



Pilot: Primary Care Low Back Pain (PCLBP)

APPLICATION TEMPLATE

Aboriginal Health Access Centres
Community Health Centres
Family Health Teams
Nurse Practitioner-Led Clinics

Please note completed applications must be received by the ministry by 5:00 p.m on November 21, 2013 by email to pclbppilot@ontario.ca

Applications should be submitted with the subject line:

“Pilot: Primary Care Low Back Pain (PCLBP) Application” – “(Name of Organization)”

If additional information is required regarding the application process please contact:

Email/phone contact information:

Disclaimer

It is the applicant’s responsibility to ensure that all information provided by the applicant is up-to-date and correct to the best knowledge of the applicant.

It is the applicant’s responsibility to ensure that the application reaches the ministry on, or prior to, the application closing deadline. The ministry is not responsible for applications that are lost, delayed, misplaced or misdirected.

By submitting applications, applicants acknowledge that this is not a competitive procurement/tender and that determination of the successful candidates for funding shall be made at the ministry’s sole and absolute discretion.

Consent

The ministry frequently receives requests for the release of contact information. By submitting this application template, your group consents to the release of the information contained in question 1 to requesting individuals or organizations, if the group’s application is successful.

Application Evaluation

1. Scoring

Section 1: Contact Information	0 Points
Section 2: Defining Target Population	10 Points
Section 3: Core Team and Services	30 Points
Section 4: Readiness to Integrate and Operate	15 Points
Section 5: Evaluation, Ability to Measure and Show Results	20 Points
Section 6: Other Information	0 Points
Section 7: Applicant Acknowledgement	0 Points

Total 75 Points

2. Qualitative Factors

Total 25 Points

All applications will be collectively assessed to maximize the optimal distribution of funds across the province taking into account qualitative factors such as rurality, type of innovation, size of grant etc.

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SECTION 1: ABOUT YOUR PRIMARY HEALTH CARE ORGANIZATION

1. Contact Information

Name of Primary Health Care Organization	
Mailing Address	
Name of Primary Contact	
Mailing Address of Primary Contact	
City/Town	
Postal Code	
Phone	
Fax	
E-Mail	
LHIN Name	

2. Is your Primary Health Care Organization incorporated? If yes, please provide full incorporated name.

3. Provide a brief (4-6 sentences) description of your PCLBP Project. (Maximum 150 words)

4. Are primary care providers in your organization involved with the Inter-professional Spine Assessment and Education Clinic (ISAEC) Pilot? If yes, your primary care organization is ineligible to participate in the PCLBP pilot.

SECTION 2: DEFINING TARGET POPULATION

5. Please describe the patient population that you or your organization will serve with this proposal. Your answer will be evaluated on how clearly you describe (maximum 200 words):
- a. The health care needs of the target population as it specifically relates to low back pain (LBP);
 - b. The gaps that currently exist in health service availability to these patients; and
 - c. Other (provide details in the comment box below).

6. Provide an estimate of the anticipated number of patients that would be included in your patient cohort and provide details on how you arrived at that estimate. (Maximum 100 words)

SECTION 3: CORE TEAM AND SERVICES

7. Please explain how allied health provider(s) (any combination of: chiropractor (DC), physiotherapist (PT), occupational therapist (OT) and kinesiologist (KIN) eligible for inclusion) as outlined in this proposal, would assist to meet the needs of the patient population, as described in Q.6. (Maximum of 250 words)
- If the model employs a combination of allied health provider (s) describe how each provider would work together to enhance an existing LBP management program or design a new LBP management program if one does not currently exist.

8. If creating a new LBP management program, describe in detail the services you intend to provide to the target population. At a minimum, all projects should provide a combination of the following services: Patient Education, Assessment, Referral and Treatment. (Maximum of 300 words)

9. If enhancing an existing LBP management program, describe the new services that will be added to improve LBP management in the target population. At a minimum, all projects should provide a combination of the following services: Patient Education, Assessment, Referral and Treatment. (Maximum of 300 words)

10. How will your group collaborate with other agencies to improve service integration and provide patients with LBP issues with enhanced care aimed at streamlining system navigation?

Describe any collaborating partners and include details on proposed partnerships, roles, level of commitment/ involvement in the program, in-kind support and/or opportunities to leverage other funding sources or complementary programs. (Maximum of 300 words)

Examples of collaborating partners could include:

- Community Care Access Centres
- Hospitals (including Emergency Departments, ambulatory health services, mental health outpatient clinics, crisis centres, etc.)
- Local Health Integration Networks
- Health Links
- Long Term Care Homes,
- Community Support Services / Assisted Living Services
- Mental Health and Addiction Agencies
- Other (provide details in the comment box below)

SECTION 3: READINESS TO INTEGRATE and OPERATE

11. Does your group currently have adequate space to accommodate (additional) allied health provider(s)?

12. What are the key steps (e.g., promote program) required to launch the project? When will it be operational (e.g., earliest start date)? (Maximum of 200 words)

13. Does your insurance coverage provide adequate, comprehensive general liability protection and professional liability protection for the integration of services that will be delivered by the allied health provider(s)? (Maximum of 50 words)

SECTION 5: EVALUATION, ABILITY TO MEASURE AND SHOW RESULTS

14. What measures will you use to evaluate the success of your project? Metrics should align with the following categories:

1. Experience of Care

- Improved patient knowledge and practice of low back pain self-management techniques
- Improved patient experience of care
- Improved provider/ team experience
- Improved provider awareness and comfort with non-invasive low back pain management strategies

2. Population Health

- Improved patient clinical outcomes

3. Per Capita Cost

- Decreased inappropriate utilization of health care resources (e.g., diagnostic imaging and surgical referrals).

Include details in the box below. (Maximum of 50 words)

15. How do you plan to evaluate these metrics? Which systems will you use to collect data?

Clearly outline how the success of the project will be determined and describe the tools that will be used to evaluate the metrics. For example, what data is available and regularly reported on that could be leveraged to assess the impact of the pilot. (Maximum of 300 words)

16. For each evaluation measure selected, what result do you anticipate achieving in the first 3, 6, 9 and 12 months of the project? Provide a clear description of the result(s) (performance goals) you anticipate achieving during the demonstration project. These results should be directly related to the measures identified in Q15. (Maximum of 200 words)

SECTION 6: OTHER INFORMATION

- *No score is awarded for Section 6; the information is being collected for information only.*

17. Please provide details on the total funding request and resource requirements.

- **PCLBP pilot funding is one-time and time-limited.**
The expectation is that successful projects will direct the majority of funding to service delivery. However, funds may be directed to administrative and project management support and overhead. (Maximum of 200 words)

Expenditure	Resource requirements (e.g., full-time equivalent (FTE) or % of an FTE)	Funding requirement
# of Allied health providers* (specify position):		
Administrative supports		
Project Management		
Other (specify)		
Subtotal		
In-kind contribution		
Total		

SECTION 7: APPLICANT ACKNOWLEDGEMENT

We, the undersigned, acknowledge the submission of our application to the ministry for the Primary Care Low Back Pain Pilot. If additional space is required, please copy the signature line and paste it below.

Applicant Signature
Applicant Name:
(please print)

Witness

Date