Ontario Health atHome

Bundled High Intensity Home Care – LTC

Toronto Central, Central East, Central West,

Central, North East, North West, South East

Mississauga Halton

November 7, 2025

The deadline for submission is November 20, 2025 by 11:59PM

Please submit questions and completed submission template to BundledHomeCare@ontariohealthathome.ca with subject line: "Request for Service – Bundled High Intensity Home Care – LTC"

1.0 Respondent Information

Primary Contact Information

Organization Name	
Contact Name	
Contact Title	
Mailing Address of Applicant	
City	
Postal Code	
Contact Phone #	
Email Address	
Identify the Ontario Health atHome region(s) for which you are submitting a proposal. Note: **You may only select region(s) where your organization is currently contracted to provide services.**	☐ **Toronto Central** ☐ **Central East** ☐ **Central West** ☐ **Central** ☐ **North East** ☐ **North West** ☐ **South East** ☐ **Mississauga Halton**

Partner Contact Information *(*if joint venture or sub-contracting with another Service Provider Organization. Duplicate chart if multiple sub-contractors)

Organization Name	
Contact Name	
Contact Title	
Mailing Address of Applicant	
City	
Postal Code	
Contact Phone #	
Email Address	

2.0 General Information

Interested Service Provider Organizations must submit a proposal(s) by November 20, 2025 at 11:59 p.m.

Submission must include:

- Completed Respondent Information section
- Completed Request for Service Questions and Response Template (Appendix 2), maximum 12 pages, Arial font size 11

Timetable:

Issuance of Request for Service Documents	November 7, 2025
Deadline for Respondents to Submit Requests for Clarification/Questions	November 13, 2025
Issue Response to Questions Document	November 14, 2025
Deadline for Request for Service Submission	November 20, 2025
Evaluation Period	November 21-26, 2025
Issuance of Contract	November 27, 2025
SPO Sign-back	December 1, 2025
Bundled services go-live	December 8, 2025

Ontario Health atHome reserves the right to award a contract to one or more respondent(s) in each geographic area and may propose modifications to patient volumes or geographies to ensure Service Provider Organization (SPO) capacity matches bundled services needs. Ontario Health atHome may cancel, amend, or otherwise withdraw this Request for Service at any time without notice or liability. Submission of a response does not create any obligation or commitment on the part of Ontario Health atHome for a contract award.

3.0 Compensation

Compensation will be a fixed bundled rate of $5,000 per patient per week to provide Bundled High Intensity Home Care - Long Term Care services. The funds may be used to provide patients with any of the authorized Ontario Health atHome services and may also include an option for respondents to purchase or provide additional 'non-traditional' services, or community support services that better enable patients to safely remain at home. Where patient admissions or discharges occur mid-week, payment of funds will be pro-rated on a daily basis to the first or last day patient care was provided.

4.0 Contract Template

The contract document will consist of a provincial template Services Agreement or Amending Agreement, as the case may be. The Agreement will include Special Conditions detailing geographies, patient volumes, a rate description, reporting requirements, as well as a Consolidated Services Schedule, a price form including the weekly bundled rate, and a Performance Schedule with specific performance indicators and targets (see Appendix 1. Evaluation Metrics).

5.0 Evaluation Criteria

1. **Organizational System and Health Human Resources Capacity:** Evidence of sufficient staffing capacity, infrastructure, technology and experience delivering services to high-needs patients in the selected geographies. This must include:
    - The ability to deliver both planned and unplanned visits, including extended and shift-based services, supported by a consistent team of full-time, part-time, and supervisory staff.
    - Built-in redundancies to address scheduled or last-minute book offs, do-not-send requests,

or other changes to staff assigned to provide service to the patient without missed care

- 24/7 on-call support for both planned and unplanned needs, including triage services to support emergency department (ED) diversion, while collaborating with the Most Responsible Care Provider (MRCP) to proactively address any changes in patient's status, including chronic medical conditions or acute conditions that do not require emergency intervention.
- Support for indirect care coordination (i.e., activities that facilitate the delivery of patient care such as developing and iterating care plans, coordinating referrals to community agencies, completing re-assessments and supporting communication among healthcare providers)
- The ability to deliver the bundled services without compromising the capacity to meet contractual performance targets for existing services provided to Ontario Health
- Dedicated leadership for planning, administration and evaluation of the bundled services, including leadership on-call
- Established processes to identify, report, and resolve complaints and patient/staff safety, and resources to support quality improvement cycles as required
- Ability to respond to bundle service offers through Health Partner Gateway (HPG) within 15 minutes of submission, and providing service to patients within 24 hours of acceptance of service offer bundle
- Ability to support real-time transparency for Ontario Health atHome, enabling visibility into all units of care as they are being planned and delivered. This may include access to SPO's portal(s), Business Intelligence tool(s), Electronic Medical Records (EMR) or Health Information System (HIS)

Respondents must demonstrate and are expected to deliver services across both rural and urban settings. Particular attention will be focused on innovative strategies proposed to support care delivery for the bundled services and maintain capacity to meet performance targets for existing services in rural areas.

2. **Innovation:** Develop and implement a service delivery model that expands the scope of fee-for-service home and community care by incorporating innovative programming and emerging services that will enhance patient care. This should include collaboration with partners or direct delivery of alternative services (e.g., pharmacy, meals on wheels) that improve patient satisfaction or outcomes, as well as technology-enhanced services (e.g. remote monitoring, virtual visits, real-time scheduling and visit tracking, patient/caregiver communication and reporting tools). A key focus must be on addressing the full spectrum of patient needs, including both clinical and social determinants of health, through targeted interventions and system-level mechanisms.

3. **Implementation Feasibility and Timeliness:** Ease of implementation and integration with existing Ontario Health atHome systems and processes, with initial authorizations of the bundles, re-assessments, patient care reporting and billing continuing through existing Ontario Health atHome channels. Ability to implement the model no later than December 8, 2025. Able to demonstrate a solid implementation plan across all urban and rural geographies for the full suite of services and volumes. Where appropriate, recommendations or requirements for bundled services or process adjustments by Ontario Health atHome should be identified if they are implied by the model.

4. **Transition Planning, Health System Integration, and Stability at Home:** In collaboration with Ontario Health atHome, effectively support timely patient transitions to the Bundled High Intensity Home Care – LTC services. The proposal must include clearly defined steps and timelines from

notice of planned admission to admission date, addressing same-day admissions. Respondent should also present strategies to achieve full (100%) referral acceptance and ensure continuous support for patients remaining at home, guaranteeing no missed care. Additionally, the plan should incorporate evidence-based interventions aimed at minimizing ED visits and preventing hospital readmissions.

5. **Existing Performance for Ontario Health atHome in the Proposed Geographies.** Consideration will be given to the respondent's current performance, including their demonstrated compliance with contractual requirements and capacity to maintain contracted 'usual care' service levels under their existing agreement with Ontario Health atHome.

APPENDIX 1 - Background Information on Bundled High Intensity Home Care-LTC

Funding Recipient/Lead	Toronto Central, Central East, Central West, North East, Central, North West, South East, Mississauga Halton

Model Description

The goal is to deliver high-intensity, personalized 'Bundled High Intensity Home Care – Long-Term Care' services to adult Alternate Level of Care (ALC) patients or at-risk patients who can safely be stabilized in the community. The bundled services will use a fixed weekly rate payment model prorated by day for admissions and discharges.

This bundled services aims to enhance the quality of life of patients by delaying or reducing long-term care admissions and preventing hospital readmissions, enabling the health system to allocate resources more effectively and ensure patients receive care in the most appropriate setting.

Services may be delivered through a combination of in-home visits or shifts by regulated health professionals, unregulated staff, and/or through technology-enabled (virtual) care. Services will be assessed by outcomes and patient satisfaction. Respondents are expected to provide, at minimum, all existing Ontario Health atHome service types and delivery models including Personal Support Services, Nursing Services, Occupational Therapy, Physiotherapy, Speech Language Pathology, Nutrition, Respiratory therapy, Social Work as well as the provision of necessary Medical Supplies & Equipment to patients. The bundled services should also include a plan for provision of services such as, but not limited to:

- Pharmacy support;
- Lifeline services;
- Meal delivery services;
- Remote patient monitoring;
- Respite care;
- Shopping assistance;
- Social and recreational;
- Telephone reassurance and security checks;
- Transportation-medical appointments;
- In home Laboratory services;
- Interpretation services; and
- Others as required.

Scope of Services and Accountabilities

Ontario Health atHome:

- Manages patient eligibility and initial referrals to bundled services.
- Conducts the initial patient assessment, authorizes bundle, and connects with the provider (care conferences) to facilitate a smooth transition in care.
- Reviews, manages and approves requests for patients to transition to alternate bundled services or other levels of care when clinically indicated.
- Participates in weekly huddles with SPO care team members to discuss and resolve broad care issues and provide input and support in the management of complex patient care needs.
- Manages service provider performance based on capacity, patient outcome and patient satisfaction metrics and applies remedies as needed to ensure a consistent level of care.

- Manages billing and payment for service bundles.

Service Provider Organization (SPO):

- Supports planning from notice of planned admission to start of services as ordered by Ontario Health atHome.
- Coordinates the continuous planning and scheduling of services, ensuring care is delivered to meet both the patient's needs and Ontario Health atHome's standards of satisfaction.
- Manages the ongoing adjustment of care plans and the reassessment of services to meet patient's needs. The SPO can:
    - Modify service frequency or intensity (e.g., BID PSW to daily PSW visits)
    - Adjust the service type or modality of services (e.g., transition from in-person to virtual Physiotherapy)
    - Deliver fractional hours of PSW services as needed
    - Introduce additional services within the bundle that might enhance the patient's experience or outcomes. These could include:
        - community support services (e.g., transportation services, meals, social programming, activation),
        - technology-enhanced services,
        - behavioral supports,
        - Nurse Practitioner supports,
        - Pharmacy, or
        - partnerships with other health system partners (e.g. primary care) to provide this more integrated care.
- Ensure the provision of all necessary medical supplies and equipment.
- Provides all Indirect Coordination of services and engages with health partners within the scope of the bundle.
- 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.
- Participates in weekly huddles with Ontario Health atHome Care Coordinators to discuss and resolve broad care issues and collaborate on the management of complex patient care needs.
- Takes all reasonable steps to manage complaints, reduce risks to ongoing care, and mitigate challenges delivering services in the home environment.
- Reports patient complaints, safety incidents and risks to patient care to Ontario Health atHome via existing complaints and event reporting platforms (ETMS, RL Datix).
- Supports urgent patient needs and facilitates ED diversion 24 hours a day.
- Submits shadow billing data to Ontario Health atHome to monitor the number of care units and community support services provided to each patient.
- Tracks and reports on metrics and performance targets as required by Ontario Health atHome weekly.
- Completes an InterRAI HC if it is not included in the referral package, is older than 3 months, or if the patient's condition changes. Upload the completed RAI HC to the Integrated Assessment Record (IAR) in real time.
- Must not subcontract, assign or delegate any services to a Third Party without prior written approval of Ontario Health atHome.

Target Patient Population

Inclusion

- Adults with a crisis designation; or
- Individuals undecided about LTC, or on the trajectory of transitioning to Long-Term Care (LTC), who wish to remain at home for as long as possible.

Exclusion

- End of life patients and pediatric populations

Target Population Volume Estimate

Ontario Health atHome reserves the right to adjust the service volumes based on the patient population demand and requirements.

OH atHome Area	Estimated Target Volume of Weekly Active Patients Post Ramp up Period
Toronto Central	145
Central East	80
Central West	35
Central	80
North East	35
North West	35
South East	80
Mississauga Halton	80

Evaluation Metrics

The Service Provider must make accurate data available to Ontario Health atHome to support the tracking of all required performance metrics. The Service Provider must have the capacity to support the weekly collection of these metrics, and others, via billing submissions, regular data submissions, ad-hoc reports, automated provider reports, electronic portals or other reporting forms. These metrics will include, but not be limited by the indicators below:

Quantitative

- Number of eligible patients enrolled / number of eligible patients – Target 100%
- Length of stay (minimum, maximum, median, and total)
- Number of discharges by disposition
- Number of hospital readmitted patients / number of patients enrolled – Target 0%
- Number of ED visits/ number of patients enrolled – Target 0%
- Hours from referral receipt to start of first service (minimum, maximum, median, and total) – Target $\leq$ 24 hours
- Number of referrals accepted / number of referrals – Target 100%
- Number of missed care (number of events of missed care / number of delivered hours or visits plus number of events of missed care) – Target 0%
- Number of units of care (hours or visits) per service type (in person and virtual) / number of eligible patients enrolled
- Total volume (hours or visits) of service provided by community support services partners / number of patients enrolled
- Type and volume (hours or visits) of 'non-traditional or emerging services' provided as a part of

the bundle
- Total cost (if usual care services delivered based on shadow billing) / number of patients enrolled
- Number and type of complaints and adverse events in the home / number of patients enrolled – Target 0%
- Number of patient requests to transition from bundled services to long term care bed / number of patients enrolled – Target 0%

Qualitative
- Number of patients/caregivers reporting improved quality of life or sense of safety at home / number of patients enrolled – Target ≥ 95%
- Number of active staff identifying job satisfaction as good to excellent / number of active staff – Target ≥ 95%
- Patient or caregiver interviews conducted – Target ≥ 95% – describing:
    - Goals and expectations for the services at the start of services
    - Whether services received have met those expectations

APPENDIX 2 – Request for Service Questions and Response Template

	Written Submission – Overall point value 100	Points
1.	**General Description** What is your organization's vision, and what relevant experience, strategic partnerships, and resources make it well-suited to deliver Bundled High Intensity Home Care – LTC services to the target population in both rural and urban settings?	5
2.	**Service Model** Describe the bundled care service model your organization proposes to deliver and how your approach will provide safe, dependable Bundled High Intensity Home Care – LTC services in the community. Detail your plan to coordinating complex patient discharges within 24 hours of notice of planned discharge, and detail how your staffing structure is designed to facilitate the prompt transition of high-needs ALC patients in accordance with Ontario Health atHome timelines. Include how you would approach initial and ongoing care planning conversations with the patient, how you propose to allocate resources/services based on individual patient needs. Detail how you will ensure service redundancy in the event of unanticipated changes to patient needs, or to staffing availability. Describe how these bundled services can be implemented, monitored, and tracked using existing referral, notification, billing, or reporting systems.	20
3.	**Health Human Resources Capacity** For each service area you propose to serve, detail: 1. The number of patients your organization will be able to serve by geography based on the 'Target volume of weekly active patients' chart. 2. Your existing part-time and full-time Health Human Resources (HHR) complement, by worker type (including, but not limited to, all workers meeting existing qualification requirements for Ontario Health atHome services). It is expected that at least 80% of the work force is full-time equivalent and the remaining 20% part-time. 3. Any new or additional unregulated workers who would provide patient services, if applicable, along with a rationale for their inclusion and a description of the scope of services they will provide. 4. Your projected HHR capacity needs once the bundled services is fully implemented, as well as any plans and timelines needed to ramp-up capacity from launch on December 8, 2025 to full implementation, with the goal of achieving 100% referral acceptance. 5. How you will provide these services without disrupting the existing services you provide to Ontario Health atHome.	20
4.	**Service Model or Technology Innovations;** Detail any 'non-traditional' or 'emerging services' you will make available to patients, their families, Ontario Health atHome or the broader healthcare system to support Bundled High Intensity Home Care – LTC services for patients. Identify the specific innovations or technologies your model proposes for the provision of Bundled High Intensity Home Care – LTC services. How will these innovations better serve patients and/or the healthcare system? Describe any technology or tools that will be made available to patients, their families or Ontario Health atHome providing real time information on services, schedules, or patient care.	10

5.	**Risk Management, Changes to Patient Care Needs and Prevention of Unplanned Hospital visits** Describe how you will communicate in real time about patient care and changing patient needs, and any process steps to make adjustments to care plans or scheduling. Describe how you will work with patients and families to manage patient complaints, worker re-assignments, out of scope service requests and worker safety concerns to prevent interruptions in patient care. Describe how you will optimize service and care delivery to prevent Missed Care. Describe how you will eliminate avoidable Emergency Department (ED) visits and Hospital admissions. Describe what urgent/on-call services will be available to support emergency patient needs.	20
6.	**Performance Measurement** In addition to (or in lieu of) the indicators proposed, what specific indicators would you propose to track to determine the success of the bundled services and why? What technologies, tools, or processes will you put in place to ensure that the performance or quality data you report is accurate, reliable, and verifiable?	10
7.	**Existing Performance** Please list all active Quality of Improvement Notices (QINs) your organization currently has within the proposed area and/or region.	10
8.	**Recommended Improvements for Consideration** Describe any changes or recommendations you would make to the service model described herein that will improve the care available to patients through the bundled services**.**	5