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South West CCAC / CASC
Community Care Access Centre
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

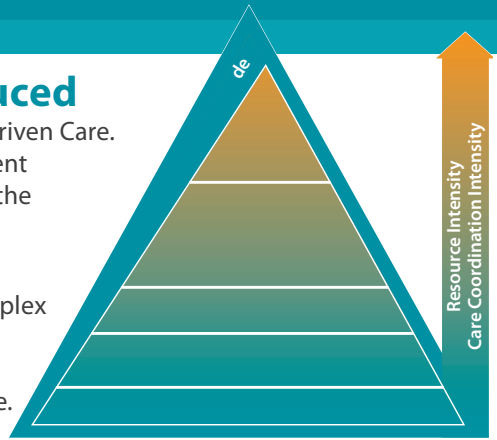
September 2012 Volume 1 Issue 1

Welcome. The South West CCAC provides home care, supports hospital discharge, arranges long-term care placement, provides access to Adult Day Programs and other community services, and much more. As Ontario develops its new Seniors Strategy we look forward to working closely with our primary care partners to improve care for our shared clients and patients. Already CCAC care coordinators are working on site in more than 100 primary care practices, and more will follow. If you'd like to have a CCAC care coordinator on site, contact Jennifer Thompson at 519-474-5675 or email jennifer.thompson@sw.ccac-ont.ca.

— Sandra Coleman, CEO

Specialized Care Coordination Introduced

The South West CCAC is implementing Population-based Client-Driven Care. CCAC care coordinators will specialize in working with specific client populations, with the most intense care coordination focused on the most complex clients and clients with chronic disease.



Among the benefits of this approach:

- Case managers will be directly involved in the daily care of complex clients and clients with chronic disease, and work closely with primary care physicians to support them at home.
- Clients and families will be empowered to manage their own care.
- More clients will be able to stay in their own homes.
- Specialized teams will provide high quality, efficient care based on their knowledge and experience.

"CCAC care coordinators are important supports to palliative patients and their families, helping them feel confident that the right resources can be marshaled to comfortably keep them at home. They are also very good at anticipating future needs and getting prepared, so that when things change, it's not a crisis."

— Dr. Joshua Shadd, a primary care physician who focuses his practice on palliative care

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To refer a patient to the CCAC:
> Connect with the care coordinator on site if you have one
> Call 310-2222
> Fax a referral form (available at www.sw.ccac-ont.ca > Partners > Primary Care)

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Home First Update

Alice, 86, fell in May and fractured her left shoulder and pelvis. She was in hospital until July and might have waited longer for placement in a long-term care home. Thanks to the Home First approach and an enhanced CCAC service plan, Alice was able to go home before making any decisions about her future.

> The CCAC offers up to 24-hour home care while clients settle in at home.
> Only one-third of Home First clients move on to long-term care.

The program is now available for patients being discharged from London Health Sciences Centre, St. Thomas Elgin General Hospital, Tillsonburg District Memorial Hospital, the Grey Bruce Health Services Owen Sound site and will soon be launched in Woodstock and Ingersoll.

OHIP Billing Codes when working with CCAC

> K070, K071, K072 for CCAC referral and home care supervision
> K124 for case conferences
> K038 for completion of long-term care health report

STAY IN TOUCH Check out information resources and sign up for our email alert service at **www.sw.ccac-ont.ca > Partners > Primary Care**.