exploratory future-oriented questions that could build new care paradigms. Questions changed from “What does past data tell us about…?”and “How might we improve…?” to “What if…?”

After explicitly naming structural issues underlying the vast racial disparities in health in the US, participants asked what if social prescribing adopted an intersectional anti-racism lens to design new systems of care? Such a lens could help mitigate unintended harm and help promote equity across diverse, marginalized, and historically underserved populations. Importantly, it could help shape broader and more holistic narratives around systems of care and ensure that health inequities are not further reinforced by health promotion efforts.

Ultimately, all participants recognized that existing health organizations were not designed to promote equitable health outcomes, and grappled with the question of “what if power embedded in social prescribing initiatives was decentralized to amplify the work of organizations focusing on marginalized and BIPOC populations?”

NEXT STEPS

The COVID-19 pandemic laid bare how larger social determinants such as housing, employment, social support structures, mental health, social isolation, and access to safe areas for physical activity impact the overall health and well-being of individuals and communities. “Design for Social Prescribing: Bridging Silos for Health Promotion” explores new care paradigms to help address some of these and other society’s most pressing challenges. Our work thus far suggests that transformation in US health systems will require an in-depth understanding of the ways in which diverse stakeholders have arranged themselves to seek, deliver, and experience care services, including but not limited to those belonging to health systems.

The US is undergoing significant demographic, sociocultural, and structural shifts that will require new models of care that account for complex social factors beyond conventional health care services. Social prescribing presents great promise, particularly in a society with high levels of social isolation. In fact, prolonged social isolation and loneliness increased during the ongoing COVID-19 pandemic, with 66% of adults—and 75% of young adults aged 18-34—reporting increased social isolation during the COVID-19 pandemic. This may lead to long-term health consequences across generations. As Surgeon General Vivek Murthy highlighted in his book, Together: The Healing Power of Human Connection in a Sometimes Lonely World, “An invisible crisis plagues America today. It’s responsible for more sickness, suffering, and death than almost anything else. It is loneliness. It is often underneath addiction, suicide, and even obesity.” We believe this is a transformational moment for a pivotal shift in how social structures, communities and health care institutions work together to enable population-level well-being interventions that can help us rebuild our social fabric for greater cohesion.

The goal for this project was not to develop a rigid plan to be followed by a small set of stakeholders. Nor was it to provide specific solutions to pre-selected challenges. Instead, we consider this work to be an exploratory step, where we searched more for relevant questions than definitive answers. While limited in providing a deep understanding of the complex challenges underlying social prescribing, this work has resulted in greater openness of participants involved to consider diverse ideas that can impact their work. It also accelerated learning across stakeholder groups about new opportunities in this space—a critical condition for advancing a nation-wide movement. The convening allowed several voices leading social prescribing initiatives in the US to come together as a group, learn from one another, and explore non-traditional multi sectoral collaborations.

These explorations have been advanced through different pathways, which we highlight in the immediate impact section. In parallel to supporting these and other activities, the collaborators of this project are currently exploring ways to structure a long-term initiative, involving diverse stakeholders alongside participants of the convening to expand and accelerate the social prescribing movement in the US. Part of this exploration will also focus on developing accessible tools of advocacy and building a common language that helps diverse stakeholders connect with the “meaning” behind the movement.

IMMEDIATE IMPACTS

‘Design for Social Prescribing: Bridging Silos for Health Promotion” was an initial exploration that took place within a six month timeframe. Despite the brief timeframe of each phase, wrapped up in an 8-hour workshop, learning was accelerated and new opportunities across diverse stakeholder groups were sparked. As of the publishing of this report, we have heard from participants about several actions that were taken related to their involvement in this project including:

Awareness programs

- Advisory sessions to start-ups, and foundations on how to bring design into their social prescribing initiatives.
- A social prescribing session included in a Harvard University Black Health Matters conference.
- Informational sessions on social prescribing for multiple state service commission executives.

Knowledge products

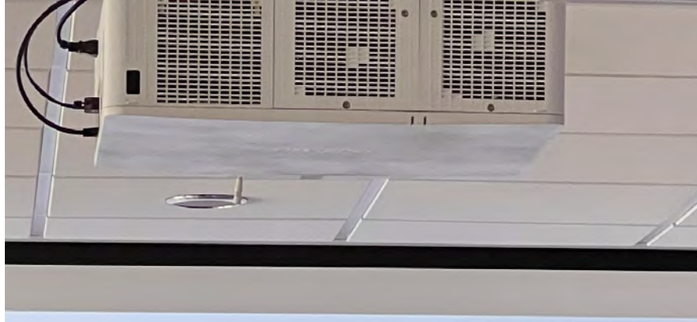
- A shared database of community resources created collaboratively by Social Prescribing USA and the Foundation for Social Connection. The goal is to give hospitals and schools access the ability to build a dialogue across states to share insights, making it easier for other states to build on their own exchange.
- A list of resources for those interested in supporting the movement housed on the Social Prescribing USA website.
- A conference proposal to the office of the Mayor of New York City, who is interested in driving forward social prescribing.

Research Initiatives

- The Center for Arts and Medicine at the University of Florida started the development of a set of key common outcomes for social prescribing research in the US. This is part of an ongoing effort to conduct case studies of 20 social prescribing pilots in the US.
- The Center for Arts and Medicine at the University of Florida launched a social prescribing implementation science study in the US.
- Increased participation in a Harvard University initiative focused on nature exposure for mental health benefit.
- The Center for Arts and Medicine at the University of Florida prioritized anti-racist principles to design the analysis of their evaluation of social prescribing pilots in the US, which will include a focus on equity implications and impacts at each site. They will evaluate variances in health outcomes between different demographic subgroups who participate in an SP program and synthesize evidence related to accessibility, equity, and inclusivity.

Collaborative ecosystems

- A partnership agreement between Americans for the Arts and EpiArts Lab in the University of Florida Center for Arts in Medicine to invest in a study to assess the feasibility, acceptability, and suitability of social prescribing in arts and culture programs in the US. This initiative aims to inform a national strategy for policy advocacy and change.
- Exploration of a physicians working group



APPENDIX

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I. Agenda

The order of activities shaping the convening during Phase II: Broadening Perspectives. This program consisted of two working sessions on October 27 and 28, 2022 located at Harvard's Innovation Lab (Batten Hall, 125 Western Ave, Allston, MA).

Day 1
Thursday, October 27, 2022
Doors Open @ 12:30 PM ET

1:00–1:40 PM - Introduction
Welcome by Reena Shukla
Overview of Social Prescribing by Dan Morse
Relevant Questions by participants
Orientation to Design by Andre Nogueira

1:40–3:00 PM - Breakout Sessions
Exploring Systems

3:00–3:30 PM - Break

3:30–4:15 PM - Breakout Sessions
Understanding User Experience

4:15–4:45 PM - Group Discussion
Patrick Whitney on Design and the Economy of Choice

4:45–5:30 PM - Group Debrief
Teams present and share Day 1 reflections

6:30–8:30 PM - Reception

Day 2
Friday, October 28, 2022
Doors Open @ 8:00 AM ET

8:00–8:30 AM - Continental Breakfast

8:30–9:00 AM - Reflection on Day 1
Adedoyin Eisape on Overcoming Anti-Black Racism in Health Systems

9:00–10:00 AM - Breakout Session
Creating Value and Cross Pollination of Ideas

10:00–10:30 AM - Break

10:30–12:15 PM - Shareout of concepts
Teams present and discuss new questions

12:15–12:30 PM - Whole Group Discussion
Discussion on next steps

12:30–1:30 PM - Lunch

1:30–5:00 PM - Open Space
Free form collaboration time.

II. Participants

A list of the hosts, organizers, observers, and participants of the convening during Phase II: Broadening Perspectives.

1. Host

D-Lab's Builder Fellow who initiated and led the Design for Social Prescribing project.

2. Participants

Participants spanned across diverse areas including health care, arts and culture, volunteerism, public health, government, community development, nature conservation, technology, academia, and design.

3. Participant Observers

Participants who also served as observers took note of the experience and the learnings, insights, questions, and key themes that emerged.

4. Organizers

D-Lab team members who supported the project from inception to implementation.

Reena Shukla

Builder Fellow, D-Lab
Harvard T.H. Chan School of Public Health
MA

rshukla@hsph.harvard.edu

Host

Reena Shukla is a Builder Fellow at the D-Lab. She is a Foreign Service Officer and serves as a public health specialist with the United States Agency for Development (USAID). Reena has over 15 years of experience working to advance complex global health issues with long-term assignments in Brazil, Mozambique, Zimbabwe, Washington, D.C., and Pakistan. She is passionate about harnessing multidisciplinary approaches to catalyze inclusive solutions to advance health and well-being across communities, organizations, and systems.

Reena's experiences working in global public health across 5 continents inspired her to explore how can design knowledge help organizations gain deeper insights across diverse contexts and develop integrative approaches that advance health and well-being. Given the rise of urban populations across the globe and its implications on people's daily life, she became interested in exploring the intersection of design and public health in order to promote broader urban well-being.

Reena graduated from the University of Michigan with a Bachelor of Arts and Master's in Public Health focused on Health Policy and Management/Global Health. She is fluent in Spanish, Portuguese, Nepali, and Urdu. She is also actively engaged in arts and culture and serves on several national committees on building evidence on the intersection of arts and culture for public health and broader well-being.

David Andersson

Arts Team Project Lead
Bloomberg Philanthropies
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Participant

David Andersson is on the Arts & Culture Team at Bloomberg Associates, the pro bono municipal consulting arm of Bloomberg Philanthropies. In this role, he advises cities in their efforts to support their creative sectors by offering guidance in equitable grantmaking, public art investments, data collection and evaluation, and non-profit governance. He is an advisor to the World Cities Culture Forum, and he manages the Bloomberg Philanthropies Asphalt Art Initiative, which helps cities around the world use art and community engagement to improve street safety and revitalize public space.

Prior to joining Bloomberg Associates in 2018, David worked as the Director of Special Projects for the New York City Department of Cultural Affairs. He holds an undergraduate degree from Harvard University and is a practicing visual artist.

Chris Appleton

Founder and CEO
Art Pharmacy
GA

chris@artpharmacy.org

Participant

Chris Appleton is Founder & CEO of Art Pharmacy, a solution through which health care providers, payers, and cultural partners work together to improve patient mental health and emotional well-being. A social entrepreneur, Chris has spent his career developing organizations where the arts meet civic life. Previously, Chris was Co-founder and Executive Director of WonderRoot, where he was focused on social change movement-building through the arts.

Chris and his work have been featured in the New York Times, CNN, ABC, CBS, NPR, Fast Company, and more. Chris has been honored with numerous awards, including the Americans for the Arts National Emerging Leader Award, Emory Center for Creativity and the Arts Community Impact Award, and New Leaders Council Alumni Award. He was a special guest at the 2011 White House Youth Summit, member of the 2019 Class of Leadership Atlanta, and received honors such as Atlanta Business Chronicle's 40 Under 40, Georgia Trend's 100 Notable Georgians, Outstanding Atlanta Class of 2014, and World Economic Forum's Global Shapers.

Currently pursuing his Executive MBA from Kellogg School of Management at Northwestern University, Chris is engaged in a range of initiatives beyond his professional work. He helped build Vote with Dignity, a healthy democracy effort improving the voting experience through line-warming and neighborhood engagement. He has served on numerous boards including the Grady Health System's Ambassador Force, City of Atlanta Mayor's Affordable Housing Advisory Board, Americans for the Arts EL Council, Alliance Theatre Advisory Board, Health Connect South Advisory Board, and more.

Chris lives in Atlanta, GA with his wife, Annie, and two young children, Alexander and June.

Amy Bantham, DrPH

Founder and CEO
Move to Live More
MA

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Participant

Dr. Amy Bantham is the CEO/Founder of Move to Live®More with a mission to help people live healthier, longer, more active lives. A research and consulting firm addressing physical inactivity, obesity, and chronic disease through cross-sector collaboration and innovation, Move to Live More provides services to clients in three sectors—health care, health & fitness and communities. A certified health and wellness coach, personal trainer, and group exercise instructor, Amy is also a researcher and published author. Her work focuses on physician exercise prescription and referral, physical activity behavior change, physical activity in underserved populations, health benefits of physical activity independent of weight loss, and physical activity and mental health. She holds a Doctor of Public Health from the Harvard T.H. Chan School of Public Health.

Mary Brown

Culture Consultant
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MI

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Participant

Mary Brown is a seasoned DEI professional and an avid researcher with a solid background in human-centered design, organization behavior, learning development, and change management.

She has worked for organizations such as Spectrum and Priority Health, where she held the roles of Lead in the DEI and the Transformation, Innovation & Culture teams. Mary is a Doctoral Candidate for Organizational Leadership at Pepperdine University, Malibu, California. Mary focuses on complex leadership theory for leveraging diversity, creativity, and innovation within organizations.

Her dissertation focus is on Psychological Safety as it relates to organizational change management, adaptability, and agility. She also has an MA in Organizational Leadership from Gonzaga University, Spokane, Washington, a BSc in Business Management from the University of Phoenix, West Michigan Campus, and Executive Education in Design Strategy and Innovation from Weatherhead School of Management, Case Western Reserve and Artificial Intelligence Business Strategy from Sloan and CSAIL, Massachusetts Institute of Technology.

Rachel Chen

Co-founder
Harvard Undergraduate Initiative
for Social Prescribing, Harvard College
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Participant Observer

Rachel Chen is a fourth-year student at Harvard College. She co-founded the Harvard Undergraduate Initiative for Social Prescribing to advocate for Social Prescribing as a means of empowering patients and building resilient communities through holistic care.

In exploring how the U.K. model can be adapted to the US context, she published a long-form article with TIME magazine highlighting the US Social Prescribing movement and its pioneers. She is currently building out the infrastructure and evaluation framework for a pilot program at the Cleveland Clinic and serves as a Visiting Collaborator at the National Academy for Social Prescribing.

Zeya Chen

Research Assistant, D-Lab
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Participant

Zeya Chen, MDes, is a design researcher working at the intersection of human behavior, emerging technologies and public health. Her research focuses on using behavioral design approaches and system thinking nudging ethical considerations into practical data-driven public health services. Currently, she is a Research Assistant at D-Lab, Harvard T.H. Chan School of Public Health, responsible for the US and Hong Kong parts of research under the Whole Life: Designing Life After Covid-19 project.

Before joining D-Lab, Zeya worked as a research fellow at ideas42, where she explored design discourse in between behavioral economics and public policy. She also worked as a UX Researcher at Health + Design Integration Lab in Rush Univeristy, focusing on translational research of accelerating certain medicine in market through digital health technology.

Zeya holds a Master of Design degree from IIT Institute of Design, and a Bachelor of Science degree in Industrial Design from Wuhan University in China. She specializes in leveraging design methods and tools to develop strategic services and systematic solutions in multidisciplinary teams. Her work has been honored by Core 77 , Fast Company, and iF Design for Notable Health & Wellness Award and 2022 World Changing Idea.

Emmeline Edwards, Ph.D.

Director, Division of Extramural Research,
National Center for Complementary and
Integrative Health, NIH
MD

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Participant

Dr. Emmeline Edwards is director of the Division of Extramural Research of the National Center for Complementary and Integrative Health (NCCIH). In that capacity, she is responsible for development of scientific programs or areas of science that fulfill NCCIH's mission as well as planning, implementation and policy. NCCIH is one of 27 components of the National Institutes of Health (NIH), with a mission to define, through rigorous scientific investigation, the usefulness and safety of complementary and alternative medicine interventions and their roles in improving health and health care.

Before coming to NIH, Dr. Edwards earned her PhD in Neurochemistry from Fordham University, did postdoctoral research in behavioral pharmacology and neuroscience at the State University of New York, and was a tenured Associate Professor in the Department of Pharmacology at the University of Maryland. Her research there focused on the neural mechanisms of complex behaviors and characterization of a genetic model of affective disorders. She also served as Chair of the Graduate Studies and Research Committee and Member of the Dean's Executive Council at the University of Maryland.

Currently, Dr. Edwards is Co-Chair of the trans NIH Music and Health working group and member of the Interagency Task Force on the Arts and Human Development. Dr. Edwards is also Chair of World Women in Neuroscience (WWN), an independent mentoring and networking organization, with the primary mission of identifying, promoting and implementing mentoring and networking opportunities for women neuroscientists across the world.

Sonia Epstein

Co-founder
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Prescribing, Harvard College
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Participant Observer

Sonia Epstein graduated summa cum laude from Harvard College in 2022 with an AB in History & Literature and secondary in Global Health and Health Policy. She currently works as a Research Assistant at Boston Children's Hospital and as a science writer, with a particular interest in health equity as it is impacted by the social determinants of health.

Her senior thesis examined the sociopolitical dimensions of the campaign against tuberculosis in Mandate Palestine/ Israel from 1922-1957, research for which she received highest departmental and college recognition. She is a National Academy for Social Prescribing Visiting Collaborator and co-founder of the Harvard Undergraduate Initiative for Social Prescribing

Charlemya Erasme

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Participant Observer

Charlemya Erasme (she/her/hers) is a Haitian-American who cares deeply about systemic-level change and alleviating suffering. She holds a Bachelor of Science in Biology and a Master of Science in STEM Education with a concentration in Science Education.

Her professional experiences include collaboratively creating and advocating for social justice education initiatives. Currently, She works as an instructional designer. Within her current role, She co-develops learning opportunities relevant to the translational research community.

Adedoyin Eisape

Racial Equity and Inclusion Program
Manager
Health Care for the Homeless
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Participant

Adedoyin Eisape explores equity, resilience, and autonomy through interdisciplinary community engagement and participatory methods to incorporate lived experience and academic analysis towards transformative change. Working with non-profits and state entities supporting education, housing, and health initiatives across the Northeastern United States has made her aware of power and positionality's role in perpetuating violence and oppression in diverse communities.

In her current roles as a Racial Equity and Inclusion Program Manager II and an Anti-Bias Review Board Member, she supports the implementation of equity-centered best practices with an eye toward human-centered change management. Her research integrates an anti-racist, biosocial, design thinking approach to establish a holistic perspective of the determinants of health and wellness in marginalized populations, as demonstrated by her latest collaborative work, See Change: Overcoming Anti-Black Racism in Health Systems.

L Fahn-Lai, Ph.D.

Associate Researcher, D-Lab
Harvard T.H. Chan School of Public Health
MA

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Participant

L Fahn-Lai, PhD (they/them) focuses on Systems Design and Invention at the D-Lab, where they bring together design, ecology, and systems thinking to help imagine healthier, happier communities. Their intent is to explore ways to bridge human security and the natural world and find alignment between the bodies we live in and the environments we inhabit.

Formally trained as an evolutionary biologist, but with a background in experimental pedagogy and visual and interaction design, L helps the D-Lab advance on integrative approaches for faster, broader, and deeper research into human and organizational behavior. Their work explores the use of advanced design frameworks and methods to create space for marginalized voices and integrates multiple perspectives in framing problems and finding solutions that improve population health and well-being. They also support the D-Lab's capacity-building programs by developing educational experiences that translate the principles and practice of design to diverse audiences.

L holds a dual AB in International Relations and Human Biology and an MSc in Ecology and Evolutionary Biology from Brown University. They earned a PhD in Organismic and Evolutionary Biology from Harvard University, where they studied the form, function, and evolutionary origins of the mammalian shoulder musculoskeletal system.

Edward Garcia

Founder and Executive Director
Foundation for Social Connection,
DC

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Participant

Edward Garcia (Eddie) is the Founder and Executive Director of the Foundation for Social Connection – a US-based non-profit organization dedicated to the translation of scientific research to real-world solutions to address social connection. He sits on the Board of Directors for its sister-organization, the Coalition to End Social Isolation and Loneliness – a non-profit advocacy organization fighting to raise national awareness and policy change to combat the negative impacts of social isolation and loneliness within the US. He is also the Co-Chair of the Global Initiative on Loneliness and Connection, a partnership with 11 countries across the globe focused on raising global awareness, supporting knowledge dissemination, and the development of systemic, nationally-based strategies to address social connection.

Eddie's 20 years working in US-government health care and social services programs has made him knowledgeable in a multitude of health and social policy issues. He has led and been actively involved in numerous multi-stakeholder coalitions aimed at improving our nation's health care delivery and financing systems and served within the US Department of Health and Human Services and US Congress between 2006-2016. Eddie holds degrees in political science and comparative health politics from Boston University and a Master of Health Science in Public Health from the Johns Hopkins Bloomberg School of Public Health. Eddie works and resides in Washington, DC USA.

Bogdan C. Giurca

Clinical Champion Lead
National Academy of Social Prescribing
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Participant

Bogdan is a British physician, currently working as Lead of the Global Social Prescribing Alliance, launched by England's Secretary of State for Health and Social Care, founded in collaboration with the WHO, United Nations, World Health Innovation Summit, and NHS England. He is also the national Clinical Champion Lead at the National Academy for Social Prescribing (NASP), chair and founder of the NHS England Social Prescribing Champion Scheme (2015-2022) consisting of over 20,000 doctors, medical and health care related trainees and students.

His work has influenced national and international health care policy and has been instrumental to spreading and scaling Social Prescribing nationally and internationally hosting ministerial visits from over 15 countries, as well as implementing Social Prescribing in the core curriculum of the majority of universities and medical schools within the UK. Bogdan has contributed to several peer-reviewed publications and policy documents, including the NHS Long Term Plan, the Personalised Care Model, GP Partnership Review, as well as authoring three books on medical education.

Bogdan currently teaches at Imperial College London (leading the Social Prescribing module), is a Collaborator for the Harvard Global Health Institute, and has recently been named as part of the HSJ100: Top 100 Most Influential People in Health (UK, 2022).

Kathleen Guytingco

Research Assistant, D-Lab
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Participant

Kathleen Guytingco combines her interests in public health, data analytics, and systems thinking to bridge the gaps between advancements in digital health technology and the unjust realities of health ecosystems in low and middle-income countries. She is keen to apply design to prioritize human-centered impact in health innovation and technology and create systems that enable better choices and processes for people to lead healthier lives.

At the D-Lab, Kathleen applies data analytics, system dynamics modeling, and design frameworks to understand complex challenges that emerged during this pandemic at the individual, community, and institutional levels. She incorporates data analytics with compelling storytelling methods to frame and explore prototypical ideas for public health interventions.

Kathleen holds a dual BA in Global Health and Asian Studies from the University of Michigan. She is currently pursuing a Master's in Health Management at Harvard School of Public Health. Before attending Harvard, Kathleen was a data product manager at Medcheck based in Manila, Philippines, where she used data analytics and storytelling to bring meaningful insights to inform physician best practices, expand pharmaceutical R&D methods, and create new use cases for data demonstrating clinical effectiveness to improve patient outcomes.

Emily Haber

CEO
Massachusetts Service Alliance
MA

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Participant

Emily Haber has over 30 years of experience in planning and community development. Emily joined the Massachusetts Service Alliance (MSA) as CEO in 2008. She is responsible for helping steer MSA in its support of organizations that rely upon volunteers and corps members to meet critical needs in communities across the Commonwealth.

Before joining MSA, Emily served as program director of Boston Main Streets, a public-private initiative of the City of Boston established to revitalize Boston's many neighborhood commercial districts. Emily was on the board of the Massachusetts Nonprofit Network and the Association of America's State Service Commissions and is currently on the Board and Steering Committee of Temple Hillel B'nai Torah and on the Steering Committee of Voices for National Service. She holds a BA from Vassar College and a Master's in City Planning from the Massachusetts Institute of Technology.

Ardeshir Z. Hashmi

Chair of Geriatric Innovation
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Participant

Dr. Ardeshir Z. Hashmi MD, FACP is the Endowed Chair of Geriatric Innovation and Section Chief of the Center for Geriatric Medicine at Cleveland Clinic.

Dr. Hashmi completed a two year postdoctoral research fellowship at Yale University. He completed his Internal Medicine residency at the Yale-Saint Mary's Hospital in Connecticut, where he served as Chief Medical resident. He then trained at Massachusetts General Hospital as a Clinical and Research Fellow in Geriatrics before becoming Faculty and then Medical Director of MGH Senior Health-Harvard Medicine. Dr. Hashmi subsequently transitioned to the Cleveland Clinic in 2017.

He is a Fellow of the American College of Physicians, a graduate of the Clinical Process Improvement Leadership Program and the Value Based Health care Delivery via the Harvard Business School Institute of Strategy& Competitiveness. Dr. Hashmi is also certified as an Advanced Peer Coach through the Cleveland Clinic Center for Excellence in Coaching and Mentoring. He is Co-Chair of the national American Geriatrics Society (AGS) Patient Priorities Care American Geriatrics Society Special Interest Group (SIG) and serves on the AGS Health Systems Innovation Economics & Technology Committee.

Dr. Hashmi is also member of the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM). He is an alumnus of the prestigious Tideswell Emerging Leaders in Aging (ELIA) national leadership development program (in conjunction with the American Geriatric Society and the University of California San Francisco) and the ACLGIM LEAD programs.

Dr. Hashmi's niche area of interest is the intersection of affordable technology solutions and geriatric population health in the service of our most vulnerable populations.

Jules Hotz

Journalist
Solutions Journalism Network
NJ

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Participant

Julia Hotz is a solutions-focused journalist with stories in Wired, The New York Times, The Boston Globe, TIME, Popular Science, Scientific American, and more. After studying sociology at the University of Cambridge, she joined the Solutions Journalism Network, where she helps other journalists and entrepreneurs do and spread rigorous, evidence-based reporting on solutions to today's biggest problems. She's currently writing a book called "The Social Prescription" -- an on-the-ground look at Social Prescribing success stories around the world.

Before becoming a journalist, Julia wore many non-journalism hats, including: high school English teacher, bartender, pizza shop waitress, math tutor, and summer camp "forest ranger" for five-year-olds who wanted to do everything but be in a forest.

Staci Jasin

Executive Director
COGdesign

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Participant

Staci believes in the power of place to transform lives and elevate individual and planetary health. She is Executive Director of COGdesign, a small but mighty organization greening neighborhoods throughout the Boston area, and the founder of Harvard Nature Rx. Staci is a trained ecological landscape designer with experiences as a climate change social entrepreneur, STEM educator, and non-profit leader. For the past 15 years, her work has straddled landscape and environmental design, place-based education, and natural climate solutions, developing and managing programs that center community voice and participatory design. She is committed to co-envision, build, and create equitable systems where the benefit of green spaces is accessible to all.

Staci also holds roles as an educational consultant, adjunct faculty at Boston Architectural College and volunteer with Conservation Law Foundation. When Staci is not connecting others to build out their visions for wellbeing, she is restoring herself out of doors – paddleboarding, gardening with her two kids, and taking walkabouts in built and natural environments. She also dreams of the wide desert vistas of her childhood home in the southwest. Staci holds a BA in geology and environmental studies, M.S. in landscape and urban design, and EdM with a focus on human development, environmental health, and policy.

Prapti Jha

Design Strategist & Researcher, D-Lab
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Participant

Prapti Jha is a design-led innovator who uses human-centered design processes and systems thinking to bridge the gap between user needs and business. She specializes in driving interdisciplinary teams to develop experiences and strategic solutions backed by research and accelerated by design methods and tools.

She has nine years of experience working with organizations across multiple industries. Her experience includes working as an Innovation Catalyst at Ford Motor Company, where she helped multidisciplinary teams across departments to re-imagine the mobility space. She also worked as a Senior Design Strategist at Cisco Systems, focusing on humanizing and democratizing the cybersecurity space. In her current role as a strategist and researcher at the Harvard T.H. Chan School of Public Health, she leverages behavioral design to catalyze human-centered and systemic solutions to advance the health and well-being of people at the grassroots level.

Prapti has co-founded an initiative, We Speak Innovation, through which she has spoken to 2000+ people globally in multiple industries about design-led innovation. She believes that at the heart of it all is the focus on people - our behavior, motivations, and all the little quirks that make us human.

Sonia Lala

Design Strategist & Researcher, D-Lab
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Participant

Sonia Lala, (MEng, MDes) leads Systems and Behavioral Research for the D-Lab. She leverages design knowledge to explore and address multiple dimensions of well-being as a cohesive system. She is passionate about uncovering the compelling “what” and “why” of an individual or community narrative and works with people in the context of change to identify a better, more elegant “how” through co-creative ideation, prototyping, and implementation of solutions.

At the D-Lab, Sonia supports the research and competency-building programs and contributes to the evolution of new methodologies at the intersection of design and public health. She rigorously investigates diverse areas of inquiry in order to make sense of complexity and clearly articulate a point of view through verbal and visual presentations.

Prior to joining the D-Lab, Sonia was an innovation consultant at Doblin (Deloitte), where she helped clients in a variety of industries, including both the public and commercial health care space, to identify and pursue new opportunities through design research and strategy, concept development, and user-testing of prototypes. She transitioned into the field of design research from a career as a federal regulator for the Canadian Nuclear Safety Commission, where she focused on human factors and radiation safety challenges in high-risk environments such as nuclear power plants and cancer care facilities.

Sonia holds a Master of Design from IIT Institute of Design (ID), a Master of Clinical Engineering from the University of British Columbia, and a Bachelor of Engineering Physics from McMaster University. While at ID, her explorations in health and well-being included the areas of prenatal care for underinsured women, sound and touch therapies for dementia, novel applications for continuous cardiac monitoring technology, and the patient experience during external-beam radiation therapy.

Aly M. Lokuta

Senior Director of Arts + Well-being
New Jersey Performing Arts Center
NJ

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Participant

Aly Maier Lokuta, MA (she/her) is the Senior Director, Arts & Well-being at the New Jersey Performing Arts Center (NJPAC). A multidisciplinary artist, Aly comes to NJPAC with years of experience in the integration of arts, health, and community development.

Since entering the field of arts in health, Aly has built networks and relationships nationwide through organizations and initiatives such as the Creating Healthy Communities Arts in Public Health Initiative and the National Organization for Arts in Health. She was the inaugural Assistant Director of Arts in Medicine and Arts Program Manager for NYC Health + Hospitals, the largest public health system in the US, and on the Advisory Task Force for the first Social Prescribing pilot in the US: CultureRx out of Massachusetts. She also teaches Advanced Professional Seminar in the graduate program at the UF Center for Arts in Medicine.

As Senior Director of Arts & Well-being, Aly leads innovative research, evaluation, and programming at the intersection of arts and health, serving communities in Newark and New Jersey.

Maddie Maier

Co-founder
Harvard Undergraduate Initiative for Social Prescribing, Harvard College
MA

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Participant Observer

Maddie Maier is a senior at Harvard College studying Human Developmental and Regenerative Biology with a secondary in Psychology. Her interest in Social Prescribing began after her work with a community-based care clinic that worked to prevent homelessness in Los Angeles.

Later, while working with the National Academy for Social Prescribing, she investigated how to forge sustainable community relationships at the policy level when implementing Social Prescribing and is excited to bring those ideas to a US context. Currently, she is a National Academy for Social Prescribing Visiting Collaborator and co-founder of the Harvard Undergraduate Initiative for Social Prescribing.

Maanasa Mendu

Member
Harvard Undergraduate Initiative for
Social Prescribing, Harvard College
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Participant Observer

Maanasa Mendu is a junior at Harvard College studying Neuroscience with a secondary in Global Health and Health Policy. Her interest in Social Prescribing began after volunteering as an activities' assistant at a senior living community and resource advocate at the Harvard Square Homeless Shelter and Crimson Care Collaborative. Maanasa interned at the Center for Quality Improvement and Innovation at the Ryan White HIV/AIDS program where she worked on the create+equity collaborative. Maanasa has also worked with the Mass Cultural Council to help evaluate CultureRx, a pilot of social prescription in MA. Currently,she is a member of the Harvard Undergraduate Initiative for Social Prescribing.

Nicole Morgan

Research Coordinator
Center for Arts in Medicine
University of Florida
DC

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Participant

Nicole Morgan, MA, is a Research Coordinator for the Center for Arts in Medicine (CAM) at the University of Florida. In addition to managing the Center's Interdisciplinary Research Lab, Nicole provides support to CAM research projects and initiatives, including the EpiArts Lab, the One Nation/ One Project initiative, and the Creating Health Communities initiative.

Nicole also brings experience in clinical research, having coordinated behavioral studies and clinical trials at the Institute on Aging in UF College of Medicine's Department of Geriatric Research, as well as at Shands Arts in Medicine on research assessing the use of Integrative Therapies at the bedside for patients undergoing treatment for Acute Myeloid Leukemia. In addition to this work, Nicole has spearheaded research assessing the use of Graphic Medicine for pre-health students as a means of building clinical empathy, and implemented an arts in health project designed to build vaccine confidence in the University of Florida student body.

Dan Morse

Founding Director
Social Prescribing USA, CA

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Participant

Dan Morse is the co-founder of Social Prescribing USA, a network of leaders working to advance the US Social Prescribing movement. His team of volunteers are coordinating a US grassroots physician movement, organizing a network of 400+ experts, and catalyzing prospective pilot studies in collaboration with professors at Harvard, Stanford, University of Michigan, reps from hospitals, Cleveland Clinic and the NIH. Aimed to be the "public town square" of the moment, the organization is also building a free site to allow people to find social prescriptions by zip code.

Dan has spent the past decade focused on social determinants of health, from organizing place-based health interventions in Detroit to founding an award-winning health empowerment restaurant. Today, Dan is on the founding team of a new Bachelor's degree-granting college in San Francisco, called Make School (now Dominican University). The college prepares students from disadvantaged backgrounds to get jobs at companies like Apple, Google, Tesla, and NASA. Dan has pioneered data-driven programs that address students' social determinants of health and foster academic success. He graduated from University of Michigan Ross School of Business with honors.

Kate Mulligan, Ph.D.

Assistant Professor,
Social and Behavioural Health Sciences
Dalla Lana School of Public Health
University of Toronto, Canada

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Participant

Dr. Kate Mulligan is the founding director of the Canadian Institute for Social Prescribing and a senior advisor to the Canadian Red Cross on knowledge mobilization and determinants of health.

A 2021 "pillar of the pandemic," Kate is an Assistant Professor in Social and Behavioural Health Sciences at the University of Toronto's Dalla Lana School of Public Health and School of Cities, where her research and teaching focus on scaling and spreading promising approaches to health equity, healthy public policy, and community leadership in health.

Kate is a public member of the Toronto Board of Health and co-chairs the Global Social Prescribing Alliance. Find Kate on Twitter @KateMMulligan.

Varshini Odayar

Co-founder
Harvard Undergraduate Initiative for Social Prescribing, Harvard College
MA

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Participant Observer

Varshini Odayar is a senior at Harvard College studying Neuroscience and Social Anthropology with a secondary in Global Health and Health Policy. Her interest in Social Prescribing began after her work at the Center for Respite Care in her hometown, Cincinnati Ohio, conducting research surrounding care management, housing prescriptions, and medical care for homelessness with acute medical conditions. She has worked with the National Academy of Social Prescribing for building student awareness surrounding Social Prescribing. Currently, she is a co-founder of the Harvard Undergraduate Initiative for Social Prescribing and visiting collaborator at the National Academy of Social Prescribing.

Mo Sook Park

Visiting Scientist, D-Lab
Harvard T.H. Chan School of Public Health
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Participant

Mo Sook Park, EdM, directs programs and relationships for the D-Lab. Her interest is in exploring the intersection of design, adaptive leadership, and management sciences to help mission-driven organizations prioritize the health and well-being of their people, teams, and ecosystems as equally critical to the missions they serve.

At the D-Lab, Mo works closely with the co-founders, leveraging her 20+ years of experience in leadership and organization development to oversee the research agenda and design and implement competency-building programs for multiple grant-funded projects. Key to her role is the management of relationships and dynamics with external partners and stakeholders, particularly when it comes to implementing complex change initiatives. Mo Sook is the founder of i-D Leadership Consulting, a leadership and organization development consultancy helping organizations from across sectors develop their people, systems, and cultures in alignment with their purpose.

Mo Sook is an Adjunct Faculty member at the IIT- Institute of Design and a faculty member at the Federal Executive Institute in the Office of Personnel Management (OPM), where she designs and delivers leadership development programs for Senior Executives of the federal government. She also serves on the Board of Directors for the Adaptive Leadership Network. Mo Sook Park received her EdM from the Harvard Graduate School of Education where she designed her own program on Leadership and Organization Development.

Sheila Phicil

Director of Innovation,
Health Equity Accelerator
Boston Medical Center
MA

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Participant

Sheila Phicil is the Director of Innovation at Boston Medical Center's (BMC) Health Equity Accelerator where she develops initiatives that advance racial health equity. Before her current role, Sheila served as the Administrative Director of the Neurology Department at BMC where she oversaw the operations and finance in support of the Department's clinical, research, and teaching missions.

Sheila has 13 years of experience in health care spanning policy, strategy, and operations. She has worked at multiple health care institutions including Brigham and Women's Hospital, Dana Farber Cancer Institute, and the Veterans Health Administration. Sheila holds two Master's degrees in Public Health and Financial Economics and is a Certified Project Management Professional (PMP). In 2020, she received the BMC Leadership Impact Award for transformative leadership on diversity, inclusion, and health equity.

In 2022, Sheila was one of 24 high-potential health care leaders selected to participate in the Massachusetts Health Leadership College fellowship program. Sheila believes every system is perfectly designed to produce the results it gets. Therefore, she is passionate about innovating systems of care designed to work for and with vulnerable and marginalized populations. Sheila also has a knack for storytelling to shed light on complex issues, often drawing from her lived experience as a first-generation Haitian American woman.

Tracy Parris-Benjamin

Director
Community Health and Health Equity
Horizon Blue Cross Blue Shield
NJ

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Participant

Tracy Parris-Benjamin is a master's-level licensed Social Worker, integrator, and equity champion, who works to sustain support for advancing diversity, equity, accessibility and inclusion . Ms. Parris-Benjamin holds a distinguished record of health care innovation and transformation. With the primary goal of achieving equitable health for all, Ms. Parris-Benjamin works with Horizon's extensive value-based network to lead the development of innovative health programs targeted toward marginalized populations.

Ms. Parris-Benjamin's experience demonstrates her work as an advocate for community-based programs and other health care initiatives. She leads several workgroups and discussions around increased awareness and stigma reduction of substance use disorders and has championed programs for HIV-positive pregnant teens and their families, survivors of domestic violence, individual and group counseling, parenting workshops to reunite families, and care coordination for underserved and chronically ill persons. She promotes the need for increased cognizance on the impact of health disparities and inequities in health care, for underserved populations and persons of color.

In 2019, Ms. Parris-Benjamin received distinguished honors from Diversity MBA as a top leader under 50 and top 100 Women of Influence in 2020. She is a fellow of the New Jersey Health care Executives Leadership Academy. Ms. Parris-Benjamin has appeared in media leading discussions on trauma informed care, community engagement to mobilize health education, COVID-19 and access to resources in high-risk communities.

Chris Rudd

Founder
Chi By Design
IL

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Participant

Chris Rudd is an award-winning designer, community organizer, and founder of ChiByDesign, a Black-owned and people-of-color-led social and civic design firm. Chris has a deep background in social equity work, systems change, and youth development. He's worked with youth and community residents on the south and west sides of Chicago, supporting them in designing new anti-racist infrastructures to enable an equitable future.

Chris is a former Clinical Professor of Practice and Lead of Community-led Design at the Institute of Design (ID) at IIT, where his work focused on developing the co-design practice and the creation of an anti-racist design field. Chris is a former Stanford Institute of Design (d.school) Civic Innovation fellow, Chicago Urban League IMPACT fellow, a 2021 Illinois Science and Technology Coalition Researcher to Know and a 2022 World Changing Ideas honoree.

Prachi Saxena

Design Strategist
Blue Cross Blue Shield
IL

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Participant

Prachi Saxena is passionate about helping organizations de-risk the future by imagining creative solutions via a systemic lens. Currently a Design Strategist at the Innovation Incubator at BlueCross Blue Shield (IL, TX, OK, MT, NM), she explores problems with high business uncertainty to reimagine health futures.

She is rooted at the intersection of Anthropology and Design with a Master's in Psychological Anthropology from the University of Chicago, as well as a Master of Design from the Institute of Design, where she was the recipient of the Peter W Cherry Design Foundation Fellowship. She is passionate about asking gnarly questions, flipping orthodoxies, and making the abstract tangible.

She has consulted on projects ranging from service concepts to promote energy savings for low-income families to proposing sustainable solutions for revitalizing Brownfields in segregated regions of South Chicago. In the health space, she has brought a future-oriented, multi-disciplinary, and culturally curious perspective to problems such as health inequity, aging in place, childhood immunizations, etc. She plays a critical role in growing the design practice at her organization and evolving methodologies to conduct real-world low-fidelity pilots in a complex, highly regulated environment such as health care.

In her time at the Institute of Design, she also headed the student association IDSAB (2018-19) and supported conferences such as Design Intersections (2018). As a strategic designer, she hopes to bring rigorous systemic thinking and methods to tackle complex social issues.

Dr. Alan Seigel

Family Physician
Contra Costa Health Services
CA

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Participant

Dr. Alan Siegel has worked since 1999 as a Family Physician within the Bay Area's Contra Costa Health Services (CCHS). Over the past decades, Alan has pioneered many new programs related to Social Prescribing at his clinic including Nature Rx, Walk with A Doc, and the Expressive Arts Training Program focused on healing through creativity.

A 2019 UCSF Champion Provider Fellow, Dr. Alan also started the Bay Area's Health Leads Program to address social determinants of health. He serves on the board of the National Organization for Arts and Health (NOAH) where he initiated the Clinical Well-being & Burnout Working Group.

Jill Sonke, Ph.D.

Research Director
Center for Arts in Medicine
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Participant

Jill Sonke, PhD, is research director in the Center for Arts in Medicine at the University of Florida (UF), director of national research and impact for the One Nation/One Project initiative, co-director of the EpiArts Lab (a National Endowment for the Arts Research Lab at UF), and currently serves as Senior Advisor to the CDC Vaccine Confidence and Demand Team on the COVID-19 Vaccine Confidence Task Force.

She is an affiliated faculty member in the UF School of Theatre & Dance, Norman Fixel Institute for Neurological Diseases, the Center for African Studies, the STEM Translational Communication Center, and the One Health Center, and a consulting editor for Health Promotion Practice journal.

Käthe Swaback

Creative Youth Development Officer
Mass Cultural Council
MA

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Participant

Käthe Swaback is a visual artist, arts administrator, and funder with an MA in art therapy. In 2019, Käthe joined Mass Cultural Council's Creative Youth Development (CYD) team where she also co-leads the arts and health initiative, CultureRx: Social Prescription pilot. Her passion for exploring the impact of the intersections of social justice, health, and community building through the arts stems from over 25 years of work as an artistic and program director in CYD organizations.

She joined the core team of Raw Art Works in 1994 where she developed, taught, and supervised others in a full continuum of 50+ programs for more than 15 years. From 2008-12, she led The Boston Youth Arts Evaluation Project, culminating in the publication of a handbook and workbook, with BYAEP receiving statewide recognition for Excellence in Collaboration awarded by the Massachusetts Nonprofit Network.

She has continued this work through the CYD National Partnership, Youth Arts Impact Network, and the national CCRM Data Collaborative project. Swaback's focus also includes working to advance health equity, mental health, and well-being. In May 2022, she was honored to receive the Parent/Professional Advocacy League's 2022 Excellence in Family Leadership Award for work in mental health advocacy.

Linda Tomaso, Ph.D.

Postdoctoral Research Fellow
Department of Environmental Health
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Participant

Linda Powers Tomasso investigates nature as a health-promoting exposure and intervention strategy through her postdoctoral research at the Harvard T.H. Chan School of Public Health.

Her mixed-methods approach to exposure assessment brings qualitative insights into a discipline typically determined by quantitative factors to learn what motivates nature-seeking behavior, what barriers exist to nature engagement, and how these factors affect equity of nature access and climate adaptation.

An MS from Georgetown, MA from Harvard in Environmental Management, and an early career with the US State Department shaped Linda's policy knowledge which is indispensable to her current research. Her favorite places to be in nature are the snowy woods and underwater.

Marete Wester

Senior Director of Arts Policy & National Initiative for Arts & Health Across the Military, Americans for the Arts
DC

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Participant

Marete Wester joined the staff of Americans for the Arts in April 2006 after a more than 20-year career as a non-profit arts executive, educator, writer and consultant. She currently serves as the Senior Director of Arts Policy and the National Initiative for Arts & Health in the Military (NIAHM) at Americans for the Arts (AFTA) where she helps advance and develop cross-sector policy issues and strategic alliances nationally and internationally.

Her current portfolio includes arts and military/veterans issues, international engagement, public health and the environment. In her early tenure at AFTA, she has helped to develop and launch several policy forums and new projects in partnership with national non-profit as well as federal agencies. Working with a coalition of partners, she helped launch and now facilitates the National Initiative for Arts & Health Across the Military—an effort that brings military/civilian agencies in to advance the use of arts and creativity as tools for health for all service members, Veterans, their families and caregivers. Since 2016, she has served as AFTA's Creative Forces Project Director for the Creative Forces: NEA Military Healing Arts Network since 2016.

An experienced administrator of cross-sector collaborations and initiative development, she has stewarded public and private strategic partnerships including the US Department of Defense, Department of Veterans Affairs and Veterans Health Administration, Department of State as well as the National Endowment for the Humanities. She holds a bachelor's of music performance degree from Wilkes University, PA and a master's degree in Arts Administration from Drexel University in Philadelphia.

Catherine Wieczorek

PhD Candidate
Human-Computer Interaction & Design
Pennsylvania State University
PA

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Participant

Catherine Wieczorek, MDes, (she/her) is a designer and researcher working at the intersection of design and public health. She studies how to integrate critical data studies and design research approaches in community-based practices to develop technologies that can improve the well-being of individuals and communities. Currently, she is a second year PhD student in Human-Computer Interaction & Design at the Pennsylvania State University in the College of Information Science and Technology.

Previously, Catherine worked at public health research centers and consultancies including the D-Lab at the Harvard T.H. Chan School of Public Health, Flip Labs, and the Design Lab at the Center for Interdisciplinary Inquiry and Innovation in Sexual and Reproductive Health (Ci3) at the University of Chicago. There, she worked as a multidisciplinary designer to conduct field and design research, build partnerships with community members, develop products, services, and strategies aimed at improving health and community resilience, and support general operations including communications and pursuing funding opportunities. Her work has been recognized by Core 77 and Fast Company, and covered by National Public Radio and Design for America.

Catherine holds a Master of Design degree from the IIT Institute of Design and a BA in Visual Communication from Loyola University Chicago. She served as a board member for AIGA Chicago where she co-developed a workshop series that taught design frameworks and methodologies to graphic designers and non-profit professionals.

Amanda Yarnell

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Participant

Amanda (she/her) joined Harvard T.H. Chan School of Public Health in 2022 as Senior Director for its Center for Health Communication, where she is preparing public health leaders to communicate credible health information to an increasingly fragmented world. In that work she leverages two decades of experience in science and health journalism, media product development, and audience engagement.

Prior to joining Harvard Chan, Amanda worked as a science journalist and newsroom leader at Chemical & Engineering News (C&EN), an award-winning nonprofit science news outlet published by the American Chemical Society. Under Amanda's leadership C&EN grew from a print magazine to a vibrant multichannel news operation used by more than 8 million people a year.

Amanda currently serves on the advisory board of Drug Hunter, a nonprofit news startup that covers pharmaceutical discovery and development. She holds a Bachelor of Arts in Chemistry from Johns Hopkins University and a Masters of Science in Chemistry from MIT.

Patrick Whitney

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Organizer

Mr. Whitney is the former dean of the Institute of Design (ID), Illinois Institute of Technology (IIT), where he was the Steelcase/Robert C. Pew Professor of Design and an IIT distinguished professor. During his leadership of ID, the school created the first PhD program in design in the USA, transformed ID into a leading institution in design methods and theory, and created an executive education program translating design to organizational leadership.

Mr. Whitney is widely regarded as a thought leader for pioneering the notions of human-centered design and strategic design. He conducts executive seminars and advises many organizations including Aetna, BP, Godrej & Boyce (Mumbai), Proctor & Gamble, SC Johnson, Texas Instruments, and government agencies in Denmark, Hong Kong, India, and the UK. Business Week has featured him as a design visionary for bringing together design and business; Forbes named him as one of six members of the "E-Gang" for his work in human centered design; Fast Company has identified him as a "master of design" for his leadership in the design field of linking the creation of value for users and economic value for companies; and Global Entrepreneur Magazine named him one of 25 people worldwide doing the most to bring new ideas to business in China.

Mr. Whitney earned his bachelor of fine arts in visual communication design at the University of Alberta, followed by a master of fine arts in design at the Cranbrook Academy of Art. Mr. Whitney was appointed associate professor and chair of the Division of Design at Minneapolis College of Art and Design in 1979. Five years later, he was appointed associate professor and head of communication design at the ID. In 1987, he was appointed professor and director, and then dean of the institute.

André Nogueira, Ph.D.

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Organizer

André Nogueira, PhD, (he/him) is the co-founder and deputy director of the Design Laboratory at the Harvard T.H. Chan School of Public Health, where he also serves as a research scientist and instructor for the Department of Health Policy and Management. André investigates how design frameworks and methods can help improve the well-being of people, organizations, and the ecosystems within which they live. He currently leads solution-oriented research projects and publishes on two complementary paths: one is field-focused, advancing design knowledge; the other is project-focused, exploring complex application areas related to improving well-being.

André was awarded in the first 40 under 40 Public Health Catalyst Awards by the Boston Public Health Congress. His work has been funded by the USAID, Bill and Melinda Gates Foundation, Kresge Foundation, Chicago Community Trust, Chicago Food Policy Action Council, Feeding America, US Fish and Wildlife Service, the Association of Fish and Wildlife Agencies, among others. He teaches Design for Social Innovation at Harvard T.H. Chan School of Public Health and at the IIT-Institute of Design, mentoring graduate students from multidisciplinary backgrounds, including public health, public policy, business, public administration, design, and education. He also advises corporate senior executives and leaders in the social sector across the globe interested in building design capacity within their organizations.

III. Initial Questions Raised by Participants

A list of questions generated by the participants at the start of the convening. These questions represent relevant challenges participants are exploring as part of their efforts to expand Social Prescribing movement in the US.

Users

- What are our assumptions of each other's worlds? How might we set our assumptions aside in the future?
- How do we ensure that cultural organizers and artists benefit from these new structures?
- How are different cultures represented in the six US pilots?
- Who is unintentionally left out of processes?
- Are there certain kinds of activities or artistic disciplines that are particularly impactful for Social Prescribing? How do we know that?

Offerings

- How do we get the idea of Social Prescribing integrated into existing work to support folks who want to engage in volunteerism?
- How do we create and integrate this work into multidirectional referral systems such as other social determinants of health?

Value

- How do we bring Social Prescribing to support wellness for health care workers?
- What role can students play?
- What role do federal agencies play in this conversation?
- What is a sustainable financing model?
- How can we get policy makers on board and think beyond cost effectiveness?
- How can we connect with the corporate sector?
- How can corporations be involved in SRX?
- How do we build in a value-based model?
- How do we work on social determinants of health in the most vulnerable places?
- What is the role of the practicing physician? How do we transform medical education?
- What will it take for elected officials to embrace and not politicize the term "Social Prescribing?"

Operations

- How can organizations help transfer learnings from Canada to pilots in the US?
- How can I leverage existing infrastructure to adopt Social Prescribing in my organization?
- How do we measure success?
- How do we scale Social Prescribing?
- How can we connect community groups to build this network for Social Prescribing?
- What is the evidence and how will we get it beyond traditional tools?
- How will we acknowledge histories and futures?
- How do we scale appropriately in a hyper-diverse context?
- How do we get everyone to start demanding Social Prescribing across communities and systems?
- How do we bring policy, research, and practice together?
- How can you maintain care and accompaniment in a medicalized model?
- How do we create cultures and tools for Social Prescribing?

Strategy

- If we build it, will they come?
- What causes civic engagement?
- What does Social Prescribing look like for resource-constrained communities?
- How do we encourage valuing of communities amid a culture of individualism?
- Is health care the appropriate setting for Social Prescribing?
- What are similar movements we can learn from?
- Why shouldn't this be at the forefront of health care (prevention)?
- Is there one or do we need multiple models?
- Why has the western biomedical model discredited traditional practices?

IV. Groups

A list of the teams participants were assigned to with representatives from different sectors and industries.

1 Group One

- Amanda Yarnell
- Bogdan Chiva Giurca
- Chris Rudd
- Charlemya Erasme
- Käthe Swaback
- Nicole Morgan

2 Group Two

- Chris Appleton
- Dan Morse
- David Andersson
- Prapti Jha
- Tracy Parris-Benjamin

3 Group Three

- Adedoyin Eisape
- Alan Seigel
- Emmeline Edwards, PhD
- Jill Sonke, PhD
- Sonia Lala

4 Group Four

- Amy Bantham, Dr.PH
- Ardeshir Z. Hashmi
- Catherine Wieczorek
- Edward Garcia
- Kate Mulligan, PhD

5 Group Five

- Aly Maier Lokuta
- Emily Haber
- Staci Jasin
- Sheila Phicil
- Prachi Saxena

6 Group Six

- Kathleen Guytingco
- Linda Tomaso
- Marete Wester
- Mary Brown
- Zeya Chen

V. Action Situation

A description of a complex, yet common action situation involving a patient-health care provider interaction in the US health care system. This action situation was used as a background for teams to develop their work.

It is winter in Dearborn, Michigan, and Nadia has received a call from the neighborhood clinic to schedule an in-person appointment with Dr. Hernandez, her new primary health care doctor. The goal is for them to get to know each other and discuss Nadia's recent rheumatoid arthritis diagnosis.

Born in Guatemala, Dr. Hernandez moved to the US to pursue a career as a primary care physician. After concluding his courseload at Indiana University, Dr. Hernandez went to Michigan for his residency program. Three years into the program, he married Tom. The couple has been living together for four years, with the last three years being during the COVID-19 pandemic.

Nadia, on the other hand, has experienced significant losses over the past few years. Her husband of 40 years passed away from COVID-19 this past year, and most of her friends from the Arab American community have moved closer to their children for increased support as they have grown older. Her two children, Yusuf and Ismail, both lost their jobs and had to leave Dearborn to search for new opportunities. Their current income instability impedes frequent visits.

During the call, Nadia talked to Paul, a trained social worker at her neighborhood clinic. In addition to scheduling a follow-up visit, Paul was supposed to obtain information about any recent changes related to Nadia's rheumatoid arthritis. While reviewing her medical record, Dr. Hernandez noted that Paul documented Nadia's low proficiency with the English language, her impatience when asked to repeat information, and her hesitancy to visit the clinic during the winter because she could not drive. Although not certain, Paul also documented that Nadia was showing signs of depression.

VI Stakeholders

A description of different stakeholders involved in the action situation. At the convening, each team was assigned a stakeholder and ideated on concepts centered on that stakeholder's aspirations, needs, and related problems.

1 Nadia, Patient

Nadia emigrated to Dearborn, Michigan, 42 years ago with her husband Ramy and had two children, Yusuf and Ismail. Ramy recently passed away from COVID-19, and most of her friends have moved away from Dearborn, Michigan. She was recently diagnosed with rheumatoid arthritis, and her physician also noted signs of depression.

2 Dr. Hernandez, Health Provider/Physician

Dr. Hernandez moved from Guatemala to the US to become a primary care physician. Dr. Hernandez recognizes how his patients' larger social needs impact their health. He is burned out and feels overwhelmed by his workload after significant attrition in his clinic.

3 Paul, Community Health/Social Worker

Paul is a social worker from Livonia, Michigan, and finds great satisfaction in supporting health care patients. He is frustrated by the lack of resources for social workers to conduct outreach visits and provide continued support for patients.

4 Michigan, State Government Agency

The State of Michigan has seen a dramatic increase in hospitalizations from mental health issues over the past three years. State officials are looking for robust evidence to explore the introduction of arts and nature-based interventions in order to confront this public health emergency.

5 Solidarity, Community-based Organization

Solidarity is a trusted community partner that has provided community services in Dearborn, Michigan for the past 35 years. Its mission is to "make everyone feel at home," and receives funding from individual donations and the inter-faith community, as well as county resources.

6 Collective, Health Insurance/ Payer of Health Services

Collective Health Insurance is the national health insurance plan for the population over the age of 65. It is currently undergoing a transformation and is interested in exploring innovations to reduce costs and advance disease management and health promotion approaches.

VII. Platform Concepts

A Whole View description of the platform concept developed by each group integrating the viewpoints of strategy, operations, offerings, value, and users.

1

Collective Community Care

For individuals from marginalized and vulnerable populations that can benefit from biopsychosocial health services, Collective Community Care is a platform offering trauma-informed and anti-racist interventions where users co-create emotional, practical, financial, and social support services for their well-being.

What business are we in?
Collective Community of Care addresses biopsychosocial needs of marginalized and vulnerable populations.

Who is it for?
Marginalized and vulnerable populations are made up of individuals like “Nadia” (patient stakeholder used during the workshop) who can benefit from access to biopsychosocial health services. Yet, they often need scaffolded support systems to ensure that they have access to such services - i.e. transportation, financial, and the invitation to co-create interventions.

How to make it?
Collective Community Care must have a deep and trustworthy connection with other organizations working in its surrounding community. To activate local stakeholders, it needs to work on a flexible partnership model that can address lingering and emerging biopsychosocial needs of marginalized and vulnerable populations. It also needs to develop best practices that can be adopted and adapted by others, increasing access to services and embedding the culture of inclusion and care into the community.

What to make?
Collective Community Care is a center that co-creates emotional, practical, and financial solutions together with patients through anti-racist, trauma-informed, and healing-centered biopsychosocial health services.

Why does it create value?
Collective Community Care addresses barriers faced by patients who are most in need of biopsychosocial interventions. It works directly with stakeholders in its surrounding context to lowers health costs for local residents, while increasing trust in existing health systems. Local stakeholders participate in this ecosystem to increase their impact while strengthening their networks with others interested in repairing harm and improving health outcomes for marginalized and vulnerable populations.

2

Integrating Health

For physicians who wish to provide effectively, culturally competent care, gain the trust of their patients, and also priorize their own well-being, Integrating Health is a platform that connects health providers with a diverse network of stakeholders, community assets, and evidence-based services that expand medical practices beyond conventional one-to-one clinical interactions.

What business are we in?
Integrating Health enables people to prioritize positive health outcomes for themselves on a daily basis. While it provides value to diverse user groups, its main focus is on enabling shared responsibility for a patient's health and well-being beyond the medical practice to include an ecosystem of stakeholders.

Who is it for?
There are many physicians and other healthcare providers who want to provide care effectively, as well as be trusted and culturally competent in relation to the patient's social context. Yet, many feel they lack proper ways to engage with the stakeholders surrounding a patient's life, or high-quality data to inform their work.

How to make it?
Integrating Health must be able to create a broad and diverse trustworthy network of stakeholders across sectors, and ensure their exchanges are as smooth as possible. It must also create a system of accountability that expands the responsibility of healthcare beyond the physician to welcome other stakeholders into the healthcare practice. Ultimately, it must create an easy-to-use and accessible information system for diverse audiences to access different resources, data, stories, and best practices.

What to make?
The Integrating Health expands the current 1:1 model of physician-patient interaction by connecting physicians with community organizations influencing the broader social context of the patient. It considers the patient's health as much as the doctor's health and well-being, providing a mechanism for health systems to integrate considerations of social, environmental, behavioral, cultural, and aesthetic factors determinanting the health of these two constituencies.

Why does it create value?
Integrating Health connects government agencies, insurance companies, health institutions, and community organizations interested in prioritizing positive health outcomes. Based on a physician's recommendation, insurance companies refer patients to community organizations that can help improve their health outcomes. Insurance companies benefit from lower operational costs and community organizations increase their impact. Physicians are incentivized by local government agencies to use this infrastructure. In turn, government leaders gain greater credibility in the communities they serve.

3

Link Co-Creators

For community members who wish to build their capacity to co-create equitable wellness plans that fit people's needs and aspirations, Link Co-Creators offers trauma-informed and anti-oppressive capacity-building training, access to resources, and ways to learn about their communities' needs.

What business are we in?
Link Co-Creators builds capacity of community members to promote health in their communities.

Who is it for?
There are several local agents who can have significant influence in the health of community members but who are not a part of the healthcare system. To be able to properly link community efforts and the work of healthcare providers, these people need to be authorized by health systems and empowered by the community, including support and trust of both parts to properly gather data on people's daily lives, treatment adherence, and health outcomes.

How to make it?
Link Co-Creators must train selected community members on equity, trauma, and anti-oppression services to be able to engage with and serve the needs of diverse populations. They will also need to constantly update their understanding and connections with existing and emerging community services, while making sure that community members and health systems acknowledge their roles and authority in the community they serve.

What to make?
Link Co-Creators empowers select community members to work closely with patients to co-create equitable wellness plans. It offers trustworthy connections to other people, services, resources, and experiences in the community in response to the patient's needs.

Why does it create value?
Link Co-Creators establishes enduring relationships between patients and trustworthy community members empowered to promote health across their communities. This new capability is supported by insurance companies who have their costs reduced and by strained healthcare systems who have their workload decreased. Community members and patients participate in this ecosystem as it enables them to engage with people they trust and participate in safe activities that are available in the community.

4

Community-Based Ecosystems

For state government agencies who want bipartisan support from elected officials, Community-Based Ecosystems provides equitable access to community-based data to support policy design, and demonstrate the benefits of centering programs on historically and compotemproarily marginalized and excluded communities.

What business are we in?
Community-Based Ecosystems creates opportunities for government leaders to gain bipartisian support by demonstrating how community-centered programs improve well-being outcomes.

Who is it for?
Most leaders in State Government Agencies are interested in gaining bipartisan support from elected officials and senior leadership to support their projects.

How to make it?
Community-Based Ecosystems must be able to attract and retain engagement of community leaders to promote long-lasting impact. The program must also commit to the community's timeline, and establish credibility with community members so there is continued support in data collection and evaluation. Lastly, the program be competent in gathering, analyzing, and translating evidence of its various programs' impact.

What to make?
Community-Based Ecosystems is a program that provides members of marginalized communities access to funding and support for gathering and translating evidence to impact. Through an equitable approach towards well-being promotion and evaluation, it creates new conditions to flip conventional narratives on solution ownerships and storytelling.

Why does it create value?
Community-Based Ecosystems works with members of marginalized communities and research institutions to collect, analyze, and disseminate equitable data and insights that can further garner bipartisan support in well-being promotion programs. It also supports policymakers in their policy design and evaluation by demonstrating the benefits of centering state programs on the well-being needs of marginalized communities.

5

Interconnected

For community organizations who wish to expand their presence and influence, Interconnected offers a platform for partnership formation and resource support across community organizations that builds their capacity to act together as caregivers in the community.

What business are we in?
Interconnected bridges silos across community organizations to increase their impact.

Who is it for?
Many community organizations are interested in acting as a community caregiver, helping community members overcome day-to-day challenges and achieve better health outcomes. Yet, many challenges they face cannot be met by a single organization, demanding they partner with other organizations to expand their capacity to serve community members.

How to make it?
Interconnected must be able to help community organizations cooperate in response to the aspirations and related problems of their community members. While the majority of the work will be co-created and delivered by members of the platform, Interconnected must carry the ability to include other agents, such as private corporations, state government, and research institutions that can expand the platforms' competency to create value for the community.

What to make?
Interconnected offers a platform of integrated, equitable, and accessible services to help each other address the unique needs of community members. At its core, this platform includes a stable information infrastructure, operational support, funding, and available human resources to facilitate cooperation between organizations.

Why does it create value?
Interconnected creates new conditions for community organizations to work together in order to increase their impact without compromising the efficiency of their operations. All stakeholders are expected to work in concert to sustain funding, inform and design policy and other interventions that impact their context, and build cultural competence to contribute to the community ecosystem.

6

Neighbors in Health

For insurance providers who want to address health inequality, Neighbors in Health creates low cost and culturally sensitive pilots of social interventions that help insurance companies justify coverage parity in service delivery through rigorous collection and analysis of data collected.

What business are we in?
Neighbors in Health is an alternative insurance system focused on promoting health and catalyzing meaningful and wholistic change in modern health insurance companies and government agencies.

Who is it for?
Insurance providers are seeking novel ways to address health inequities and improve financial outcomes for themselves and their customers. Yet, leaders within these organizations need evidence to support the exploration of innovative approaches to service delivery.

How to make it?
Neighbors in Health must be able to work with leaders within health insurance companies, furnishing evidence and appropriate material help them include social interventions to their portfolio. This system must also be able to increase awareness of health and cost benefits of social interventions among government leaders.

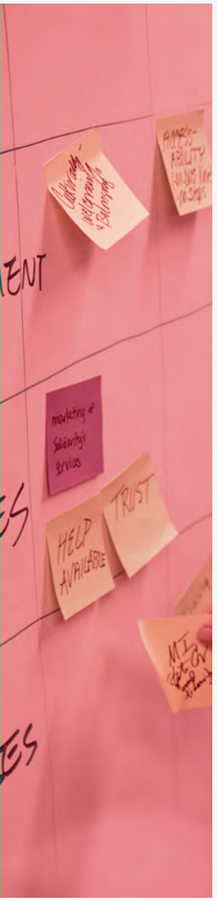
What to make?
Neighbors in Health provides an alternative insurance system that promotes culturally sensitive and accessible pilots of social interventions, including access to the arts, nature, and community organizations, alongside traditional healthcare services This system has a feedback mechanism built in for data gathering and program evaluation, empowering leaders working in insurance companies to participate, and use its database to make the case for transformational change within their own organizations.

Why does it create value?
Neighbors in Health contributes to a virtuous cycle of improving health outcomes through continuous health promotion. It connects patients with community assets, lowering long-term costs for insurance companies and healthcare providers, while improving relational trust with the community and customers. Data collected is analyzed and translated into novel insights that can unleash transformational change within insurance companies and in public policy design processes.

Design for Social Prescribing

Bridging Silos for Health Promotion

March 1, 2023



Report written collaboratively by: Andre Nogueira, Reena Shukla, Mo Sook Park, and Patrick Whitney with approval by all collaborators and participants.

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Photos by: Kent Dayton, Photographer for the Harvard T.H. Chan School of Public Health

Acknowledgment

This project was led by D-Lab's Builder Fellow, Reena Shukla, who had the vision to bring design to support the social prescribing movement. Her vision was made possible with the support of key collaborators, stakeholders who gave their time to be interviewed, and the 40 participants of the convening held in October 2022 as captured in this report.

A special thanks to David Andersson, Chris Appleton, Charlemya Erasme, Staci Jacin, Dan Morse, Jill Sonkie, Käthe Swaback, and Marete Wester for providing feedback on this report.

Key Collaborators

The project was led by the Design Laboratory at the Harvard T.H. Chan School of Public Health in collaboration with the Center for Arts in Medicine of the University of Florida and Social Prescribing USA.

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Additional Collaborators

World Health Organization

National Academy for Social Prescribing

Global Social Prescribing Alliance