HealthLink
South Georgian Bay Community
Let's Make Healthy Change Happen

Overview for Physicians and Providers

Health Links bring together voluntary groups of health care providers to develop new and better ways of coordinating services for patients and local residents. Health Links are accountable to the LHIN for improving the health outcomes and experiences of the patients served in defined geographic regions with a minimum of a 50,000 population.

The South Georgian Bay Community Health Link serves the areas of Collingwood, Wasaga Beach, Clearview, Stayner and parts of Blue Mountain.

We are already working with GBFHT, SGB CHC, CGMH, NSM CCAC, Sunset Manor LTC, 211/Community Connection and Breaking Down Barriers. Others like Hospice Georgian Triangle, Bayhaven Senior Care Community and Collingwood Nursing Home, along with our volunteer group Home for Life, are also heavily involved.

Key objectives:

Do it better – do it cheaper. If we can provide a better experience, and keep our patients out of hospital, we will be moving in the right direction.
Ask the patient – and listen to them! Involve them in the planning and tailor the plan to meet their personal goals
Collaborate and work together to create a single, shared care plan with coordinated services
Ask the patient up-front, and design their care with their full participation
Look for creative ways to apply existing services to achieve a more efficient but better health experience for the patients
Assist the patient with getting the services in place
Measure patient satisfaction throughout

The first focus for all Health Links is creating personalized care plans for the five percent of patients who are the most complex and use the most health care resources (also called high users). This includes frail older adults, those with multiple chronic conditions, and people with mental health and addictions challenges.

The biggest change that's introduced by the Health Link is that the patient is assigned a Navigator, who will work with the patient to identify, put in place and coordinate all the services needed, even if they are not directly related to health care.

The Navigator will contact the patient to arrange an interview, to discuss the patient's personal goals, challenges and circumstances. From there, the Navigator will work together with the patient to come up with a coordinated plan that is tailored specifically. The Navigator will stay in contact with the patient and will review and update the care plan as needed.

Sometimes the patient's story will be presented at our Think Tank teleconference, where local providers brain-storm together to come up with suggestions to help patient's with complex circumstances to move towards their goals.