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South West CCAC
Community Care Access Centre

CASC
Centre d'accès aux soins communautaires du Sud-Ouest

# Primary Care BULLETIN

News from the South West CCAC, your partner in home and community care.

## EMR use in the South West is on the rise – how can we support you?

The Partnering for Quality (PFQ) program has begun a study to understand how Electronic Medical Records (EMRs) are being used in primary care practices in the South West, and in turn, how PFQ can better support users.

In November, PFQ will be sending an electronic survey to all primary care practices in the South West. Participation in the survey will inform the PFQ team, and help you maximize investments in EMRs. Information from the study will contribute to the development of:

- Tailored support for EMR use that extends beyond current vendor supports
- Improved efficiency and coordination of care via the ability to match EMR use to clinical work flows
- Case studies and testimonials of EMR use within the South West
- eHealth initiatives that provide EMR users a more complete view of patients' health records beyond primary care
- A shared understanding of the current state of EMR use across the South West
- A strong user network

We look forward to your participation in the study. Please help us, so that we can help you!

**Please contact Rachel Labonté, PFQ Program Lead at rachel.labonte@sw.ccac-ont.ca with any questions or call 519-474-5675**

## South West adopts single standardized referral form


Referring a patient to the South West CCAC is now easier than ever. Simply visit

**www.sw.ccac-ont.ca > partners > south west primary care > making a referral to the CCAC**

and fill in our new, standardized referral form. The new form is standard across the entire South West region, and can be filled out online. Once completed, send it to the CCAC via your on-site care coordinator, efax, or regular fax, and a Care Coordinator will arrange to connect with the patient right away.

## Health Links work continues in the South West

Health Links is a strategy to help address the needs of the five per cent of patients who account for two thirds of all health-care costs. The strategy aims to provide these patients – who typically have multiple, complex conditions – better, more efficient care.

In our region, the Huron Perth Health Link has received its funding and is now recruiting a project team to support the implementation plan, while the London Health Link has received verbal approval and is currently awaiting its official designation.

The Elgin Health Link and North and South Grey Bruce Health Links are in the process of completing their readiness assessment documents and will be engaging with primary care, hospitals and community partners in each of these regions in order to submit their assessments this fall.

As a key partner in this work, the South West CCAC helps get patients care at home when they need it, communicates health updates to primary care physicians at key transition points in Health Links patients' journeys and provides ongoing nursing consults in the community to help complex patients avoid unnecessary visits to the Emergency Department.

# South West Intensive Home Care team

The South West Intensive Home Care team is comprised of more than 40 Registered Nurses and Nurse Practitioners who provide rapid-response nursing care to high-risk patients, as well as care to patients with chronic conditions and to palliative patients who are approaching the end of life. The team is a valuable partner to primary care providers in the provision of care to complex patients, and enables the South West CCAC to provide important services to patients via specialized roles:

- *Rapid Response Nurses* help high-risk patients get home and stay home safely by providing in-home care within 24 hours of hospital discharge. They work with primary care providers and members of the community care team to keep these patients safely at home and help reduce rates of readmission to hospital
- *Geriatric Resource Nurses* have specialized skills in the care of frail, elderly patients with complex health issues. The nurses work with primary care physicians and other health-care professionals to provide geriatric assessments through the use of comprehensive assessment tools
- *Community-based Nurse Practitioners* collaborate with primary care physicians and their teams to ensure patients receive seamless, integrated, high-quality care that contributes to positive outcomes in the community. They provide clinical oversight within their scope of practice to complex patients when access to primary care is compromised, or unavailable, or when additional intervention is needed in the community to fully support complex patients
- *Hospice Palliative Care Nurse Practitioners* offer specialized services related to palliative care and end-of-life care in the community and work collaboratively with primary care to provide hospice palliative care in the community
- *Mental Health and Addictions Nurses (MHANs)* in District School Boards in the South West work with students with mild to complex mental health and/or substance abuse issues, their family members, primary care physicians and other specialists to help students go back to school after hospitalizations and to help students and families get the support they need in the community

To connect with the South West Intensive Home Care Team, please talk to your Care Coordinator, or contact Melody Boyd at melody.boyd@sw.ccac-ont.ca or 519-377-1074.

## YOUR DIRECT CONNECTION TO THE CCAC

It is vitally important that each primary care practitioner have access to the CCAC. As such, the South West CCAC is committed to connecting 100 per cent of our primary care partners with one of our Care Coordinators by the end of this fiscal year.

Care Coordinators can act as your single point of contact with the CCAC and will visit you on a regular basis. They can help you better understand the CCAC and the referral process, and are a resource with which to discuss common patients and to work collaboratively to determine how best to help and support them. Care Coordinators can also participate in screening and early identification activities in your clinics. These connections are a fundamentally important part of offering quality, collaborative home and community care to patients.

We have been contacting our primary care partners by phone to connect them with a CCAC Care Coordinator, and will be continuing to do so over the coming months.

**If you would like to arrange for a CCAC Care Coordinator to be connected with your practice immediately, please contact**
Jennifer Frazakerley at jennifer.fazakerley@sw.ccac-ont.ca or 519-539-0901, extension 5073.