INTEGRATED CLIENT CARE PROJECT

ICC Project Evaluation Request for Proposals (RFP)
Integrated Client Care Project: Wound Care Evaluation Guidelines & Application

Issue Date: Tuesday January 19, 2010

Submission Deadline: Monday February 15, 2010

Closing Time: 5:00 pm (EST)

Prepared by:

Aging at Home Evaluation Project Management Office
Institute for Clinical Evaluative Sciences
2075 Bayview Avenue, G1 06
Toronto, ON   M4N 3M5
(416) 480-6091

TABLE OF CONTENTS

1.0 Introduction

2.0 Background and Purpose

- 2.1 Wound Care Early Implementation Site Terminology
- 2.2 Description of Program to be Evaluated: Wound Care
- 2.3 Implementation of the Early Implementation Site Model
- 2.4 Purpose of the Wound Care Evaluation
- 2.5 Evaluation Deliverables
- 2.6 Minimum Requirements
- 2.7 Collaboration Requirements
- 2.8 Timelines
- 2.9 Funding

3.0 Table – Outline of RFP Process

- Evaluators' Pre-Proposal Conference Call: January 26, 2010 at 10:00 am
- Proposal Deadline: February 15, 2010 by 5:00 pm
- RFP Changes or Amendments
- Aging at Home Expert Review Panel Evaluates Proposals: February 17 – March 10, 2010
- Final Evaluator Selection: March 10 – 24, 2010
- Finalize Contract: March 25 – 31, 2010
- Contract Approval: April 15 – 29, 2010

4.0 Application Process

- 4.1 Format and Deadline
- 4.2 Guidelines

5.0 Research Ethic Board Approvals

6.0 Review Process and Eligibility Criteria

- 6.1 Eligibility

7.0 Monitoring, Performance Measurement and Evaluation

8.0 Terms of the Award

9.0	Appendix 1 – Detailed MOHLTC and CCAC Would Care Evaluation Interests
	Appendix 2 – Overview of Key Wound Care Early Implementation Site Evaluation Activities and Timelines
	Appendix 3 – Key Indicators of Success

ICC STRATEGY EVALUATION – WOUND CARE EVALUATION

KEY DATES	
January 19, 2010	RFP release date
January 26, 2010	Pre-proposal conference call
February 15, 2010	RFP submission
March 24, 2010	Notification of successful applicant

1.0 INTRODUCTION

On December 15, 2008, the Minister of Health and Long-Term Care announced the ‘Strengthening Home Care Services in Ontario’ Strategy. One component of the Strategy seeks to promote better health outcomes for Ontarians through an Integrated Client Care Project. The Integrated Client Care (ICC) Project is a multi-year initiative introduced to test new, more integrated models of care in a number of sites across Ontario. The ICC Project is sponsored by the Ministry of Health and Long-Term Care (MOHLTC), the Ontario Association of Community Care Access Centres (OACCAC) and the Collaborative for Health Sector Strategy at the Rotman School of Management, University of Toronto. The Project unites Community Care Access Centres (CCACs), service providers and health sector stakeholders in developing, implementing and evaluating a value-based model of care that is organized around clinical conditions with the goal of improving health outcomes for clients. Additional details about the project are available at the ICC Project website (www.ccac-ont.ca/icc).

The ICC Project stems from research suggesting that more integrated approaches to care result in better health outcomes and more cost-effective care overall. The goal of the evaluation is to study the client and system impacts of integrating care and the policies required to support the transition to an integrated client care model.

Early evaluation sites will be implementing a client-centred approach to organizing service delivery either according to specific clinical conditions or client care groupings. The first clinical grouping in the ICC Project to be implemented is wound care. Wound care early implementation sites are designed to improve integration of the necessary services for individuals with venous leg wounds and diabetic foot ulcers who are receiving care through this CCAC Project. The scope of change focuses on improving the wound care provided by CCAC contracted service providers within CCAC service baskets. Ultimately, using a continuous quality improvement approach, the early implementation sites seek to improve the quality and outcome of care for wound care clients. Wound care early implementation sites are expected to be implemented in one or more CCACs beginning in April 2010. A full description of the evaluation framework developed for the wound care client grouping is available at http://www.ccac-ont.ca/Upload/on/General/ICCP/ICCP_Evaluation_Framework_Final.pdf

The purpose of this request for proposals is to select an evaluator or evaluation team to assess the implementation of the CCACs' wound care early implementation sites in relation to the ICC Project's objectives.

2.0 BACKGROUND AND PURPOSE

2.1 WOUND CARE EARLY IMPLEMENTATION SITE TERMINOLOGY

There are five key terms relating to the Wound Care Project that warrant defining for the sake of clarity.

1) **Wound care early implementation site** refers to a participating CCAC, a lead provider and an integrated multidisciplinary team that is implementing or intends to implement new service delivery models for CCAC wound care clients. While the early implementation sites will likely include acute care clients, clients considered for evaluation will be clients requiring long stay or maintenance wound care services. Wound care models will incorporate the new integrated care design elements defined by the ICC project team (see Appendix 1). There are four ICC early implementation sites. The project team and CCACs are currently involved in a process where they will identify primary service providers and their multidisciplinary team by the end of February 2010. The number of sites for implementation may vary across the four different CCACs.
2) **ICC wound care delivery model** refers to the new integrated care design elements defined by the ICC project team.
3) **Multidisciplinary team** refers to the team of service providers which is established by the primary service provider to deliver care specific to the clients needs.
4) **Phase 1: Implementation stage** refers to the initial planning and development phase undertaken by CCACs, primary service provider and their multidisciplinary teams. The implementation stage ends when all of the elements comprising the new integrated delivery model are successfully established within an early implementation site (an initial estimate is 18 months following the model's introduction).
5) **Phase 2: Outcome and Impact stage** refers to the on-going delivery of integrated care/quality improvement through a bundled reimbursement model in selected sites. The focus in this phase is on tracking client and health system outcomes resulting from delivery of the new model. This phase will end approximately three years after initial implementation of the model.

2.2 DESCRIPTION OF PROGRAM TO BE EVALUATED: WOUND CARE

CCACs purchase home care services from service providers using a competitive procurement process that involves issuing requests for proposals according to specific services, geography or client types. Contracted services are paid for by CCACs on the basis of a fee-per-unit of service rather than by a unified cost to achieve service goals. Typically, service contracts cover individual services rather than integrated services.

This means that in cases where wound care clients require more than one service, they might receive care from several provider agencies.

By implementing an integrated service delivery model for certain types of wounds, with support services being based on an episode of care rather than on units of different services, the CCAC-selected early implementation sites of the wound care client grouping will incorporate new integrated delivery protocols in order to improve both service quality and client outcomes. Please refer to Appendix 1 for a detailed list of the key elements of the new approach to service delivery developed for the wound care client grouping.

2.3 IMPLEMENTATION OF THE EARLY IMPLEMENTATION SITE MODEL

Wound care early implementation sites will be carried out in two phases, considered here in greater detail. Implementation of Phase 1 activities are the responsibility of the participating CCAC sites. Sequencing of the steps within each phase may be concurrent and provide an opportunity for the selected evaluator to shape elements of the program's design and implementation including, but not limited to, data collection methods and client intake processes.

Phase 1: Implementation stage (expected to be competed within 18 months after initiation)

Key steps that must be accomplished before the end of the implementation stage include:

1. Integrated care protocols being implemented

- Integrated, multidisciplinary care teams established; background information provided to selected teams.
- Support for the development of new business processes, value stream mapping, etc., provided to selected teams through the Change Foundation.
- New design elements introduced.
- Integrating mechanisms and structural supports established in relation to new teams.

2. Client intake to new intervention commences

- New entrants assigned to integrated care team or usual practice team.
- Existing clients also assigned to integrated care team or usual practice team.
- May be some opportunity to randomize assignment

3. Data collection beginning about payment/incentive alignment with new delivery model

- Providers continue to be reimbursed on a fee-for-service basis (perhaps with some enhanced coverage of costs).
- Available information on costing assumptions/models associated with best practices made transparent to providers.
- Data tracked in order to establish a bundled price.
- Bundled price established and confirmed, although the provider may continue to be reimbursed through fee-for-service during early implementation stages.

4. Integrated Delivery Model being successfully established

- Integrated care intervention/new design elements established and stabilized.
- Providers or teams move from fee-for-service payment to new bundled price.
- Continuous quality improvement is ongoing.

Phase 2: Outcome and Impact Stage – Integrated care/quality improvement outcomes (expected to be completed within approximately 18 months of the implementation stage being completed).

- The outcome and impact evaluation commences for outcomes that can be attributed to new integrated care protocols.
- Considering the outcome and impact evaluation in further detail, particular attention should be directed to:
    - How results have been influenced by the structure and process of the project.
    - The key transferable lessons drawn from your analysis.
    - The economic analysis to be conducted within the early implementation sites.
- Rigorous evaluation of the bundled reimbursement model will also be a focus of this stage, in addition to tracking impact of mature state model more generally.

Currently, wound care early implementation sites are in the design phase. Early implementation sites have been self-identified and efforts are underway to finalize participation. The purpose of releasing the RFP at this stage of development is to select an evaluator during the early design stage to support the development of a sound evaluation design. For example, prior to finalizing an evaluation design, the evaluator or team of evaluators will work collaboratively with the CCAC(s) and participating providers to finalize a recommendation to ensure feasibility, maximize participation and minimize additional workload for providers. Areas for finalization will include the choice of options for randomization which considers the nature of the interested CCAC(s) and their service providers.

2.4 PURPOSE OF THE WOUND CARE EVALUATION

The evaluation of the wound care early implementation site(s) has two primary objectives:

1. To evaluate the effectiveness of the model of care as implemented by select CCACs and their providers. The evaluation is expected to:
    - Compare early implementation sites employing the new integrated model with a usual practice model.
    - Measure the effects of project interventions for clients, for providers, for informal caregivers and for the health system.
        - Outcome patterns should be examined using quantitative, qualitative and contextual data to enable processes, structures and outcomes to be reconciled.
    - Establish a methodology to quantify value and return on investment.
    - Establish baseline information in order to measure progress over time.

2. To identify fundamental design characteristics found at early implementation sites introduced by the participating CCACs during the implementation phase of the evaluation. This phase of the evaluation is expected to:
   - Identify fundamental design differences and key transferable lessons to support the transfer of innovative and successful project models.
   - Produce and disseminate evidence of what has worked well and identify opportunities for improvement at the project level to enhance the effectiveness of the strategies employed by the CCACs and their service providers to ensure that the services provided have greater impact.
   - Better understand the client, program and system level characteristics that underpin successfully integrated health care delivery initiatives.

A detailed list of wound care evaluation interests is attached in Appendix 2.

2.5 EVALUATION DELIVERABLES

The following list outlines the key deliverables that must be included in any Wound Care Project evaluation proposal.

A number of key deliverables are required during and following the evaluation:

- To ground the evaluation in evidence, a literature review is required which demonstrates the available knowledge. The literature review can include academic research, grey literature, jurisdictional studies or other relevant material. It is important to note that the evaluator will have access to existing systematic literature reviews that have been completed by the Medical Advisory Secretariat. A literature review currently being conducted by Toronto Health Economics and Technology Collaborative through the Ontario Health Technology Advisory Committee, specifically with respect to intermediate care for chronic wounds, will also be made available when it is completed (anticipated April 2010)
- An implementation phase interim report.
- An implementation phase final report.
- An outcomes and impact report.
- Comprehensive electronic presentations and other summary materials for stakeholder usage to be submitted with each final report.
- Evaluators are expected to attend and present their findings/progress-to-date at Annual Research Network and Research Congress events organized by the AAH PMO.
- Knowledge translation plan which includes a dissemination plan to share the research findings and implications with key policy and program staff within the CCACs, the MOHLTC and the provider community. The plan should provide details for all proposed knowledge translation activities.

These key deliverables have been grouped to reflect the three-part structure of the proposed evaluation model.

1. Part 1: Provide a structured report of key evaluation findings from selected early implementation sites at the end of the implementation phase (approximately 18 months after the evaluation commences) describing:
    A. **The structure of wound care early implementation sites**
        - The resource/structural components that are planned or being developed to deliver the model.
        - The characteristics of the model and the setting.
    B. **The process used at the site**
        - The types of services/activities planned or being developed.
        - The mechanisms and processes planned for integrated care delivery.
        - The challenges encountered when developing the model.

    C. **Baseline findings and early initial outcomes**
        - The experience of clients and informal caregivers.
        - Homecare sector costs.
        - Health system utilization.

It is expected that a report describing the implementation stage will inform funders and policy makers about the issues encountered when implementing the project at all sites.

2. Part 2: Provide a structured report of key evaluation findings from selected early implementation sites at the end of the outcome and impact stage of the project (approximately 3 years after the evaluation commences) describing:
    A. The structure of the site:
    - The resource/structural components that are used to deliver the model.
    - The characteristics of the model and the setting.

    B. The processes used at the site:
    - The types of services/activities provided and how they were provided.
    - The mechanisms and processes provided for integrated care delivery and degree of integration established (extent, depth and scope).
    - The challenges encountered when implementing the model.

    C. Outcomes:
    - The impact on clients and informal caregivers.
    - Changes in home care sector costs.
    - Health system impact.

3. Part 3: Provide an analytical report discussing the link between the process, structure and the outcomes of the two phases of the project describing:
    - Client impact, cost-effectiveness and the broader economic impact of the new integrated wound care delivery model compared to a usual practice model.
    - The relationship between process, structure and outcomes to the fullest extent that such a relationship can be deduced.

- Hypotheses concerning applicability of the model to other sites as well as the characteristics of the client population best served by the model.

2.6 MINIMUM REQUIREMENTS

The results of this evaluation will inform future decision-making by the MOHLTC and CCACs about the funding, design and delivery of Ontario's ongoing ICC Project in the pursuit of better health outcomes for specific clinical conditions and/or improved care for the same or reduced costs. The CCACs and the MOHLTC want to make decisions informed by the best evidence possible in planning for and allocating funding to support integrated health care programs.

The wound care client grouping has been selected as the preliminary integrated care model, a model which has the potential to significantly improve client outcomes and health care sustainability for specific wound care services. To determine whether such integrated care programs have indeed improved client outcomes and health care sustainability, an evaluation of the wound care early implementation sites should provide relevant information about the delivery model, the characteristics of those client subpopulations best served under the model, the likely impact of this delivery model for clients, and its economic impact on government-funded systems.

With the findings of this evaluation, the CCACs seek to increase their understanding and awareness of how to optimize the value of the wound care program for clients and the health system. It is anticipated that the CCACs will use the resulting information to inform decisions about implementing an effective integrated care service model across the province and to alter funding allocations to achieve key performance targets.

For this evaluation to meet these purposes, it will require designs capable of yielding strong inferences, hypotheses, or causal relationships. Such designs may be achieved by including an appropriate control group and by using quantitative or qualitative methodologies to analyze findings about client outcomes and health care sustainability.

The analysis of evaluation findings must provide the highest possible degree of internal validity and generalizability of the results and provide a thorough consideration of the effect of the new integrated delivery model.

Proposals designed to make it possible to draw inferences about best practices for the ongoing ICC project and/or attribution of effect, whatever their methodology or design, will be considered of interest.

At a minimum, it is expected that evaluators conduct an in-depth evaluation of at least one service provider team associated with one CCAC early implementation wound care site. It is not expected that an equivalent evaluation be conducted at each site but that the sample allow clients at an early implementation site to be compared to an appropriate usual practice comparison group. This may include sites in one or more of the four in order to derive key findings generated by the new ICC delivery model about client level outcomes and costs, evaluators should plan to include client and service

data from the largest sample size possible within the evaluation budget ceiling and provide an opportunity for all interested CCACs and contracted service providers to participate in the evaluation of integrated care. Key outcomes should include:

- Client outcomes and informal caregivers experience (in particular, impact on quality of life*; rate of wound care reduction*; time to achieve functional status*; complications and adverse effects*, and client and caregiver experience).
- The value and cost-effectiveness of the new wound care intervention* and change in costs* compared to usual practice over the term of the project.
- Health system utilization (change in client utilization of ER, LTC homes, ALC days and community services).
- The broader economic impact of the new ICC delivery model from the perspective of the home care sector; the health care system and broader government systems (e.g. social assistance, community and social services, etc.) compared to usual practice.

** This data will be routinely collected and reported by providers at all participating sites and will be available to the evaluator.*

2.7 COLLABORATION REQUIREMENTS

It is expected that evaluators will demonstrate flexibility and a strong commitment to and capacity for working collaboratively, in particular to:

- Work collaboratively with educators and quality improvement advisors who will be assisting early implementation sites to streamline information and processes and provide an effective additional resource to CCACs and service providers.
- Work collaboratively with CCACs and participating providers to ensure feasibility, maximize participation and minimize additional workload for providers before finalizing and implementing the evaluation design.
- Leverage and align this evaluation project with concurrent and related wound care evaluation initiatives (e.g. OHTAC field evaluation) to maximize the learning potential.
- Demonstrate a willingness to share experiences and key learning with evaluators to be selected in the future that will be evaluating integrated care models for other priority client groups.
- Demonstrate a willingness to share experiences and key learning with the network of evaluators evaluating the Aging at Home Strategy.

2.8 TIMELINES

The Wound Care evaluation is expected to take up to three years to complete.

1. Implementation Evaluation: 18 months

- Initiate work in April/May 2010.
- Progress report required by November 2010.
- Deliver final implementation evaluation report by September 30, 2011.

2. Outcomes and Impact Evaluation: 18 months

- Progress Report required by March 2012.
- Final report due by March 31, 2013.
- The evaluation team may be asked to provide periodic updates throughout the project to support the information needs as identified by the AAH PMO.

2.9 FUNDING

The maximum funding available for Wound Care evaluation for Phases 1 and 2 will not exceed $1.5 million. This funding will be provided over a three year term.

3.0 OUTLINE OF RFP PROCESS

The outline below describes the procurement process that will be followed by the Aging at Home (AAH) Management Committee[1] after the RFP release on January 19, 2010.

EVENT	DESCRIPTION	DATE
Evaluators' Pre-Proposal Conference Calls	Optional call providing a forum to answer any questions generated by the RFP. **Global Crossing Teleconference Line: 1-800-747-5150, access code 480 6091.**	January 26, 2010 at 10:00am
Proposal Deadline	Any RFP revisions will be issued in the form of an addendum and will posted on the ICES website for access by all potential Evaluators prior to the proposal due date. **Only complete proposals will be considered.**	February 15, 2010 at 5:00pm
AAH Expert Review Panel Proposal Evaluation	Responses from Evaluators to the ICC RFP will be evaluated based on the merits of each proposal. The AAH Expert Review Panel will determine which evaluations can best serve the needs and objectives of the specific Integrated Client Care project according to the criteria outlined in section 6.0.	February 17 – March 10, 2010
Final Evaluator Selection	The selected Evaluators will be notified and a time scheduled for final contract negotiations.	March 10 – 24, 2010
Finalize Contract	The AAH PMO will work with the selected evaluator to obtain necessary signatories on the contract between ICES and the selected evaluator.	March 25 – 31 2010

[1] Between August and December 2009, the evaluative phase of Ontario's Aging at Home Strategy began by establishing the Aging at Home Strategy Evaluation project management office (AAH PMO) at the Institute for Clinical Evaluative Sciences (ICES). In addition to managing the evaluation activities associated with the AAH Strategy Evaluation, the AAH PMO has also been tasked managing the evaluative phase of the Integrated Client Care Project.

4.0 APPLICATION PROCESS

This RFP is an opportunity for selected Evaluators to inform the ICC Project and to help contribute to its success. Proposals will be subject to a relevance review by an Expert Review Panel with the Aging at Home Management Committee awarding the contract.

4.1 FORMAT AND DEADLINE

Please employ the following formatting guidelines when preparing your submission:

- Arial or Times New Roman 12 point font must be used. Condensed type is not acceptable.
- Text must be single-spaced, with no more than six lines per inch. Margins must be at least 1 inch.
- Funding amounts should be in Canadian dollars, rounded up to the nearest dollar.
- Use clear language and avoid technical jargon.
- 20 page limit.

The applicant must submit one (1) electronic copy of his or her proposal in MS Word format to the following email address: catia.creatura-amelio@ices.on.ca no later than February 15, 2010 at 5:00 p.m. Proposals or parts thereof received after this deadline will not be considered.

Please ensure that the email subject line contains the words **Wound Care Evaluation** in the title in order to facilitate the tracking of all submitted documents.

In addition, please submit **ten (10) double-sided hard copies** of the proposal to the AAH PMO at ICES before the deadline of 5:00 p.m. on February 15, 2010.

4.2 GUIDELINES

The following is an outline of the suggested minimum content for the proposal. Guidelines for completing each section are included below, but applicants should feel free to add any other material they deem relevant to their proposal within the specified 20 page limit.

In responding to this RFP, applicants should prepare separate sections clearly labeled as outlined below. Applicants should also include in their proposal a table that summarizes key facts from their proposal such as important timelines itemized by phase and evaluation budget. Each proposal must include the following components:

A. Cover Letter

- Identify the principal evaluator and, if relevant, evaluation team members.
- The name, address, phone and fax numbers, email address, and signature of the project team leader.
- The names, role, affiliation and signature of other team members.

- The name, address, phone and fax numbers, email address, and signature of the designated officer of the administering organization.
- The total proposal budget.
- The project's start and end date.
- A short summary of the proposed evaluation (150 words maximum).

B. Table of Contents

The table of contents must clearly identify the components of the proposal.

C. Short Summary of Evaluation (500 words maximum)

The purpose of the short summary is to provide a plain language summary of the proposal. The summary should include the objectives, principal methodologies and the potential program, policy or practical outcomes or impact of the evaluation.

D. Research Plan

In this section outline your evaluation approach and the type of research that you will undertake to address the RFP's requirements. Include a detailed plan which documents your recommended methods; recommended sample plan; key assumptions; and criteria for success.

Please ensure that your proposal discussion includes the following components:

1. A description of how the evaluator/evaluation team will provide the specified deliverables, including a detailed description of your proposed research methods, objectives and measures.
2. A description of the previous training or experience that the evaluator/evaluation team has related to the specific qualitative and/or quantitative methods proposed.
3. An explanation of how your recommended methodology will address the RFP's goals (see Appendix 2 for suggested methodological approaches).
4. A description of how your evaluation design will address the evaluation's requirements.
5. A work plan for the length of the evaluation, including the expected timeline for this project and key milestones. This work plan will be reviewed quarterly by the AAH Management Committee.
6. A knowledge translation plan which specifies the deliverables that will emanate from the evaluation process. The deliverables may include activities such as written management summaries, onsite workshops, web-based conferences, interactive reporting tools, two page policy briefs and technical briefings.
7. The critical success factors and the risks you see for this project.
8. A statement from the evaluator that acknowledges the requirement to work collaboratively with participating CCACs, service providers, educators and quality improvement advisors to finalize an evaluation plan and as part of ongoing implementation.

E. Budget

9. The budget should include details of the proposed evaluation costs on a fiscal year basis (April 1 to March 31). Please use the following headings to explain the following relevant budget items:
    - Personnel Services
    - Personnel
    - Supplies and Service
    - Travel
    - Equipment
    - Other

F. Team Members

10. A description of each team member and his/her role in the project including qualifications and experience with respect to the home care sector and the integrated care research and program assessments. Please include a list of the 10 (maximum) most recent and relevant publications in scholarly, academic and or industry publications including articles published in refereed journals, books, monographs, conference proceedings, chapter(s) in books and reviews.

G. Additional Information from Applicants

11. Explain how will you keep the AAH PMO informed of the project's status: In what format and with what frequency? If you are applying as a group, will there be a dedicated project manager on your evaluation team?
12. Identify what project steps will be outsourced, if any.
13. Detail what type of support you will offer once the report has been delivered.
14. Provide details of your quality assurance and data protection/disaster recovery practices.

5.0 RESEARCH ETHIC BOARD APPROVALS

It is expected that any evaluation which requires client specific data will obtain Research Ethic Board Approvals (REB) from an approved REB at an Ontario-based institution, or equivalent. The REB must apply the principles of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* [2]*.* This requirement should be reflected in the timelines of the Research Plan submitted for consideration.

6.0 REVIEW PROCESS AND ELIGIBILITY CRITERIA

Applications for the evaluation for the wound care early implementation site(s) will be assessed by an independent and impartial Expert Review Panel assembled specifically to review RFP submissions. The Expert Review Panel will consist of 8-12 members and

---

[2] • Please see http://pre.ethics.gc.ca/eng/policy-politique/initiatives/revised revisee/Default/

consists of experts working in fields related to integrated client care who will determine the practical relevance of the proposed evaluation and academic researchers who will assess proposals for their scientific merit. Upon reviewing the recommendations made by the Expert Review Panel, the Management Committee through the PMO will notify the successful applicant.

There are six steps involved in the review process:

1. The initial review will be conducted by the AAH PMO to ensure that all applications are complete and contain all the required documentation.
2. All complete submissions will be reviewed by an Expert Review Panel with representation from both the academic community as well as the service provider sector.
3. If required, a technical review by external experts will be sought by the AAH PMO.
4. The Expert Review Panel will conduct a financial review of the budget submitted by potential evaluators. An external financial assessment will be obtained if deemed necessary.
5. The Expert Review Panel will make recommendations to the AAH Management Committee about which applications are most relevant, effective, feasible, and represent good value for money.
6. Recommendations made by the Expert Review Panel will be considered by the AAH Management Committee for approval and final decision.

Each project will be assessed on the following criteria, which include but are not limited to:

1. The proposed candidate and/or evaluation team having demonstrated experience and the qualifications to conduct evaluations in the health care field as evidenced by a track record of evaluations within a relevant field.
2. The proposed candidate's and/or evaluation team's knowledge/experience of care integration in Ontario, particularly the problems and challenges the health care sector faces around integrating care.
3. The proposed candidate's and/or evaluation team's understanding and experience with community care, specifically with the CCAC and service provider organizations.
4. A sound research plan which demonstrates the quality of the proposed research methods including feasibility, appropriateness, rigour, validity and the level and complexity of the analysis.
5. The proposed candidate's and/or evaluation team's leadership and project management skills which will enable the evaluator to accomplish the objectives of this evaluation.
6. The demonstrated capacity of the proposed candidate and/or evaluation team in the area of care integration, including evidence of ongoing interaction with active researchers and programs in the area of integrated care or complementary fields, which will allow the evaluator to accomplish the objectives of this evaluation.

7. The proposed candidate's and/or evaluation team's plan for knowledge mobilization and exchange activities for key stakeholders including the MOHLTC, the LHINs and other relevant stakeholders such as health and social services-related partners, health and social services system decision-makers and the larger community.
8. The proposed plan to involve relevant evaluation partners (CCACs, service providers) in the relevant stages of the evaluation, from planning and implementation to knowledge mobilization. This section should show a demonstrated ability to work collaboratively.
9. The financial integrity of proposal including, but not limited to, the ability to remain on budget.

6.1 ELIGIBILITY

To be eligible to receive ICC Evaluation funding, the applicant must be part of at least one of the following categories:

- Ontario-based researchers or a collaborative led by an Ontario-based researcher, who will be given preference.
- An Ontario post-secondary institution or an affiliated institution (including hospitals and research institutes).
- An Ontario non-governmental/not-for-profit health sector organization (including community or charitable organizations).
- An Ontario-based corporation or organization.

7.0 MONITORING, PERFORMANCE MEASUREMENT AND EVALUATION

The Management Committee is committed to demonstrating results to Ontarians for the money invested in the ICC Project Evaluation(s). Therefore, processes for gauging progress, for monitoring the appropriate use of funds and for measuring performance and program evaluation have been put in place and must be adhered to during the term of the evaluation.

8.0 TERMS OF THE AWARD

The evaluator/evaluation team approved to receive funding and, where relevant, their administering organization, will sign an evaluation contract with ICES which details conditions related to: the amount of funding; the payment schedule and funding period; reporting and auditing requirements; the expenditure of funds; and intellectual property rights. For the purposes of the ICC Project Evaluation, the host Ontario university/consultancy will be considered the administering organization. The contract is issued to the evaluator and/or administering organization for signature by the CEO or designated officer upon approval of funding by the AAH Management Committee.

Successful applicants/administering organizations will commit to the following as a condition of funding:

- Final report – Upon completion of the evaluation, recipients must submit a final report to the Management Committee in a format defined by the AAH PMO.
- Financial reporting - Statements detailing budget-to-actual expenditures must be submitted to the AAH PMO one month after the end of each quarter (April to June, July to September, October to December, and January to March) during the funding period, signed by the designated financial officer of the administering organization. The final budget-to-actual expenditure statement should also be signed by the designated financial officer and a signatory of the agreement. These statements should include an explanation of variances and report any changes made to the approved agreement budget.
- Intellectual Property Rights – The ownership of, and all rights to the intellectual property resulting from the evaluation activities supported in whole or part by the AAH PMO, will be determined by the administering organization's policy related to Intellectual Property. If the administering organization has no such established policy, intellectual property will be negotiated between the evaluator and, if applicable, the administering organization and the AAH PMO. In either case, the AAH PMO, the MOHLTC and the CCACs shall have the non-exclusive right to access and use the project data and to publish such project data and any results or findings.
- Release of Information – It is a condition of AAH PMO funding that evaluators consent that the AAH PMO, MOHLTC and the CCACs have the right to use and release of information about them and their research in relevant forums and publications.
- Acknowledgements – All publications resulting from this evaluation must acknowledge the AAH PMO, the Ministry of Health and Long-Term Care and the CCACs as a source of financial support. All publications should indicate that the opinions contained are those of the authors, and no official endorsement by the funders is intended or should be inferred.
- Publications - It is an expectation of funding that evaluators will seek appropriate publication opportunities in refereed journals and academic publications. Academic freedom will be respected and evaluators will have the right to publish results of the evaluations.

APPENDIX 1 – DESCRIPTION OF NEW SERVICE MODEL FOR THE INTEGRATED WOUND CARE PROJECT

The following have been identified as the key elements of this new approach to service delivery that together will be implemented by CCACs and providers and assessed by the selected wound care clinical grouping evaluator.

1. Case Management

- Case management involves adopting the most effective case management approach for client populations, recognizing the variation in client complexity and need for different levels of care interventions (e.g., the use of specialized case managers for client populations).
- The current service delivery redesign shifts the process away from having the CCACs authorize units of service to their monitoring of trends and client outcomes.

It is expected that the use of case management for wound care clients will ensure that more focused attention is paid to the individual needs of clients and caregivers.

2. Coordinated Assessment

- Assessment for client eligibility for care remains with CCACs. However, CCACs will now also explore opportunities to streamline their approach to client assessment and eliminate duplication of multiple assessments by members of the multidisciplinary team (e.g., assessment teams, integrated assessment tools and shared outcomes).

It is expected that the effect of coordinated client care assessments will reduce the need for clients to repeat their care requirements.

3. Integrated Clinical Service Delivery

- Based on an assessed need, client care will be provided by a multi-disciplinary team who may work for one provider or a group of providers. However, regardless of the employment arrangement of team members, one organization will be accountable to the CCAC for clinical coordination, clinical outcomes and contract performance. The capacity for information sharing, collaboration, decision-making and reporting agreed upon outcomes across and between team members and partners is essential.
- The composition, mix and skills of the multidisciplinary team will be based on the client's clinical conditions.
- Integrated clinical service delivery requires that service providers are accountable for all services, including medical supplies and equipment.

It is expected that the effect of integrating client service delivery will be better coordinated and seamless care.

4. **Clinical Best Practice**
    - Clinical best practice demands the consistent use and sharing of leading evidence-based practice by each CCAC and their service providers (e.g., agreed upon clinical best practice methods such as shared care paths across all providers of care including those in other partnering organizations).
    - Using clinical best practice requires that client care be based on outcomes which are tracked, reported and evaluated against performance targets.

It is expected that the effect of applying clinical best practices will be better care stemming from consistent practice and expertise.

5. **System Navigation**
    - Having the CCAC case manager adopt an enhanced system navigator role will improve system linkages, communication and coordination across the client's cycle of care (e.g., acute, primary and community).

It is expected that effect of having the CCAC case manager adopt an enhanced system navigator role will allow clients to seamlessly transition between different care providers and to access services in accordance with care needs.

6. **Bundled Reimbursement**
    - CCACs will adopt a bundled reimbursement model for the cycle of care where a single payment will be provided for all services related to a specific treatment or condition, possibly spanning multiple providers or multiple settings.
    - The bundled reimbursement approach will also create incentives to encourage service innovation and reward outcomes.

It is expected that the effect of the CCAC's using bundled reimbursements will be a more efficient use of resources leading to improved service access and wait times.

<u>**Participating Sites**</u>

There are four CCACs and multiple service providers participating in the wound care clinical grouping. Interested CCACs include: Central West CCAC, North East CCAC, Erie St. Clair CCAC, and Champlain CCAC. For a better understanding of the contracts and services managed by CCACs, refer to the OACCAC public website at http://www.ccac-ont.ca/OACCAC/Contracts.aspx?EnterpriseID=15&LanguageID=1&MenuID=78

<u>**Expected Outcomes**</u>

By implementing the integrated service delivery model for certain types of wounds according to an episode of care rather than units of different services, the vision for

success for wound care at early implementation sites is comprised of a number of factors.

i. The establishment of excellent provider teams and the creation of incentives to improve the value of services for wound care clients.
ii. The improvement of integrated delivery within home care, including:
    - An increase in client-centeredness and service quality.
    - An increased accountability for client clinical outcomes as each provider becomes accountable for the overall clinical outcome of the individual client.
    - The accelerated development of best practice care plans.
    - The supported development of case costing.
iii. An increase in the effective use and linkages of resources across the health system.
iv. Services meeting the assessed needs of clients with fewer unmet needs and reducing the burden of illness.
v. Improved health status and quality of life in wound care clients.
vi. The more efficient and sustainable use of health care resources.

APPENDEX 2 – DETAILED MOHLTC AND CCAC WOUND CARE EVALUATION INTERESTS

In setting out full descriptions of their interests and expectations, the MOHLTC and CCACs are establishing optimum or ideal scenario. The two recognize that evaluators may have reasons for not considering all of these interests achievable, and welcome submissions that set out clear discussions about possible limitations foreseen by the evaluator, why they are seen to be limitations, and whether or not there are ways of addressing them.

The following list documents topics of interest to the Ministry of Health and Long-Term Care and the CCACs in evaluating wound care client grouping. The topics are grouped under the headings of structure, process and outcomes. Applicants are advised to identify topics that they consider relevant to meeting the deliverable requirements and feasible in terms of work expectations.

1. STRUCTURE

a) Necessary resource/structural components needed to deliver the project.

For example:

- Key stakeholders/participants in this project, e.g., clients, families, health care teams, health care organizations, professional associations, and administrators.
- Involvement of key stakeholder/partners in developing, implementing, and evaluating the project.
- Project's governance structure and whether consensus amongst all stakeholders/partners was established early and revisited regularly.
- Description of organizational culture, strength of the leadership, and shared visions of an integrated health care delivery system, paying particular attention to visionary coherence and the impact on the way that team members interacted and provided care.
- Resources and supports/structures required to develop and implement the project (e.g., at the organizational, health care system, and legislative level) —
    - Human resources, e.g., characteristics of the providers.
    - Physical resources, facilities.
    - Information technology.
    - Organizational policies and supports.
    - Education/training.
    - Partnerships/collaborations with other providers across the health and social care system.
- Resources and supports/structures that are/were missing but that are important to include in other similar projects.
- New roles or changes to current roles and responsibilities that were required to implement the project (e.g., from a professional perspective, organizational perspective, system perspective).

b) Characteristics of the project and the setting.

For example:

- Characteristics of the individual clients receiving the intervention (clinical and functional profile).
- Characteristics of the individuals providing the intervention, (e.g., project staff. including mix of professionals providing the intervention, etc.)
- Characteristics of the setting.
- Nature of professional interactions (e.g., between client and clinician, team members, providers and CCAC).
- The need/rationale for this project.
- The goals and key features/components of the project, including evidence-based data to support these key features.
- Exploration of expected outcomes and the timeline for achieving these outcomes.
- Exploration of anticipated barriers and facilitators to achieving success.

2. PROCESS

a) Types of services/activities that were provided and how they were provided.

For example:

- Types, location, and intensity (frequency, duration, resources) of services or activities that were provided.
- Describe the use of any information technology and communication mechanisms (e.g., electronic records, data collection systems, computerized assessments, e-referrals), including the principle aim of incorporating technology into the project design (to reduce costs and duplication of assessments, improve quality, track utilization and outcomes, provide more frequent service to client, enable better service provider coordination).
- Whether the intervention delivered is being utilized as planned and whether services and activities differ significantly from what was originally anticipated.
- Changes that have occurred since the project's implementation (e.g., staffing, technology, change management, reimbursement practices).
- Explore aspects of the project that worked particularly well. Describe areas of the project that can be improved and how.
- Barriers and facilitators to developing and implementing the project. Describe strategies used to maximize facilitators and minimize barriers.
- Points of access for receiving services and processes to maximize accessibility. If applicable, where there was more than one point of access, describe the processes to ensure seamless care delivery.
- The level of project uptake by clients and their caregivers, e.g. services recommended versus services received; information/education available versus information/education utilized.

- Describe any active participation by clients and their family or informal caregivers and any mechanisms to encourage their participation.
- Factors that facilitated or hindered formal service use from the perspective of clients and their informal caregivers. Discuss the facilitators or barriers (if any) encountered by vulnerable or disadvantaged subpopulations.
- Level of client and provider compliance to the different care plans or components of the project.
- Use of any alternative therapies.

b) Mechanisms and Processes for Integrated Care Delivery

Provider role in integrating home care delivery:

- Detail the extent, scope, and depth of integration within multidisciplinary team.
- Describe the processes and mechanisms for integration. Consider whether these integration processes and mechanisms included administrative, financial, organizational, clinical and service delivery; whether integration is being developed and implemented within the context of population needs and focused on the goals of improved health outcomes and higher quality of care; and whether integration has been an ongoing process.
- Describe the uptake and use of standardized care delivery through multidisciplinary teams and the use of provider-developed, evidence-based clinical care guidelines and protocols.
- Describe strategies and processes put in place to facilitate change management and continuous quality improvement.
- Describe how staff was supported in their efforts to adapt to work changes through education or incentives.
- Consider the impact on provider satisfaction of moving to integrated delivery.
- Examine provider compliance with the care plan and compliance with best practice clinical care guidelines
- Explore the extent to which the provider team became more specialized and skilled in treating wound care clients, including whether the project resulted in an increased capacity and clinical ability to handle more clinically challenging clients.
- Consider the extent to which duplicative or low-value activity or processes were replaced by higher value activities and processes.
- Examine the facilitators or barriers to achieving integration or increased specialization.

CCAC role in promoting horizontal integration:

- Review the extent to which the wound care early implementation site(s) have integrated with primary care, community or acute care services. Describe the mechanisms used to achieve this integration and explore the effectiveness of the CCAC in facilitating horizontal integration (include the extent of connection and the success of working relationships).

- Assess whether and how this project increased communication and collaboration and how it reduced duplication among providers across the health care continuum. Describe the system of change protocols and mechanisms used to achieve these results.
    - For example, discuss the: availability of common information systems shared between providers; shared information on common clients; standardized assessment/care planning processes; agreed upon referral practices relative to other agencies; shared performance management systems; common interfaces; integrated delivery models that involve multiple agencies; and shared management and budgeting systems.
- Determine the barriers and facilitators to collaborating with other service providers and agencies when implementing this project.
- Gauge the extent to which the project is improving the management of the client's condition over the cycle of care and consider whether transition points are being managed more effectively (e.g., more seamless delivery to client, reduced waiting, more appropriate care).

<u>Funding, incentives and other approaches to improve outcomes:</u>

- Describe the use of performance management approaches used to improving client outcomes.
- Describe the use of funding incentives to effectively reward innovation and improve client outcomes.
- Describe factors within the project that promote future sustainability.
- Review the rate at which new learning occurred and was disseminated both to the project's participating and non-participating providers.
- Explore whether the project increased learning opportunities that in turn augmented preventative care practices.

3. OUTCOMES

a) Project:

For example:

- Consider those anticipated outcomes that were not achieved.
- Discuss those outcomes that were unexpected or unanticipated.
- Review the benefits of this project to clients and their families, to health care providers, to your organization, to the system as a whole and probe any future anticipated benefits.

b) Impact on clients and informal caregivers:

For example:

- Explore the extent to which anticipated health outcomes for clients are being achieved. Possibilities include —
    - Improved quality adjusted life years

    - Decreased levels of pain
    - Improved chronic disease management
    - Decreased time to achieve functional status
    - Faster rate of wound area reduction
    - Reduced adverse effects
    - Reduced complications and number of recurrences
    - Increased length of time in between recurrences
    - Reduced rate of amputation.
- Examine the rate of change in client health outcomes from baseline measures.
- Compare whether outcomes for participants in the project were significant versus outcomes of non-participants. Explore any differences that can be identified that appear related to the use of the project intervention.
- Describe whether the impact on client or system outcomes attributed to one model is significant when compared with others where different program models have been implemented and are being compared.
- Explore client and caregiver experience and the extent to which they were satisfied that the project resources were addressing their needs.
- Conduct an analysis of which clients appear to benefit most from particular supports and services and at what cost.

c) Health system impact and economic analysis:

For example:

- Examine whether the project improved the cost-efficiency of service providers.
    - Change in home care costs over a cycle of care
        - Utilization of all services and supplies [3] (e.g. nursing visits + medical supplies and equipment + other home care services)
        - Total cost of all home care services and supplies.
- Consider whether a change in provider reimbursement resulted in efficiency gains, improved client health and/or increased the value of care to clients.
- Extent to which the project likely averted costs in health care system. Possibilities include a —
    - Change in client utilization of health system resources
        - Reduced unscheduled ED visits
        - Reduced ALC days
        - Reduced or delayed utilization of long-term care.
- For different models being compared, calculate —
    - The differences in per person cost of use of service
    - The differences in unit cost of service
    - The factors that account for these differences.

---

[3] All services and supplies will be tracked for a 12 month period prior to the project determining the feasibility of a capitation reimbursement model.

- Explore and describe the cost-effectiveness, implementation efficiency, sustainability and scalability of the project to the region.

APPENDIX 3 - KEY INDICATORS OF SUCCESS

To ensure early implementation sites are on track for achieving success, the following key indicators of success have been identified:

RESULT	PROPOSED MEASURES
PROCESS	
Excellent provider teams are established and incentives are created to improve value of services for client	# of participating sites/# new integrated delivery teams • Integrated wound care intervention established • Degree of alignment with provincial integrated delivery protocols
Improved integrated delivery within home care, including increased client centeredness and quality	Established effective integrated care delivery within home sector • Degree of integration (Extent, scope, and depth of integration) • Absence of duplication Improved CCAC/service providers' experience • Staff turnover and absenteeism • Satisfaction; process of care; clear roles and responsibilities • Knowledge/understanding of clients' condition and overall care plan • Access to information
Increases in the effective use and linkages of resources across the health system	Established effective integrated care delivery across sectors • Degree of integration • Primary care involvement
Services meet assessed needs of clients with fewer unmet needs and reduced burden of illness	Improved clients' experience • Client compliance with the treatment plan and self care • Access to services and information • Cultural/language equity of services • Satisfaction level • Unmet needs • Client distress • Process of care Improved informal caregivers' experience • Satisfaction level • Unmet needs

	• Caregiver burden and distress
OUTCOMES	
Improvements in health status and quality of life	Improved health/recovery • Improved quality of life • Faster rate of wound area reduction • Improved depression level • Improved chronic disease management Decreased time to recovery or reduced time to return to normal activities • Decreased time to achieve functional status, standing/walking • Reduced complications (infections, amputations) Disutility of care or treatment processes • Reduced adverse effects (i.e. complications attributed to provider error) Enhanced sustainability of recovery and nature of recurrences • Reduced number of recurrences • Increased length of time in between recurrences
Efficient use of health care resources	Improved cost efficiency in home care • Change in home care costs over a cycle of care: – Utilization of all services and supplies [4] (e.g. nursing visits + medical supplies and equipment + other home care services) – Administrative costs and costs associated with case management – Total cost of all home care services and supplies Cost avoidance in health care system • Change in client utilization of health system resources – Reduced unscheduled ED visits – Reduced ALC days – Reduced utilization of long-term care – Reduced wait times
Ultimate outcome:	(Equivalent) health outcomes achieved at (a lower) cost (or better outcomes achieved at a comparable cost over the full

[4] All services and supplies will be tracked for a 12 month period prior to the project determining the feasibility of a capitation reimbursement model.

Improved value	cycle of care) • Wound recovery in relation to total cost to home care • Wound recovery in relation to total health care costs • Quality adjusted life years