Social Prescribing Onboarding Orientation Package

Prepared for Executive Directors, Hiring Managers, and Supervisors hosting Community Connectors through UWBC's Social Prescribing Program

Table of Contents

Section 1: Introduction

Welcome Message & Purpose of this Package

This orientation package is for Executive Directors, Hiring Managers, and Supervisors who are supporting Community Connectors (CCs) through United Way BC's Healthy Aging programs.

It provides foundational knowledge, tools, and expectations to support effective onboarding, supervision, and alignment with BC's social prescribing model.

Overview of Social Prescribing in BC

Social prescribing connects older adults to community-based services, activities, and supports that address the **social determinants of health** — including social connection, housing, transportation, financial security, and access to culturally safe spaces.

BC's approach to social prescribing is:

- **Community-led and strengths-based:** Focused on participant goals and mobilizing local community assets to strengthen connections and address barriers
- **Equity-driven and culturally humble:** Recognizing systemic barriers and supporting inclusive, culturally safe opportunities
- **Relational and action-oriented:** Building trusted relationships that empower participants to engage meaningfully with community supports
- **Focused on addressing the social determinants of health:** Supporting holistic wellbeing through trusted pathways to social, cultural, and practical supports
- **Collaborative across sectors:** Strengthening partnerships between healthcare providers, community organizations, and participants to create integrated, supportive systems for aging in place

---

The Role of Community Connectors (CCs) in Social Prescribing

Community Connectors:

- Engage older adults referred through healthcare and community pathways
- Facilitate strengths-based conversations to understand "what matters" to participants
- Co-create wellness plans and connect participants to community opportunities
- Map assets, build partnerships, and strengthen local community networks

---

Alignment with United Way BC's Healthy Aging Strategy

Community Connectors are central to United Way BC's collaborative model for healthy aging.

They strengthen the system of supports by bridging healthcare, community, and older adults, and by addressing the social determinants of health through relational, community-led approaches.

Through their work, Connectors reduce isolation, support aging in place, promote equity, and help build more resilient, connected communities across BC.

Section 2: Understanding the Community Connector Role

Who is a Community Connector?

A trusted relationship-builder who supports older adults to strengthen their health and wellbeing by connecting them to community-based supports, activities, and networks.

Connectors strengthen both individual lives and the broader community ecosystem.

Core Competencies & Key Skills

- Builds trust and practices active listening
- Applies strengths-based, trauma-informed, and culturally humble approaches
- Identifies and mobilizes community assets
- Works independently with strong time management and organization
- Maintains appropriate professional boundaries and practices self-care
- Communicates effectively across diverse settings
- Navigates basic technology for documentation and communication
- Adapts creatively to emerging needs and opportunities

Note:
While BC has adapted social prescribing to reflect local strengths and priorities, the **Canadian Social Prescribing Link Worker Competency Domains** provide additional helpful context around the knowledge, skills, and attributes important for success in this work.

Scope of the Role

Participant Support:

- Receive and manage referrals
- Conduct intake conversations focused on strengths and goals

- Co-create personalized wellness plans
- Facilitate warm connections to community resources and activities
- Conduct light-touch follow-up to adjust support as needed

Community Building/ Multisectoral Collaboration:

- Build and maintain collaborative relationships with multisectoral partners
- Map assets and identify service gaps
- Advocate for inclusive, accessible communities
- Engage in Communities of Practice and peer learning

Examples of Community Connector Impact

Community Connectors create impact at both the individual and community levels by strengthening relationships, reducing isolation, and weaving networks of support.

For example, a Connector might work with an isolated senior to help them reconnect to a cultural or recreational group that aligns with their interests, supporting improved social connection and wellbeing.

At the community level, a Connector might partner with libraries, recreation centres, or cultural organizations to create new social opportunities, or work with multiple agencies to address common barriers such as transportation, digital access, or language inclusion.

Connectors also strengthen referral pathways between healthcare and community services, advocate for more age-friendly spaces, and help communities better support healthy aging through collaboration and community development.

Note:
Additional stories and real-world scenarios from Community Connectors across BC are provided in Appendix A for your reference.

Section 3: Hiring the Right Community Connector

Sample Job Description

A sample Community Connector job description is in **Appendix B**. It outlines the responsibilities, qualifications, and attributes needed for success.

Interview Guide

Use interviews to assess key competencies aligned with the relational, community-centered nature of the role.

Focus on exploring:

- Ability to build trust and foster belonging
- Understanding and application of equity and cultural humility
- Capacity for independent work, asset mapping, and creative problem-solving
- Comfort using basic technology for communication and tracking

* Sample interview questions are provided in **Appendix C**.

Tips for Identifying the Right Fit

Look for candidates who:

- Build trust naturally and work relationally
- Are community-minded and resourceful
- Practice cultural humility and understand systemic barriers
- Thrive in flexible, participant-driven environments

Be cautious of candidates who:

- Focus primarily on task completion or service referrals
- Struggle with flexible, evolving community work
- Lack awareness of equity or systemic challenges affecting older adults

The right Connector embraces both **individual support** and **community development** as integrated parts of their work.

Section 4: Onboarding & Setting Up for Success

Overview

Each agency has its own onboarding processes. The following guidance is provided by United Way BC (UWBC) to support the specific onboarding needs of Community Connectors within the provincial social prescribing initiative.

This framework is not prescriptive — it is meant to **complement existing onboarding practices** by offering tools, timelines, and guidance to help new Connectors build confidence and align with BC's collaborative approach to social prescribing.

Supporting a Strong Start: Key Elements

During the first few months, supervisors are encouraged to support Connectors to:

- Understand their role, scope, and expectations
- Engage with UWBC-led training and tools
- Build connections with peers and local community partners
- Begin practicing both participant-facing and community-building components of the role

A sample onboarding checklist is provided in **Appendix D**.

Orientation Timeline & Key Milestones

The timeline below outlines UWBC's recommended onboarding progression for Community Connectors during their first six months. Agencies can adapt this to suit their internal processes.

Month 1:

- Begin **Part 1** of the **Community Connector training modules**
- Review the **Social Prescribing Implementation Guide**
- Create an account on **Healthy Aging CORE**
    - Explore SP discussion forums

    - Access templates for social prescribing posters, brochures, and outreach materials
- Connect with the **UWBC Regional Healthy Aging Specialist** who supports their service area
- Add **Regional Communities of Practice (CoPs)** to calendar
- Begin introducing self to local community partners
- Connect with other Community Connectors through CORE and CoPs
- Start developing a community asset map

Month 2:

- Complete **Part 1 and Part 2** of the Community Connector training modules
- Attend a **UWBC-led Community Connector Orientation Session** (offered monthly starting May)
- Deepen connections with local service providers
- Continue asset mapping and peer learning through CoPs and CORE

Month 3:

- Begin supporting first few participants with intake and wellness planning
- Apply training in real-time and continue learning from experience
- Share early reflections with supervisor and/or Regional Specialist
- Continue building community relationships and collaborative pathways

---

Month 6:

- Support an active participant caseload
- Maintain and update a comprehensive community asset map
- Strengthen referral pathways and partnerships
- Remain engaged in CORE, CoPs, and relevant learning opportunities
- Reach out to your UWBC Regional Specialist for support as needed

Regular check-ins with supervisors and/or Regional Specialists are encouraged throughout onboarding.

Sample Work Plan or Weekly Schedule

Community Connectors' schedules vary depending on caseloads, outreach needs, and local priorities. A typical week may include:

- **Participant engagement** (40–50%): intake, wellness planning, follow-ups
- **Community engagement** (30–40%): outreach, asset mapping, partnerships
- **Administrative tasks** (10–20%): documentation, CORE engagement, training modules, CoPs

Flexibility is key — supervisors should support Connectors to adapt their time based on real-world opportunities and community needs.

Connecting Community Connectors to Peer Networks

Early connection to the broader social prescribing network is essential for learning and sustainability.
New Connectors should be encouraged to:

- Join **Healthy Aging CORE** and participate in SP discussion forums
- Attend monthly **Communities of Practice (CoPs)** hosted by UWBC
- Connect with peers across the province for shared learning and support
- Access and adapt CORE's outreach materials (e.g., SP posters, brochures)

There are also opportunities for in-person connection and learning, such as the **Canadian Social Prescribing (CISP) conference** and potential **regional or provincial Community Connector gatherings.** Where possible, Connectors are encouraged (and may be expected) to attend these events.

Social Prescribing program funding provided to agencies may be used to support attendance, travel, or related expenses. Peer learning networks help strengthen both the Connector and the broader community-based system of care.

Section 5: Supervision & Ongoing Support

Supervising the Community Connector Role: Best Practices

Community Connectors thrive when supervisors understand the distinct nature of the role: it's relational, community-based, and flexible by design. Effective supervision supports clarity, accountability, and reflection — without pulling the CC into unrelated tasks.

Supervisors are encouraged to:

- Meet regularly for check-ins and coaching
- Reinforce the participant-led, strengths-based nature of the work
- Respect the defined scope of the CC role
- Support alignment with UWBC's model and training expectations

Creating a Supportive Work Environment

Supportive environments offer:

- Clear expectations and documented role scope
- Permission to say no to tasks outside the role
- Flexibility to respond to community needs
- Time for professional development and peer learning (e.g., CoPs, CORE)

Maintaining role clarity helps protect Connectors from burnout and ensures program integrity.

Managing Boundaries, Burnout, and Role Creep

Because the role is relational and often involves working with isolated or vulnerable individuals, burnout is a real risk.
Supervisors play a key role in:

- Encouraging boundary setting and self-care
- Creating space for reflection and support
- Monitoring for early signs of burnout
- Avoiding "role creep" — assigning administrative, case management, or unrelated outreach duties outside the CC scope

Note:* UWBC has seen instances where Connectors were assigned unrelated tasks. This undermines the intent of the role and contributes to burnout. **SP program funding is intended only for the delivery of the Connector role as defined in this package and LOA.

Performance Monitoring & Probation Options

To support role clarity, alignment, and early development, agencies are encouraged to implement the following:

- **1-month check-in:** Focus on orientation progress, training completion, and early experiences
- **3-month performance review or probationary milestone:** Review progress on onboarding goals (e.g., training, first participant support, asset mapping)
- **6-month formal review or probationary period end:** Assess caseload support, peer engagement, asset mapping progress, and fit with the role

Suggested Performance Monitoring Tools & Practices

Supervisors can support learning and development through:

- **A shared work plan or onboarding checklist** (**see Appendix D**)
- **Regular reflective check-ins** (what's working, where support is needed)
- **Milestone tracking** aligned with UWBC's onboarding timeline
- **Feedback tools** based on CC core competencies (**see Appendix E**)
- **Peer observations or CoP debriefs** to inform supervision

Performance monitoring should focus on **alignment with the SP model**, **relationship-building**, **boundary management**, and **community engagement**, not just outputs.

Section 6: Expectations & Supports

What We Provide to the Community Connectors

United Way BC provides a range of supports to ensure Community Connectors are well-equipped and well-connected in their roles:

- Access to the full **Community Connector training modules**
- A recurring **virtual orientation session** for new Connectors
- Monthly **Communities of Practice** for peer learning and collaboration
- Ongoing access to the **Social Prescribing Implementation Guide**
- Access to **Healthy Aging CORE**, including:
    - Templates (e.g., posters, brochures, intake tools)
    - Peer discussion threads and sector resources
    - Event recordings, stories, and toolkits
- A **UWBC Regional Healthy Aging Specialist** available for guidance and troubleshooting
- Invitations to **in-person sessions**, such as the Provincial Summit or regional consultations
- Optional webinars and learning opportunities organized in response to connector needs

What We Ask of the Community Connectors

Community Connectors are part of a provincial network of programs supported by United Way BC. While delivery will reflect local needs, all Connectors are expected to:

- Complete the **Community Connector training**
- Attend a **UWBC-led orientation session**
- Participate in **monthly Communities of Practice (CoPs)**
- Join and actively use **Healthy Aging CORE**, including the closed Social Prescribing group
- Connect with their **UWBC Regional Healthy Aging Specialist** as needed
- Attend **in-person learning events**, such as the CISP conference or CC gatherings, where feasible
- Participate in required **reporting and evaluation** activities

- Represent the Social Prescribing program professionally and in alignment with UWBC values

---

Reporting Requirements and Accountability

Reporting is a shared responsibility between UWBC and funded agencies, and helps strengthen the quality, learning, and impact of our collective work.

Community Connectors and their host organizations are expected to:

- Submit **quarterly progress reports** (e.g., participant counts, program developments)
- Submit an **annual outcome report** covering program outcomes, accessibility, impact, and participant satisfaction
- Collect and report on indicators aligned with UWBC's key learning attributes:
    - Program standards & progress (e.g., new participants, service types, waitlists)
    - Accessibility (e.g., demographics, underserved populations)
    - Participant satisfaction (e.g., feedback on access, quality, and experience)
    - Impact (e.g., changes in social connection, confidence, quality of life)
- Notify UWBC of any major staffing, delivery, or program changes
- Participate in **evaluation activities**, including reflection, storytelling, or feedback processes

Templates, deadlines, and tools for reporting will be provided. UWBC's approach to evaluation is developmental, collaborative, and focused on continuous improvement.

Section 7: Tools & Resources

Wages Guidance & HR Considerations

While United Way BC does not prescribe specific wage rates, we recognize that many agencies use collective agreement benchmarks to guide their HR planning. Fair and competitive wages are essential to attracting and retaining skilled Community Connectors, whose relationship-based work is central to the success of social prescribing in BC. While non-clinical, this role requires specialized knowledge, strong interpersonal skills, and consistent engagement — all of which are harder to sustain without appropriate compensation. Aligning wages with sector standards supports stability, equity, and long-term program impact.

One commonly used reference is the **Community Social Services Employer's Association of BC (CSSEA) wage grid**, which outlines roles and salary ranges for non-profit employees across BC.
The role of **Community Connector** is listed within the wage grid (page 9), and may be relevant for agencies already operating within this framework.

You can explore the CSSEA wage grid here: 🔗 CSSEA Wage Grid
Note: You are encouraged to check whether your agency uses this or other collective agreements when planning for recruitment and compensation.

Social Prescribing Implementation Guide

This guide provides an overview of BC's approach to social prescribing, including guiding principles, implementation considerations, and how the Community Connector role fits within broader systems of care.
The guide is included in this package and also available on Healthy Aging CORE.

Community Connector Training Modules (Overview)

All Community Connectors are expected to complete the online training modules hosted on Thinkific.

Topics include:

- Introduction to social prescribing in BC
- The Community Connector role and ecosystem
- Community asset mapping
- Skills for connection and relationship-building
- Wellness planning and referral practices
- Connector well-being
- Monitoring and evaluation

Supervisors are encouraged to familiarize themselves with the training to support Connectors effectively.

CORE Discussion Forum & Online Supports

Healthy Aging CORE BC is United Way BC's central platform for sharing knowledge, tools, and connections related to healthy aging and sector-wide collaboration.

CORE includes:

- A wide-ranging **library of resources** and templates
- **Discussion forums** organized by topic and audience
- Access to past **recordings**, community stories, and learning events
- Notices about upcoming webinars, grants, and regional gatherings

Community Connectors are encouraged to join the **closed Social Prescribing group on CORE**, which serves as a peer learning space just for CCs.

In this group, you can:

- Share questions and resources
- Browse outreach and intake templates
- Stay updated on Communities of Practice and other CC-specific opportunities

Key Contacts for Ongoing Questions

Each agency and Community Connector is supported by a team at United Way BC, including:

- **Regional Healthy Aging Specialists**, based on service area

- **UWBC Managers and Leadership** within the Healthy Aging team
- **Prab Sandhu**, Healthcare System & Community Specialist and Social Prescribing Lead

These contacts are available to assist with implementation, onboarding, peer connection, and alignment with provincial priorities.

Section 8: Appendix

Appendix A: Community Connector Impact Stories

North Vancouver – Overcoming Isolation through Exercise

Ellen, a senior in North Vancouver, had become largely homebound and socially isolated — some days she barely found the energy to leave the house for groceries. A concerned nurse referred her to a social prescribing program at Parkgate Community Services, where **Community Connector** Angela worked with Ellen to co-create a wellness plan focused on getting her more active and engaged with others. Soon, Ellen was attending an *"Active Living with Chronic Pain"* exercise class alongside peers.

"It helps a great deal to be with other people who are experiencing the same sort of thing."

Through these connections, Ellen rediscovered a sense of community and no longer feels so alone.

Abbotsford – Navigating Systems to Restore Independence

Bevy-Ann's return to Canada after 22 years away turned into an arduous journey filled with bureaucratic obstacles. After her husband's death, she came back to BC only to find she lacked proof of citizenship — without it, Bevy-Ann couldn't access Old Age Security, seniors' supplements, or even secure proper housing. A serious fall left her in a wheelchair, and her apartment was not wheelchair-accessible.

Referred by a hospital social worker to Archway's Social Prescribing program, she met **Community Connector** Trina. Trina spent hours on the phone with government offices, helped Bevy-Ann complete complex forms, and advocated for her pension and housing. With Trina's support, Bevy-Ann secured documentation, moved into accessible housing, and began rebuilding her life.

“Trina helped me get back to the person I was — happy and helping other people. She came in at a very critical point in my life.”

Bevy-Ann now attends a weekly seniors’ lunch and has started exploring a new hobby — *“more independent than I was,”* she says.

Maple Ridge – Relief from Pain and Loneliness

In Maple Ridge, a senior suffering from chronic pain and deep loneliness was referred to the Social Prescribing program.

“Life changing. Quite honestly I didn’t want to live anymore until I started to receive the help.”

The **Community Connector** helped secure a dentist and funding for necessary medical care, finally relieving their pain and helping them reconnect with others.

“You assisted with finding a dentist and the funding for dental and medical care so I was no longer living in pain and alone.”

The program not only addressed their physical discomfort but also restored their sense of connection and hope.

Nanaimo – Building Community and Hope through Kitchen Socials

In Nanaimo, **Community Connectors** partnered with local physicians to host *Kitchen Socials* — group cooking nights that bring older adults together for shared meals and conversation.

Many seniors arrived nervous and unsure after long periods of isolation. But by the end of the evening, the transformation was clear.

“I haven’t talked this much in over two years! I haven’t felt this hopeful and optimistic in a very long time.”

Community Connector Amber described witnessing *“the joy, lightness, and hope”* on people’s faces. Kitchen Socials became more than meals — they fostered friendships, community belonging, and renewed confidence.

These stories highlight the deep, meaningful impact Community Connectors make in communities across British Columbia — from addressing social isolation to navigating complex systems, creating community, and supporting personal transformation.

Appendix B: Community Connector Sample Job Description

Job Title: Seniors Community Connector

Job Summary:

A Seniors Community Connector plays an integral role in bridging the gap between healthcare and social care. As a Social Prescribing professional, you partner with community organizations to provide non-medical support to improve the overall health and well-being of older adults in your community.

The Seniors Community Connector will work with older adults who are referred from Health Care Professionals and community partners to connect with community supports and services through referrals, applications, advocacy, and introductions. This role includes a diverse range of responsibilities – from conducting assessments and co-developing personalized care plans, to providing practical support to older adults and their families, to establishing, and maintaining relationships with people and organizations in the community offering supports to older adults. Your experience, training and interpersonal skills help you to make meaningful connections as you discern their unique needs. Through your work with local agencies and professionals, you will make a positive impact on the lives of older adults and the community.

The Seniors Community Connector will work in collaboration health care referrers and other Seniors Community Connectors in the province to create an environment where seniors at-risk of frailty will be able to access resources and support.

The goal of this position is to assist older adults to age safely in the right place by providing them with the social connections they require and build and maintain partnerships and connections of community-based seniors services in your area.

Qualifications: ***Education, Training and Experience:***

- Bachelor's degree in social service or related Human Services field or a combination of relevant education and experience
- Strong knowledge of seniors' issues and challenges related to healthy aging.
- Experience working with seniors and diverse populations from different cultures and socio-economic backgrounds.
- Knowledge of the community resources, programs and services.
- Minimum two (2) years recent related experience.

Job Skills and Abilities:

- Demonstrated ability to connect with and support seniors.
- Demonstrated skills in the areas of crisis intervention and conflict resolution.
- Demonstrated ability to recruit and supervise volunteers.
- Strong collaborative skills and proven ability to establish and maintain effective working relationships with all internal and external contacts.
- Excellent written and oral communication skills and ability to clearly explain instruction to others.
- Ability to work independently with strong time management and organizational skills.
- Strong computer skills.
- Valid driver's license and reliable vehicle with appropriate insurance.

Key Duties and Responsibilities:

Community Development

1. Build and maintain networks within community and strengthen relationships withing the community-based senior serving sector.
2. Use an asset-based community development approach to identify and mobilize individuals, and organizations providing and supporting older adults.
3. Engages and participates learning opportunities such as in community of practices, planning tables or networking events.

Assessment and management of referrals

4. Connects, liaises, and establishes partnerships with local health care professionals to create and maintain referral pathways.
5. Maintains an active caseload of seniors with short-term needs through referrals from health care professionals and community agencies.
6. Prioritizes referrals to meet individual participant's needs.
7. Understand hospital discharge procedures assist with supporting seniors transitioning back home following discharge.
8. Implementing safety precautions when visiting seniors in the community, including their personal residence.
9. Completes intake process to assess strengths, needs, abilities, and risks using motivational interviewing techniques such as active listening, conflict resolution and observing behaviour.
10. Use various assessment tools to determine challenges, needs and risks related to healthy aging and develop routines, structures, and resource referrals to reduce risk of frailty.
11. Interpret participants' complex physical requirements and social needs.
12. Maintains a high level of confidentiality in all matters related to clients and community partners.

Wellness Plan development

13. Supports seniors to access appropriate range of activities and suitable community resources by developing individual wellness plans.
14. Using a "what matters to you" approach refers seniors to community=based services, observes and assesses the participant's engagement with resources including (example: emotional, psychological, and functional status), and modifies activities to meet the participant's changing

needs.

15. Provides information regarding appropriate community resources to socially support the participant and their families.
16. Effectively collaborates within the Agency's and community's Seniors Services to provide multidisciplinary care for the best interest of the senior.
17. Assists with connection to a primary care provider.
18. Engages and participates in educational training for seniors on topics such as healthy aging and other relevant topics.

Documentation of referrals

19. Documents participant's interactions, wellness plans, reports, and other administrative duties as required.
20. Provision of follow-up note to continuing community health care provider if requested.

Evaluation

21. Participates in evaluation of programs including collection of participant data, reporting at regular intervals, and attending communities of practices.

Job Description has been updated and amended with approval of employee and Director.

_____ _____

Human Resources **Date**

_____ _____

Employee Signature **Date**

_____

Employee Name (Please Print)

Appendix C: Sample Interview Question Bank

1. Motivation & Understanding of the Role

- What drew you to this role, and how do you see it contributing to healthy aging in your community?
- In your own words, what is social prescribing and why is it important?
- What excites you most about being a Community Connector?

2. Community Experience & Relationship Building

- Tell us about a time you built trust or maintained a long-term relationship with someone in a community setting.
- How do you go about learning a new community and making connections?
- Describe a situation where you had to work across organizations to support someone. What worked well?

3. Equity, Inclusion & Cultural Safety

- Share a time you supported someone with lived experience different from your own. What did you learn from it?
- How do you incorporate cultural humility and inclusion into your everyday work?
- What does trauma-informed care mean to you in a role like this?

4. Self-Management & Practical Thinking

- How do you prioritize when everything feels important?
- Walk us through how you'd structure a week with multiple new referrals, follow-ups, and documentation needs.
- Describe a time you had to work independently or without much direction. How did you stay on track?

5. Comfort with Technology & Tools

- This role involves using tools like email, spreadsheets, and online forms. Can you describe your comfort level and past experience with those?
- How do you stay organized and keep track of your tasks and follow-ups?

6. Connector Qualities, Community-Building & Personality Fit

- What qualities make someone a good fit for this kind of community-based work?
- How do you build trust and make people feel comfortable quickly?
- Tell us about a time you brought people or groups together toward a shared goal or project.
- What's your comfort level with reaching out to new people or starting something from scratch?
- How do you stay creative and engaged when working in dynamic, sometimes ambiguous community settings?
- Describe how you've used curiosity or openness to build connections in past roles.
- What would you do if you felt stuck or unsure how to move forward on a participant's plan?

7. Reflection, Growth & Resilience

- Share a time you received feedback that helped you grow.
- How do you care for your wellbeing in a role that involves supporting others?
- What helps you reset or stay grounded after a tough day?

Appendix D: Onboarding Checklist for Community Connectors

This checklist outlines key onboarding steps to support alignment with United Way BC's provincial social prescribing model.
It is intended to complement (not replace) internal onboarding processes. Supervisors are encouraged to adapt or incorporate it as needed.

Getting Started (Weeks 1–2)

- Log in to **Thinkific** and begin **Part 1** of the Community Connector training modules
- Review the **Social Prescribing Implementation Guide**
- Sign up for **Healthy Aging CORE** and explore:
    - SP discussion threads
    - Downloadable **marketing templates** (posters, brochures, outreach tools)
- Connect with the **United Way BC Regional Healthy Aging Specialist** for your area
- Add your region's **Community of Practice (CoP)** sessions to your calendar
- Begin introductions to key community partners for asset mapping

By the End of Month 1

- Continue progress through **Part 1** of the training modules
- Participate in CORE discussion forums or post an introduction
- Begin building a **Community Asset Map**

By the End of Month 2

- Attend a **United Way BC Community Connector Orientation Session** (offered monthly starting May)
- Complete **Part 1 and Part 2** of the Community Connector training
- Attend a **Community of Practice (CoP)** session
- Continue strengthening connections with local partners
- Continue contributing to asset map and participating in CORE

By Month 3

- Begin supporting your **first few participants**
- Apply wellness planning and facilitate early community connections
- Continue peer learning through CoPs and CORE

By Month 6

- Support an **active participant caseload**
- Maintain and update a **comprehensive community asset map**
- Strengthen referral pathways and collaborative partnerships
- Continue engaging in peer spaces: CORE, CoPs, webinars
- Reach out to your **UWBC Regional Specialist** for support as needed

---

This checklist reflects key UWBC-led onboarding components.
Agencies are encouraged to supplement with their own internal onboarding steps.

Appendix E: Community Connector Competency-Based Feedback Tool

This tool is designed to support supervision and reflection during check-ins or formal reviews (e.g., at 1, 3, or 6 months). It offers a strengths-based framework aligned with the Community Connector training modules and the goals of BC's social prescribing model.

How to Use This Tool

This template is intended to guide supportive conversations between supervisors and Community Connectors.
It is **not a rigid evaluation form**, but a flexible tool to help surface insights, celebrate growth, and identify where support may be needed.

Note: Community context, geography, and time in the role will influence progress in each area.

Expectations should be adjusted based on factors such as:

- Rural vs. urban service delivery
- Availability of referral pathways or assets
- Community readiness
- The Connector's time in the role (new vs. experienced)

You are encouraged to adapt or expand this tool to suit your agency's supervision style.

Competency Feedback Template

COMPETENCY AREA	REFLECTION PROMPTS	SUPERVISOR NOTES / FEEDBACK
Relationship Building	Builds trust with participants, listens actively, engages with empathy	
Cultural Humility & Equity	Applies trauma-informed, inclusive practices; reflects on biases; supports access for marginalized groups	
Boundaries & Role Clarity	Maintains appropriate boundaries; declines out-of-scope tasks; refers as needed	
Participant Engagement	Uses “what matters” conversations; co-creates wellness plans; supports without overstepping	
Community Building	Maps assets; builds partnerships; contributes to community-level collaboration	
Communication & Organization	Uses tools confidently; documents clearly; communicates effectively	
Use of Supports & Networks	Attends CoPs; uses CORE; reaches out to peers and Regional Specialist as needed	
Self-Care & Resilience	Demonstrates self-awareness; sets boundaries; seeks help when needed	

Overall Reflections

What's going well?

_____

_____

_____

_____

_____

_____

What support could help the Connector continue to grow?

_____

_____

_____

_____

_____

_____

Any areas to revisit in future check-ins?

_____

_____

_____

_____

_____

_____

We'd love your feedback on this Orientation Package to help us strengthen support for Community Connectors across BC. Please take a moment to share your thoughts: Orientation Package Feedback Survey

UWBC CONTACTS:

Vancouver, North Shore, Richmond, Sea to Sky & Sunshine Coast

Dr. Beverley Pitman
beverleyp@uwbc.ca
604.969.8331

Ravi Grewal
ravig@uwbc.ca
604.268.1300

Burnaby, New Westminster, Tri-Cities, Surrey, Langley, Maple Ridge & Fraser Valley

Elise Goertz
Eliseg@uwbc.ca
236.427.4074

Dr. Indira Riadi
indirar@uwbc.ca
604.268.1342

Interior BC

Lisa Cyr
Lcyr@uwbc.ca
250.860.2356

Northern BC

Sarrah Storey
Sarrahs@uwbc.ca
250.699.1681

Vancouver Island & Gulf Islands

Cheryl Baldwin
Cherylb@uwbc.ca
236.427.4215

Amanda Marchand
amandam@uwbc.ca
604.708.4053

Health Care System & Community Specialist

Prab Sandhu
Prabhrajs@uwbc.ca
236.427.8936