GRAND RIVER HOSPITAL

Advancing Exceptional Care

Waterloo Wellington Regional Renal Program

Renal Plan 2015 - 2019

CCO Ontario Renal Network

A message from the Regional Director and the Chief of Nephrology

Peter Varga and Dr. Gerald Rosenstein

Each year, our region experiences an increase in the number of residents who are faced with acute and chronic kidney disease. This trend is expected to continue as we observe significant changes in our population. These include the increasing prevalence of risk factors such as aging, diabetes and high blood pressure.

As well, increasing numbers of our residents are receiving cancer care as well as cardiovascular surgery. Our ability to reverse this trend and reduce the incidence of kidney disease can be enhanced through the application of strategic priorities, establishing partnerships within our community, and the active engagement of our patients and their families in developing plans of care collaboratively. Together, we can improve the lives of people living with kidney disease, and offer hope and support to those who must deal with it for the first time.

Peter Varga, Program Director, Grand River Hospital
Regional Director, Ontario Renal Network

Dr. Gerald Rosenstein, Chief of Nephrology, Grand River Hospital
Assistant Clinical Professor of Medicine (Adjunct), McMaster University

Peter Varga

Dr. Gerald Rosenstein

Executive Summary

On behalf of the Integrated Renal Program Council, Grand River Hospital is pleased to present this strategic plan to our community with an overview of how the Regional Renal Program will improve the lives of those at risk of and living with chronic kidney disease.

In alignment with the 2015 to 2019 Ontario Renal Plan developed by the Ontario Renal Network (ORN), our regional strategic plan supports the ORN's three overarching goals of:

- Empowering and supporting patients and family members to be active in their care;
- Integrating patient care throughout the kidney care journey; and
- Improving patients' access to kidney care.

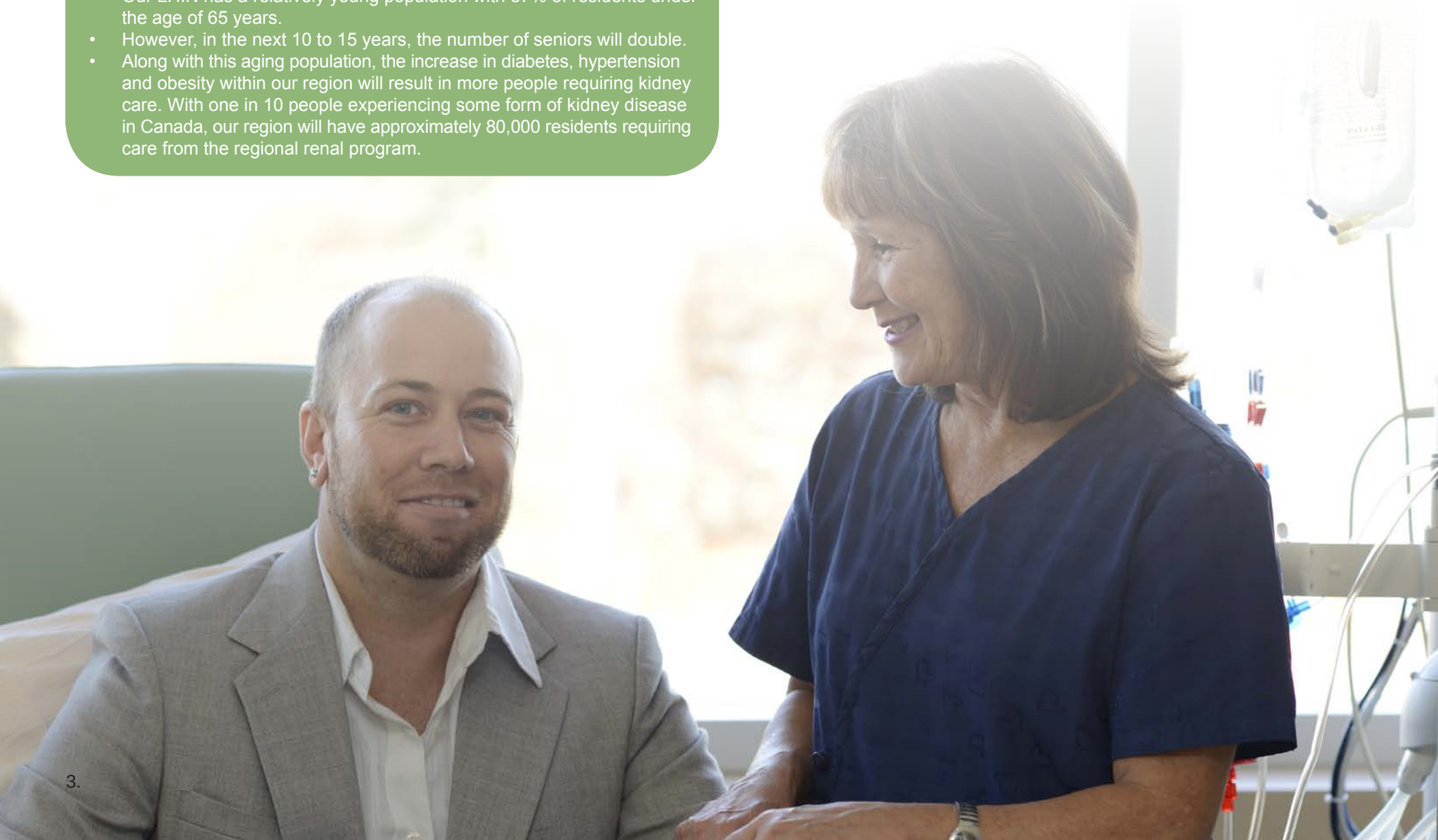
With additional feedback from our patients, families, internal and external stakeholders and partners within the community, this plan reflects the key priorities within our community and will advance the care of chronic kidney disease for patients within our region. It will also provide the foundation to develop our annual work plan and outline a roadmap to meet the care needs within our community. We will apply a person-centred and a patient experience based approach to those living with kidney disease.

Based on the collective feedback of those who participated in our survey, the regional renal program strategic priorities are to:

1. **Build effective relationships with our patients and their families**
2. **Develop strong partnerships with primary care practitioners in the management of chronic kidney disease**
3. **Increase the availability of palliative and end-of-life care for our renal patients and families**
4. **Improve the patient experience for pre-transplant services**
5. **Improve access and support for independent dialysis within our community**
6. **Ensure sufficient capacity is available across the continuum of renal services**

Waterloo Wellington Regional Profile

- The Waterloo Wellington Local Health Integration Network (LHIN) is home to approximately 787,000 people; 5.7% of the population of Ontario.
- Since 2007, the Waterloo Wellington LHIN population has increased on average by 1.2% each year.
- Our LHIN has a relatively young population with 87% of residents under the age of 65 years.
- However, in the next 10 to 15 years, the number of seniors will double.
- Along with this aging population, the increase in diabetes, hypertension and obesity within our region will result in more people requiring kidney care. With one in 10 people experiencing some form of kidney disease in Canada, our region will have approximately 80,000 residents requiring care from the regional renal program.



In our region:

Renal Services

The Grand River Hospital (GRH) Regional Renal Program is one of 26 regional renal programs in Ontario and is the single provider of acute and chronic kidney disease services within Waterloo Wellington. Grand River Hospital first began nephrology services in 1973, and officially became a regional renal program in 1976. Since then, the renal program has continually grown and evolved.

Today, the regional renal program provides the full continuum of renal services including early identification, delay of disease progression, modality selection, acute hemodialysis, independent dialysis (home hemodialysis and peritoneal dialysis), pre-transplant preparation and ongoing chronic kidney disease (CKD) services within Waterloo Wellington. During the past 15 years, the renal program has grown from 300 patients to more than 500 patients receiving dialysis, the highest level ever experienced within our program.

Our satellite units support dialysis patients in Kitchener, Guelph and Palmerston areas. The units support stable patients living in these areas reducing the need for travel to and from KW's main campus and receiving care closer to home.The satellite hemodialysis units are located at GRH's Freeport Campus, Guelph and Palmerston.

Waterloo Wellington is listed as LHIN 3 and ranges between 401-600 CKD prevalent patients. The GRH regional renal program is the eighth largest program in Ontario, and the third largest community-based (non-academic) program.

Size and Growth

Hub and Spoke Model

The renal program operates with a Hub and Spoke model, with the KW campus as the hub, and the satellite locations in Freeport campus, Guelph and Palmerston as the spokes.

In total, there are 74 hemodialysis stations in the regional program. Within Waterloo Wellington, there are over 500 patients receiving dialysis, and nearly 60,000 annual hemodialysis treatments provided directly by the renal program. There are also over 140 home dialysis patients who live independently at home and are able to care for themselves within our community. Growth has been experienced in all services provided by the renal program. In the past, the annual growth rate was very high, ranging from 8% to 12% annually! However, over the past five years, the renal programs annual growth rate has been more consistent and ranging between 2.5 to 3.5% overall.

- The regional renal program does not offer dialysis care to individuals less than 18 years old
- Grand River Hospital's pre-transplant kidney program partners with London Health Sciences Centre and Hamilton Health Sciences Centre

The Ontario Renal Plan II (2015 to 2019)

In March 2015, the Ontario Renal Network released the second provincial renal plan for Ontario. This four-year plan builds upon the previous work accomplished within the first provincial plan where independent dialysis, body access, provincial funding, and capacity assessment were key priorities. The second Ontario renal plan is focused on patients, families and key stakeholders within the community. In many ways the second Ontario renal plan is the people's plan, with a very high focus on the patient's experience and journey through kidney disease.

Empower and support patients and family members to be active in their care

Growing a person-centred renal care system:

- Shared decisions
- Self-management
- Patient-reported outcomes
- Collaboration

Integrate patient care throughout the kidney care journey

Facilitating seamless transitions in care:

- Primary care
- Palliative care
- Transplant

Improve patients' access to kidney care

Developing solutions to barriers in accessing care:

- Rural and remote
- First Nations, Inuit, and Métis
- Community and home care
- Vascular access/peritoneal dialysis access services
- Glomerulonephritis and pregnancy

Enablers

Reporting • Information Management/Information Technology • Partnerships & Engagement • Evidence & Knowledge Generation • Value Assessment • Performance Management • Knowledge Transfer & Exchange • Funding Policy & Operations Infrastructure & Capacity Planning • Emergency Preparedness

We Asked You!

Having the input and comments from our patients, families and members within our community was essential to identifying our priorities. The renal program will continue to engage patients to ensure our services are person-centred and meeting their kidney care goals.

Of the current second Ontario Renal Plan...

Which initiatives within the plan would you consider the most important for your region?

Please provide one or two words...

Describe the MOST POSITIVE aspect(s) of renal care in your region.

As a stakeholder of the renal system...

What are your greatest concerns? What keeps you up at night?

Our priorities

Waterloo Wellington Regional Renal Plan

1. Build effective relationships with our patients and their families
2. Develop strong partnerships with primary care practitioners in the management of chronic kidney disease
3. Increase the availability of palliative and end-of-life care for our renal patients and families
4. Improve the patient experience for pre-transplant services
5. Improve access and support for independent dialysis within our community
6. Ensure sufficient capacity is available across the continuum of renal services

1. Build effective relationships with our patients and their families

What does this mean?

Patients and their families will be supported by their renal health care team as they actively plan and execute their kidney care.

Key initiatives	By 2019:
• Strengthen the Renal Community Council (RCC) role in building relationships with patients and families • Build the participation and involvement of the Patient and Family Advisory Council (PFAC) • Develop methods for patients and their families to engage with other patients during their kidney care journey	• We will implement formal opportunities for patients and families to actively engage with the regional renal program • Patients and their families will have access to peer support and ‘care coaches’ when planning their kidney care • The renal program will organize an annual community day for patients and families

This strategic plan is taking steps in the right direction in keeping the patient in the centre of planning. Patients need to feel that their input is not just worthy, but necessary!

Rosemary Lejeune, patient

2. Develop strong partnerships with primary care practitioners in the management of chronic kidney disease

What does this mean?

The regional renal program will work collaboratively and in partnership with primary care providers to better understand the needs of CKD patients within our community and to improve renal resources for primary care practitioners.

Key initiatives

- Identify a primary care representative to support planning and ongoing initiatives within our region
- Ensure participation and engagement of key regional committees and partners involved with chronic kidney disease
- Establish an effective working relationship with primary care providers involved in CKD to better understand their needs within the community

By 2019:

- We will increase primary care's accessibility to regional renal services
- We will implement electronic and digital tools to enhance chronic kidney disease care within the region
- Regional renal referral forms will exceed 98% utilization by primary care

As our population ages, primary care physicians and our health care system must support the increasingly complex medical conditions of our patients. Although the primary care physician must remain as the hub, it is essential that close relationships with specialists are fostered. As nephrologists, we strive not only to be readily accessible and available to our primary care colleagues, but also to offer them the tools to allow them to initiate appropriate investigations and co-manage renal patients.

Dr. Gerald Rosenstein, Chief of Nephrology

3. Increase the availability of palliative and end-of-life care for our renal patients and families

What does this mean?

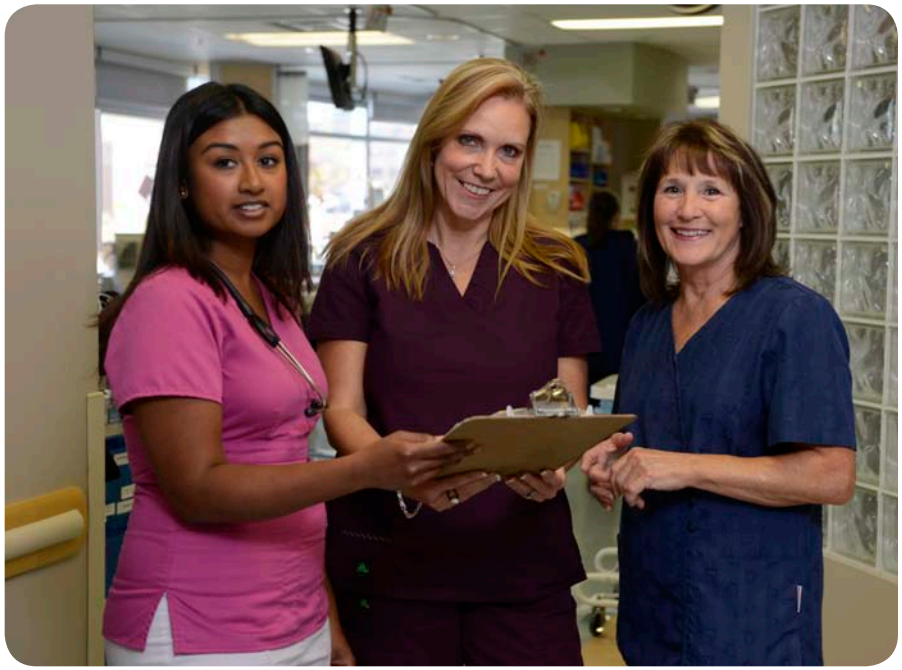
All CKD patients and their families will have access to advanced care planning, palliative and end-of-life care using a holistic person-centred approach.

Key initiatives

- Development of regional palliative care maps for chronic kidney disease patients
- Implement tools to assist with early identification and management of those who wish to consider palliative care
- Establish partnerships and participation within our region for palliative and end-of-life care services

By 2019:

- We will provide our patients and their families with information and access to best practice standards for palliative and end-of-life care
- We will advance the Ontario Declaration of Partnership and Commitment to Action, to integrate standardized palliative care for chronic kidney disease patients
- Patients and their families will state they were given the support and the ability to die in a place of their choice



Palliative care can and should be integrated into the patient and family journey at any point where palliative care needs are identified: symptoms which require management, psychosocial and spiritual needs, practical needs or needs for information and personal decision making - all with quality of life being the paramount value.

The integration of palliative care into the renal plan will promote access to the palliative care approach early, intermittent palliative care throughout the illness journey and access to enhanced palliative care if and when the need for it is identified. This care can be provided whenever and wherever the patient resides.

We are very excited to be a part of this enhanced vision!

Dr. Donna Ward, palliative care physician

4. Improve the patient experience for pre-transplant services

What does this mean?

The regional renal program will work collaboratively with pre-transplant patients and their families to identify and meet their care expectations during the patient's journey.

Key initiatives

- Establish a pre-transplant working group that includes patients and their families
- Engage PFAC members to review the pre-transplant processes and patient expectations
- Develop formal partnerships with the Trillium Gift of Life Network and kidney transplant centres

A photo of Candice (right) and her mother (left), who donated a kidney to save Candice's life.

By 2019:

- We will establish a model of care where patients can easily understand their progress within pre-transplant preparation
- Patients and their families will experience fewer barriers and delays to completing the pre-transplant process

"In every step of my kidney journey, GRH staff were there to ensure that I felt safe, informed and prepared for my next steps. I am grateful for the amazing care I have received.

I am very hopeful for the future state of kidney care as we work with incredibly innovative, respectful and brilliant minds at GRH, the Ontario Renal Network, the Waterloo Wellington Local Health Integration Network and surrounding hospitals to create a future without kidney failure. Until we see that day, I am confident that the renal plans both at the local and provincial level will create a comprehensive, personalized care system to ensure that renal patients will receive the utmost respect, knowledge and care that they deserve.

Thank you to Grand River Hospital and all of the partners working so tirelessly to ensure high quality care for renal patients in our region. You are truly making a difference in the daily lives of patients and the future of kidney care."

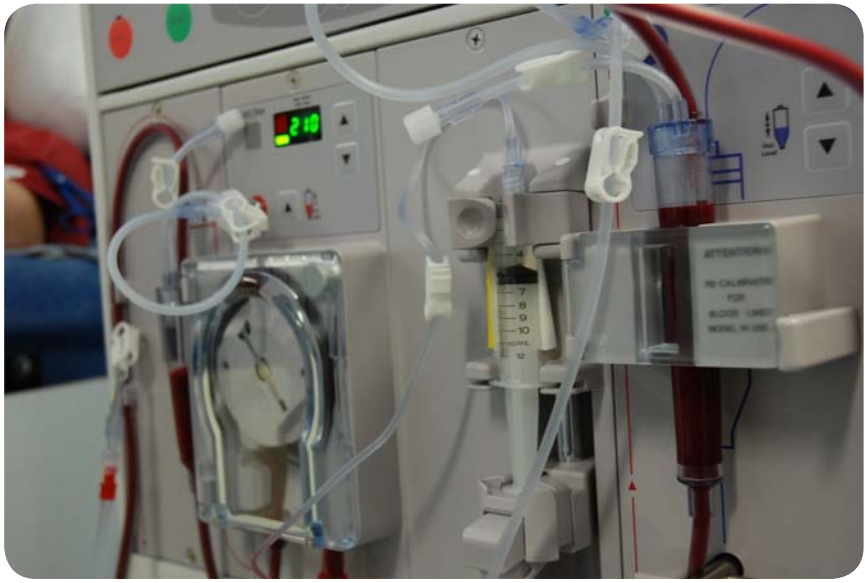
Candice Coghlan, patient

5. Improve access and support for independent dialysis within our community

What does this mean?

More patients will be given the opportunity to self-manage and maintain their independence when on dialysis within our community.

Key initiatives	By 2019:
• Understanding the barriers to home dialysis and implementing solutions within our community • Encourage self-management for patients when working with our professional health care team • Implementing a new care model for dialysis patients	• We will give more patients the ability to receive dialysis within their home • We will increase the number of patients on home dialysis within our region • The renal program will exceed the 28% overall prevalence of home dialysis



"Our regional renal program is an excellent program. It not only allows me to go on dialysis on my schedule, but also lets me take control of my own health."

James Zieske, patient

6. Ensure sufficient capacity is available across the continuum of renal services

What does this mean?

Patients will have the opportunity to receive their care within a reasonable time period, closer to home and within reasonable travelling distance.

Key initiatives	By 2019:
• Establish regional priorities with our community partners and in partnership with the ORN • Developing a regional master plan for CKD services • Work collaboratively with the Ontario Renal Network to complete the biannual Renal Capacity Assessment	• We will provide our community with a 10-year CKD master plan within our region for all CKD services • We will establish new partnerships within our community to expand the options our patients will have for receiving kidney services

Partners in Care Across the Region

Moving Forward

These six strategic priorities provide the regional renal program with a roadmap to advancing kidney care for our community. Building new partnerships with local agencies will help support our patients and their families as they deal with the many challenges experienced with kidney disease. Most importantly, these strategic priorities will ensure a person-centred approach throughout their kidney journey, and ensure our patients and families actively participate in managing their kidney care.

“To plan is to identify needs and develop a strategy to reach our common goals. For those of us living with the effects of chronic kidney disease, there is a need for a strong voice and a strong plan. This regional renal plan provides that voice and a clear direction for the future of renal care within our region. The needs of people within our renal community have been heard. It is with a sense of hope that those affected by this disease look to the future outcomes which will unfold as this plan is implemented with the goal to enhance our lives.”

Dianne Wilbee, Patient and Family Advisory Council member

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