

# Supporting every patient's journey

Waterloo Wellington Regional Renal Program 2019-2023 Strategic Plan



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## A message from the Regional Program Director and Medical Leaders

*The number of people in Ontario requiring dialysis continues to rise every year and these increases are seen throughout our region. This increase is being driven by population growth, aging and significant risk factors for the development of kidney disease such as diabetes and high blood pressure. For the Regional Renal program in Waterloo Wellington, the growth in dialysis patients is expected to reach 22% over the next 10 years.*

*The release of the third Ontario Renal Plan coincides the 10th anniversary of Ontario Health Renal Network. Over the past decade, there have been significant improvements in the way kidney care services are delivered and managed in the province and in Waterloo Wellington. External factors such as COVID-19 provide both challenges and opportunities for innovation in our delivery of quality care. This strategic plan not only aims to ensure the region is well prepared to support the community through capacity planning and every patient's unique journey, but it has a strong emphasis on early intervention to slow kidney disease progression. Working together, we will achieve our common goal to create a system that delivers meaningful improvements in the care for people affected by chronic kidney disease. Keeping in alignment with the goals identified in the provincial Ontario Renal Plan 3, the regional plan addresses the six priorities:*

1. Person-centred 2. Safe 3. Equitable 4. Efficient 5. Effective 6. Timely



Dr. Andrew Burke  
Regional Medical Lead



James Bellamy  
Regional Program Director



Dr. Gerald Rosenstein  
Chief of Nephrology

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## A message from our Renal Patient and Family Advisory Council

“ When planning for the future it is so important to look into our past and evaluate the present with honest eyes. Over the past five years we as a council have been given unprecedented access to the process and have had a voice in almost all facets of our renal community. A patient member of our council has been invited to sit in, and participate in the recruitment of program staff. We have continued to work with our friends and community partners from the Kidney Foundation of Canada, and have added the Grand River Hospital Foundation to that list, leading to new fundraising efforts in support of the Grand River Regional Renal Program. I am proud to say that we have done a complete overhaul of the Patient Welcome Kits. Just recently we launched a home page for the Renal Patient and Family Advisory Council, which gives better access to information for those patients who aren't physically at the hospital and the ability to use the Communication Forms so their concerns can be resolved in a fast and far more efficient way.



**Brendan Cote**  
Chair, Renal Patient and  
Family Advisory Council

It is clear that it has been a very busy few years and this list is just barely touching the surface of the good work of our council members. However, as it has seemed to overshadow everything else over the last several months, COVID-19 has taken a large portion of time and energy. As a council we have continued to meet regularly, just over the phone. We have created questionnaires to make sure our program, and council are meeting the expectations of the patients we represent and can improve in ways that you, our fellow patients can be proud of.

Last but certainly not least I want to extend a big thank you to all the doctors, nurses, and every member of the support staff for all their hard work during this pandemic. It takes a great amount of courage to push forward in the face of times like these, and in a volatile environment like the one you all face. Your calm and caring standard has not wavered but strengthened making it possible for us to continue to focus on the renal side of our fight without losing our cool in the face of COVID-19.

Our Heroes are the GRH Renal Staff!

# Waterloo Wellington Regional Renal Program

**3** hospital sites



current population served  
**775,000**



## Population breakdown

146,560 residents who are immigrants

10,185 residents who self-identify as Aboriginal

26,380 residents who identify as Mennonite

Our overall health status (self-reported)



**20.3%**  
of residents smoke



**37.5%**  
report eating the recommended number of healthy foods



**50.0%**  
report they are overweight or obese

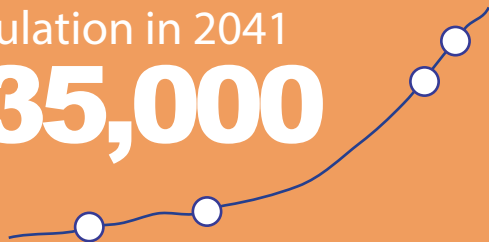


**56.7%**  
report being physically active

The chronic conditions with the highest mortality rates in Waterloo Wellington are cancer, ischemic heart disease, and stroke.

our projected population in 2041

**835,000**



**550+**

patients receiving dialysis



**3rd largest**

largest community-based (non-academic) program and 8th largest renal program in Ontario

# Renal care in our region

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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.

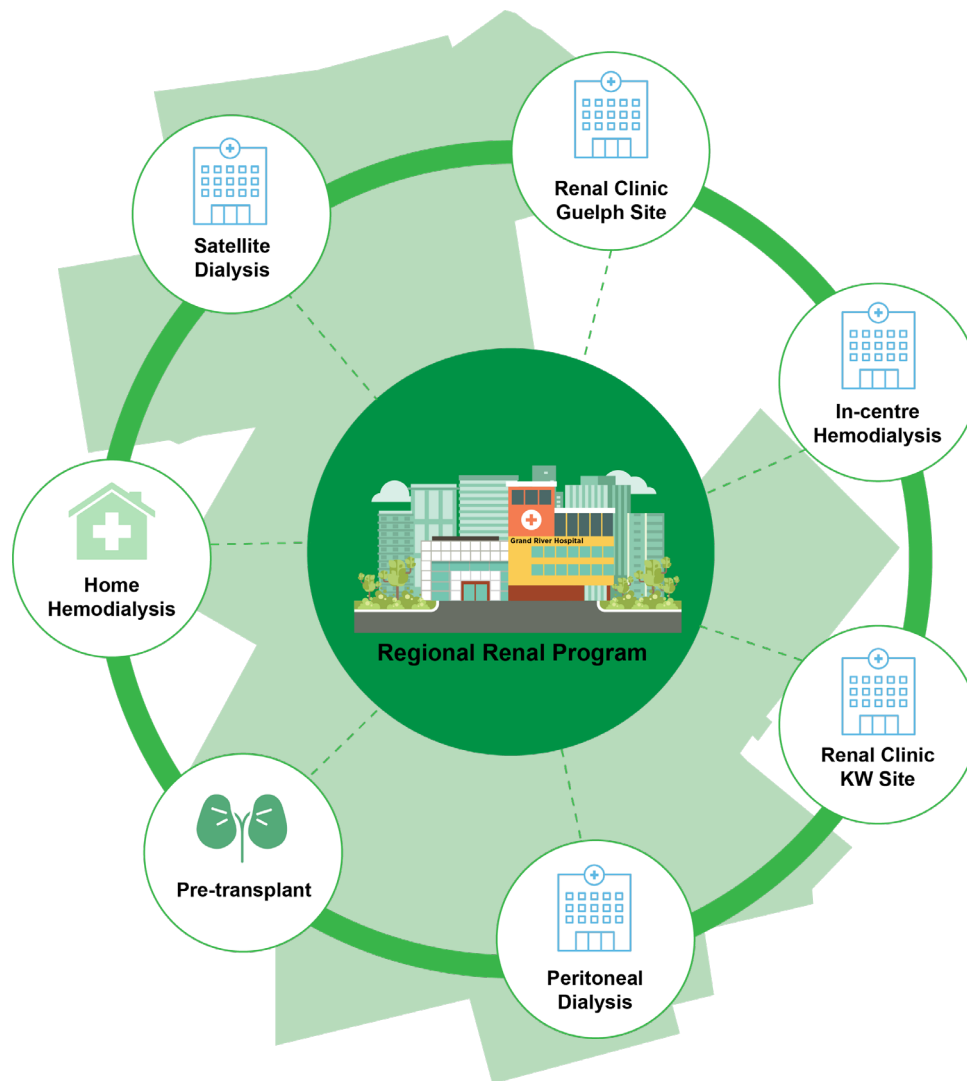
Today, the regional renal program provides the full continuum of renal services including:

- 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 Region

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.



# Our services



The renal program operates with a hub and spoke model, with Grand River Hospital's KW Campus as the hub, and the satellite locations at the Freeport Campus, and in 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 regional program. There are also over 140 home dialysis patients who live independently at home and are able to care for themselves within our community.

The regional renal program offers dialysis care to individuals greater than 18 years old.

Grand River Hospital's pre-transplant kidney program partners with London Health Sciences Centre and Hamilton Health Sciences Centre.

# Independent care, closer to home

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A good beginning leads to a successful journey. All new dialysis patients start their journey in the Right Start Unit (RSU) with the Vision of actively involving patients in their care: Right Patient, Right time, Right place.

The Multi-disciplinary Team ensures all patients receive the information and support needed to match their specific needs. A culture of self management and independence is promoted within the RSU through increased patient knowledge about their kidney disease. Patients are empowered to make quality decisions regarding their care, while remaining in alignment with their own values. Independent dialysis and optimal body access are desirable goals to assist patients in regaining control over their kidney health.

## Marcia's Story

Marcia began dialysis in the Right Start Unit where she received support and education to make informed decisions about her health. After a couple of weeks, Marcia decided that doing Home Hemodialysis would be her best option.

"Although I have been on a journey with kidney disease for a while now, I just started dialysis treatments this year. When I was told that I would be able to dialyze at home, that was very freeing for myself and my family. It meant that I could have more flexibility to work around the schedules of my family which includes young kids. I was able to have more time at home with my family.

The nurses in the Home Hemo unit were such gifted teachers and it is clear that they are very passionate about what they do and that they care deeply for every patient in the unit. Although learning to administer my own treatments may have seemed like a daunting task at first, the nurses were able to appropriately pace the learning for me. From the training to the installation to the clinic visits, everything happened so smoothly and they always tried to accommodate my needs. I am very grateful to the Home Hemo unit at Grand River Hospital and for everyone who was involved in making this a possibility."



Marcia C.  
Home hemodialysis patient



# Building on our accomplishments

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Our direction for 2019-2023 is built on a foundation of accomplishments from our previous plan. Over the last 5 years, we have made significant advancements towards our goals of improving the patient experience; building partnerships with primary care providers; helping patients self-manage while on dialysis and receive care closer to home.

## Building effective relationships with our patients and their families

Patient and Family Advisory Council (PFAC) members in our Renal program continue to play a pivotal role in the development and integration of new ideas, equipment, clinical practice and most recently COVID operations. The members of the Council meet routinely to address concerns and to discuss future operations, keeping quality of care and safety at the forefront.

The PFAC has advocated for new and better equipment such as adjustable, electric dialysis treatment chairs, thermometers, and blood pressure cuffs. They have developed the Renal Welcome Kits that are given to each new dialysis patient that enters the program. The Renal Welcome Kit includes kidney information pertaining to diet, medication, choice of dialysis options, emergency planning and important contact information.

PFAC members have played an instrumental role in developing our own PFAC page on the Grand River Hospital website. This site provides the opportunity to share information amongst the kidney community and receive feedback in ways that were not previously available. Even through the COVID pandemic, PFAC maintains a virtual presence for program collaboration.

The PFAC also remains strong advocates for the Kidney Foundation and assists in the support and recognition of local fundraisers and charity events. Additionally, members are often involved as advisors for corporate initiatives such as strategic planning within Grand River Hospital.

Most recently, the PFAC has assisted the Renal program with COVID operations related to physical distancing, wearing masks, entry screening, and ongoing safety precautions. The perspective of patients and families gives rise to many new and innovative ideas within our program and plays a very valuable role in our program development.



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## Developing strong partnerships with primary care providers

Navigating transitions in healthcare are often challenging. Education and information sharing between Primary Care and Nephrology physicians strengthens the link to enable a smoother continuum through collaborative care. Engaging the Primary Care community in a variety of educational sessions to provide resources and tools enables a patient-centred shared care approach.

Embedding the Ontario Renal Network's Kidney Wise Toolkit into the electronic medical records used by Primary Care physicians facilitates information transfer to Nephrologists for timely access to services.

Understanding the variety of situations that our patients in the community are challenged with, collaborative partnerships with care providers ensures that necessary supports are available to align with patient's values. The integrated use of community Nursing Agencies bridge periods of additional aid for patients, which enables them to maintain a level of independence with home dialysis therapies. Extending this concept through partnerships with several Long Term Care Homes, resident patients have access to home therapy regardless of their housing arrangement.



## Increasing palliative and end-of-life care for renal patients and their families

The transition to palliative and end-of-life care is often a difficult decision to make for patients and families, and knowing what services are needed and who to go to can be just as overwhelming. In our dedication to increasing these services for renal patients and their families, Nan Miller and Steve Gobran are nurse practitioner leads for palliative care in Renal Program and works with patients across Waterloo Wellington to help guide their journey to palliative and end-of-life care with compassion and support.



While every patient's care needs are different, Nan works with patients and their families to better understand what is needed for their palliative care journey. This includes the initial palliative consult which is preferably home visit with significant others present.

"From there we discuss introducing community palliative services and working together with the community palliative NP/MD, and the patient's Primary Care Provider," says Nan. "This process is a true partnership across regional services."



Nan also provides clinical support for community palliative nursing and is a liaison with community for collaborative care - member of Waterloo Wellington Hospice and Palliative committee. She organizes home visits with patients as needed, and, when the time comes, works with families during the transition to Hospice, providing clinical data to hospice, as well as emotional support for the patient and their family.

Since she began her role in 2017, Nan has worked with "37 patients from the initial consult with each patient/family, then following up with them routinely until referral to palliative team community, then checking in with the patient and family as needed."

Steve Gobran (top) &  
Nan Miller (bottom)  
Nurse Practitioner Leads

"Every patient and family has a significant impact on me," says Nan. "I keep every thank you card."

## Meeting the care needs of pre-transplant patients

In 2016 a Transplant Handbook was created for patients that included a care map to guide them through the transplantation process. The Handbook was updated in 2019 to highlight the integration of Transplant Ambassador Program (TAP). TAP is a recent and most welcome addition to the regional program. The Ambassadors are transplant recipients or transplant donors who engage with patients who have chronic kidney disease. They are able to share their story and experiences with patients who may one day require a kidney or who would be willing to donate. This has provided invaluable information for patients and is a new form of engagement with patients.

Since the Access to Kidney Transplant initiative launched in Fall of 2017, Grand River Hospital has seen the transplant referral rates nearly double annually. The promotion of transplantation as a modality choice in the Predialysis Clinic has increased and there are plans to enhance the education pertaining to pre-emptive kidney transplants. Patient referral packages to Transplant Centres are initiated 25 times faster with the additional support of the Renal Transplant Nurse Liaison role.



Chantal  
Renal Transplant Nurse

# Developing our strategy

This plan is the outcome of an extensive engagement process and incorporates thoughtful feedback from patients and caregivers, as well as regional health care partners. Each offers their unique perspective to provide valuable insights into renal care and areas of opportunity to work together as a system. Together we looked at the changes taking place in the health care system such as the formation of Ontario Health and ways to leverage partnerships. The Plan outlines six strategic priorities, which aligns with the goals and strategic objectives of the Ontario Renal Plan 3 (2019-2023), and the current and projected needs of patients and families in Waterloo Wellington.



**98**

stakeholders  
consulted

**15**

organizations &  
groups represented

**7**

patients &  
families engaged

**4**

focus group  
sessions



# Our strategic goals for 2019-2023

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1. Person-centred: Partner with patients and caregivers to strengthen an inclusive kidney care system.
2. Safe: Empower patients, caregivers and healthcare professionals to reduce avoidable harm.
3. Equitable: Enable responsive and respectful kidney care for patients, regardless of who they are or where they live.
4. Efficient: Improve the efficiency and coordination of the kidney care system.
5. Effective: Deliver kidney care using best evidence.
6. Timely: Improve patients' access to the care they need.

# WORKING WITH YOU TOWARDS OUR GOALS



## PERSON-CENTRED

Partner with patients and caregivers to strengthen an inclusive kidney care system

### STRATEGIC OBJECTIVES

- Build a comprehensive Mental Health plan for Waterloo Wellington renal patients in collaboration with regional resources.
- Strengthen early identification and support for patients who would benefit from a palliative approach to care.

### Measurement of Success

- Provide tools and resources to facilitate mental health support conversations
- Home dialysis rates achieve provincial target.
- Dedicated pathways to support patients choosing Conservative Care developed.
- 100% goals of care, including substitute decision maker, completed for multi-care kidney clinic (MCKC) and dialysis patients.



## SAFE

Empower patients, caregivers and healthcare professionals to reduce avoidable harm

### STRATEGIC OBJECTIVES

- Create a safe medication management culture for the Waterloo Wellington renal population.
- Embrace the capabilities of electronic Health Information Systems (HIS) to ensure the patient's story follows along with them through their healthcare journey.

### Measurement of Success

- Maximize the effectiveness of the HIS to manage medications across the patients' continuum of care.
- Implement clear discharge plans
- Develop a renal triage phone system to improve communication between renal program staff/nephrologists and patients/community providers.



## EQUITABLE

Enable responsive and respectful kidney care for patients, regardless of who they are or where they live

### STRATEGIC OBJECTIVES

- Develop a strategy to engage with underserved populations (e.g. Waterloo Wellington First Nations, Inuit, Metis, Urban Indigenous and Mennonite) to improve their kidney care.
- Leverage collaborative opportunities focused on diversity, equity and inclusion at Grand River Hospital and Grand River Regional Cancer Centre.
- Improve access to dialysis services in long-term care homes.

### Measurement of Success

- Implement a plan to reduce barriers to accessing services for people with health inequities, including in rural and remote locations.
- Noted improvement in the cultural competency of health care providers.
- Increase implementation of home hemodialysis in LTCHs.

# WORKING WITH YOU TOWARDS OUR GOALS



## EFFICIENT

Improve the efficiency and coordination of the kidney care system

### STRATEGIC OBJECTIVES

- Support an improved coordination of prevention and care between Waterloo Wellington Renal Program and partners in primary, home and community care
- Optimize system and capacity planning, funding models and data collection to support efficient use of resources.
- Participate in research and innovation opportunities to advance kidney care.

### Measurement of Success

- E-referrals and e-consults within primary care electronic medical records implemented.
- Leverage clinical documentation to drive data collection and analytics.
- Increased participation in research and innovation initiatives.



## EFFECTIVE

Deliver kidney care using best evidence

### STRATEGIC OBJECTIVES

- Strengthen care delivery for patients with glomerulonephritis, polycystic kidney disease, and women with chronic kidney disease requiring maternal health care.
- Incorporate the benefits of peer support programs throughout the continuum of renal care.
- Optimal coordination of renal care delivery for admitted patients

### Measurement of Success

- Peer to peer support groups established.
- Standardize practices for the provision of admitted patient dialysis therapies across the region.
- Polycystic kidney disease clinic established.



## TIMELY

Improve patients' access to the care they need

### STRATEGIC OBJECTIVES

- Develop a planned approach to increase access to kidney transplantation with a focus on living kidney donor transplants.
- Ensure access to high-quality care in multi-care kidney clinics (MCKC) utilizing various delivery methods including remote access.
- Promote and enable dialysis at home.
- Enhance access to vascular services.
- Develop a capacity plan to meet increased need for dialysis.
- Work with Ontario Health and Ontario Health Teams to provide coordinated and seamless kidney care services.

### Measurement of Success

- Participate in the Ontario Renal Network Access to Transplant Initiative pilot project.
- Establish clear patient pathways for transplant options.
- MCKC/Glomerulonephritis clinics redesigned to embed virtual care and best practices
- Develop MCKC patient welcome kit
- Vascular access metric meet or exceed provincial targets.
- Home hemodialysis metrics meet or exceed provincial targets.
- 10 year capacity plan completed.

