COMMUNITY HEALTH CENTRES
OF NORTHUMBERLAND

Primary Care Integrated Geriatric Teams

Community Health Centres

A **Community Health Centre** (CHC) in Ontario is a non-profit organization that provides comprehensive, team-based **primary health care** and support services, **especially for people who face barriers to care**. In addition to Primary Care (physicians/NPs/RNs) CHCs focus on health promotion, illness prevention, and community wellbeing. CHCs are **rooted in the communities they serve** and work to address the social factors that affect health, such as housing, income, and food security.

Ontario's Community Health Centres

Every One Matters.

CHC Northumberland

CHCN was founded (in 2007) to address the healthcare needs of individuals facing barriers to access, such as those without a local doctor, seniors, individuals experiencing homelessness or food insecurity, and those dealing with mental health challenges or addictions. Our services encompass primary care, mental health and addictions counselling, diabetes education, geriatric outreach, a memory clinic, low-income dental care, and various health promotion and community development activities.

MINT® MEMORY CLINIC

COMMUNITY HEALTH CENTRES OF NORTHUMBERLAND

GAIN Geriatric Assessment & Intervention Network

GAIN & MINT at the CHCN

GAIN
Geriatric Assessment & Intervention Network

- 1 NP
- 1 Social Worker
- 1 Pharmacist
- 1 BSO RPN
- 1 Specialized Geriatric RPN
- 2 PSWs
- 1 Clinical admin
- 2 Consulting Geriatricians

MINT® MEMORY CLINIC

- 1 physician
- 1 BSO RPN
- 1 Pharmacist
- 1 Admin support

NOTE: Not all positions are 1.0 FTE

GAIN 2024/2025

Assessments per Team (FY 2024/25)	
Assessment	Instances Recorded
Comprehensive Geriatric Assessment (CGA)	165

Assessments per Team (FY 2024/25)	
Assessments (identified/completed during visits)	Instances Recorded
Visit for Cognitive Screen	199
Visit for Dementia Assessment	6
Visit for Functional Abilities Assessment	81
Visit for General Assessment	215
Visit for Medication Review	257

***Note**: These figures may not appropriately capture all the assessment and/or reassessment done by providers during client visits. The CHCN in working with providers to standardized the process, to ensure all providers are recording in the same manner.

GAIN 2024/2025

Waitlist & Wait Times (as of May 14, 2025)	
# clients on Waitlist	Avg. Wait Time
8	3 months

Referral Sources (FY 2024/25)	
Source	# of Referrals
EMS / Police	15
GEM Nurse / ED	17
Home and Community Care	41
Hospital	25
Other GAIN Team	2
Primary Care Provider	143
Self-Referral	16
Specialist	16
Other Source	15

GAIN CGA Outputs/Outcomes

- Initiation of diagnostics/investigations (requisitions/referrals sent)
- Diagnosis/prognosis discussions
- Education (patient and family)
- Initiation of interdisciplinary team supports (i.e. BSO nurse, social work etc.)
- connection to in-home community supports (Ontario Health at Home)
- Connection to community programs (Community Care, VON adult day program, Alzheimer's Society programs like Minds in Motion etc.)
- Connection to caregiver support groups (local at CHCN or Ontario Caregiver Organization, Alzheimer Society First Link etc.)
- Advanced care planning discussions/connections with agencies to help implement PoAs etc. (i.e. Northumberland Help & Legal Centre)

***Note t**hat this area is difficult to respond as CGA outcomes vary greatly with each assessment. In general, outcomes include:

MINT 2024/2025

Assessments per Team (FY 2024/25)	
Assessment (identified by appointment type)	Appointments
Full Client Assessments	32

Assessments per Team (FY 2024/25)	
Assessments (identified/completed during visits)	Instances Recorded
Visit for Cognitive Screen	21
Visit for Functional Ability Assessment	6
Visit for General Assessment	32
Visit for Medication Review	41

MINT 2024/2025

Waitlist & Wait Times (as of May 23, 2025)	
# clients on Waitlist	Avg. Wait Time (FY 2024/25)
32	401.4 days

Note: The average wait time (as of May 23, 2025) is 12-18 months. This takes into account new clients, clients that require follow-up, and availability of appointments. For example, at this time, there is one appointment available in the July 2025 clinic, with the next available appointment after that in September 2025 clinic (approx. 4 months away).

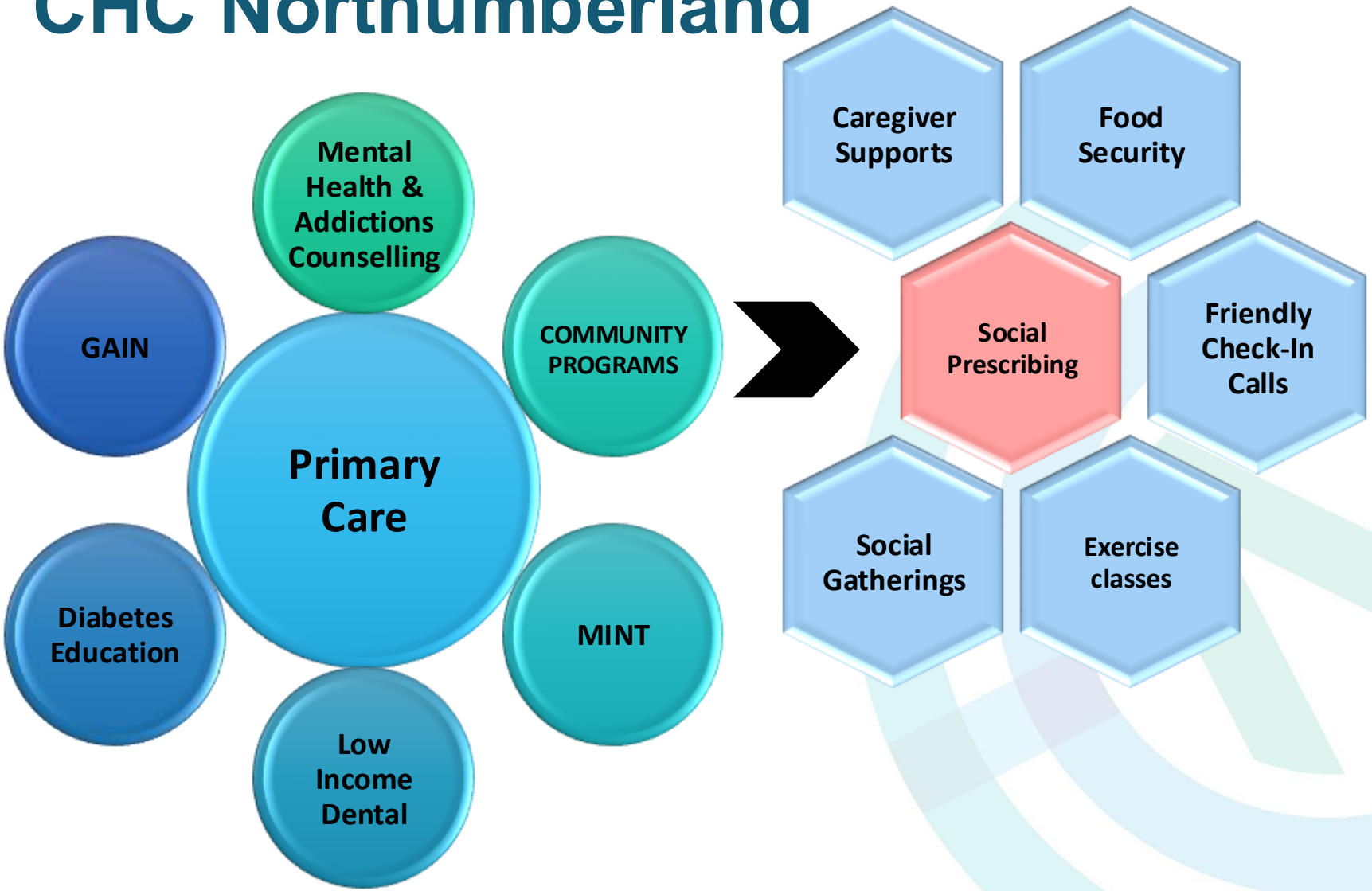
MINT Access Criteria

Broad assessment access criteria, with clients referred to the clinic who are often:

- 50 – 90 years of age
- Having/seeing/experiencing cognitive changes – the clinic often provides baseline cognitive testing

The MINT Memory Clinic tends to see less complex clients than GAIN. Triage assists in determining need and whether the client requires escalation. More often than not, it will be the GAIN team that transfers appropriate clients to the MINT team. The Clinic sees clients from a broader geographical area, as many clinics outside of the (Northumberland) area will only see clients who are part of their Family Health Team (FHT).

CHC Northumberland



Social Prescribing as a Bridge to other services

Social prescribing is a holistic approach that connects people with non-medical resources and activities to improve their health and well-being. It addresses the social determinants of health, **such as social isolation, lack of access to resources**, and **mental health issues**, by providing referrals to community organizations and programs.

WHY?

Build independence

Re-engage with community life

Enhance their overall quality of life

Social Prescribing

Connecting Seniors to Community Supports

CHCN's social prescribing program links isolated seniors with **local non-clinical services**, such as:

- Friendly visiting programs
- Exercise and wellness classes
- Arts and cultural groups
- Volunteer opportunities
- Transportation services
- Food programs

This helps reduce loneliness, increase mobility, and encourage active community participation.

Social Prescribing

Personalized Support from a Trusted Provider

Seniors are referred by their primary care provider or other health team member to a **Community Connector** who works with them to:

- Identify social needs and interests
- Set meaningful goals
- Create an action plan for engagement
- Follow up and adjust supports as needed

This one-on-one approach builds trust and ensures seniors feel heard and supported.

Social Prescribing

Improving Mental and Emotional Wellbeing

Isolation often leads to depression, anxiety, and cognitive decline. Social prescribing helps combat this by:

- Promoting meaningful social connections
- Encouraging purpose through structured activities
- Increasing self-confidence and reducing stress

Social Prescribing

Reducing Reliance on Medical Interventions

When social needs are addressed, seniors are less likely to overuse emergency services or frequent visits to the doctor. This shift:

- Improves health outcomes
- Frees up healthcare resources
- Encourages a more holistic, **wellbeing-focused model of care**

Social Prescribing

Empowering Seniors to Thrive

At CHCN, social prescribing is part of the broader **Model of Health and Wellbeing** that recognizes the **social determinants of health**. It empowers seniors to:

- Build independence
- Re-engage with community life
- Enhance their overall quality of life

Challenges

- Complexity of clients
- Limited and unstable funding (project based)
- Staffing and Capacity Constraints
- Fragmented Community Supports
- Integration and Awareness
- Measuring Impact
- Digital and Accessibility Barriers

Opportunities

- Strengthening Partnerships with Community Organizations
- Expanding the Role of Social Prescribing Navigators
- Leveraging Digital Tools and Remote Access
- Building Evidence and Case for Investment
- Enhancing Health Equity and Inclusion

Thank you!