Expression of Interest for the TelePalliative Care Project

January 16, 2017
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1 INTRODUCTION

As a world leader in telemedicine solutions, including remote patient monitoring, Ontario Telemedicine Network (OTN) has the experience and leadership to implement innovative care models to benefit patients throughout their care journey. To date, more than 10,000 patients have been enrolled in Telehomecare across 10 of the 14 LHINs to help them manage their congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The subsequent successful trial implementations of Telehomecare in diabetes, post-acute monitoring, chronic kidney disease and mental health, as well as congregate living, reinforces OTN’s strong capabilities to leverage opportunities to further mature into new models of care.

OTN has been awarded funding from Canada Health Infoway (CHI) and the Ontario Ministry of Health and Long Term Care (MOHLTC) to plan, implement, and evaluate a hospice palliative care project. The aim of the project is to expand the existing Telehomecare program with a project designed specifically for individuals with a progressive life limiting illness. The identification of project partners is an essential component of the project. To ensure that OTN engages in a fair and transparent process, the OTN project team has partnered with the Ontario Palliative Care Network (OPCN) secretariat and the OPCN governance councils to release an Expression of Interest (EOI) to engage Regional Palliative Care Networks (RPCNs) across the province.

Submissions from RPCNs will be evaluated and scored on a set criteria outlined in Section 3 of this EOI. EOI applicants may be contacted for a readiness assessment to determine the engagement of their team partners and leadership, review of patient data for target populations, and review of the proposed care model. At least 2 EOI applicants will be selected to ensure that the project can achieve an overall minimum total number of 450 patient participants.

In responding to this EOI, OTN welcomes partnerships between health service providers, primary care practices, and/or other community agencies, working collaboratively with their RPCNs to integrate care throughout the continuum for individuals and families living with a life-limiting illness. OTN is collaborating with OPCN to ensure the project aligns with OPCN’s mandate and provincial direction for palliative care as outlined in the Declaration for Partnership.

The timelines for the EOI submission, review, and selection of successful project partners are outlined on the following page.
2 TELEPALLIATIVE CARE PROJECT BACKGROUND

2.1 Background

Hospice palliative care is a holistic, inter-professional approach aimed at addressing the physical, psychosocial and spiritual needs of a progressive life-threatening illness. 1 The Canadian Hospice Palliative Care Association (CHPCA) reinforces that symptom management is vital right from the time of diagnosis, not simply at the end of life. 2 The recently released Health Quality Ontario (HQO) “Palliative Care at the End of life” report advocates for early palliative care intervention and support for care in the location of choice. 1 Earlier palliative care can lead to better quality of life throughout the illness trajectory. 2 It should start sooner to ensure high-quality care, according to the “Palliative and End-of-Life Care” Provincial Roundtable Report. 3 However, a number of challenges exist in the current healthcare system:

- Nearly two-thirds (64.9%) of patients receiving palliative care die in hospital but most Ontarians prefer to die at home 1 (70-80% of Canadians would prefer to die at home) 2
- Approximately 63% of patients receiving palliative care had an unplanned emergency department visit 1

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1 Health Quality Ontario (2016). “Palliative Care at the End of Life”. Queen’s Printer for Ontario. 1-52.
2 Canadian Hospice Palliative Care Association CHPCA (2002). “A model to guide hospice palliative care: Based on national principles and norms of practice”.
• About 62% of patients receiving palliative care had at least one hospital admission in the last 30 days of life.¹
• Only 43.3% received palliative home care services.¹
• There will be 40% more deaths each year by 2020 that will contribute to a demand in palliative care.⁴
• 70% of Canadians do not have access to palliative care, and seniors account for 75% of deaths each year.²
• Avoiding ED visits alone in the last month of care could save the Ontario healthcare system an estimated $11.1M/year.⁵
• The Auditor General⁶ estimates the costs of providing palliative care in the last month of a patient’s life to be approximately:
  • $1,100 per day in an acute-care hospital bed
  • $630 to $770 per day in a bed in a palliative-care unit
  • $460 per day in a hospice bed
  • Under $100 per day where at-home care is provided
• Caregiver burnout is a key contributor to trips to the emergency room in the last stages of life. The cost of home-based palliative care is approximately $25,000 per month and mainly absorbed by lost caregiver wages and out of pocket expenses.⁷

Telehomecare currently supports patients with CHF, COPD and diabetes through remote tablet-based daily monitoring of physiological parameters coupled with structured learning experience and health coaching based on individualized patient and family needs. Telehomecare empowers patients to take a more active role in their health. OTN proposes expanding the existing Telehomecare program with a project designed specifically for individuals with a progressive life limiting illness who prefer to receive care in their community, allowing for better quality of care and significant cost savings.

2.2 Purpose

The objectives of the project include:

1. **Improving patient and family caregiver experience with their care**

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¹ Health Quality Ontario (2016). “Palliative Care at the End of Life”. Queen’s Printer for Ontario. 1-52.
² Canadian Hospice Palliative Care Association CHPCA (2002). “A model to guide hospice palliative care: Based on national principles and norms of practice”.
³ Canadian Hospice Palliative Care Association CHPCA (2012). “Fact Sheet: Hospice Palliative Care in Canada”.

Telepalliative Care EOI
2. Increasing access for patients and families to resources/programs/care teams/support/etc.
3. Improving patient outcomes (i.e. preferred location of death: % of patients who died in desired location, pain and symptom management)
4. Increasing primary care engagement in providing palliative care to patients who have palliative care needs
5. Reducing unnecessary transfers to acute care (i.e. % ED visits and % hospital admissions avoided)
6. Improving provider experience with a novel care model (i.e. utilization of technology, communication, care navigation/coordination)
7. Improving transitions between care settings (i.e. from hospitals to primary care, between primary care and hospice, between hospitals and hospice, etc.)
8. The ability to scale the improvements and technology to a regional and provincial level
9. The ability to fund, resource and sustain the improvements and technology solutions on an on-going operational basis.

2.2.1 Proposed Approach

The EOI has been developed in collaboration with the OPCN to align with their mandate to:
- **Be a principal advisor** to government for quality, coordinated, palliative care in Ontario
- **Be accountable** for quality improvement, data and performance measurement and system level coordination of palliative care in Ontario
- **Support regional implementation** of high-quality, high-value palliative care

OTN will work collaboratively with the OPCN to select project partners via the RPCNs. OTN will work with at least 2 RPCNs to implement the project for a total minimum of 450 patients/families living at home and who would benefit from a palliative approach to care that is supported by care teams within the community. Given the possibility that only 2 RPCN applicants will be selected, each applicant should expect to meet a requirement to enroll a minimum of 225 patients. The EOI will be issued to all RPCNs to ensure that all regions have an equal opportunity to participate.

Applicants are required to have the support and sign off of their RPCN leadership (i.e., LHIN CEO and Regional Cancer Program Regional VP) in addition to the leadership from the lead organization and leadership of partner organizations. A signoff template can be found under Appendix B.

2.2.2 Project Goal and Care Model

About 1.3 million Ontarians suffer from late-stage chronic disease in Ontario, and as these individuals live longer with their conditions, the demand for care at home and in the community increases (next page Figure 3).
The goal of the project is to enable more patient/family-directed support, identify and address emerging patient and family issues/trends, increase primary care engagement in palliative care, and provide collaborative connections among the patient’s care team while keeping the patient home, well supported and comfortable.

Virtual hospice palliative care models could address an individual’s and family goals and objectives at different points in time along the hospice palliative care continuum, for example:

- patients and caregivers at the self-management and stabilized treatment phase may want to actively seek more information or education about the diagnosis and their palliative journey, participate in support groups, or complete self-assessments to proactively share with providers;
- those at the health complications / pain and symptom management phase may benefit from an online tool that brings different providers together around the patient for more intensive case management, shares the advanced care plan, keeps the patient out of the hospital, offers family and caregivers educational support, supports better management through self-monitoring with alert notification to providers, or enables virtual home visits;
- those at end-of-life may have increased dependence upon home services and clinical support, be in need of bereavement counselling and linkage to community support.

The project’s care model could include advance care planning, timely symptom management, intensive case management, care navigation, education, and caregiver support. Additional aspects of care could be addressed such as the need to increase touchpoints or have a more connected relationship with patients and families, enable continuity of care across various settings, or
facilitate interprofessional collaboration and communication. As more patients are starting to seek electronic means to transfer information and interact on some virtual level with their providers, the model of care could include a component that is patient or family-initiated and driven.

Successful EOI applicants will be provided with a virtual care technology solution that meets the privacy and security requirements of CHI and of applicable laws to utilize over the course of the project. The virtual care solution may be multifaceted and include, remote patient monitoring, video, and use of communication tools that help tailor care to each patient’s personal values and goals. The virtual care technology solution will increase the timeliness of care interventions and enhance ongoing communication and collaboration of the care team through tailored information provided to each provider. The ability for the virtual technology solution to support integration with other existing systems and technology at partner sites will be explored. The cost of the virtual care technology solution will be supported by OTN as a component of the project.

2.2.3 Role of OTN

OTN will work collaboratively with project partners to design, plan, implement and evaluate the Telepalliative care project. OTN will lead the following project components:

I. Project Governance structure
II. Project partner selection and engagement
III. Contracts and agreements
IV. Project planning, management and implementation (including reporting of deliverables to CHI)
V. Budget and funding allocations
VI. Support for clinical model, site training, adoption and change management
VII. Virtual technology solution procurement, privacy and security
VIII. Project communication
IX. Project evaluation
X. Sustainability planning and lessons learned

2.2.4 Role of the Ontario Palliative Care Network

OTN is working in collaboration with the OPCN to ensure alignment with their provincial mandate for hospice palliative care. OPCN will support the following project components:

i. EOI development and distribution
ii. Evaluation of EOI submissions and partner selection
iii. Partner in project Governance structure
iv. Clinical advisement
v. Participant in project communication
vi. Participation in project evaluation, lessons learned and sustainability planning
2.2.5 Role of Project Partners

Project partners will be engaged in the project planning, be responsible for the site implementation and participate in project evaluation. Key responsibilities and accountabilities will include:

I. Active leadership involvement of all partners in project governance (RPCN governance structure, LHIN, CCAC, Service Provider Organizations, Hospice)
II. Sign off on project funding and data sharing agreements
III. Identify functional requirements and business needs for the technology solution to support a care model based on accepted norms of quality practice
IV. Commitment to implement the virtual technology solution as procured by OTN
V. Project management support
VI. Confirmation of clinical model (eligible patients, adoption of best practice care pathways, communication among circle of care, etc.)
VII. Commitment to project patient adoption (enrolment) targets
VIII. Recruitment of staff resources to support project deliverables as defined by funding agreement
IX. Ensure effective and clinical supervisory support
X. Ability to recruit and retain dedicated care team to support the project
XI. Project site communications (including all partners), adoption and change management support
XII. Collection of project evaluation data
XIII. Commitment to ensuring on-going sustainability of implemented changes and technology
XIV. Active participation and support for taking improvements and technology to a regional and provincial level
XV. Participation in sustainability planning and lessons learned reporting

3  EOI SUBMISSION REQUIREMENTS

Submitting partners are requested to complete the following criteria and provide evidence to support their submission in attached appendices. Guidelines are provided for the word count to each criteria to encourage a concise and focused response. A weighted scoring approach will be used to evaluate six (6) criteria of the EOI response.

3.1  Collaboration (15%)

3.1.1  Lead Organization and Project Partners
List your lead organization and project partners contact information. Sign off is also required by your LHIN CEO, Regional Cancer Program Regional VP, the lead organization for the project, and all partners. A template for sign off is provided at the end of this document under Appendix B.
Lead Organization

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Name and Title</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
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</table>

Partners

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Contact Name and Title</th>
<th>Email</th>
<th>Phone</th>
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<tr>
<td></td>
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</tbody>
</table>

3.1.2 Description of Partners
Describe your lead organization and project partners, including roles/responsibilities. Describe the ability of the project lead organization and partners to provide leadership to support project success and collaboration. Describe how partners will collaborate to achieve project outcomes and deliverables. Describe how your RPCN will be engaged in this project. Describe the leadership support. *(500 word maximum)*

3.1.3 Partner Experience
Outline the lead organization and partners’ previous project experience and outcomes (evidence of past experience is requested). How have your organizations worked together in the past? Provide a description of any past experience(s) embedding technology into care model. *(350 word maximum)*

3.2 Clinical Process Flows (15%)

3.2.1 Project Impact
Describe the impact of your proposed project on health system performance, patient outcomes and improvements in care provision, and patient experience.
*(350 word maximum)*

3.2.2 Care Delivery Model
a) The hospice palliative care continuum spans from initial diagnosis of a life-limiting illness to death and bereavement. Describe your project and the component(s) of the hospice palliative care continuum that your project would focus on. Identify how your proposed project will impact overarching project objectives outlined in section 2.2.
*(350 word maximum)*
b) Describe your processes and clinical work flows from referral intake, assessment, care plan and communication with patients and families circle of care.  
(250 word maximum)

c) Describe how a virtual care technology solution could be embedded into your care model and what/if any impact it will have on the clinical work flows described in section 3.2.2b. Are you currently using or can you suggest any virtual care technology solutions/tools that should be considered for use in this project?  
(300 word maximum)

3.3 Patient, Family, Caregiver, and Clinician Engagement (25 %)

3.3.1 Target Patient Population
Describe the target population for project enrolment including eligibility criteria. Provide evidence to support sufficient patient volume to support project patient targets of at least 225 patient enrolments. Include data analysis, in an attached appendix, related to patient referrals, visits, length of stay, hospital admissions/ED visits, etc. as proof of sufficient target patient volume.  
(350 word maximum)

3.3.2 Patient, Family, Caregiver and Clinician Engagement
Describe your strategies to engage your key stakeholders including palliative care health service providers, primary care clinicians, patients, families and caregivers in this project to meet project timelines and deliverables (i.e. referrals, adoption targets, patient and caregiver participation in evaluation, etc.)  
(350 word maximum)

3.3.3 Change Management
Describe your strategies to support front line staff through the change management process as the project begins, evolves and, matures. What are the potential barriers and risks to implementing the proposed project? What are the mitigation strategies?  
(350 word maximum)

3.4 Evaluation (20%)
OTN will lead the evaluation component of the project. Describe ability of the lead organization and partners to participate in project evaluation and report on project impacts and outcomes over the course of the project implementation. What key metrics should be included in the project evaluation? Describe the availability of resources (i.e. Decision Support, Project Manager, etc.) to support the data collection and analysis components of the project evaluation.  
(350 word maximum)
4 TIMELINES

4.1 Project Plan

A high level project plan is provided. Funding for this project is provided by CHI. We recognize the transition underway in Ontario for hospice palliative care, however some of these timelines and associated deliverables are set by CHI and cannot be changed.

Please identify any potential risks and/or barriers in your ability to meet these timelines and describe any mitigation strategies.

<table>
<thead>
<tr>
<th>Task Name</th>
<th>Start</th>
<th>Finish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site project team selection</td>
<td>Jan. 2017</td>
<td>Feb. 2017</td>
</tr>
<tr>
<td>Agreements</td>
<td>Feb. 2017</td>
<td>Mar. 2017</td>
</tr>
<tr>
<td>Develop clinical model</td>
<td>Feb. 2017</td>
<td>May 2017</td>
</tr>
<tr>
<td>Process flow development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and clinician engagement plan</td>
<td>Feb. 2017</td>
<td>Mar. 2017</td>
</tr>
<tr>
<td>Evaluation plan</td>
<td>Feb. 2017</td>
<td>April 2017</td>
</tr>
<tr>
<td>Site implementation plan</td>
<td>Mar. 2017</td>
<td>May 2017</td>
</tr>
<tr>
<td>Training</td>
<td>April 2017</td>
<td>May 2017</td>
</tr>
<tr>
<td>Patient enrollment</td>
<td>May 2017</td>
<td>Mar. 2018</td>
</tr>
<tr>
<td>Adoption target - active use</td>
<td>May 2017</td>
<td>April 2018</td>
</tr>
<tr>
<td>Evaluation report</td>
<td>Feb. 2018</td>
<td>April 2018</td>
</tr>
<tr>
<td>Lessons learned and sustainability plan</td>
<td>Dec. 2017</td>
<td>April 2018</td>
</tr>
<tr>
<td>Project Close out</td>
<td>Mar. 2018</td>
<td>June 2018</td>
</tr>
</tbody>
</table>

5 FUNDING AND IN-KIND CONTRIBUTIONS

5.1 Funding (5%)

Funding up to $100,000 will be available over the course of the project to each successful EOI applicant. Funding is provided to support the following project roles/activities for lead and partner organizations:

- Project Manager & Project Coordinator(s)
- Business lead
- Network/IT support
- Privacy lead
- Communication lead
- Decision support analyst

Funding cannot be utilized to support the hiring of clinicians for direct patient care related to the project, capital purchases, conference attendance, computers or devices.
Provide an overview of the project resources you would acquire with project funding from OTN and required qualifications for these roles.

5.2 In Kind Contributions
Describe any cash or in kind contributions from the lead organization and partners to support project implementation. Provide a high level budget outlining the key activities and associated in kind budget.

6 SUSTAINABILITY AND SPREAD

6.1 Sustainability and Spread (20%)
Assume that this project will successfully meet the key metrics defined in the project evaluation. Describe how your Telepalliative Care model will be funded on an ongoing basis. Describe how ongoing resources will be made available for sustainability, and the source of funding you propose for ongoing operations of the model including building capacity at the local level and future costs of the virtual care technology solution. Outline past experience with scaling a similar initiative from a project to ongoing operations. In addition, a primary objective is to scale the improvements and technology solutions across your region, and more generally across the province. Describe the mechanisms you would use to ensure applicability at a regional and provincial level and how you would share best practices across your region and to other regions across the province.

(500 word maximum)
**APPENDIX A: EVALUATION OF EOI RESPONSES**

A weighted scoring approach is used to evaluate six (6) criteria of the EOI response. The weighted score allotment is as follows:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weight (%)</th>
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<tbody>
<tr>
<td>Collaboration Between Organization Partners</td>
<td>15</td>
</tr>
<tr>
<td>Clinical Process Flow</td>
<td>15</td>
</tr>
<tr>
<td>Patient, Caregiver and Clinician Engagement**</td>
<td>25</td>
</tr>
<tr>
<td>Evaluation</td>
<td>20</td>
</tr>
<tr>
<td>Funding and Budget Plan</td>
<td>5</td>
</tr>
<tr>
<td>Sustainability Planning</td>
<td>20</td>
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<tr>
<td>TOTAL WEIGHTED SCORE</td>
<td>100</td>
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</table>

**Patient, Caregiver and Clinician Engagement evaluation threshold must be at least 70% of the total available points (at least 17.5 of the possible 25). A response that does not achieve minimum 70% of the total available points in this section will not receive further consideration in the process.**

**Two steps of the Evaluation Scoring process are:**

1. **Independent Scoring.**
   A scoring process will be used by an EOI Evaluation Team. The total of all sections is added to give the overall weighted score.

2. **Group Discussion**
   During group discussions, evaluators may determine a need for oral or written clarification on a response. Clarifications may be different for each responder and address one (1) or more responder’s response. Responders shall only provide additional information to clarify their original response. This is not an opportunity for the responder to change their response to the original question.

**Scoring Scale Used in the Evaluation of the Weighted Criteria**

<table>
<thead>
<tr>
<th>Score</th>
<th>Quality of Response</th>
<th>Description of Response</th>
<th>Weaknesses in Response</th>
<th>Confidence in Proposed Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Superior</td>
<td>Exceeds the criteria. Answers with precision and relevance. Exhibits outstanding knowledge, creativity, innovation or other factors.</td>
<td>None</td>
<td>Very High</td>
</tr>
<tr>
<td>4</td>
<td>Good</td>
<td>Meets the criteria. Comprehensive response in terms of detail and relevance.</td>
<td>Minor - not in key areas</td>
<td>High</td>
</tr>
<tr>
<td>3</td>
<td>Acceptable</td>
<td>Meets the criteria is most aspects but fails in some areas. Acceptable level of detail, accuracy</td>
<td>Moderate - does not</td>
<td>Moderate</td>
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<tr>
<td>Rank</td>
<td>Score</td>
<td>Rating</td>
<td>Description</td>
<td>Strengths</td>
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<td>2</td>
<td>Limited</td>
<td>Fails the criteria in most aspects but meets some. Limited information; inadequate. Answers not clear or directly relevant.</td>
<td>Exist in key areas - outweighs strengths</td>
<td>Low</td>
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<tr>
<td>1</td>
<td>Inadequate</td>
<td>Significantly fails to meet the criteria. Inadequate detail provided. Criteria not answered, or answers not directly relevant to criteria.</td>
<td>Significant and numerous</td>
<td>No Confidence</td>
</tr>
<tr>
<td>0</td>
<td>Not eligible for consideration</td>
<td>Completely fails to meet the criteria. Response significantly deficient / no response.</td>
<td>Significant and numerous</td>
<td>No Confidence</td>
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At the conclusion of the evaluation scoring process the top ranked proponents will be selected to enter into a Form of Agreement to participate on this project. The process to develop these formal agreements will commence once the project partners are selected. This EOI provides an outline of key deliverables that will be included in the Form of Agreement (i.e. patient enrollment of minimum 225, agreement to utilize virtual care technology procured by OTN, patient and clinician engagement, participation in project evaluation, etc.). Confirmed timelines for the Project Plan will also be included in the Form of Agreement.
APPENDIX B: PROJECT SIGN OFF

Please complete leadership sign off from RPCN leadership (i.e., LHIN CEO & Regional Cancer Program Regional VP), the lead organization, and all project partners.

Signatures are required from leaders who have signing authority.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization &amp; Title</th>
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