Access to Care
Frequently Asked Questions
September 26, 2012

1. **Do the Access to Care recommendations consider the transportation requirements for such a large geographical area?**

   There are no specific transportation recommendations. Some geographic areas in the South West have been able to support transportation initiatives already. Health Care Organizations and South West LHIN staff members are monitoring these initiatives in order to understand what future opportunities there may be. One planning initiative in the South West is evaluating non-urgent transportation of patients between health care agencies. The goal will be to create consistency in both funding and access for this service. Travel time and transportation will be taken into account as final recommendations on CCC/Rehab services are completed.

2. **Where does Home at Last (HAL) fit into the Home First Program as it includes transportation and settling in?**

   Home at Last is a one of the services available for clients going home from hospital. It includes making sure your home is safe, getting fresh groceries, having prescriptions filled, etc. This is one of the services that CCAC case managers in hospital would be using in order to help seniors at risk of complex discharge get home.

3. **How will palliative care be integrated into the Access to Care initiative?**

   There is work ongoing with end of life care providers in the South West that dovetails with Access to Care, but it is not the central focus under the Access to Care initiative. Some clients who have been supported to go home on the home first initiative do become palliative, so supports need to be in place. This is organized on an individual client basis with their CCAC case manager. There is also broader end of life work happening in the South West to support best practice in end of life care.

4. **What programs are in place with this strategy to provide support for the client's caregiver?**

   CCAC case managers are identifying caregivers' needs when assessing and working with clients who are going home. We are planning to interview caregivers as part of our evaluation to ensure we are planning for the support that they need. The increases that are being recommended in adult day program spaces are intended to provide relief to caregivers when their family member is attending the program for the day.

5. **Best practice for specific populations such as those who have suffered a stroke, indicate that a minimal critical mass is needed to maintain the professional expertise these patients require. How will this be enabled in the small units that are included in the recommendations?**

   When the recommendations on realignment of services were developed there was an attempt to strike a balance between critical mass for maintaining professional expertise and the distance people would need to move for services.

6. **Have you considered the possibility of "grandfathering" in existing assisted living clients that do not meet the new Provincial criteria?**

   Any transition of assisted living clients would be done on an individual client by client basis with clients and their caregivers. Clients would not be moved out of a service if an appropriate alternate was not available. If there is an opportunity to transition the client to other services without having a negative impact on the client, then the change in service would be implemented so that other clients can access assisted living services.

7. **Can you speak to creative ways that we could be applying the assisted living model to persons with dementia who desire to remain in their homes?**

   In the Access to Care Assisted Living/Supportive Housing and Adult Day Program Report, there is a recommendation on the development of hub models and how groups of people might best benefit from assisted living. Organizing the services in a hub model would provide the flexibility to be able to serve people with dementia challenges in their own home. We are also exploring what populations might benefit from electronic monitoring in their homes and those with dementia may be one of those groups.

8. **How do people living with persistent mental illness fit into Access to Care?**

   The Access to Care initiative has focused on seniors and adults with complex needs. There is work ongoing with mental health providers in the South West that dovetails with Access to Care, but it is not the central focus under the Access to Care initiative. Please see the mental health and addictions capacity plan report on the South West LHIN website (add in link). This report has information on services currently available for individuals with mental health and addictions challenges and identifies areas where further capacity should be developed.

9. **Is there a process outlined to adjust the accountability agreements of hospitals that may see an increase or decrease the number of CCC/Rehab beds they will be operating?**

   During the fall of 2012 a financial and human resource impact analysis will be completed in partnership with hospitals to understand the impact to organizations of proposed realignment recommendations. Once recommendations on where CCC/Rehab services will reside in the South West, individual Hospitals and South West LHIN staff will work together to finalize any changes to accountability agreements.

10. **Where can we access more information about the Access to Care initiative?**

    Access to Care has a page on the South West LHIN website that is updated regularly with new information. If you are interested in receiving regular electronic newsletters, please contact Andria Appeldoorn at Andria.Appeldoorn@sw.ccac-ont.ca.