Centretown CHC

Seniors Outreach Team

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A little bit about Centretown CHC

Centretown Community Health Centre has been an active part of the community since 1969, providing a wide range of health and social services to support local residents.

As a nonprofit, multi-service organization, our diverse team—including doctors, nurses, social workers, counsellors, dietitians, health promoters, and outreach workers—works together to promote a healthier, more connected community.

Culture of outreach, seniors team has been part of Centretown for 50+ years.

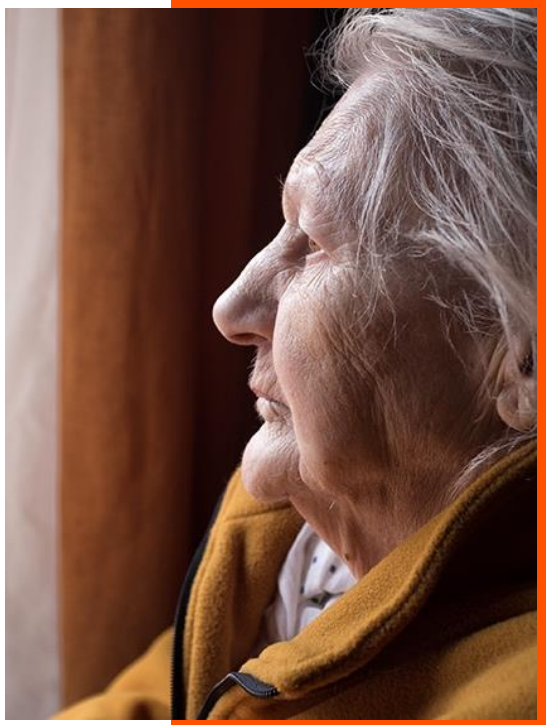


Table Of Contents

Who we serve

- 65 years old or above
- Lives alone or isolated
- Lacks support network
- Living in poverty
- Suffers from chronic illness and/or pain
- Recent visits to the emergency department
- Recent change in memory/cognition
- Falls in the last 3 months
- Recent changes in mood/behavior
- New medical diagnosis within the last 3 months
- Weight loss, or increase in less than 2 months
- No shows for medical appointments
- Concerns for general safety and abuse

How geriatric services are integrated?

CHC's provide whole person care from birth to end of life.
Components of senior friendly care at Centretown CHC:

-Primary care: all providers have the capacity to do home visits.
-**Seniors outreach team**
-Health promotion: with chair exercise, walking and cultural clubs, or coffee connections
-New comers and urban health team
-foot care (free)
-mental health services, individual counselling or groups (for depression anxiety)
-addiction services for clilents over 55 (LESA)
-walk in counselling and crisis prevention
-volunteer opportunities

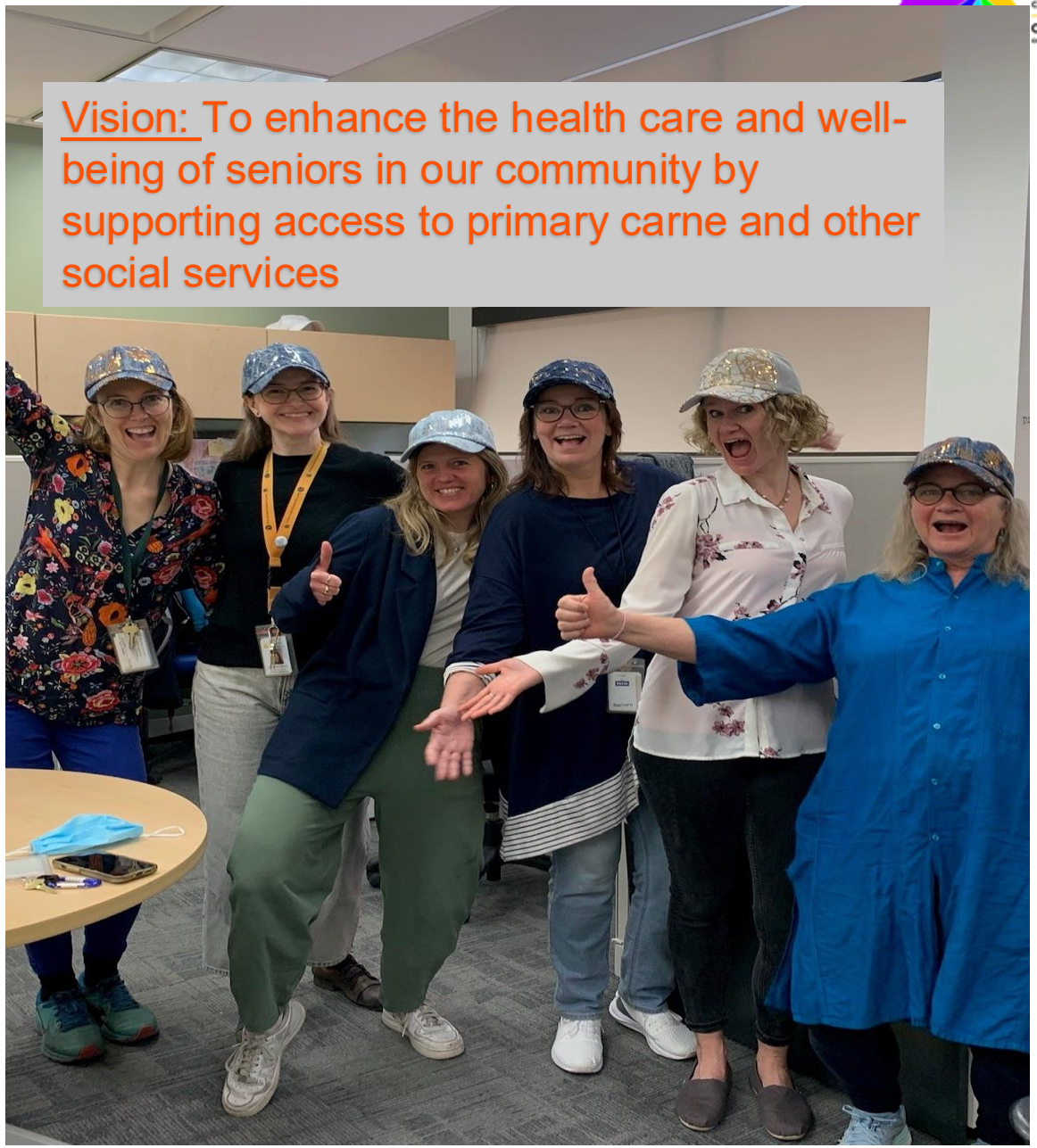
Meet the seniors team

The seniors outreach team consists of:

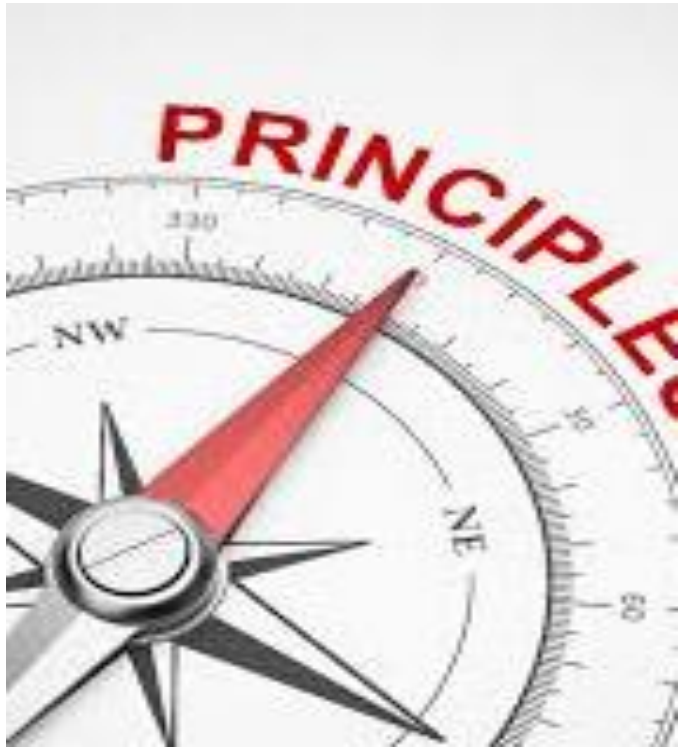
- 3 nurses
- 1 community health worker/navigator
- 2 NPs and one MD

We receive internal referrals (from providers at the center
And external referrals from the community, hospital and greater community resources.

We also do geriatric consults to support partners



Guiding principles



- Providing client-centered care, using a strength based approach
- Applying a geriatric lens to assessments
- Supporting what matters most to the client
- Building trusting relationships
- Fostering resilience
- Reduce barriers to health care from individual to the system
- Advocacy at the System level
- Working with multi-disciplinary teams
- Collaborating with community partners
- We do not duplicate services
- We are not emergency services

Seniors outreach services

Seniors Outreach Services

Home visits
Accompaniments
Geriatric health assessments
Chronic disease monitoring
Care plans
Outreach
Advocacy- for the individual client and for the senior's community as a whole
Social prescribing
Case management
Improve health literacy and Compliance
Reducing isolation/loneliness
Preventative care/ screenings
Making referrals and warm handovers
Family conferences
System Navigation
Collaborating with community partners
Fostering strong professional relationships with inter CCHC teams and external partners.

Seniors flow..

- Comprehensive geriatric assessment/intake in the home with client and possible support person (build trust and relationship)

- Assessment of determinant's of health
- Once trust established, collaborate with community partners and provide warm introductions (require lots of advocacy).

- Support their primary care journey until they become acutely palliative, are placed, or pass away.

- Meet regularly for case conferencing

- Reaching out to emergency contact, or providing a means for them to be part of the visit in person or by phone.

- Provide healthcare teaching that is accessible and individualized to person.

- Participate for committees that advocate for seniors in the Committee for Vulnerably Houses, Social Prescribing Committee.

Lessons learned

-Working with vulnerable seniors takes time and they are easily overwhelmed.
-Be prepared to ‘sit in the dark with the client’ and build trust.
-Don’t make assumptions
-View the greater community as an extension of your team
-You are often a detective and also a historical record keeper
-Old people are allowed to live with risk
-If you don’t consider the social determinant's of health in your care plan, it will most likely fail.
-Clients have direct access to the team, which decreases issues with delay in care.
-When team members are off, we cover each others caseloads.

Indicators of success

- Reduction of emergency room visits
- Meeting someone whether they are at and seeing them improved well being
- Address some of the social determinant's
- You helped them accomplish their goal: they managed to stay in their own homes as long as they possibly could.
- A self report, they told you that you helped them

Client story: Maureen

"Client goes to walk in at the Civic-unknown about family GP. Lives with son on and off-relationship unstable. Client housed, landlord not looking after his property and doing repairs
Looking after property and wants client gone. Client requires support as she is 65 and Salus transitioning to seniors team. Referral source
Worked with client for 2 years.
There may be verbal abuse between son and client.
Chronic pain, psychotic symptoms (client believes she is growing hair and pulls her skin). Teeth are poorly manage"

Supporting Maureen in her care

Description
Transfer her care to NP as client required home visits, as client not comfortable with men. Moved her pharmacy to one that would do home deliveries

Description
Allowed for a psychiatrist appointment in a home visit and to start medications for her depression..

Description
Allowed for home care assessments with Seniors nurse present, but did not accept support

Description
Initially unwilling to leave the apartment (even to have dental work done).
4 years later, did agree to attend cataract appointments and surgery

Description
Attended her first in visit appointment at the health centre and met with diabetes assessment.

Interventions

Thank You

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