Cowichan Seniors
Community Foundation

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What is the Cowichan Seniors Community Link Project?

First let's address Social Prescribing.

Social prescribing is most clearly defined as a mechanism for linking patients with non-medical sources of support within the community. The idea that prevention is better than cure is brought to life with social prescribing. It aids seniors with 'ageing in place', giving them a better quality of life, and in turn cuts down on their need for the health care system.

Support might include:

- Finding a suitable physical activity
- Getting nutritional support
- Learning new skills to maintain independence
- Connecting to volunteering opportunities in the community
- Finding and joining a social club
- Help with finding aid, or completing and delivering forms

Social Prescribing has been proven to be an effective means of enabling Primary Care Givers to refer patients with practical, social or emotional needs to a range of local, non-clinical services through the support of link workers. The term Link Worker is relatively new to Canada, yet has been in place for some time in other areas of the world, such as in the U.K. It refers to the role of the individual who assists clients to fill in the gaps between available services and the knowledge of the services by health care providers, connecting patients to the services, with the goal of reducing the demand on emergency health care. As the ageing population grows, this issue will be of increased concern. Link Workers provide a proactive means to lessen the demand on medical services to some degree.

The Cowichan Seniors Community Foundation has received funding by the United Way (Lower Mainland Division) to staff a Community Link Worker model to fill this gap in the communities of the CVRD. Debbie Johnson has recently been hired (Contact information below) to fill this position.

For the next 2.5 years, Community Link Worker support will be available throughout the Cowichan Valley to assist senior clients over an extended period of time (3-4 visits over a year) to develop wellness action plans that include nutritional, physical, social and medical actions to improve quality of life, with the aim of extending independent living while decreasing the need for emergency medical services. This team will also work with the Primary Care Network, the medical community, and local non-profits to identify and address client needs.

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