

South East
Community Care Access Centre



Centre d'accès aux soins communautaires
du Sud-Est

Partnerships in Primary Health Care

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What is the SE CCAC and what do we do?

- We provide and coordinate home and community health care services to 10,000 clients across the South East on any given day and to over 26,000 in any year.
- In addition to home care services, we act as a connector and navigator in the health care system by assisting clients and providers to get the right care at the right place and time.
- We perform this connector / navigator role in many ways by having a presence in hospitals and primary care settings, and by providing a consumer access point to information and referral services by web and by phone.

How do we relate to Primary Health Care?

- We are by the nature of our work part of the Primary Health Care system in the South East and need to work in relationship with family physicians and others to be successful.
- We are particularly focussed on the care of the frail and vulnerable in our communities – most of these people live with multiple and complex chronic diseases.
- Research and experience shows us that we can be most effective by partnering with others.

How would CCACs and FHTs work together?

- Early identification of patient issues
- Mobilization of community resources
- Rapid response to changing patient needs
- Chronic disease management support
- Enhanced and coordinated end-of-life care
- Emergency department and acute care admission avoidance

Components of the Model

- On site dedicated case management
- Matching of case manager to physician caseloads to build trusting relationships
- Face to face communication with physicians and patients
- IT connectivity to CCAC data through secure remote web access
- On going monitoring and feedback to physician
- Collaborative work processes with members of the FHT

Observed Outcomes of CCAC Case Manager – FHT Partnerships

- Successful and sustained collaborative relationships with improved communication
- More efficient use of physician time from working with one primary case manager
- More appropriate and efficient use of health care system resources
- Enhanced case management of patients
- Improved patient outcomes (e.g. health, wellness, and self-management)
- Increased patient satisfaction
- Enhanced information management

The federally funded “National Home Care and Primary Health Care Partnership in Practice Project” demonstrated the following results:

- *“Reorganizing home care case managers to align with family physicians makes sense, can happen quite easily and is not costly. It enables the effective leveraging of both physician and case manager competencies to the patient’s benefit and the provider’s satisfaction.”*

“Without exception, physicians who have worked in partnership with a home care case manager do not want to revert back to the traditional relationship.”

CCAC Work in Progress

- The CCAC is currently completing work on a consumer and provider web portal that will provide information on the health and related services available in the South East. We have dedicated the necessary resources to keep this up to date and to grow its functionality.
- We are in the middle of consolidating our multiple access points across the South East into a single call centre (one 1-800 #) which consumers and providers will call to get information and referral services across the South East. Consumers will also receive system navigation services and access to home care services through this access point.
- We are increasing our hours of availability in hospitals and hospital ERs.
- We are currently actively working with three FHT in the South East to establish the collaborative model. In addition, discussions have begun with other FHTs and CHCs.