Ontario Health atHome

Bundled High Intensity Home Care

Questions and Answers

Question	Answer
CONTRACTS	
Are we required to use the provincial template Services Agreement, or can our proposal be completed using our own Home Care template? If the provincial template Services Agreement is required, could you please advise where we can retrieve a copy of it?	The provincial template Services Agreement will be issued upon award. The templates can be found here: https://ontariohealthathome.ca/partners
Is there any flexibility in go-live timing?	Updated RFS and go live timelines will be shared with SPOs via email. Prior to go live, Ontario Health atHome will confirm SPO readiness to ensure continuity of care and there is no service disruption.
What is the projected contract term for this new Bundled High Intensity Home Care program, will it be continuing beyond March 31st, 2026?	The contract term for this RFS is until March 31, 2026. In all cases, Ontario Health atHome's top priority is to ensure continuity of patient care and that there are no service disruptions.
Are Joint Ventures allowed?	Joint Ventures are not permitted. SPOs may subcontract for the provision of services, as needed.
Could my entity create a consortium where we were the legally binding party for the contract but sharing the delivery with a consortium of respected players?	No, consortiums will not be considered.
Are SPOs permitted to subcontract to other organizations to deliver any clinical, community, or non-traditional services, and are there any restrictions on who may be subcontracted?	SPOs may subcontract any clinical, community, or non-traditional services as needed, with no specific limitations on the types of organizations they may engage. However, all subcontracted providers must be capable of delivering services in full compliance with all Ontario Health atHome standards and requirements.
Must formal partnership agreements be in place before submission or can they be finalized post-award? What approvals or notifications are required from Ontario Health atHome before subcontracting arrangements can be implemented? Can existing, approved subcontractors be used or are new approvals required?	Subcontract partnerships may be established following contract award, with all subcontractor approvals proceeding in accordance with existing Ontario Health atHome approval process. Existing, approved subcontractors can be used, without delaying go live.
Who holds legal and operational liability when services are delivered through subcontracted organizations?	As outlined in current Agreements, the contracted SPO shall remain fully responsible and accountable for all contractual obligations, including the submission of all required documentation and reporting (e.g., clinical documentation, evaluation metrics, key performance indicators, and risk events) to Ontario Health atHome. The SPO also retains full legal and operational liability in the event of a safety incident or adverse outcome.

Question	Answer
Are we able to submit for a geographic area that we service for OH atHome? Example – We have a contract to provide services in CE area and we provide in Scarborough only. Are we able to submit for that geo area only?	Yes. If you only have a contract to provide services in a geography (e.g., Central East), then you can only submit an RFS for that geography. The expectation is that services are to be provided in the entire Ontario Health atHome geography for which you are submitting a proposal.
Are lead organizations or respondents required to be prequalified for all home care services?	The lead organization or respondent is not required to be prequalified for all home care service types but must be prequalified to service at least one home care service type.
When will the draft contract and associated schedules be available for review? Having access to this information prior to proposal submission would help ensure accurate responses and allow for detailed operational and pricing planning.	Contracts will be issued to successful SPOs upon completion of the evaluation period. Updated RFS timelines will be shared with SPOs via email.
Can you please confirm whether the title page, Respondent Information and table of contents are excluded from the 12-page limit specified in the submission requirements (maximum 12 pages, Arial font size 11)?	The cover letter, title page, respondent information and table of contents are excluded from the 12-page limit. Any attachments, beyond the 12-page limit, will not be accepted.
Relationship with Existing Contracts: Are these two new Bundled High Intensity Home Care contracts intended to replace existing Ontario Health atHome service contracts, or will they operate as an addition to our current agreements?	The Bundled High Intensity Home Care contract will be a stand-alone agreement and will not replace existing Ontario Health atHome Service Agreements.
"Respondent should also present strategies to achieve full (100%) referral acceptance and ensure continuous support for patients remaining at home, guaranteeing no missed care"- **Are these minimum requirements or targets?**	Referral acceptance will be included as a performance standard.
Are there penalties for failing to meet the 15-minute response time on Health Partner Gateway (HPG)?	At the discretion of Ontario Health atHome, repeated failure to meet the 15-minute response window may result in performance management up to and including termination of the contract.
What is the Ontario Health atHome definition of missed care for these programs?	The number of events of Missed Care (Fixed Period or Hourly Visits) in a week / the number of delivered Hourly Visits plus the number of events of Missed Care (Fixed Period or Hourly Visits) in that week.
Are KPIs as per current agreement or are these new e.g. 100% missed care. What is the total list of KPIs tracked for this group?	The KPIs for Bundled High Intensity Home Care are outlined in the RFS and will be identified in the Service Agreement for successful SPOs. Any new KPIs will be co-created with the successful respondents, as required.
Is SPO expected to provide to full target volume of patients or can we apply to service a partial volume?	Ontario Health atHome reserves the right to award the contract to one or multiple SPOs within a geography. As a result, the target volume may be shared across multiple awarded SPOs, and applicants may therefore be selected to serve a partial volume.
Are SPOs permitted to submit 1 application to service multiple OHaH regions, or are SPOs required to submit 1 application per OHaH region serviced?	A single submission document may be provided for multiple geographies within the same service stream. Respondents are required to identify which geographies they can service.

Question	Answer
Will Ontario Health atHome provide templates or tools for weekly reporting, or is the SPO expected to develop its own?	Ontario Health atHome will provide a template/portal for weekly reporting to SPOs.
PATIENT SERVICES	
Can Ontario Health atHome please define direct vs indirect coordination of services that the SPO will be responsible for with health partners within the scope of the bundle? (i.e. does the SPO need to bring suggestions to OHaH to directly coordinate or can the SPO coordinate appropriate services directly)?	SPOs will engage with patients and caregivers to coordinate appropriate services within the bundle (Indirect Care Coordination). This includes activities that support patient care, such updating care plans, coordinating referrals to community agencies through partnerships and facilitating communication among healthcare providers.
Who will be responsible for the provision and management of Medical Equipment and Supplies (MES)?	The provision of MES will be managed and funded by Ontario Health atHome. Orders will be placed through Ontario Health atHome-contracted vendors in accordance with existing provincial policy and local processes. Ontario Health atHome will track associated MES costs to inform planning for the 2026-2027 fiscal year.
What is the anticipated amount of time required to reach the post ramp-up weekly patient volumes?	There will be a gradual increase in volumes, week-over-week until maximum targets are achieved. Ontario Health atHome is refreshing its onboarding process to ensure consistency and support successful patient transitions.
Will all of the people actually have their own homes?	Patients might reside in other settings including a retirement home or congregate setting.
Can we offer to supply housing in order to create a Deliberately Occurring Retirement Community with numerous people taking up home in the same physical complex?	No, housing costs are not included as part of the bundle.
What percentage of the 570 are in the dementia category?	For the LTC stream, the percentage of patients with dementia is unknown. Patient identification process is under development.
What is the model of EHR continuity or transfer? Will hospitals be aiding interoperability of information?	We will continue to use CHRIS for all EHR, as per current practice.
We recognize the importance of striving for no missed care; however, there may be rare situations—such as winter storms or other unforeseen emergencies—where service interruptions are unavoidable despite our best efforts. Could Ontario Health atHome clarify how the 0% missed care performance expectation is applied in the context of such unavoidable circumstances? Are there allowances or contingency protocols for events beyond the service provider's control?	The definition of missed care applies, as currently outlined in contract and reporting requirements.
Staffing Expectations: Are there minimum staffing ratios or mix requirements for RN, RPN, PSW, allied health professionals, etc.?	SPOs are to determine staffing requirements to support the patient, based on patient need. We expect the Bundle to include all appropriate regulated health professionals and non-professional staff.

Question	Answer
What is Ontario Health atHome's definition for full-time equivalent for this request for service?	Ontario Health atHome is in alignment with Ontario's Employment Standard Act.
Is the "80% full-time" expectation measured by headcount, total worked hours, or FTE percentage across the program?	FTE ratio = [Number of active full-time direct staff in the program in a week ÷ Number of active direct staff in the program in the same week] × 100% For clarity, FTE ratio measures the proportion of active direct staff employed full-time by the SPO across the program during a specific week, expressed as a percentage.
Section 5.0 Evaluation Criteria: Can you confirm this indicates Ontario Health atHome's expectation/ understanding that care can be provided using the existing workforce?	To ensure all the services within the bundle are delivered to patients without disruption, the service provider will utilize an 80% full-time staffing complement/part-time staffing strategy.
Can you provide some guidance around how Ontario Health atHome would prefer "casual" workforce headcount is to be calculated into this expectation?	The SPO should include details on staffing model to meet the expectations of the bundle care plan.
What willingness is there to work with SPOs to provide services to patients in hard to serve areas?	The SPO is responsible for determining how service provision will be accomplished for the full bundle.
Appendix 1, Scope of Service Accountabilities, SPO – it is noted that the SPO Coordinates the continuous planning and scheduling of services, ensuring care is delivered to meet both the patient's needed and OHatH standards of satisfaction. Can you define the "standards of satisfaction"?	When describing "standards of satisfaction", Ontario Health atHome will take into consideration the SPO's ability to support the patient's care needs through: • Provision of all services (i.e. types, modalities and frequency) • Meeting the accountabilities outlined
Appendix 1 – Can you clearly define scope of the service bundle? The scope includes provision of care but then indicates "not limited to". This will help us understand what might be outside of scope given that OHatH is asking we engage with OHatH when adding services beyond the scope of service bundle. What might an example of this be?	The scope of the service bundle includes all services needed for the care plan. Ongoing engagement will occur with Ontario Health atHome Care Coordinators.
Can you also confirm that while there is a requirement for 24/7 overnight coverage for triage of urgent matters, this does not require 24/7 access to the client's assigned Nurse, Therapist, or Case Manager specifically?	24/7 support may include regulated health professionals and/or a case manager. The goal is for the patient to have access to any service type in order to mitigate an ED visit or hospital admission and keep the patient safely in the home.
Can the "refusals" protocol be utilized in the ramp-up period, and if so, can you elaborate further on such?	The goal is to have full acceptance of bundle referrals. No refusals will be contemplated.
Can Ontario Health atHome confirm or clarify the expectation regarding the commencement of services within 24 Hours from acceptance – this would refer to the commencement of the Personal Support Services portion of the services bundle, correct?	This refers to the commencement of any service available in the bundle that is required by the patient within 24 hours of acceptance, based on the initial assessment provided by the Ontario Health atHome care coordinator.

Question	Answer
To what extent does Ontario Health expect standardization of the reactivation care pathway across providers, and where is flexibility permitted to adapt to local geography, cultural considerations, and Northern realities?	It is Ontario Health atHome's expectation that the care pathway be tailored to meet patient needs while taking into consideration geographic, cultural and Northern realities.
Is Ontario Health at Home able to implement a notification system including alerts through HPG to best meet the offer's 15-minute response time requirement and is the 15-minute response required 24 hrs a day, 7 days a week?	Yes, the 15-minute response time requirement is required 24 hrs a day, 7 days a week. SPOs can enable email notifications in HPG.
(Reactivation) Will Ontario Health be issuing standardized functional or cognitive assessment tools (e.g., AMPAC, TUG, MoCA) for evaluating patient progress, or should providers select validated tools independently?	SPOs may select validated tools independently and include its planned use in the proposal.
What preferred protocols or escalation pathways does Ontario Health atHome recommend for managing after-hours complex care needs, including acute deterioration or behavioral changes in patients with dementia, to prevent avoidable ED visits?	Ontario Health atHome will follows its existing escalation protocols, including evenings and weekend on-call process.
What is the duration of the weekly multidisciplinary huddles with Ontario Health atHome coordinators expected to be?	Ontario Health atHome will work with the selected SPO to co-design the frequency and duration of the multidisciplinary huddles. The duration will depend on the volume of patients being reviewed.
Will Ontario Health atHome use the same pathways framework that is currently being used for current OHaH service offers? E.g. Deconditioning, complex, neurological pathways, etc. and will there be a timeframe associated with these pathways (for example a provider end date)?	The services that are required to support the patient will be identified in the initial assessment. The type of service to be provided will vary from patient to patient, depending on care needs.
Community Support Services (CSS) & Emerging Services Integration: CSS and emerging services are described as core elements across all three bundles. Key questions include: (i)How should providers budget for CSS services such as transportation, meals, respite, social programming, activation, and safety checks?	Community support services is an integral part of each bundle; SPO should work with their local CSS organizations to determine budget and enable flexibility of supports within bundled service envelope, including through sub-contracting arrangements.
Clinical Scope, Liability & Safety: (i)What is the clinical scope of high-intensity bundled services for medically fragile ALC patients?	Refer to the model description which includes traditional and non-traditional services as required by the patient based on the initial assessment completed by the Ontario Health atHome Care Coordinator and SPO's ongoing adjustment of care plans and the reassessment of services to meet patient's needs.
Are applicant SPOs required to specifically identify in the response document the SPOs they are contemplating partnering with to create capacity in service delivery?	Yes. Details should be provided.
Are there specific protocols for ED diversion that SPOs must follow?	The goal of the bundle is to fully support the patient at home. The expectation is for SPO to provide clinical/non-clinical/non-traditional

Question	Answer
	services to patients within each bundle stream to avoid unnecessary ED visit or hospital admission. Successful SPOs are required to develop their own protocol for ED diversion.
How will qualitative metrics (e.g., patient satisfaction) be collected—by SPO or Ontario Health atHome?	As per current practice, these metrics will be collected by the SPO, with real-time access for Ontario Health atHome.
Will Ontario Health atHome provide training or onboarding for bundled service processes?	Ontario Health atHome will jointly review processes with successful RFS respondents and SPOs are responsible to train their own staff.
What is the expected turnaround time for Ontario Health atHome to approve service modifications within the bundle (e.g., adding pharmacy or respite care)?	Ontario Health atHome CC do initial assessment. Approvals for service modification are not required however, SPOs are required to engage patients and caregivers in their evolving care plan. Ontario Health atHome will use real-time data access, performance management and weekly huddles to provide oversight on quality and performance.
The RFS states "Communicates any significant changes in a patient's condition or needs to Ontario Health atHome, including engaging Ontario Health atHome when services beyond the scope of the service bundle may be required or when a transition to a different level of care is needed." Can you elaborate on what the communication with the Ontario Health atHome Care Coordinator will look like?	The Care Coordinator will be responsible for regular scheduled checks-in with both the patient and bundle holder to ensure the care plan continues to meet the needs of the patient. The service provider will not be responsible for sending APRs for bundle patients but will be responsible for reporting through other mechanisms (shadow billing, quality reporting and risk reporting). The SPO will also be responsible for calling the care coordinator to initiate a patient conference whenever significant changes occur that members of the interdisciplinary team should be aware of.
What is the anticipated length of stay for patients on this new Bundled LTC program? Can they remain on the program indefinitely? If not, will their funding change or will there be a time frame for the program e.g. must apply to LTC within a certain time frame?	This will be determined based on individual patients need. There is no predetermined length of stay or expectation that a patient must apply to LTC.
Who is the decision maker regarding the number of appropriate visits/services for clients within the bundle?	SPOs are required to engage patients and caregivers in their evolving care plan. Ontario Health atHome will use real-time data access, performance management and weekly huddles to provide oversight on quality and performance.
Will proponents be expected to follow traditional OHaH service authorization and communication pathways, or will these differ? If they will differ, how so?	No, the SPO has flexibility to modify service frequency and adjust care plans in collaboration with the patient and caregiver.
With respect to the purchasing or provision of additional "non-traditional" services or community supports, is there an expectation that the patient will pay for these services or are they within the budget of the program?	Working in collaboration with the patient and family, the SPO will be responsible for determining the need for community support services (CSS) and facilitating seamless access, where required. The SPO can use bundle funding to ensure patient has access to required services.
Scope of Services: Are non-traditional services (meals, transportation, remote monitoring, social supports) optional enhancements or expected inclusions?	We anticipate that services provided through community support services agencies will be required, as part of the patient's care plan. SPOs are required to collaborate with patients and caregivers to provide the necessary supports to ensure the patient can remain at home safely.
Is the expectation that awarded SPOs will coordinate CSS, such as Meals on Wheels and Transportation or that they will cover any costs for these services directly as part of the $5000 bundle?	Yes, the successful SPOs will coordinate CSS services and cover the cost for these services as part of the bundle.

Question	Answer
Can you please define the term MRCP (Most Responsible Care Provider), is this a reference to the person/family member/carer who is present/ closest/available to the patient and who is assuming responsibility for their day-to-day care? If yes, who would be the MRCP if there is no one available? If it is not, who would define who fulfills this role?	The "Most Responsible Care Provider" refers to the regulated healthcare professional (e.g., physician, nurse practitioner) who has overall responsibility for directing and coordinating a patient's care at a specific point in time.
Is there a maximum number of PSS/Nursing hours we would be expected to provide for clients in this program? When would regular Ontario Health atHome services kick in?	SPOs are required to manage the patient's care plan and required outcomes within the bundle. SPOs will need to follow current process for medical equipment and supplies. The amount of service provided is determined based on the individual patient's care needs.
Are there any specialized training requirements for the provider or is at the SPO's discretion to ensure staff are appropriately trained?	As per current practice, it is the SPO's responsibility to ensure that all staff are appropriately trained and competent to deliver the services safely and effectively.
After the physiotherapist assessment and care plan is developed what type of provider is able to provide follow up. Can we use OTA, PTA, Kinesiologist, Athletic Therapist or a Rehab assistant to complete those visits?	Both regulated and unregulated health professionals can be part of the care team. The specific provider delivering follow-up visits must meet the following requirements under the Agreement: (a) Possess the education, training, and experience necessary to safely and competently carry out the duties outlined in the Services Schedule. (b) Perform these duties under appropriate supervision or direction, in accordance with applicable organizational policies, procedures, and legislation. (c) Adhere to all relevant standards, codes of conduct, and requirements established by the Service Provider and/or the health team overseeing the bundled care. This means that roles such as OTAs, PTAs, kinesiologists, athletic therapists, and rehab assistants may provide follow-up care, provided they meet the above criteria.
What criteria or circumstances will trigger discharge from the program?	Admission to a LTCH, withdrawal of consent, transition to a palliative caseload.
Are patients expected to transition to regular Ontario Health atHome services at any point, for example if restorative patients achieve their functional goals?	This is an ideal discharge where patient is successful with reactivation and is no longer needing an intense care plan.
Are SPOs expected to facilitate, fund, and deliver the services listed in Appendix 1?	Yes, with the exception of Medical Equipment and Supplies (MES) provisions.
What specific information will be provided to the Service Provider Organization (SPO) through the Health Partner Gateway (HPG) as part of a Bundled High Intensity Home Care service offer?	A referral package will be sent, as per the existing process
What is the offer management process when there is more than one SPO HISH provider in a region?	Ontario Health atHome will use our CHRIS system to make service offers, as per the existing process, i.e. each patient will be a single referral and a single SPO is required to accept the entire bundled care plan.

Question	Answer
How will patients referred to this program be identified as distinct from those referred under existing Hospital Transition programs where SPOs and hospitals have direct contracts?	Service offers will be sent using a distinct service delivery type for the entire bundle.
How far in advance of a patient's discharge from hospital will referrals be made to SPOs? Advance notice of discharge is important for arranging timely services.	Advance notice will be provided as far ahead as possible to facilitate SPO engagement in discharge planning and patient conferences.
What will the hours of Ontario Health atHome Care Coordination availability be?	Care coordinator hours of availability will continue as per current hours in each geography, including evenings and weekends, statutory holidays and the on-call process.
Does Ontario Health atHome anticipate that patients will require higher-intensity service levels during the initial stabilization period, with a planned taper over time, or should service intensity be expected to remain relatively consistent throughout the duration of the bundled-care episode?	Service duration and intensity will be determined based on the unique needs of each patient.
What is the expected referral volume at go-live and how quickly will Ontario Health atHome ramp to the target volumes listed?	Please refer to the table under section "Target Population Volume Estimate" in the RFS document. There will be a staggered referral pattern to ensure SPO success and referrals will increase to the target.
Can you share the details on the geography and the related patient volumes to allow SPOs to anticipate referral volume and staffing needs (noted that it would be shared later)?	All information related to the geography volumes is available in the RFS. Toronto Central: 145 (LTC) Central: 80 (LTC) Central West: 35 (LTC) Mississauga Halton: 80 (LTC) Central East: 80 (LTC) South East: 80 (LTC) Champlain: 100 (Reactivation) North West: 35 (LTC) 50 (Reactivation) North Simcoe Muskoka: 70 (Mental Health)
Please refer to the table under section "Target Population Volume Estimate" in the RFS document. Ontario Health atHome reserves the right to adjust the service volumes based on the patient population demand and requirements.	Please refer to the table under section "Target Population Volume Estimate" in the RFS document. Ontario Health atHome reserves the right to adjust the service volumes based on the patient population demand and requirements.
How long is each patient expected to remain active in the program?	Service duration and intensity will be determined based on the unique needs of each patient.
Once a patient exits (is discharged) from the program, where might they transition other than LTC?	Depending on which bundle service the patient is in and their care trajectory, the patient can be transitioned to a number of destinations.
Will the implementation phase be by population or geography? If one SPO is providing support in multiple geographies, will a specific geography be prioritized or will each geography ramp-up simultaneously?	All geographies will ramp-up simultaneously.

Question	Answer
Estimated Client Volumes: Could you provide an approximate number of clients expected to be assigned under each of these new programs (Reactivation and LTC) within the North East region, specifically for smaller rural areas such as Hearst and Mattice?	As noted in the RFS, the anticipated volume post ramp-up for North East LTC: 35 and Reactivation: 75.
Go-Live Regions: The document indicates that regions with the highest demand will launch bundled services on December 8, 2025. Could you please confirm whether the North East region, and specifically the Hearst–Mattice area, is included in this initial implementation phase?	Yes, the North East is part of the initial phase.
Are these existing patients waiting for LTC placements or expected patients discharged from hospital? Will they require 24/7 care?	Many patients will be in hospital and community waiting for LTCH placement. Their care needs will vary.
In determining the bundled services, how many PSW hours weekly and what percentage of costs are social prescribing?	The PSW hours will be based on the patient care needs.
Are the weekly active client targets the estimated maximum number of clients that are active in the program at one time or is it the estimated weekly referral total?	The weekly active client targets represent weekly active patients after the ramp-up period.
What mechanisms will Ontario Health use to ensure timely, reliable discharge notifications including: evenings, weekends, and holidays, so providers can consistently meet the 24-hour service initiation requirement?	SPOs will be involved in pre-discharge meetings with the Ontario Health atHome Care Coordinator. Ontario Health atHome will continue to follow current local processes for service offers and after-hours notifications.
For the purpose of this RFS, can you provide the definition of crisis designation?	Crisis designation refers to the long-term care waitlist priority category.
Beyond ALC or "at-risk of ALC," are there additional eligibility criteria for program admission?	Please refer to the eligibility criteria in the "Target Patient Population" section for each bundle stream RFS.
Can you clarify the expectation of 0% hospital readmission — how is this defined? For example, would unrelated hospitalizations (acute illness, new diagnosis) count against this metric?	0% hospital readmission is defined as avoidable visits to emergency department or admission to the hospital. In other words, an admission that is not planned or ED visit that is best managed elsewhere.
What is the definition of Remote Care Monitoring in the context of this RFP?	Remote Care Monitoring (RCM) refers to the use of digital tools and technology to track a person's health, safety, and daily activities from a distance.
With respect to real-time visit verification, are SPOs expected to maintain internal capability to verify visits in real time, or provide Ontario Health atHome with direct system access?	Both.
Can volunteers (e.g., friendly visiting, telephone reassurance) be leveraged as part of the model?	Yes. Non-professional staff can be part of the care team.
Can Ontario Health atHome provide insight into the percentage or volume of referrals which will not include the InterRAI HC?	Ontario Health atHome care coordinators will continue to complete interRAI HC or RAI CA assessments upon admission to the bundle and then interRAI HC assessments at regular intervals or ad hoc thereafter.

Question	Answer
Can you please clarify what Client Risk Rating referrals received from Ontario Health atHome through this program will be?	All data will be part of the referral package. The Bundle will focus on patients who are ALC in hospital or at risk in community who can be stabilized in the community delaying or reducing long-term care admissions.
We assume given the content of the RFS that only Clients with Client Risk Rating of two (2) will be referred –can you confirm?	Patients who meet the eligibility criteria for each of the bundle care streams will be considered. Patients will be assessed based on their ability to be safely cared for at home. Please refer to the eligibility criteria in the "Target Patient Population" section for each bundle stream RFS.
Should existing clients who meet the eligibility criteria be transitioned directly into the new funding program, or will they be formally discharged from their current services with a new referral issued under the updated program?	Ontario Health atHome will send a new bundle referral.
Is there much information regarding their LTC eligibility (RAI score)?	Ontario Home atHome will continue to be responsible for the LTC placement process. Ontario Health atHome will share the patient's RAI assessment, as part of the referral process.
(for LTC) Expectations Around Rapid Activation: Are there scenarios where Ontario Health anticipates service activation timelines that differ from the standard 24-hour expectation, particularly for patients with urgent needs or crises?	The goal is to secure services as quickly as possible, which could be shorter than 24 hrs.
(for LTC) Reporting and Outcome Measures: To ensure our internal processes align with Ontario Health's priorities, are there any specific performance indicators or reporting expectations beyond what is outlined in the RFS?	In addition to, or in lieu of, the proposed indicators, respondents may propose additional monitoring indicators to assess the success of the bundled services.
(for LTC) Coordination with LTC, Hospitals, and Primary Care: Could Ontario Health atHome share any preferred approaches for communication and coordination between SPOs, LTC homes, and hospital discharge teams during transitions?	By leveraging existing communications channels (phone, email, etc.), Ontario Health atHome expects clear and timely communication and coordination between system partners during patient transitions.
(for LTC) Use of Additional Value-Added Services Within the Bundle: To maintain clarity around scope, is Ontario Health able to provide guidance on any boundaries or considerations regarding optional supportive services—such as activation, caregiver support, or virtual check-ins—offered within the bundle?	Ontario Health atHome will use real-time data access, performance management and weekly huddles to provide oversight on quality and performance. SPOs will collaborate with patients and caregivers to determine services required in their evolving care plan.
For the LTC bundle, what proportion of patients are expected to transition to LTC? What is the anticipated Length of Stay for patients expected to transition to LTC?	The LTC bundle is a destination stream. It is intended to stabilize patients and keep them at home. The current proportion is unknown at this time.
For the Reactivation bundle, is the SPO expected to have nurse practitioners and pharmacists on staff or just evidence of existing relationships?	Evidence of existing relationships.
For the Reactivation bundle, given that the patients will be medically stable, are they expected to require ongoing nursing services?	The bundle should include the services the patient needs, which may or may not include nursing.

Question	Answer
The patient volumes provided are regional. Given the size of the regions, is there a further breakdown that's more geographically based to support staffing complement and planning? Or can the local hospital information be shared so that there's an indication of hubs?	At this time, the volume is for the entire geography not a specific municipality.
If the SPO is not able to accept a patient, does the patient move to a waitlist for that SPO or to another SPO outside of the bundled care model?	It is expected that the successful SPO for that geography will accept all referrals.
Please clarify the performance metric and 0% target for patients requesting to transition from bundles services to LTC bed/number of patients enrolled. Given that many of the patients will have a crisis designation, isn't the goal LTC placement?	The bundled services aims to enhance the quality of life of patients by delaying or reducing long-term care admissions along with preventing hospital readmissions, enabling the health system to allocate resources more effectively and ensure patients receive care in the most appropriate setting.
Please provide more information regarding why behavioral supports are included in the reactivation bundle.	The SPO can include behavioural supports as an additional service to enhance the patient experience.
Why is North Simcoe Muskoka excluded from the list of regions for the LTC Request for Services?	This phase focuses on areas of the province where hospital occupancy and surge is expected to be the highest.
How flexible is Ontario Health atHome regarding innovative solutions beyond the listed services?	SPOs are encouraged to offer innovative solutions to support patients at home.
Will there be a guaranteed minimum volume per SPO or per region?	No.
Will the SPO be involved in the initial patient assessment in order to support the smooth transition of care?	Ontario Health atHome care coordinators will continue to complete the initial interRAI-CA/RAI HC assessments, in alignment with the legislation, and collaborate with the SPO prior to service being requested.
Will the provider delivering bundled services ensure continuity of care when the patient returns to regular Ontario Health atHome services, and what is the process for transferring back?	The LTC bundle and Mental Health and Addictions bundle are destination streams. If the bundle is no longer appropriate for the patient, the SPO is required to work closely with Ontario Health atHome on options for transition.
Are there required participants/timelines for the first post-admission care conference?	A schedule will be co-created with the SPO.
For the Bundled High Intensity Home Care –what is the definition of Palliative Care? PPS score, i.e., CHF or COPD?	We follow the Gold standard framework as part of current practice.
Could the Human Resource capacity include a recruitment plan if we currently don't have staff in the North West districts due to a lack of work, hence the ability to retain staff?	Yes, as long as the SPO is able to accept patients on go-live date.
What constitutes "unplanned" visits?	Visits that are not scheduled.
Does the service provider have complete autonomy over what service they will deliver based on their clinical assessment?	The Ontario Health atHome care coordinator will be responsible for regular check-ins with both the patient and SPO to ensure the care plan continues to meet the needs of the patient. Through these ongoing discussions, SPOs maintain close coordination with the patient/family and the Ontario Health atHome Care Coordinator while working directly with the patient/family on their evolving care plan.
How & who allocated the Pharmacy Services?	The SPO will need to determine if they need to contract Pharmacy Services.

Question	Answer
Relevant to lab services is Ontario Health atHome looking for STAT services, or are these managed and booked appointments?	The SPO is responsible for determining this as part of the coordination of services.
Are lab services expected to be provided on weekends or evenings?	The SPO is responsible for determining the type of services, frequency and timing of service required by the patient, as clinically warranted.
Are the lab orders expected to be on OHIP requisitions (i.e., for insured patients)?	The bundle fee includes all care, OHIP should be utilized.
What is the model of EHR continuity or transfer? Will hospitals be aiding interoperability of information?	All EHR information will continue in CHRIS as per current practice.
Is Ontario Health atHome able to implement a notification system including alerts through HPG to best meet the offer's 15-minute response time requirement and is the 15-minute response required 24 hours a day, 7 days a week?	Yes, the 15-minute response requirement is required 24 hours a day, 7 days a week. For HPG alerts, SPOs can enable email notifications in HPG.
Will Ontario Health atHome use the same pathways framework that is currently being used for current Ontario Health atHome service offers? e.g. Deconditioning, complex, neurological pathways, etc. and will there be a timeframe associated with these pathways (for example a provider end date)?	The services that are required to support the patient will be identified in the initial assessment completed by the Ontario Health atHome care coordinator?. The type of service to be provided will vary from patient to patient, depending on care needs.
Clinical Scope, Liability & Safety: (i)What is the clinical scope of high-intensity bundled services for medically fragile ALC patients?	Refer to the model description which includes traditional and non-traditional services as required by the patient based on the initial assessment completed by the Ontario Health atHome Care Coordinator and the SPO's ongoing adjustment of care plans and the reassessment of services to meet patient's needs.
Clinical Scope, Liability & Safety: (iii) For same-day admissions, what minimum services must occur within the first 24 hours (e.g., nursing, PSW, OT/PT, safety checks)?	The services that are required to support the patient will be identified in the initial assessment. The type of service to be provided will vary from patient to patient, depending on care needs.
Are applicant SPOs required to specifically identify in the response document the SPOs they are contemplating partnering with to create capacity in service delivery?	Yes, details should be provided.
QUALITY & RISK	
What is the ETMS, RL Datix?	These are examples of risk event reporting systems currently used by Ontario Health atHome. SPOs will continue to use existing local processes to report risk events/patient incidents.
Will bundled HISH patients follow the same Ontario Health atHome risk management framework, including the withdrawal of services process? Who sets expectations with the patient and family around safety plans, conduct etc.?	Yes, it will follow the current provincial standardized Patient Complaints and Patient Safety Incident Management frameworks. Contractual obligations regarding the withdrawal of service will remain intact.
What is the expected escalation pathway when care cannot be safely delivered or when urgent environmental concerns arise?	As per current practice, the SPO is expected to adhere to the escalation pathway as identified in the provincial Patient Complaints Management and Patient Safety Incident Management frameworks, as well as the contractual requirements for risk event reporting. This includes both verbal and written reporting, in accordance with the specified timelines.

Question	Answer
To what extent is Protected Health Information (PHI) access required by Ontario Health atHome?	The SPO is required to facilitate the integration of its current EMR with Ontario Health atHome's CHRIS system to ensure transparency of real-time activities (e.g., units of care as they are planned and delivered, extracting data to validate evaluation metrics).
Will Ontario Health atHome be open to establishing new privacy or data-sharing agreements that provide Ontario Health atHome with access to SPO's electronic systems and tools, enabling real-time transparency and visibility into all units of care as they are planned and delivered?	To support Ontario Health atHome's access to an SPO's portal(s), Business Intelligence tool(s); Electronic Medical Record(s) or Health Information System (HIS); an EMR access agreement may be appropriate to set out the required obligations under PHIPA for accessing patient information. Under the SPO's existing Agreement, Ontario Health atHome is a health information custodian and the SPO acts as an agent on behalf of Ontario Health atHome. As such, patient information remains under the control of Ontario Health atHome.
How will liability be shared if a patient deteriorates?	The service provider is responsible, at its own expense, for maintaining commercial general liability insurance with a minimum coverage of $5,000,000 per occurrence. This insurance covers claims arising from bodily injury, including personal injury or death, resulting directly or indirectly from the acts or omissions of the Service Provider, its directors, officers, employees, or independent contractors. Ontario Health atHome and its employees shall be included as additional insureds under the policy.
FINANCE	
Will there be specific bill codes associated with services? If so, what is covered?	Yes, there will be specific billing codes associated with services.
What are the authorized Ontario Health atHome services and the current approved price for these services?	The service bundles are all in costs but shadow billing will occur based on current SPO billing rates.
How will the billing and payment processes be integrated with Ontario Health atHome existing billing and payment systems?	Successful SPOs will follow the existing weekly billing and payment process for the new contract. New billing codes to be provided for bundled care.
Can you confirm that bundled funding will only be released once a client is formally accepted into the program (i.e., no upfront funding prior to client assignment)?	Funding commences on the first day of any service type provided to the patient.
What are the requirements for shadow billing? Will there be changes to the existing billing system in order to support shadow billing?	The process for submitting billing files remains the same, including billing for other services such as CSS or non-traditional services. Shadow billings are simply submissions of the visits/hours of care under specific billing codes that have a $0 rate, and represent the service type delivered.
How was $2500/week determined?	The amount was determined based on data analysis and scenario planning to support the expected clinical requirements and frequency of service provisions.
Is the weekly cap in service cost fully inclusive of all traditional and non-traditional services?	Yes.
Should a client require shift-based services, is this to be deducted from the $2500 per week per patient allocation or is this to be billed as an additional fee for service to the client or Ontario Health atHome?	The fixed bundled rate covers all services (including visits or shifts) that are delivered through: (a) face to face care by regulated or unregulated health professionals; and (b) technology-enabled (virtual) care, as clinically appropriate and

Question	Answer
	consistent with Ministry of Health guidance and applicable professional standards.
What are the authorized Ontario Health atHome services and the current approved price for these services?	The compensation model for bundled services is based on a fixed rate per patient, per week that covers all the costs for the provision of clinical, non-clinical and/or community support services. Shadow billing will occur based on the SPO's current billing rate(s) or, where applicable, at a rate equivalent to the average rate paid by Ontario Health atHome to contracted service providers in a similar discipline.
How will Ontario Health support or account for travel time and distance in remote and rural regions to ensure equitable service delivery and financial sustainability within the bundled model?	The fixed bundled rate per patient, per week, as outlined in the RFS, is the established payment model. Ontario Health atHome will not provide additional funding for travel.
Will there be a mechanism to increase rates over time to address wage pressures and inflation?	For this RFS ending March 31, 2026 there will be no rate adjustments.
Medical Transportation Scope: For the transportation component listed under the bundle, will this funding cover transportation for local appointments only, or can it include out-of-town appointments (e.g., for specialist visits)? If out-of-town travel is permitted, is there a defined maximum distance or geographic boundary?	Transportation costs are included in the bundle to support patient outcomes.
Lifeline Services: Regarding the inclusion of Lifeline services in the bundle: Are Service Provider Organizations (SPOs) expected to ensure clients are enrolled and paying directly for these services (e.g., client-funded subscription)? Or will these costs be covered under the bundled payment, meaning the SPO would be responsible for arranging and funding the service?	The cost for Lifeline services is included as part of the bundle payment. The SPO is responsible for arranging this service.
Who pays for medications? Will patients have a drug card?	Patients who are under 65-years old and require medication related to their treatment plan will be eligible for Ontario Drug Benefits, as per currently eligibility.
In a situation where there are safety/risk concerns, would Ontario Health atHome authorize additional funding to support security or additional staffing on-site during those shifts, to ensure that the patient remains on the bundled plan?	The fixed bundled rate per patient, per week, as outlined in the RFS document is the payment model and will not be eligible for additional funding for security beyond the fixed bundled rate.
What financial assumptions underpin the weekly bundled rates ($5,000 LTC; $2,500 Reactivation; $1,500 Mental Health & Addictions), particularly regarding: (i) Expected weekly hours of regulated and unregulated care (ii) Acuity levels of ALC and high-risk patients (iii) Indirect care, 24/7 on-call expectations, and care coordination	The amount was determined based on data analysis and scenario planning to support the expected clinical requirements and frequency of service provisions.
Who is the funder and how are the funds dispersed?	SPOs will be paid directly by Ontario Health atHome for the bundles.
In the event that a patient's admission, service hold, or discharge from the bundled services does not align with the start or end of a standard week, how will payment to the Service Provider be determined?	Where a patient's admission to, placement on service hold within, or discharge from the bundled services occurs mid-week, payment shall be pro-rated on a daily basis up to and including the first or last day on which patient care was provided.

Question	Answer
If a Doctor is engaged is it expected that they would bill OHIP FFS?	Yes.
CHRIS OPERATIONS	
The RFP states "integration with existing Ontario Health atHome systems." Could you clarify what this means in practical terms for therapy?	The SPO is required to facilitate the integration of its current EMR with Ontario Health atHome's CHRIS system to ensure transparency of real-time activities.
What system do SPO's need to meet the real time transparency needs?	SPOs are to propose how they will ensure real time transparency for Ontario Health atHome.
Can you please clarify the intended purpose of Ontario Health atHome having access to SPO's electronic systems and tools?	The intended purpose is to support care coordinator's ability to understand a patient's current care plan and any outstanding issues in real time. Evaluation and monitoring of care plans, visits, ability to support real-time transparency for Ontario Health atHome, enables visibility into all units of care as they are being planned and delivered.
Reporting, Data & Technology Requirements: (ii)How a "unit of CSS service" will be defined for shadow billing (e.g., per trip, per meal, per hour)	CSS agencies will be able to report visits or hours through the SPOs, based on current Management Information System Standards (MIS) rules for SPOs.
Reporting, Data & Technology Requirements: (iv) Whether CSS partners will have visibility into shadow billing submitted on their behalf.	No, only contracted service providers will have the ability to submit and have visibility into shadow billing.
Reporting, Data & Technology Requirements: (ii)Whether system upgrades will be reimbursed	No, system upgrades will not be reimbursed.
What specific interoperability standards are required for EMR/HIS integration with Ontario Health atHome systems?	Current interoperability requirements remain the same at this time.
Is there a preferred platform for real-time transparency (e.g., HPG only, or can SPO portals be used)?	SPO portals can be leveraged where they exist.