Who Would Benefit from a Referral?

People with complex needs who:

- Are not managing well, even with frequent doctor visits or repeated calls for assistance
- Are visiting the emergency department or being hospitalized frequently
- Can not get to regular office appointments, for whatever reason
- Are not getting the care and support they need

When you make a referral, the team works with you and the individual to develop and implement a coordinated care plan and keep you informed about the person's well-being.

Team members become the bridge between primary care and the home. Together, we will deliver great care.

Contact Information

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Cambridge & North Dumfries Health Link In-Home Team

Improving Care for People Living at Home with Complex Needs

The Health Links Approach

We know that just 5% of patients account for two-thirds of health care costs in Ontario. Why? Because these patients face complex medical, social, and emotional challenges and sometimes fall through the cracks.

The best way to help them is for the whole health system -- hospitals, family doctors, community organizations, agencies and other partners -- to work together to understand and meet their needs. This is the Health Links approach.

Health Links ensure that people with complex conditions:

- Have individualized, coordinated care plans based on their personal goals
- Have care providers who check in to ensure the plan is helping and make changes to the plan when needed
- Have support to ensure they are taking the right medications
- Have a care provider they can call who knows them, is familiar with their situation and can help

In-Home Teams

Four in-home care teams have been created to support the Health Links approach in Waterloo-Wellington. These interprofessional teams work with primary care and community partners to provide care at home for people who:

- Have complex chronic conditions, such as heart failure, chronic obstructive pulmonary disease, diabetes, or dementia
- Are very frail or have frequent falls
- Frequently go to the Emergency Department or are readmitted to hospital
- Are living with mental health or psychosocial challenges such as depression, anxiety, social isolation or substance abuse and need help to connect with resources

The teams provide holistic care based on each patient's situation and expressed goals. Each team has a CCAC Care Coordinator and other health care providers such as Nurse Practitioners, Physician Assistants, Registered Nurses, Social Workers, Pharmacists, and Outreach Workers.