60 Renfrew Drive, Suite 300
Markham, ON L3R 0E1
Tel: 905 948-1872 • Fax: 905 948-8011
Toll Free: 1 866 392-5446
www.centrallhin.on.ca

Date: June 29, 2015

MEMORANDUM

To: Providers of Hospice Palliative Care Services in Central LHIN

From: Georgina Veldhorst
Senior Director, Planning, Integration and Community Engagement
Central Local Health Integration Network

RE: Amended Call for Pre-Proposal Expressions of Interest
Integrated Hospice Palliative Care Services (RFP # - HPC_1_15-16)

The following amendments have been made to the Call for Pre-Proposal Expressions of Interest Integrated Hospice Palliative Care Services (RFP # - HPC_1_15-16) originally issued on June 12, 2015:

On page 2, in Section "Objectives & Criteria"

- **Removal of "Pain and symptom management" from the list of specialized hospice palliative care services**
- **Change of "Palliative care education" to "Education" in the list of specialized hospice palliative care services**

On page 3, in Section "Objectives & Criteria"

- **Changed item "Leverage existing Central LHIN resources (such as Central registry and single crisis line for hospice palliative care) to provide and/or deliver services" to "Leverage existing Central LHIN resources (such as Central registry and single crisis line for hospice palliative care; pain and symptom management providers; palliative care education providers) to provide and/or deliver services".**

On page 5, in Section "Expression of Interest"

- **Changed item "The purpose of this call for Expressions of Interest is to identify those hospice palliative care service providers with the interest and commitment to provide integrated services. A full Request for Proposal (RFP) will be issued in late July" to "The purpose of this call for Expressions of Interest is to identify those hospice palliative care service providers with the interest and commitment to provide integrated services. A full Request for Proposal (RFP) will be issued in early October".**
- **Changed the proposal submission deadline from 12 pm on Friday, July 10 2015 to 12 pm on Friday, August 21, 2015**

Addition of Appendix B "Health Equity Impact Assessment" template following Appendix A

In support of the Central LHIN's (LHIN) 2013-16 Integrated Health Service Plan (IHSP), the LHIN is requesting expressions of interest from current providers (Health Service Provider - HSP and/or non-HSP) of hospice palliative care services to deliver an integrated basket of hospice palliative care services as articulated in the Central LHIN Hospice Palliative Care Action Plan (See Appendix A) for the Region of York at a minimum, while simultaneously maintaining local community presence and engagement.

Background

In December 2011, the report, *Advancing High Quality, High Value Palliative Care in Ontario, Declaration of Partnership and Commitment to Action* (the "Declaration") was released by the Ministry of Health and Long-term Care (MOHLTC). The Declaration was agreed to by all LHIN CEOs with a common vision for palliative care in Ontario. The vision statement is as follows.

> "Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to help them live as they choose, and optimize their quality of life, comfort, dignity and security."

On May 31, 2011, the Central LHIN Board of Directors approved a motion to request a plan and structure from the Central LHIN Hospice Palliative Care Network to integrate the coordination and delivery of hospice palliative services in Central LHIN with a mandate to:

1. Optimize available resources
2. Promote the implementation of best practices among providers
3. Enhance equitable access

In July 2014, the Central LHIN Regional Hospice Palliative Care Program Council (RHPCPC) submitted their final recommendations for service change based on the Declaration. The following RHPCPC recommendations are relevant with respect to integration of services:
Offer a consistent basket of services and supports to patients throughout the region that can be customized based on individual needs

1. Adopt the proposed Central LHIN Hospice Palliative Care Model including centralized elements, service delivery hubs and communities of care
2. Implement appropriate intensity of care coordination and system navigation based on the needs of patients, families and caregivers by strengthening existing programs
3. Increase options in the continuum of care that support death in place of choice.
4. Leverage current partnerships and integration opportunities to optimize the patient-centred approach and efficient delivery of care and supports.
5. Implement a patient-centred approach that minimizes the number of individual providers and staff providing care

The Model recommended by the RHPCPC includes the establishment of hospice palliative care hubs that offer a full range of services to support coordinated care aligned with the vision outlined in the Declaration.

The impending opening of the MOHLTC funded residential hospice in York Region at Southlake Regional Health Centre presents a unique, and time sensitive opportunity to explore integration of

palliative care hospice services by agencies providing hospice services in the Central LHIN. The designated residential hospice beds are targeted to be operational by February 2017. MOHLTC approved funding for home care services provided in residential hospices is funded from the LHINs through the appropriate Community Care Access Centre (CCAC). All other costs associated with the operation of the residential hospice must be borne by the hospice, offset by fundraising or other mechanisms.

Objectives & Criteria

The Central LHIN currently has numerous hospice palliative care providers, many of whom are not HSPs. The Central LHIN is seeking Expressions of Interest from current providers of hospice palliative care services with capacity to provide a full basket of integrated hospice palliative care services to the residents of the York Region at a minimum, in a manner that provides consistency and continuity of care. There may be funding available from Central LHIN to support voluntary integration activities of a group of providers submitting as a consortium that is successful in the resulting RFP process.
The successful entity would be expected to meet the following objectives:

- Provide high quality, evidence-informed specialized hospice palliative care services to eligible clients in York Region including but not limited to:
    - Visiting Hospice services,
    - Case management,
    - Care Coordination and Navigation,
    - Advanced Care Planning,
    - Grief and Bereavement Support,
    - Caregiver Support,
    - Psychosocial and Spiritual Support,
    - Volunteer management, including training,
    - Education, and
    - Residential Hospice services
- Provide the majority of the basket of services directly in order to maximize consistency and continuity of service and value for money;
- Work in partnership with Southlake Regional Health Centre in the establishment of a 10 bed residential hospice;
- Enter into an accountability agreement with the Central CCAC for residential hospice services;
- Raise sufficient funds annually to cover the operation of a 10 bed residential hospice (estimated at $700,000 annually);
- Provide equitable access to agreed-upon services of consistent quality across York Region while supporting local community involvement;
- Be responsive to diverse languages and cultures;
- Improve efficiency and effectiveness (e.g. avoid duplication, lower cost, faster/better service) of service delivery;

- Leverage existing Central LHIN resources (such as Central registry and single crisis line for hospice palliative care; pain and symptom management providers; palliative education providers) to provide and/or deliver services.

Central LHIN Planning & Decision Making Approach.

Evaluation Framework	
Criteria	Weight
Sustainability: Impact on health service delivery, financial, and human resources capacity over time. The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs. Proposals will be evaluated on ability to leverage existing infrastructure, including services, volunteers, donor base and clinical expertise to serve target population to maximize the sustainability of the service with potential to for future growth. Proposals must demonstrate evidence of sustainable fund-raising capacity of a magnitude to support residential hospice operations	10%
Quality: Extent to which program/initiative improves safety, effectiveness, and client experience of health services(s) provided. Providers will be evaluated on the demonstrated track record of success of the partners serving the specific population. Proposals will be evaluated on the incorporation of existing standards and evidence informed practices in current and proposed service delivery; demonstrated expertise in serving the target population; the proposed impact of the service delivery model on safety, effectiveness and client experience.	13%
Access: Extent to which program/initiative improves physical, cultural, linguistic and timely access to appropriate level of health services for defined population(s) in the local health system. Proposals will be evaluated on the degree to which the proposed basket of services enables improved and timely access to a full continuum of specialized hospice and palliative care services for the citizens of York Region.	12%
Equity: Impact on the health status and/or access to service of recognized sub-populations where there is a known health status gap between this specific population and the general population as compared to current practice/ service. The absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, culturally, linguistically or geographically. Proposals will be evaluated on the degree to which the Region of York will be equitably served and considering the completion of a Health Equity Impact Assessment (Appendix B).	13%
Efficiency: Extent to which program/initiative contributes to efficient utilization of clinical, financial, and human resources capacity to optimize health and other benefits within the system. Proposals will be evaluated on the degree to which integration of service delivery will be achieved and will enable reinvestment of resources to improve service capacity and; the ability to leverage existing infrastructure, services, volunteers and expertise to maximize the value for money.	12%
Client-Focused: Extent to which program/initiative meets the health needs of a defined population and the degree to which patients/clients have a say in the type and delivery of care.	15%

Proposals will be evaluated on a demonstrated pattern of engagement of clients in service delivery planning and evaluation, the degree to which care continuity can be achieved for clients with existing services and the capacity to provide services in a manner that reflects the efficiency of centralized resources while respecting the localized community cultures and areas through York Region.	
Partnerships: Degree to which appropriate level of partnership and/or appropriateness of partnerships will be achieved in order to ensure service quality enhancement, improved comprehensiveness, optimal resource use, minimal duplication, and/or increased coordination. Proposals will be evaluated on the degree of integration of service delivery achieved, the ability to provide a full basket of palliative services in the future, including the ability to provide the majority of the basket of services directly to support consistency and continuity, the degree to which existing resources/partnerships will be leveraged in the delivery of service and the degree to which a local presence will be maintained.	9%
Community Engagement: Level of involvement of target population and other key stakeholders in defining the project and planned involvement in evaluating its impact on population health and key system performance. Proposals will be evaluated on the degree of engagement of impacted communities within York Region in the development of the proposal and the proposed client and community impact evaluation plan. The proposal will also be evaluated on the degree to which local stakeholders will be engaged on an ongoing basis into the future.	9%
Health Status - clinical outcomes & quality of life: Impact on health outcomes for the patient/client, including risk of adverse events, and/or impact on physical, mental or social quality of life, as compared to current practice/ service. Proposals will be evaluated on the outlined capacity to leverage collaborative inter-professional resources to support patients and their caregivers throughout their palliative care journey including post-mortem grief and bereavement services through the use of an integrated, individualized client care plan.	7%

Expression of Interest

- The purpose of this call for Expressions of Interest is to identify those hospice palliative care service providers with the interest and commitment to provide integrated services. A full Request for Proposal (RFP) will be issued in early October. Organizations responding to the RFP as part of a group proposing to merge or amalgamate and integrate services will be required to submit Board resolutions demonstrating commitment to merge or amalgamate from each of the participating organizations.
- In the submission form provided, please provide a brief description of your organization or each of the participating organizations and the current capacity to meet each of the requirements and/or the capacity to expand services to meet the requirements should you be selected a provider of integrated hospice palliative services in the future.

Please include a copy of your most recent Certificate of Accreditation, if available. The signatures of your organization's or each participating organization's CEO/Executive Director and Board Chair are required

on the proposal. The submission must be a single submission with one organization identified as the proposal process lead.

The successful proponent of the resulting RFP must apply for Health Service Provider (HSP) designation with the Central LHIN, if not currently designated as such and must attain appropriate accreditation within the first 18 months of operations if not currently accredited.

Please note that current Central LHIN hospice palliative care HSPs may have funding reassessed as a result of this process.

Questions related to the submission of proposals should be addressed to Barbara Jones, Senior Lead—Quality and Integration at barbara.jones@lhins.on.ca **by 1700 hrs on June 19, 2015**.

A Q&A teleconference will be held on **June 26, 2015 from 1000 hrs - 1100 hrs** to address questions received. **The teleconference phone number is 416 406-5763 or 1 866 596-5280, participant code 8062078#.**

All proposals must be submitted to Karen Blackley (karen.blackley@lhins.on.ca) at the Central LHIN by email no later than **12:00 p.m. on Friday, August 21, 2015,** using the attached form.

All respondents will receive a reply regarding their submission. The RFP will be directed only to those agencies that successfully pass the EOI qualifications. Successful respondents will be consulted before an RFP is issued.

Thank you for your continued efforts to address health service needs in the Central LHIN.

Sincerely,

Georgina Veldhorst
Senior Director, Planning, Integration & Community Engagement

Central LHIN

Integrated Hospice Palliative Care Services
(RFP # - HPC_1_15-16**)**
Appendix A

Regional Hospice Palliative Care Model Action Plan

Approved October 28, 2014

Ontario Local Health Integration Network

Advancing High Quality, High Value Palliative Care in Ontario Declaration of Partnership and Commitment to Action

- Collaborative effort of over 80 stakeholders from across Ontario
- Vision:

  Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to help them live as they choose, and optimize their quality of life, comfort, dignity and security.
- All LHIN CEOs signed off in December 2011

Key Elements to Achieve the Vision - Declaration

1. Broaden **access** and increase timeliness to access
2. Strengthen **caregiver supports**
3. Strengthen **service capacity** and human capital in all care settings
4. Improve **integration and continuity** across care settings
5. Strengthen **accountability** and introduce mechanisms for shared accountability
6. Build public **awareness**

Central LHIN Approach

Declaration of Partnership as Roadmap

Current State: Facts about Death in Central LHIN

- **6/10** deaths are from chronic progressive diseases
- Deaths in Central region
  - **49.1%** in acute care
  - **23.3 %** at home
  - **12.7 %** in LTC
  - **14.9 %** in complex continuing care, EDs, rehabilitation facilities
- **25%** LTC residents died in an ED or acute care bed

Sources: *Palliative Care in Ontario Report – Jan 2013 update, Health Analytics Branch

- CIHI DAD database (2011/2012) – ICD- 10CA code Z51.5
- **CIHI – DAD and CCRS database (2012/2013)

Current System Challenges: Engagement Feedback

- Inadequate or inequitable access to integrated, comprehensive, high quality care
- Lack of public communication
- Inadequate caregiver support
- Limited and inequitable service capacity across all care settings
- Lack of system integration
- Lack of clear accountability

Recommendations for System Change in Central LHIN

Broaden access and increase timeliness to access

1. Central point of access
2. One Number for crisis end of life support
3. Identification of individuals for hospice palliative approach to care
4. Offer consistent basket of services

Strengthen caregiver supports

5. Adopt the proposed Central LHIN Hospice Palliative Care Model
6. Implement collaborative and consultative models
7. Strengthen care coordination and system navigation

Recommendations for System Change in Central LHIN

Strengthen service capacity and human capital

8. Strengthen primary/generalist care service model
9. Implement education strategy
10. Support death in a place of choice
11. Strengthen long-term care homes capacity

Strengthen accountability and shared accountability

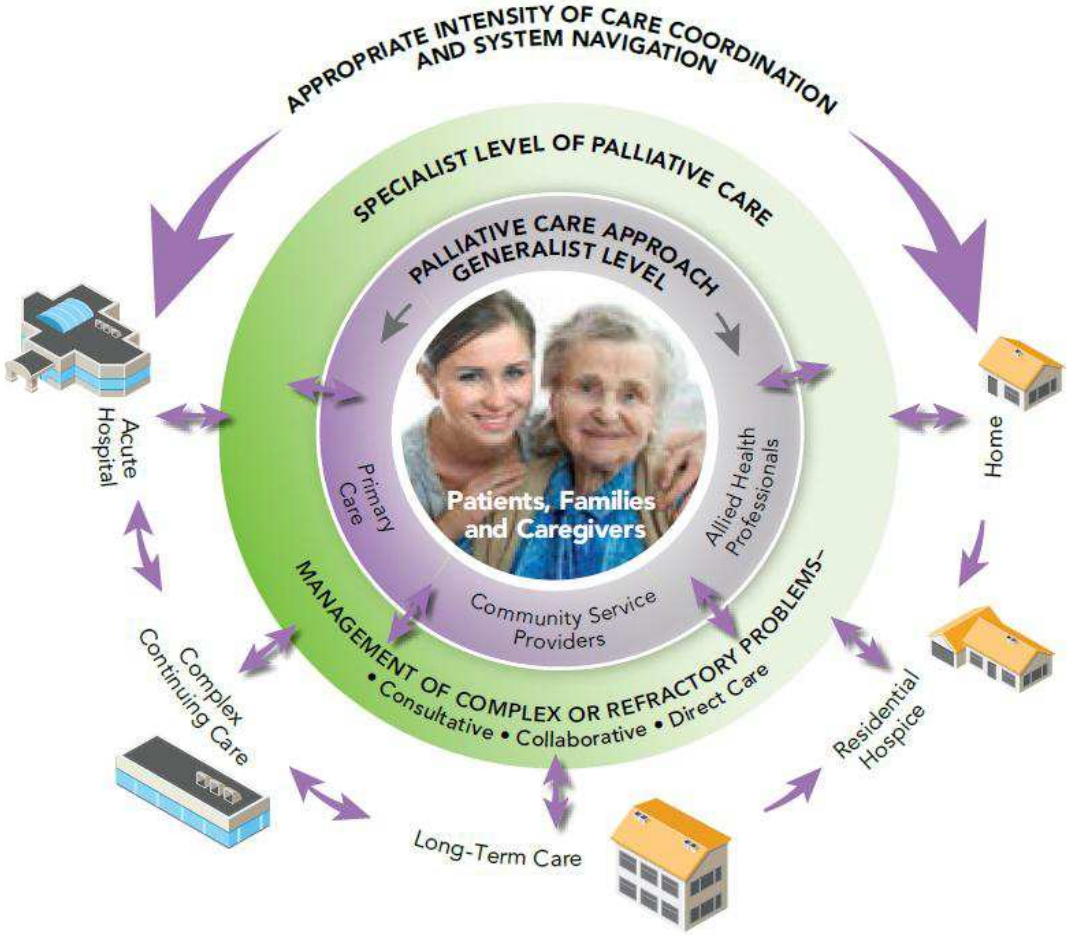
12. Leverage current partnerships and integration opportunities
13. Minimizes the number of individual providers providing care
14. Adopt provincial system data and performance indicators

Future State: Palliative Care Model for Central LHIN

The future model includes centralized, standardized and consistent elements that support integrated and coordinated care delivery by providers working in local communities.

- Communities of Care
- Centralized and Common Elements
- Hospice Palliative Care Hubs

Palliative Care Model: Communities of Care



Palliative Care Model: Centralized and Common Elements

Centralized elements

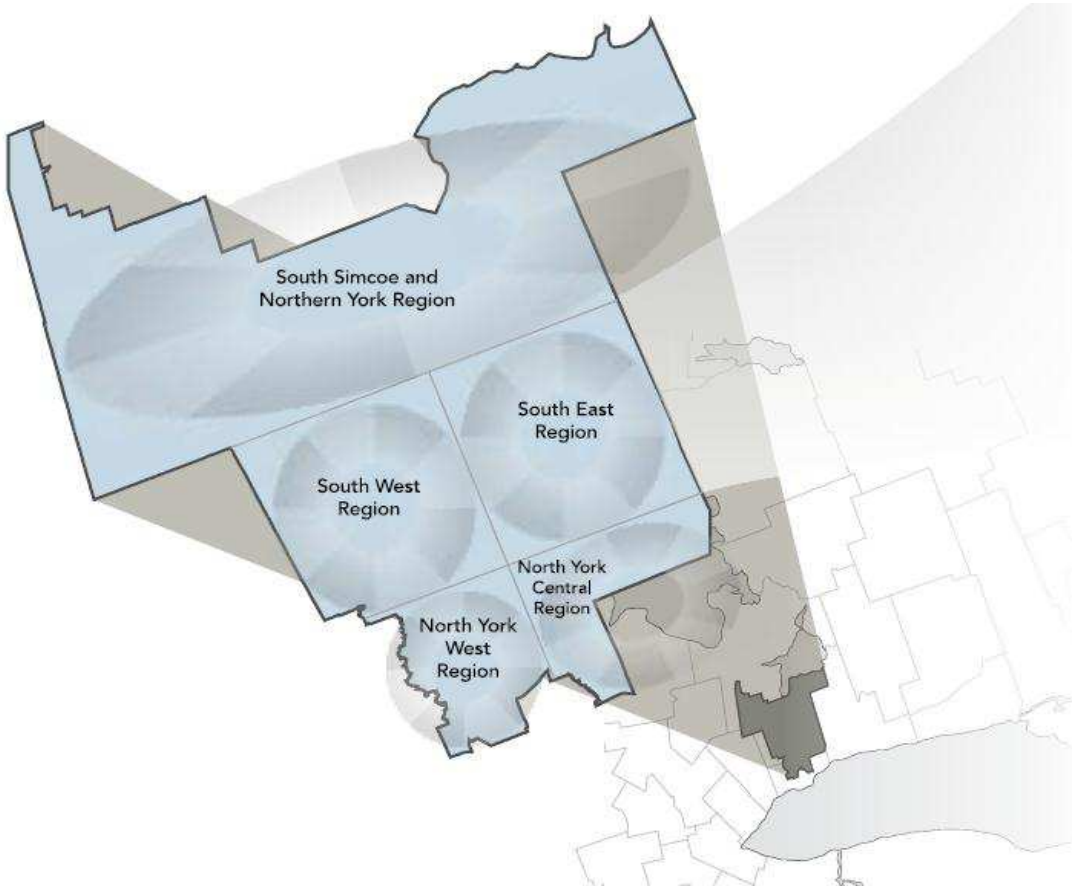
- Central point of access system for hospice palliative care services and placement
- One phone number for end of life support and crisis avoidance for patients / families
- Triaging care delivery
- Education programs

Common elements

- Early identification tools and standardized resources
- Hospice palliative care delivery by primary care providers supported by secondary experts in all care settings
- Enhanced care coordination and navigation
- Palliative care programs within every setting of care
- Consistent and equitable access to services
- Bereavement / family support
- Diversity and cultural competencies

Palliative Care Model: Hospice Palliative Care Hubs

Aligns with Central LHIN Health Links



Hub Components

- Goals of care and advance care planning
- Pain and symptom management
- Medical management and interventions
- Community support services
- Psychosocial and spiritual support
- Appropriate intensity of care coordination and navigation
- Home-like inpatient care options
- Grief and bereavement services

What Would Change for Patients, Families and Caregivers?

Change	Key Elements
Equitable and timely access for all	Access
Improved quality of life and symptom control	Capacity
Appropriate level of care based on patient-centred collaborative care plan	Integration and Continuity
Tertiary acute care when required	Integration and Continuity
Caregivers are supported	Caregiver support
Families/substitute decision makers know patient wishes	Capacity, Public Awareness
Patients die in preferred place	Capacity

Draft Action and Implementation Plan

Priority	Item	RHPCP Council Recs	Resp.	Sequencing
1	Central Point of Access for Palliative Care including system access, a resource and bed registry and system navigation	1,7,10,11, 13	CCAC with implementation task forces	Phase 1
2	Single number for Crisis and Related Protocols, including protocol development and implementation	2,11	Telehealth Advisory Service (THAS) (link to primary care, CCAC, specialists, Hospice Palliative Care Teams)	Phase 1

Draft Action and Implementation Plan

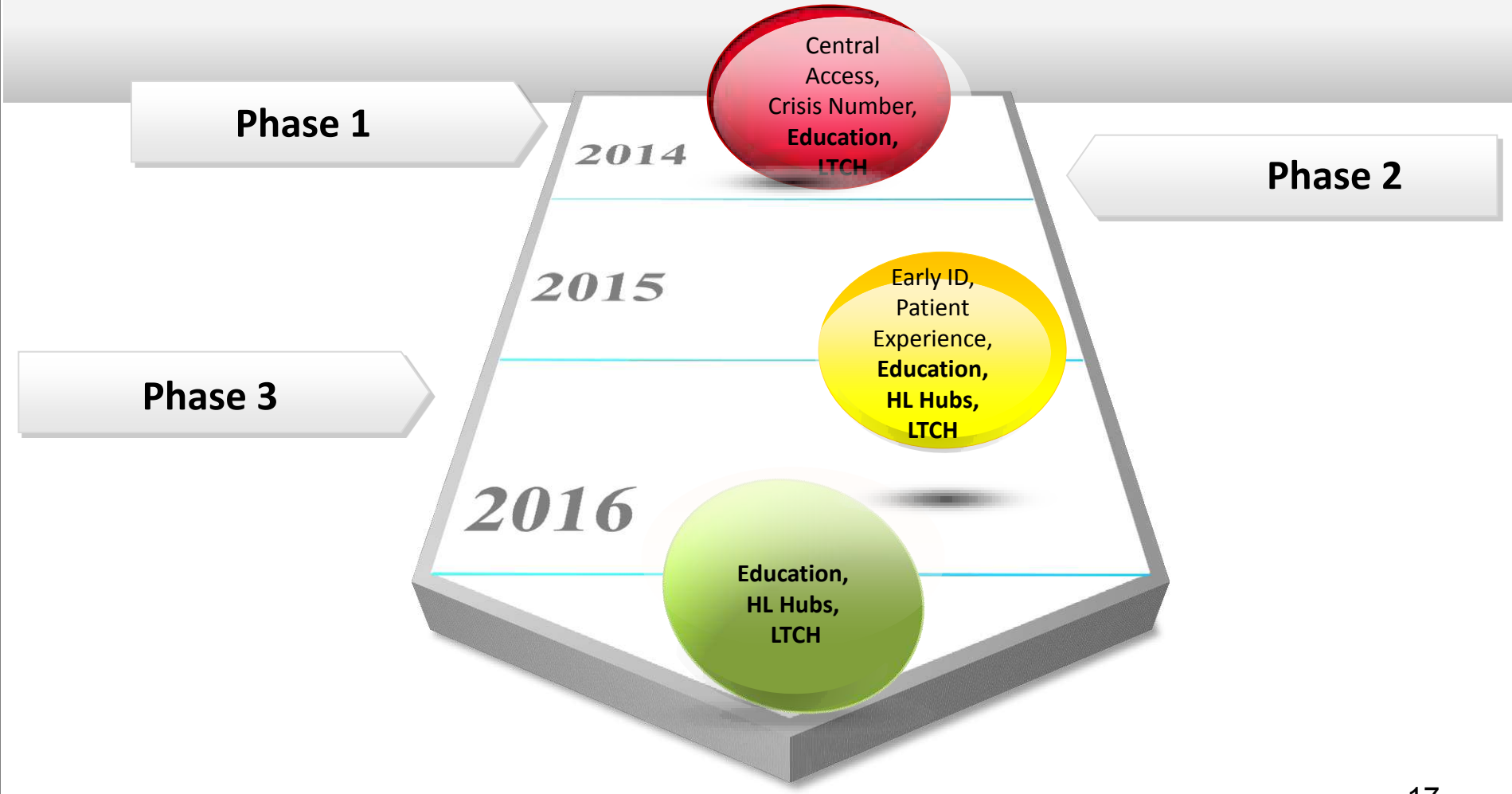
Priority	Item	RHPCP Council Recs	Resp.	Sequencing
3	Strengthen generalist and specialist capacity through education and standardized tools for providers in all care settings, including primary care Early identification and triage - Implement UK Gold Standard framework in all care settings	3,8,9,10,11	CLHIN - RFP	Phases 1,2&3

Draft Action and Implementation Plan

Priority	Item	RHPCP Council Recs	Resp.	Sequencing
4	Implement service delivery hubs aligned with the Health Links regions	4,5,6,10,11,12,13, 14	CLHIN - RFP	Phases 2&3
5	Implement Patient experience surveys in all settings (e.g. VOICES)	13	TBD	Phases 2&3
6	Strengthen LTC capacity to deliver Hospice Palliative Care according to the Declaration through crisis support, education and linkage to the hubs	11		Phases 1,2&3

Draft Action and Implementation Plan Sequencing

2014-2016



HEIA

Health Equity Impact Assessment

APPENDIX B

HEIA is a flexible and practical assessment tool that can be used to identify and address **potential unintended health impacts** (positive or negative) of a policy, program or initiative on specific population groups.

Note: The *HEIA Template* is designed to be used alongside the accompanying *HEIA Workbook*, which provides definitions, examples and more detailed instructions to help you complete this template.

Date:	
Organization:	
Name and contact information for the individual or team that completed the HEIA:	
Project Name:	
Project Summary:	
Objective for Completing the HEIA: (e.g., to determine where to best invest resources in a new policy, program, or initiative?)	
Note: This section to be filled in after completing the following HEIA template.	
Conclusions: (e.g., what decisions were made following completion of the HEIA tool?)	

HEIA Template

The numbered steps in this template correspond with sections in the HEIA Workbook. The workbook with step-by-step instructions is available at www.ontario.ca/healthequity.

Step 1. SCOPING		**Step 2. POTENTIAL IMPACTS**			**Step 3. MITIGATION**	**Step 4. MONITORING**	**Step 5. DISSEMINATION**
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

*Note: The terminology listed here may or may not be preferred by members of the communities in question and there may be other populations you wish to add. Also consider intersecting populations (i.e., Aboriginal women).

Ontario