South West LHIN

South West LHIN Residential Hospice Guiding Document

January 2017

Ontario
Local Health Integration Network

Table of Contents

Purpose

The purpose of this document is to:

- support stakeholders and interested community groups to understand the process and South West Local Health Integration Network (LHIN) expectations regarding Residential Hospice (RH) planning;
- manage expectations about what is and isn't possible or in scope for RH planning;
- ensure alignment of RH planning and implementation to the LHIN's guiding and planning and development principles;
- ensure guiding and planning and development principles can be referenced and applied while making decisions or recommendations to increase consistency and transparency; and
- enable the successful implementation of new RH resources.

The elements outlined in this document will also be used to assist the South West Hospice Palliative Care (HPC) Leadership Committee in their review of RH proposals under consideration. It will assist in identifying areas of strength within proposals and also components that may require additional development.

Background

Context

In June 2016, the Province of Ontario announced the addition of 200 new RH beds by the end of 2018/19. RH is recognized as an important element in the continuum of care and a key enabler to achieving an overall reduction in the percentage of deaths that occur in hospital. In the past, RH were developed by communities without consistent, active LHIN involvement and were funded based primarily on community readiness. Now, in order to optimize access and maximize their utility, RH beds are being planned by the South West LHIN to be a part of an integrated system or continuum of care in alignment with a regional capacity plan which identifies needs and gaps. As a specialized service, RH care is positioned as a multi-community service and locations will be expected to serve a broad catchment area aligned with the LHIN sub-regions. To ensure these services are offered in an optimal way, the role and level of LHIN involvement in RH planning has increased significantly over several years.

Leadership

To support planning efforts and provide leadership to develop and evolve a comprehensive, integrated and coordinated system of hospice palliative care, the LHIN established the South West HPC Network in December 2013 building on the strength of the previous End of Life and Hospice Palliative Care Networks in the South West. The Network has the mandate, accountability and structure to achieve the goals outlined in the Declaration of Partnership and

Commitment to Action, 2011. The Network is supported by 5 sub-region Collaborative tables responsible for providing local leadership to implement the Integrated Hospice Palliative Care Program and priorities within the LHIN, to advocate for local needs and priorities and to support a quality improvement approach and engagement activities. Membership of the Leadership Committee and local Collaboratives is detailed in the Terms of References and representative of key stakeholders including health service providers, patients/families and communities. Members are appointed by the LHIN. The HPC Leadership Committee focuses its efforts on evidence-based decision making as plans and recommendations for RH capacity expansion are considered across the South West.

Residential Hospice Capacity Planning

The RH planning work being done by the LHIN has been informed by the results of a regional capacity plan completed by the LHIN in partnership with the South West HPC Network in July 2015 and refreshed in November 2016. The report focused on a population-based approach to planning and was aligned with the provincial approach to capacity planning identified by the Ontario Palliative Care Network (OPCN). The aim was to understand the current state resources and to determine the need for additional HPC resources (bedded and community) in hospital settings, RH, and in community settings with integrated home care. RH services will complement the volunteer services, community and hospital palliative care that are already available in sub-regions. A summary of the approach and assumptions used to inform the development of the recommendations from the capacity planning report is included in Appendix A.

The approach to the development of capacity planning recommendations being leveraged for this work clearly outlines the roles of all groups involved in the process including LHIN staff, the HPC Leadership Committee and the HPC Local Collaboratives. The primary role for these groups are as follows.

- LHIN staff and leadership – lead and inform the capacity planning process and decision making to enable recommendations through funding as appropriate
- HPC Leadership Committee – develop recommendations
- HPC Local Collaboratives – moving recommendations to action

The regional capacity plan identified Huron Perth, Grey Bruce, and Elgin sub-regions as priority geographies for the establishment or enhancement of RH capacity. The HPC Leadership Committee actioned the recommendations through the South West HPC Network. The local Collaboratives in these areas are focused on planning and implementing these recommendations including developing plans for the RH beds that have been identified for each sub-region. Approval to implement RH beds is dependent on confirmed funding from the Ministry of Health and Long-Term Care. (MOHLTC). London Middlesex and Oxford sub-regions are not current priority geographies with respect to RH expansion and are not currently actively planning for additional RH services. Both of these sub-regions currently have 10 residential hospice beds in operation: St. Joseph's Hospice, London and VON Sakura House, Woodstock.

Current Status of RH Funding in the South West LHIN

In August 2016, the South West LHIN received additional annualized base funding for 2016/17 to support the expansion of RH services offered by the RH of Grey Bruce by increasing the number of funded beds from six to eight.

The LHIN has also received confirmation of MOHLTC support for the establishment of 14 additional new RH beds by 2018/19, in order to meet the LHIN's recommended bed allocation for the Grey Bruce (4 beds) and Huron Perth (10 beds) sub-regions. While the site(s) for additional beds have not yet been confirmed and approved by the South West LHIN, the Ministry is committed to providing funding for the new beds as they become operational.

What is Residential Hospice?

A residential hospice is a home-like environment where adults and children with life-threatening illnesses receive end-of-life care services.

Hospice Palliative Care of Ontario defines community residential hospices as a healthcare facility and registered charity that provides palliative care services by an interprofessional team with palliative care expertise 24 hours a day, 7 days a week in a home like setting for the individual and their significant others at no cost to the user. Facilities incorporated in a Community Residential Hospice consist of at a minimum:

- Private residential rooms;
- Community living room, kitchen and eating area;
- Quiet area;
- Tub/Shower room;
- Public washrooms meeting accessibility regulations;
- Dirty utility area;
- Supplies area/station including secure medication room;
- Administrative offices; and
- Children's play area.

Hospice Palliative Care Ontario (HPCO) and the Canadian Hospice Palliative Care Association (CHPCA) have established both provincial and national standards of care and norms of practice with which RH must comply.

Additional information related to the Provincial RH "Working definition" can be found in Appendix B.

Key Guiding Principles and Planning and Development Principles

To support decision making to guide the successful implementation of new RH in the South West LHIN aligned with the LHIN's vision for integrated hospice palliative care and a continued

commitment to quality improvement, the South West HPC Leadership Committee has developed guiding principles as well as more specific planning and development principles. These principles were endorsed by the Leadership Committee on December 6, 2016 and the South West LHIN Board on January 17, 2017.

These principles will:

- Solidify the vision and attributes of a RH as part of a high quality, high value integrated system;
- Support stakeholders and interested community groups to understand the development process and LHIN expectations;
- Manage expectations about what is and isn't possible or in scope for this planning;
- Ensure alignment during decision making to ensure consistency and transparency; and
- Enable the successful implementation of new residential hospice resources.

For the purpose of this work, guiding principles reflect broad ideas that influence consideration and decision making while the planning and development principles represent more specific guidelines that align with the guiding principles.

Guiding Principles

- Ensure every person, no matter who they are, where they live or how much they make, has **equitable** access to residential hospice;
- **Engage** patients, families, and communities in a meaningful way in both planning and ongoing operations;
- Be based on **best available data, evidence and best practices** to support a culture of **quality** that is relentless in its pursuit of improving experience of care at end of life;
- Be aligned with our commitment to **transparency**;
- Be a part of a fully **integrated** system where individuals and organizations intentionally work together to better organize and connect services to meet needs; and
- Make best use of resources to ensure **sustainability** and **feasibility.**

Domains for Planning and Development Principles

The planning and development principles that support the guiding principles are aligned with domains, core elements and pillars common across several key input documents and include:

- Accessible
- Effective
- Safe
- Patient/Family Centered
- Equitable
- Efficient/Sustainable
- Appropriately Resources
- Integrated
- Communication

Planning and Development Principles

Domain	Planning and Development Principles
Accessible	• As a multi-community service, ensure the maximum number of people in the South West LHIN have access to Residential Hospice (RH) services within a reasonable travel distance from their home (50 km radius or approx.1 hr.)

	• Leverage existing, established centralized access and waitlist mechanisms and processes to facilitate timely access and admission
Effective	• Complies with the provincial RH "Working Definition" • Is grounded in a Centre of Excellence Model • Complies with all Hospice Palliative Care Ontario(HPCO) Community RH Standards • Policies and procedures are evidence informed • Demonstrates effective governance and management to ensure organizations are successful, sustainable, and accountable

Safe	• All RH planning and operating activities are conducted in a manner that:
	  • Ensures confidentiality and privacy of patients
	  • Is without coercion, discrimination, harassment, or prejudice
	  • Ensures safety and security for all participants
	  • Identifies conflicts of interest
	• Practice complies with provincial and national standards of care and norms of practice detailed by HPCO and the Canadian Hospice Palliative Care Association
	• Able to achieve elements of terms and conditions and/or obligations to receive LHIN funding

Patient/ Family Centered	• The public and communities are actively engaged and consulted by the local HPC Collaborative when developing plans for residential hospice. • Patient and family lived experience will inform all aspects of RH planning • Processes are open and transparent to the public • A range of HPC resources and supports are provided to individuals and families at RH settings beyond end of life including bereavement
Equitable	• A unified approach to care for each sub-region is designed to meet the needs of the population not an individual community • All aspects of care are provided in a manner that is sensitive to the person and family's personal, cultural, and religious or spiritual values, conditions, beliefs, and practices, to support them to deal with the dying process
Efficient/ Sustainable	• Aligns with the regional capacity plan recommendations • Be sustainable and feasible • Consider a centralized model with/without satellite(s) to achieve equitable access to RH for all residents in a sub-region aligned with the reasonable travel principle • Proximity of residential hospices in other sub-regions or LHINs are considered to optimize equitable access throughout the region • Partnerships and technology are leveraged to extend the capacity of limited resources • Assessment and admission processes are timely and effective so placement can be facilitated when individuals are ready/appropriate for RH care
Appropriately Resourced	• Models with satellite sites of no less than 4 beds, no more than 10 beds will be explored • The financial, human, information, physical, and community resources are sufficient to sustain the organization's activities, and it's strategic and business plans • Data collection/documentation guidelines are based on validated measurement tools in collaboration with the OPCN and HPCO

	• Health human resource plan identifies adequate numbers of trained professionals and volunteers are available • Ensure the human resource plan includes medical leadership and a focus on growing the capacity of physician resources to support 24/7 palliative coverage
Integrated	• Integrated strategies to strengthen the continuum that leverage formal integration and collaboration opportunities between the RH, other HPC services and other health sectors across sub-regions are preferred • Achieve seamless transition points between services and supports in the last weeks and months of life • Related sectors and services connected to RH are linked by common practice, processes, structures, and education • Funding is distributed and directed in a way that supports an integrated continuum of care • Decision making and development processes will be open and transparent • Works closely with the HPC Network as a partner in the local Collaborative around planning and operations
Communication	• Strive to consistently and continuously provide accurate information related to planning efforts and present a unified front when providing information to the public • Information about requirements, processes and decision making at the local and regional level will be transparently available

Proposals from local HPC Collaboratives related to the development of new sub-region RH resources will need to demonstrate alignment with the elements of these guiding, planning and development principles. A RH Submission Review Support Tool (Appendix C) aligned with the principles has been developed to assist the HPC Leadership Committee in its review of RH plans under consideration. The tool assists in identifying areas of strength within the plan and also components that may require additional development.

Decision Making Process for Residential Hospice

The South West LHIN is relying on advice from the South West HPC Leadership Committee and local Collaboratives to inform the planning and development of RH capacity as part of an integrated system of hospice palliative care in the LHIN. The responsibility for final decisions related to the siting of HPC beds and the associated funding rests with the South West LHIN Board of Directors.

The local HPC Collaborative is responsible for developing the unified sub-region solution and ensuring principles have been applied throughout engagement and development of the plan. The minimum elements of a business plan are outlined in Appendix D. They complete a RH Submission Readiness Support Tool (Appendix E) that clarifies alignment with the steps identified in the approach to planning the implementation of RH. Once the Local Collaborative

has a fully developed plan, their Executive Lead introduces the proposal at the HPC Leadership Committee. This triggers the decision making process.

The steps of the decision making process for RH are as follows:

1. The HPC Leadership Committee reviews the local submission for alignment to vision and principles leveraging the RH Plan Review Support Tool which identifies elements of strength and components that require additional development (Appendix C). The Leadership Committee **endorses** the plan when they are ready for LHIN staff to review and develop a recommendation to the LHIN Board.

2. LHIN staff conduct due diligence and provide assurance to the Board that process has been followed and that the plan aligns to vision and principles. LHIN staff **recommend** that the LHIN Board consider approving the plan in principle.

3. LHIN Board receives advice and recommendation of Leadership Committee and LHIN staff and are responsible for decision making that will advance the vision for integrated HPC in a sustainable manner. Pending consideration, the LHIN Board **approves** the recommendation and support movement to implementation phase pending confirmation of funding from the MOHLTC.

Appendix F provides a summary of steps of the decision making process for RH.

Residential Hospice Funding and Accountability

RH Funding from the South West LHIN

Funding Amount

Consistent with provincial policy and based on available funding from the MOHLTC the South West LHIN provides $105,000 per RH bed in annualized funding. This funding flows once the hospice is operational, to the CCAC for the RH.

This funding amount is based on the population (adult or paediatric), the number of beds and the staffing levels needed. The Ministry consulted with key stakeholders on the recommended staffing levels and the supporting model developed for hospices that choose to be the employer includes:

- 24/7 Registered Nursing (RN) coverage – based on HPCO RH Standards
- Appropriate mix of nursing (RN and RPN) and personal support services staff based on the number of beds
- Minimum of two staff on site 24/7
- Other services will be offered through the CCACs based on assessed need (e.g., other professional services, drug card, medical supplies and equipment)

If any component of a service delivery model includes residential services, the RH funding policy must be followed. RH need to be compliant with all current provincial and federal legislation.

Use of LHIN Funds

The annualized funding provided by the LHIN for RH is the total amount available to enable the provision of nursing and personal support in the hospice. The only exception to this would be if the client needed the services of a specialized nurse, e.g. Enterostomal Therapy nursing. If RH total funding exceeds its total cost for nursing and personal support services, the remaining funds may be applied to other costs of meeting the medical needs of patients and caregivers in the RH, including:

- social work services;
- care coordination of services;
- medical supplies and equipment; and
- training.

A RH that uses funds to cover costs other than nursing and personal support services must include these details in its regular financial reports to the South West CCAC

The RH is responsible for raising funds for operating costs over and above $105,000/bed and for any capital expenses.

Funding Eligiblity

In order for a RH to be eligible to receive LHIN funding, they must:

- be in a sub-region identified as a priority for the LHIN and included in its RH planning with the OPCN;
- adhere to the HPCO Community RH Standards;
- have a building that meets the HPCO Community Residential Hospice Standards that is ready to serve clients;
- have ongoing community commitment for operating costs not covered by the provincial funding (e.g. administration, food, housekeep etc.); and
- Adhere to the South West LHIN RH guiding principles and planning and development principles.

Funding Options

The funding support for RH by the MOHLTC and the LHIN is provided to the CCAC. This funding model was chosen by the Ministry to improve consistency and efficiency related to the provision of nursing and personal support care in RH.

RH have two funding options.

1. **Health Service Provider (HSP) operates the RH and hires dedicated staff**: RH receives a funding envelope to independently employ nursing and personal support services, with an accountability agreement through the CCAC; or
2. **CCAC provides the service to the RH**: RH receives enhanced hours of service for nursing and personal support through the CCAC.

In all cases, CCACs will provide other services including case management, drug benefits, medical supplies and access to equipment and therapies (physiotherapy, occupational therapy, social work, dietary, speech language pathology) as needed.

Conditions of Funding Option 1

Under funding option 1, the RH is the service provider under the Long-Term Care Act and cannot contract another agency to receive nursing and/or personal support services. They must employ or contract the nursing and personal support staff directly. They cannot engage in a third party service provider to provide service, with the exception of needing to find replacement staff on an occasional basis from another provider. The hospice would be responsible for all services provided with the hospice.

The CCAC will negotiate an accountability agreement with the RH using the template developed by the Ontario Association of CCAC (OACCAC) based on ministry policy. The agreement clarifies the operational, accountability, financial and reporting relationships between the CCAC and the RH.

Additional key conditions include:

- the CCAC Case Manager is responsible for determining client eligibility for nursing, personal support and all other CCAC services, prior to a client being admitted to the hospice;
- must adhere to conditions for use of funds as detailed above; and
- a RN provides on-site coverage 24 hours a day, 7 days a week.

In order to retain the total annualized funding amount there would need to be a minimum occupancy of 80% over the year as reported within each reporting period (quarterly) with a year-end reconciliation.

Once the hospice begins admitting clients, the need to maintain a minimum occupancy level of 80% will be waived for the first 3 months.

Conditions of Funding Option 2

Under funding option 2, the CCAC will use the designated funding from the Ministry to provide nursing and personal support services in the RH through CCAC contracted service provider(s). The CCAC will be required to track this funding separately in their management information system and funding will not be transferrable to other CCAC services.

Although an accountability agreement is not required by the Ministry, the CCAC may choose to put into writing their commitment to the RH, e.g. the number of hours a day of RN, etc. that will be provided by the contracted service provider.

Accountability

The CCAC and the RH organization are required to maintain financial records for the allocation for year-end evaluations and settlement. Unspent funds within the fiscal year may be subject to recovery.

Performance standards will be confirmed with an accountability agreement between the South West CCAC and the RH organization consistent with those outlined in agreements with other RH within the South West.

A RH is required to report monthly on key performance indicators to the CCAC and to the LHIN and to contribute data and information to the HPC Network to support the regional and sub-regional HPC dashboard.

Additional Resources

The South West LHIN strongly suggests that partners who are planning for enhanced sub-region RH capacity consult with HPCO and obtain its:

- *Standards for Community Residential Hospice;*
- *How to Develop a Community Residential Hospice Handbook*; and
- *How to Develop a Community Residential Hospice Toolkit: A Companion to HPCO's Handbook*

These resources provide detailed resources and tips that would be beneficial in the planning process including an overview of the essential planning steps (page 29, *How to Develop a Community Residential Hospice Toolkit: A Companion to HPCO's Handbook).*

Additionally, in order to better support HPC Collaboratives and the communities they work with to make informed decision on how to approach implementation and readiness to begin operation, the following additional resources have been included.

1. Phases of RH Development (Appendix G) – Which gives an estimate of the time and resources necessary for the various phases of RH development.
2. South West LHIN Organizational Assessment Tool - To assist integration and collaboration efforts, the South West LHIN Organizational Assessment Tool has been designed to assess organizational health, human resources, quality of health services, and financial and performance improvement opportunities.

Appendix A: Approach and Assumptions to Develop Residential Hospice Capacity Planning Recommendations

Goal: To increase the percentage of deaths that occur in the "right place", by decreasing the percentage of total deaths in hospital (especially in the acute setting).

If we are to achieve this goal, the variance to the capacity benchmarks indicates that the areas with the greatest opportunity to improve are home with support (11.4% to 28%) and RH (4.4% to 12%).

Capacity data were reviewed first at the sub-region level and then at the county level where significant variance was evident. Each sub-region was reviewed looking at current capacity and the benchmarks with a significance variance was evident. Other factors such as the presence of other resources compared to other under-serviced geographies may impact overall ranking.

High priority areas were identified and ranked 1st to 5th for each hospital, home, LTC home and RH. Where a small variance between current capacity and the benchmark were identified, 2 geographies may have the same ranking.

Recommendations reflect enhancements to certain services but also include recommendations related to address best use of current resources, leveraging consistent process, etc. for geographies that have resources that are more currently maximized. Priority with respect to recommendations for funding and allocation of human resources to support the work will be given to addressing those items and areas ranked 1st, then 2nd, then 3rd etc.

Appendix B: Provincial RH "Working Definition"

According to the Province of Ontario, a RH:

- is a non-profit healthcare facility which provides specialized HPC beds and services in a homelike setting for the residents it serves and their families.
- provides care delivery from professional staff 24 hours a day, 7 days a week to meet the residents' needs in accordance with each resident's plan of care/treatment plan.
- Facilities with 3 beds or less have, at minimum, access to a registered nurse 24/7
- Facilities with 4 beds or more have a registered nurse on-site 24/7
- has a model of care which is collaborative in nature and provides palliative care using a holistic approach through an inter-professional team that has expertise in palliative care.
- has end-of-life beds where referral from any source can occur and is supported by centralized intake and assessment.
- complies with provincial and national standards of care and norms of practice detailed by Hospice Palliative Care Ontario (HPCO) and the Canadian Hospice Palliative Care Association (CHPCA).
- has a staff and collection of volunteers that in their assumed roles complete ongoing HPC training, demonstrating a commitment to life-long learning in order to maintain competency in practice.
- ensures facilities associated risk is minimized.

Appendix C: Residential Hospice Submission Review Support Tool

South West LHIN

Residential Hospice Submission
Review Support Tool

Please record your review of the Residential Hospice plan under consideration. This tool is intended to assist in assessing the plan's alignment to the South West LHIN's guiding principles, planning and development principles, processes and requirements for residential hospice. It will assist in identifying elements of strength within the plan and also components that may require additional development.

This tool will be collected from each HPC Leadership Committee member at the end of the review meeting. A summary report will be produced to share back to the submitting local Collaborative and to be included with the plan to the South West LHIN Board should the HPC Leadership Committee recommend that the Board consider approving the plan.

Please indicate with a ☑ if the plan aligns the planning and development principles described below.

A. PLANNING AND DEVELOPMENT PRINCIPLES CHECKLIST

1. **Accessible:**
   - ☐ Model reflects a multi-community service as defined in the BluePrint Vision 2022
   - ☐ Locations are designed to maximize the number of people in the sub-region that will have access to residential hospice services within a reasonable travel distance (50km or approx. 1 hr. radius)

2. **Effective:**
   - ☐ Model of care demonstrates compliance with provincial Residential Hospice "working definition"
   - ☐ Grounded in a Centre of Excellence Model (leadership, best practices, research, support and training)
   - ☐ Demonstrates commitment and ability to comply with Hospice Palliative Care Ontario Community Residential Hospice standards
   - ☐ Demonstrates effective governance and management to ensure organization is positions to be successful, sustainable and accountable

3. **Safe:**
   - ☐ Local Collaborative and Residential Hospice Working Group have demonstrated an approach to planning that has been:
     - Without coercion, discrimination, harassment, or prejudice
     - Ensures safety and security for all participants
     - Identifies conflicts of interest
   - ☐ Commitment to comply with provincial and national standards of care and norms of practice is evident

4. **Patient/Family Centered:**
   - ☐ Public, communities, and patients/families were consulted during the development of the plan
   - ☐ Evidence that patient and family lived experience has been a key input to inform planning

Ontario
South West Local Health Integration Network

☐ Evidence that patient and family lived experience will inform the operation of residential hospice resources (e.g. family council, patient/family surveys)

☐ Planning steps and activities were open and transparent to the public

☐ Model describes a variety of HPC resources and supports for end of life including bereavement

5. **Equitable:**

☐ Proposed sites are positioned to meet the needs of the population of the sub-region and not an individual community

☐ Optimized access spread across the sub-region without compromising quality of care

☐ Model of care is designed to be sensitive to the person and family's personal, cultural and religious or spiritual values, conditions, beliefs and practices

6. **Efficient/Sustainable:**

☐ Aligns with the regional capacity plan recommendations

☐ Financial aspects of plan demonstrate it can reasonably be assumed that the model is sustainable and feasible

☐ Identifies a model that will achieve optimize access to residential hospice for all residents in a sub-region aligned with the reasonable travel principle

☐ Proposed sites have factored in location of residential hospices in other sub-regions and LHINs to optimize equitable access throughout the LHIN

☐ Partnerships have been considered to optimize the sustainability of the model and to potentially extend the capacity of limited resources

☐ Technology has been considered to optimize the sustainability of the model and to potentially extend the capacity of limited resources

☐ Assessment and placement processes are designed to be timely and effective

7. **Appropriately Resourced:**

☐ If a centralized model with satellite(s) has been identified, sites have a minimum of 4 and a maximum of 10 beds

☐ The is evidence to support presence of sufficient financial, human, information, physical, and community resources to sustain the residential hospice's activities

☐ Health human resource plan identifies adequate numbers of trained professionals and volunteers to meet the demand

☐ Medical leadership and appropriate physician resources to support 24/7 coverage have been identified or a plan to grow capacity has been documented

8. **Integration:**

☐ Integration strategies or opportunities to strengthen the continuum of care between the Residential Hospice, other HPC services and other health sectors across sub-regions are identified

☐ Residential Hospice will be connected to other related service providers/sectors through common practice, shared processes, structures and education

☐ Consideration has been given to how to achieve seamless transition points between services and supports in the last weeks and months of life

☐ Model identifies an integrated, single corporate entity, governed by a single board, operated by a single management structure

9. **Communication:**

☐ A plan to consistently and continuously provide accurate information related to planning efforts to the public is identified

B. PLANNING AND DEVELOPMENT PRINCIPLES NARRATIVE

Please use the text boxes to record reflections on alignment and/or key gaps or missing elements for each of the overarching planning and development principles.

1. Accessible:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

2. Effective:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

3. Safe:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

4. Patient/Family Centered:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

5. Equitable:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

6. Efficient/Sustainable:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

7. Appropriately Resourced:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

8. Integration:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

9. Communication:

Do you feel the plan has met the key requirements?:	Key gaps or missing elements:

C. SUMMARY REMARKS

Overall reflections on the plan not covered above:
Any overall gaps or missing elements in the plan not covered above:
Any unmitigated risks:

Recommend for Board consideration:

☐ Yes, I recommend this moves forward for South West LHIN Board consideration

☐ No, redirect back to Collaborative to address identified issues

If no, please provide rationale?

Appendix D: Business Plan Content Requirements

The following is a list of the minimum contents of a sub-region business plan.

1. Project Name
2. Brief description of the project
3. Key goal(s)/objective{s} of the project
4. Background or case for support/demonstrated need
5. Target population
6. Impact of project on target population
7. Existing supports within the sub-region
8. Health system sustainability and/or benefit
9. Scope of program, services and supports
10. Proposed location(s) of services
11. Governance plan and structure
12. Management plan and structure
13. Health human resources plan
14. Reporting and accountability
15. Risk/issues/challenges
16. Communications and community engagement plan
17. Details of capital and operating costs including draft operating budget
18. Sustainability and fundraising
19. Proposed implementation plan

Appendix E: Residential Hospice Submission Readiness Support Tool

South West LHIN

Residential Hospice Submission Readiness Support Tool

The Submission Readiness Assessment is to be completed by Collaborative Executive Lead, HPC Lead and LHIN staff and included with the Residential Hospice Plan to Leadership Committee.

A. PLAN DEVELOPMENT PROCESS - Approach to Planning the Implementation of Residential Hospice

Please indicate with a ☑ if the plan aligns with the *elements of the approach to planning the implementation of residential hospice*. Use the text boxes to record reflections on alignment and/or key gaps or missing elements related to the plan development process.

☐ A plan documenting major milestones and engagement process aligned with guiding, planning and development principles was completed and submitted to the Leadership Committee at the onset of planning.

☐ Communities, patients/families, health service providers and other key stakeholders were engaged in meaningful ways in the process (to gather data and lived experience, to conduct environmental scan, to inform development of the model)

☐ An environmental scan or similar activity was conducted to understand interested communities/groups, capacity of communities to support, available resources (financial, professional and non-regulated staff and volunteers).

☐ A variety of models were evaluated to identify optimal, sustainable sub-region unified solution.

☐ Business plan and/or proposal was presented to the Local Collaborative and has been endorsed during their component of the decision-making process.

Outcome of the Collaborative decision to endorse and rationale for dissenting or abstaining votes:

Reflections on Alignment to Elements of Plan Development Process:

Ontario
South West Local Health Integration Network

Key Gaps, Missing Elements or Unmitigated Risks from Plan Development Process:

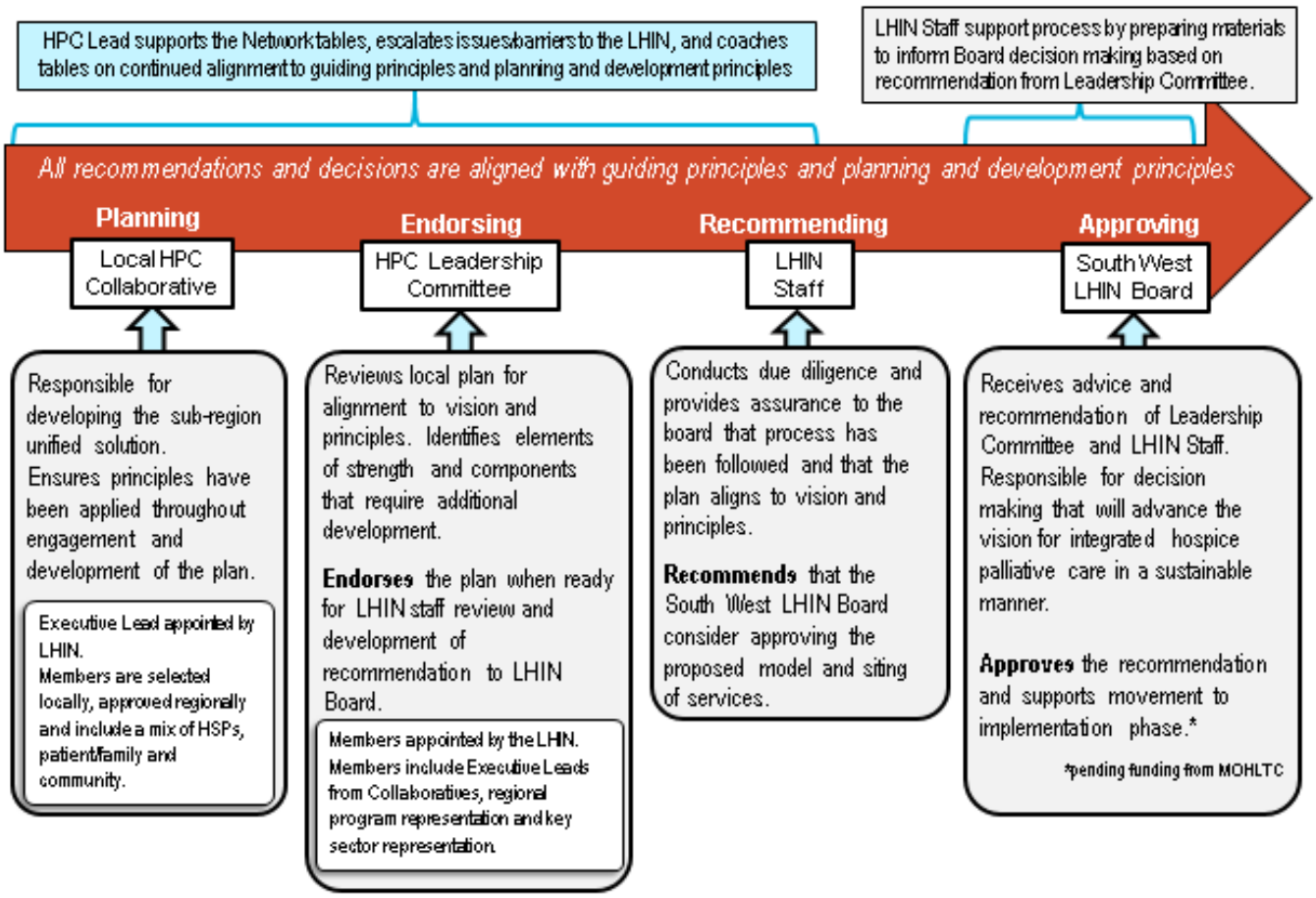
B. MINIMUM ELEMENTS OF BUSINESS PLAN

Please indicate with a ☑ if the following elements are present in the business plan:

- ☐ Project Name
- ☐ Brief Description and Goal/Objectives of the Project
- ☐ Background or Case for Support/Demonstrated Need
- ☐ Target population and ☐ Impact on target population
- ☐ Existing supports within Sub-Region
- ☐ Health system sustainability and/or Benefit
- ☐ Scope of Programs, Services and Supports
- ☐ Proposed location(s)
- ☐ Governance Plan and Structure
- ☐ Management Plan and Structure
- ☐ Health Human Resources Plan
- ☐ Reporting and Accountability
- ☐ Risks and Challenges
- ☐ Communications and Community Engagement Plan
- ☐ Details of Capital and Operating Costs including draft operating budget
- ☐ Sustainability and Fundraising
- ☐ Proposed Implementation Plan

Comments on the Elements of the Business Plan:

Appendix F: Decision Making Process for Residential Hospice



Appendix G: Phases of Residential Hospice Development

Engaging the Community

- Timeline: 3-6 months and then cyclical going forward
- Financial range: Up to $50,000
- Focus: Consultation with community and key stakeholders and needs assessment

Charting a Path: Strategy, Vision and Planning

- Timeline: 6-9 months
- Financial range: $20,000 - $150,000
- Focus: Planning and proposal development (pre-operational)
- Sometimes includes feasibility studies for both project and campaign

The Building Project: Capital Campaign and Fundraising:

- Timeline: 12-30 months
- Financial range: $1 - $4 million
- Focus: Building and implementation
- Potential for up to $100,000 to be spent on minor capital and equipment in order to facilitate progression to operational stage within following fiscal year.

Note : There is the potential that some operational funding will be available prior to admitting clients to support recruiting, hiring and training of nursing and personal support staff.

Up and Running: Operations

- Financial range: $840,000 - $2 million ongoing depending on the number of beds (based on minimum of 4 beds, maximum of 10 beds)
- Focus: Operational
- Current allocation of $105,000/bed annually from the LHIN to be used first for nursing and personal support service. If RH total funding exceeds its total cost for nursing and personal support services, the remaining funds may be applied to other costs of meeting the medical needs of patients and caregivers in the RH, including:
    - social work services;
    - care coordination of services;
    - medical supplies and equipment; and
    - training.
- Hospice must raise any additional funds for other salaries, utilities, general and office supplies, operating and facility costs, etc.

NOTE: The above information is based on data available from Hospice Palliative Care Ontario (HPCO). The dollar values and timelines are reflective of the planning and development principles being leveraged to guide residential hospice planning in the South West LHIN.

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