Ontario Renal Network
Réseau Rénal de L'Ontario

Ontario Home Dialysis Initiative

3eme Symposium de Dialyse Extra-Hospitaliere
Bruxelles Mai 2016

Dr. Peter Blake, Provincial Medical Director, Ontario Renal Network

Ontario
Cancer Care Ontario
Action Cancer Ontario

Yukon
Territoires
du Nord-Ouest
Nunavut
Terre-Neuve-
et-Labrador
Québec
Ontario
Île-du-
Prince-
Édouard
Colombie-
Britannique
Alberta
Saskatchewan
Manitoba
Nouvelle-
Écosse
Nouveau-
Brunswick

CANADIAN HEALTH CARE

Canada is a federation with very powerful provinces

Union of 2 'founding peoples' - the English and French

Ontario and Quebec historically influential

Historically, a collectivist political culture with emphasis on rights of communities more than individuals

CANADIAN HEALTH CARE

Enormous value has thus been placed on social programs, particularly healthcare

Many consider healthcare one of the defining characteristic of the country

Despite problems there is a widespread belief and that Canada is superior to the US in this area

CANADIAN HEALTH CARE ACT (1984)

Accessible - **no user fees or extra billing**

Universally available

Medically comprehensive

Public administration - **single tier**

Provincial administration but portable between provinces

CANADIAN RENAL SERVICES

Run by Provinces

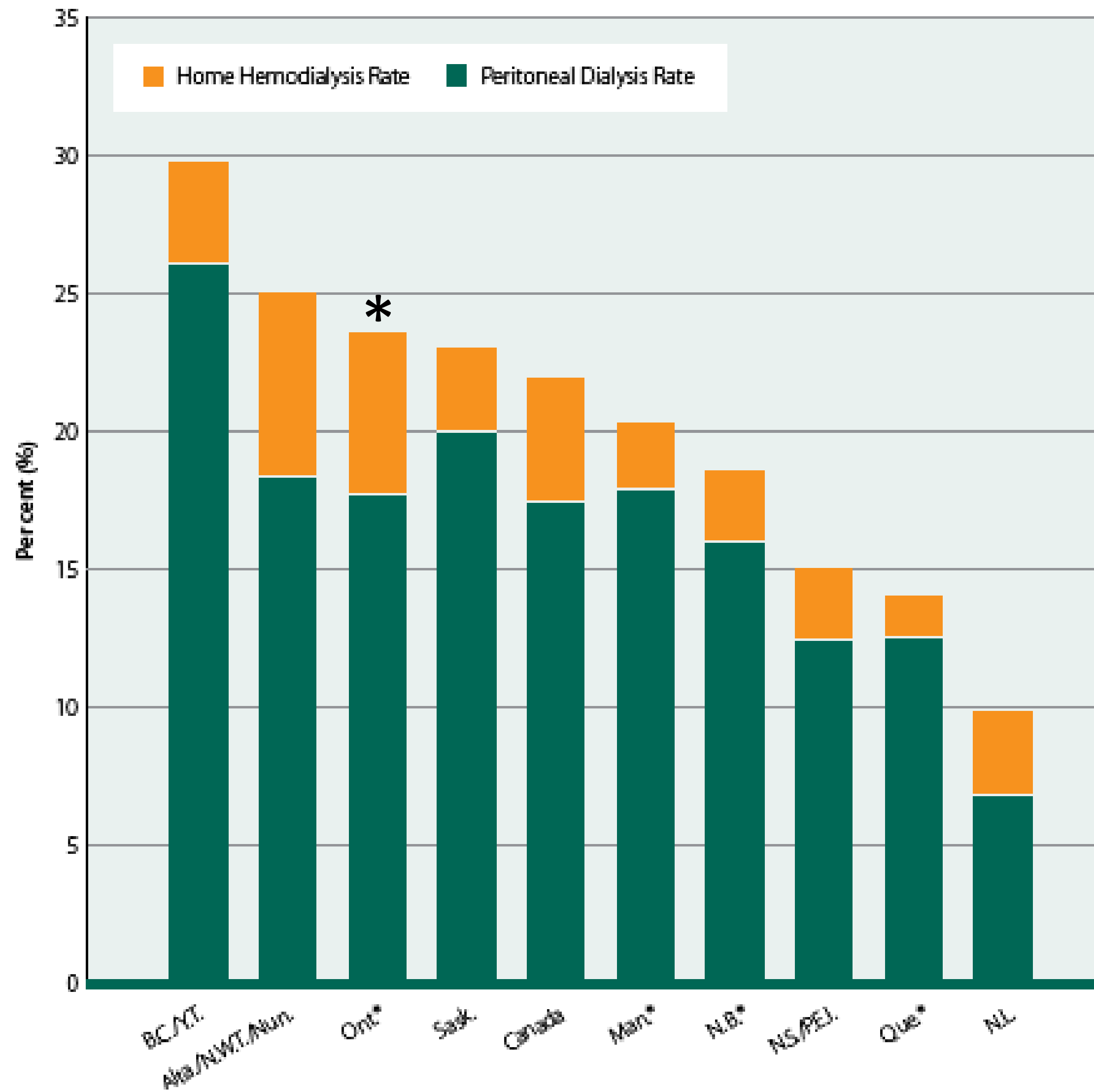
No private insurance - province is sole payer – nephrologists are fee for service

No private or extra billing by nephrologist or facility

Minimal private dialysis providers (< 2%)

Provinces strongly favour home dialysis for cost reasons

HOME DIALYSIS RATE BY CANADIAN PROVINCE 2013 Breakdown by Modality (CORR data)



2% First Nations

ONTARIO
13 million
40% of total

ONTARIO RENAL NETWORK

A government agency set up in 2009 to provide leadership and direction for renal services in Ontario

Controls $600 million budget – this gives some power and lots of responsibility

Priority is to improve care for those with CKD

BACKGROUND PRE ORN

Renal care run by Ministry staff with limited consultation

Stagnant rates of home dialysis and transplant despite Oreopoulos Report

Problems with vascular and peritoneal access

A 10 year old funding formula not accounting for daily HD which was being used in 4 to 5% of patients

No systematic data collection

Disengaged nephrologists

ONTARIO RENAL NETWORK

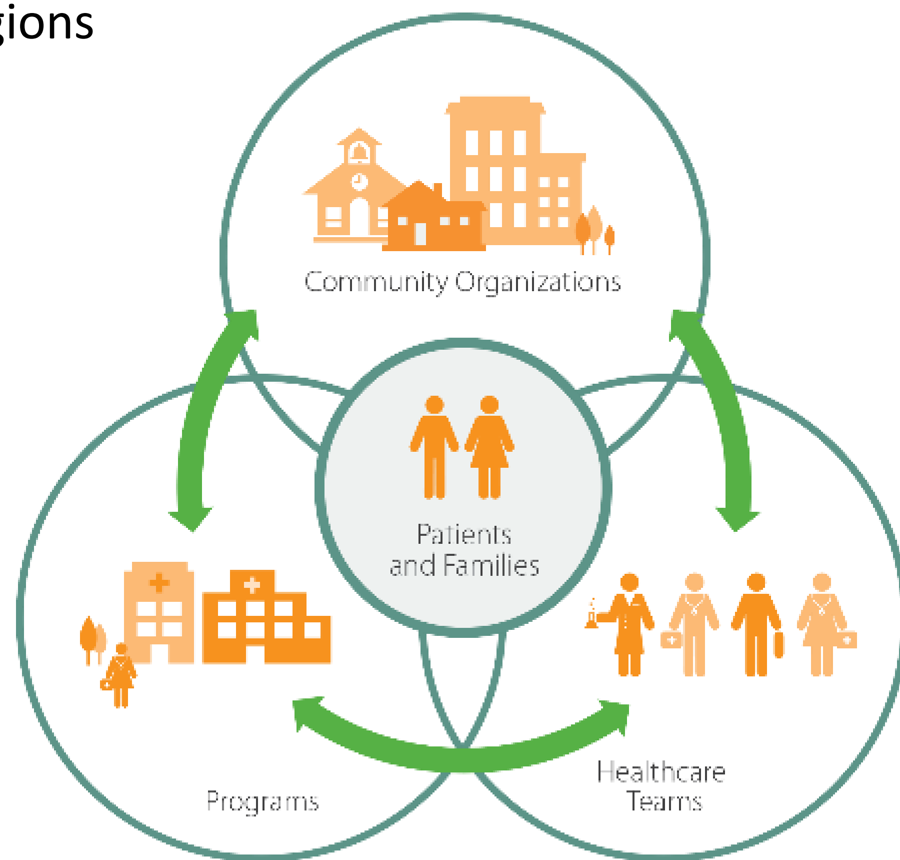
Modeled on Cancer Care Ontario and on BC Renal Agency

Run under umbrella of Cancer Care Ontario

Committed to stakeholder involvement and co-management with physicians and other stakeholders

About ORN

- 26 Regional Renal Programs in 14 Regions
- 14 Regional Directors
- 14 Regional Medical Leads
- 8 Provincial Medical Leads
- 1 ORN provincial office
- 99 Dialysis facilities
- $640 m budget (Euro 440 m)
- 11,000 + dialysis patients
- 16,000 + at CKD IV / V clinics



ONTARIO RENAL PLANS

ORN works via 3-4 year plans outlining clinical and administrative priorities

ORP I ran from 2012-15

ORP II has been launched 2015-19

Ontario Renal Network

Introduction to the **Ontario Renal Plan II**

A provincial roadmap for improving the lives of Ontarians living with Chronic Kidney Disease

AIM OF ORP-II

Quality care for CKD patients of Ontario

Patient centered care

Evidence based care

Cost effective care

Focus on structures and processes of CKD care rather than on ‘purely’ medical issues

DETERMINANTS OF CONTENT OF ORP II

Stakeholder consultation – patients, professionals, academics, organizations

Criteria of patient centred care

Evidence based medicine

Cost effectiveness

ONTARIO RENAL PLAN

Patient Centred Care

Home Dialysis Initiative

'Triple Aim Action'

Patient Centred Care

Better Clinical Outcomes

Cost

PATIENT CENTRED CARE

What the patient wants

Becoming a dominant idea in health care delivery

Lots of articles in leading medical and health policy journals

An idea whose time has come !

Person-Centred Care is not about…

- Being nice to patients
- Educating patients to do what the provider wants them to do
- Inviting patients to join committees to ensure clinical practice guidelines are adhered to

Person-Centred Care is…

- An **approach to care** that involves **partnering between patients, families and healthcare providers**.
- Care that is **respectful of**, and **responsive to**, individual **patient preferences, needs and values** and ensures patient values guide all clinical decisions. (Institute of Medicine 2001)

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COMPONENTS OF PATIENT CENTRED CARE
WHAT PATIENTS WANT

1. Comprehensive care
2. Co-ordination of care
3. Timeliness
4. Functioning e-health
5. Clear reliable communication

Change Foundation

Spragins, Lorenzetti 2008

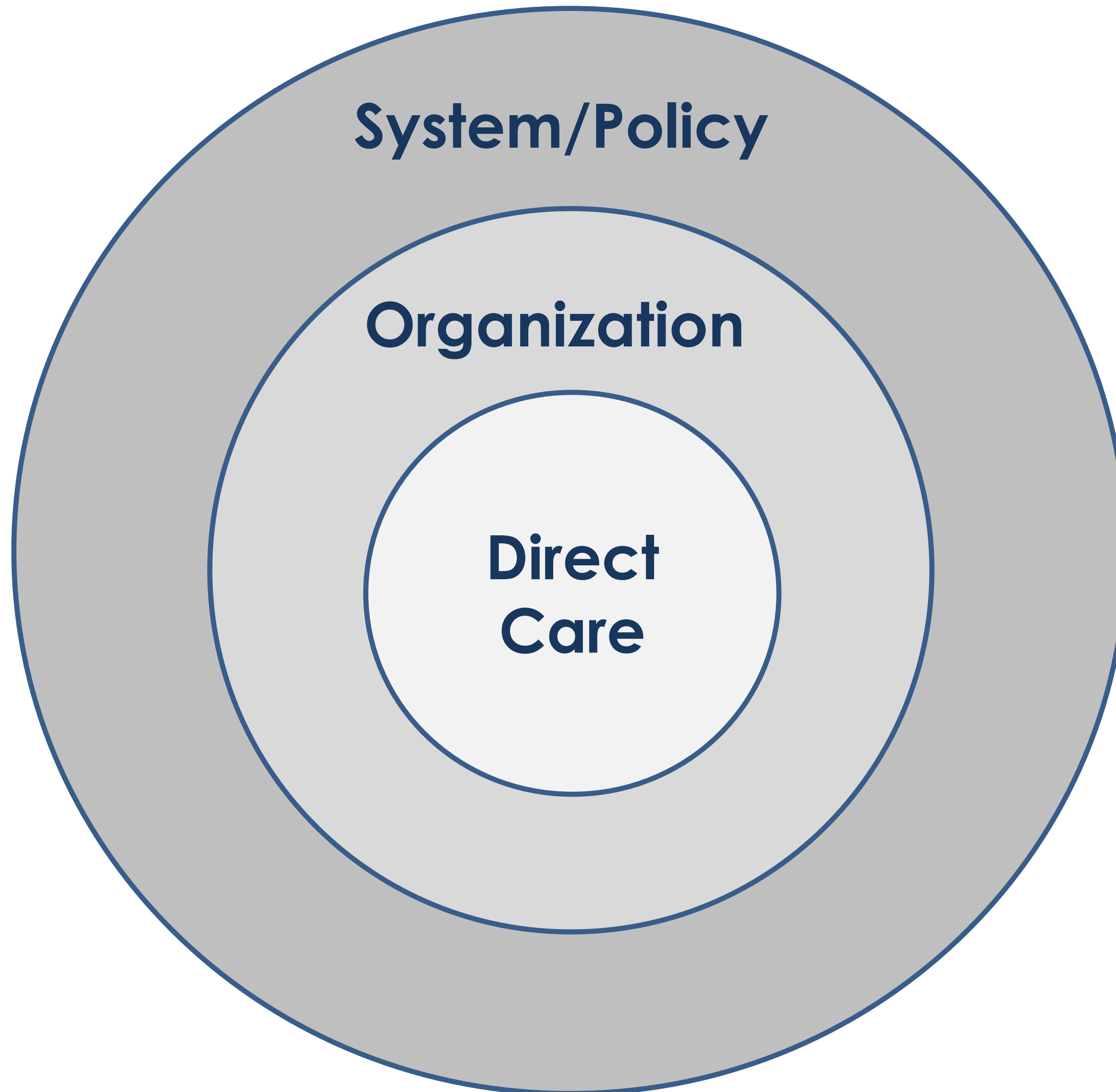
COMPONENTS OF PATIENT CENTRED CARE
WHAT PATIENTS WANT

6. Convenience
7. Respect
8. Empathy and understanding
9. Time – to be heard
10. Continuity and stability
11. Fairness

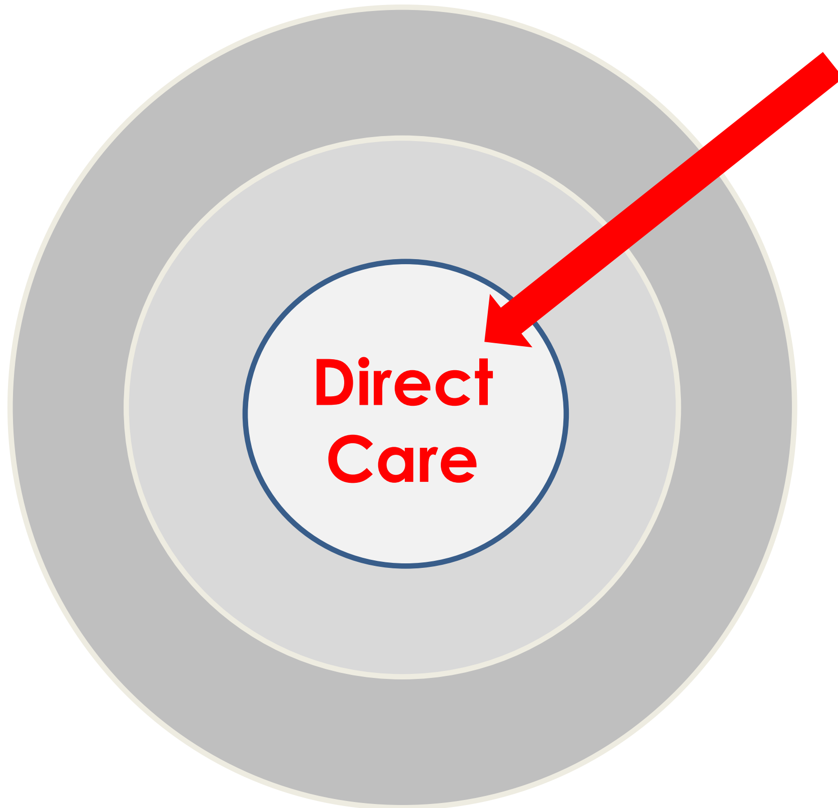
Change Foundation

Spragins, Lorenzetti, 2008

Three Levels of Patient Engagement



Engagement at Direct Care Level



Patient and Provider

Integration of patients' values, experiences and perspectives related to managing patients' health.

Patients are engaged by their healthcare provider in **shared decision-making** and supported with **self-management**

The NEW ENGLAND JOURNAL of MEDICINE

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Shared Decision Making — The Pinnacle of Patient-Centered Care

Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A.

Health Care frequently requires choices between different treatment options

SHARED DECISION MAKING

Lee and Emmanuel NEJM 2013

Aligns medical care with patients' preferences and values

"No Decision About Me Without Me"

Requires engagement and education

Use of 'Decision Aids'

Informed patients often choose less aggressive, invasive options

Right to be 'wrong'

The NEW ENGLAND JOURNAL of MEDICINE

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Shared Decision Making to Improve Care and Reduce Costs

Emily Oshima Lee, M.A., and Ezekiel J. Emanuel, M.D., Ph.D.

Informed patients often choose less aggressive, invasive options

PATIENT CENTRED CARE IN ESRD
WHY IT IS SO RELEVANT

Evidence based medicine has been disappointing in ESRD

Negative randomized trials on high Kt/V in HD and PD, on normalization of Hgb, on statins

Lack of high level evidence to support many of our practices have led to skepticism and made it easier to switch focus to patient centered care

FREQUENT CHARACTERISTICS OF ESRD PATIENTS

Socioeconomically disadvantaged

Limited life expectancy

Major burden of disease

Very impaired quality of life

Many value quality over quantity of life

Avoiding pain and discomfort a priority

PATIENT CENTRED CARE IN CKD / ESRD
WHY IT IS SO RELEVANT

Age, frailty and co-morbidity mean many patients are more concerned with quality than quantity of life – with avoidance of pain and discomfort

Many are on a palliative trajectory even though they continue to dialyze

Typical multidisciplinary approach to ESRD and intense exposure to patient both facilitate PCC

ESRD TRAJECTORIES

A proportion of ESRD patients aiming for transplantation and expecting long term survival on an ‘aggressive’ trajectory

A proportion do dialysis but are focused on comfort and symptom relief more than aggressive therapy on a “palliative trajectory”

Another group are not transplant candidates due to comorbidity or choice but are focused on medium term survival – “semi-aggressive trajectory”

SHARED DECISION MAKNG IN CKD / ESRD
WHY IT IS SO RELEVANT

CKD V / ESRD care is full of big decisions

Lack of high level evidence to guide treatment in many key areas

Often no simple right or wrong answer

SIX KEY DECISIONS IN CKD V / ESRD

Palliative option

Choice of modality

Transplant option

Access option

Timing of dialysis

End of life plan/DNR

ESRD PATIENTS

Many patients will refuse interventions that they are told may prolong their lives if they perceive the intervention as painful or unpleasant

Examples are longer dialysis, greater fluid removal, fistula creation, surgical procedures, fluid and diet restrictions

ORP II 3 Strategic Goals All Patient Centred

GOAL 1	GOAL 2	GOAL 3
Empower and support patients and family members to be active in their care	Integrate patient care throughout the CKD continuum	Improve patients' access to CKD care

ONTARIO RENAL PLAN

Patient Centred Care

Home Dialysis Initiative

WHY GROW HOME DIALYSIS?

Empowers patients by giving them responsibility for their own care

Consistent with idea of bringing care closer to home

Many patients want to do it – especially with encouragement and support

It costs much less and health care funding is increasingly constrained

Outcomes are equivalent and so it is cost effective

INITIATIVES TO GROW HOME DIALYSIS

1. A new funding formula for all modalities including frequent home hemodialysis
2. A new generous funding formula and mandate for “pre-dialysis clinics”
3. Targets for home dialysis
4. Culture of accountability
5. Nurse Navigators for each Program

INITIATIVES TO GROW HOME DIALYSIS

6. Constant benchmarking versus other programs
7. Quarterly meetings with data discussion
8. Provision of support and expert advice and site visits as required
9. Centres of Practice for PD catheter insertion
10. Assisted Home PD

INITIATIVES TO GROW HOME DIALYSIS

11. PD in Long Term Care Homes

12. Urgent Start PD

13. Technique failure and peritonitis projects

14. Financial incentives for home dialysis

15. Specific Home HD initiatives

(1) New Funding Formula

Based on real costs at a number of centres

‘Bundles’ for centre HD, home HD, frequent home HD, frequent in centre HD

‘’Bundles’ for CAPD and APD

DIALYSIS BUNDLES
Payment per year (Can $)

CAD = 0.7 Euro

CAPD	APD	Facility HD	Home HD	Home daily	Facility Daily HD
29,096#	38,145#	51,278	23,130*	35,593*	85,408

PD training not bundled but c $2,300

* + $11, 400 in Year 1 for Home HD training

(2) Pre Dialysis CKD IV/V Clinics

Funding bundle based on the cost of 6 multidisciplinary visits per year ($1,400)

Conditions are multi-disciplinary care, education and a commitment to engage in shared decision making

Criteria now being altered from eGFR < 30 to 2 year risk of ESRD > 10% based on Tangri Kidney Failure Risk Equation (KFRE)

SIX KEY DECISIONS IN CKD IV / V
The Cockpit of Renal Care

1. Timing of dialysis
2. Choice of modality
3. Palliative option
4. Transplant option
5. Access option
6. DNR / End of life plan

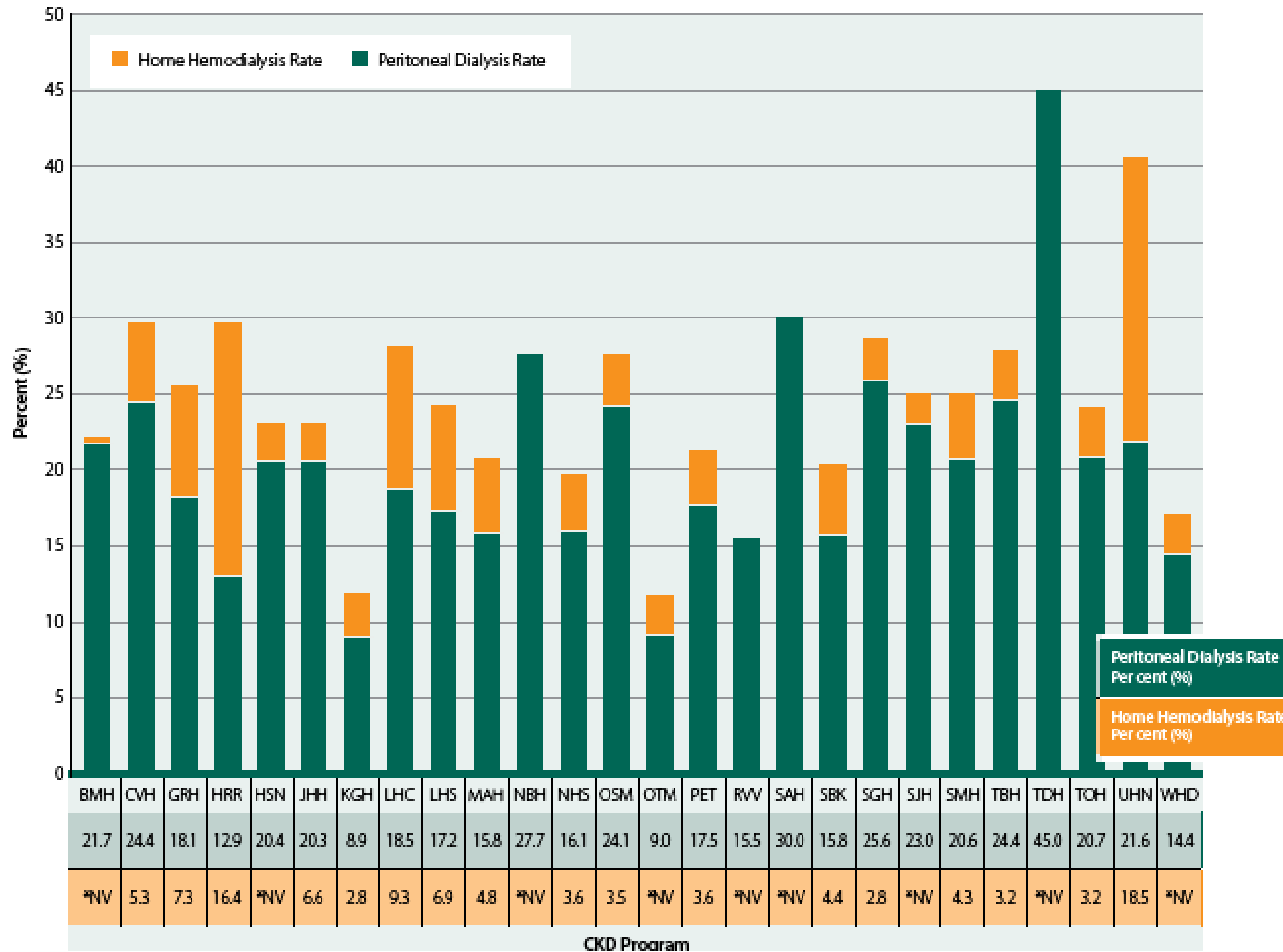
(3) HOME DIALYSIS TARGETS

In ORP I (2012-15), target was 40% incident attempt within 6 months of initiating dialysis

In 2015, switched to provincial home dialysis target of 28% by 2019

Also individual achievable home dialysis targets for each program based on existing rate – i.e. 0.5, 1.0 and 1.5% growth per year for top, mid and low tercile respectively

HOME DIALYSIS RATE BY PROGRAM 2015
Breakdown by PD and Home HD



CKD Program	BMH	CVH	GRH	HRR	HSN	JHH	KGH	LHC	LHS	MAH	NBH	NHS	OSM	OTM	PET	RVV	SAH	SBK	SGH	SJH	SMH	TBH	TDH	TOH	UHN	WHD
Peritoneal Dialysis Rate Per cent (%)	21.7	24.4	18.1	12.9	20.4	20.3	8.9	18.5	17.2	15.8	27.7	16.1	24.1	9.0	17.5	15.5	30.0	15.8	25.6	23.0	20.6	24.4	45.0	20.7	21.6	14.4
Home Hemodialysis Rate Per cent (%)	*NV	5.3	7.3	16.4	*NV	6.6	2.8	9.3	6.9	4.8	*NV	3.6	3.5	*NV	3.6	*NV	*NV	4.4	2.8	*NV	4.3	3.2	*NV	3.2	18.5	*NV

ORN Atlas 2016

(4) NURSE NAVIGATORS

ORN fund a Nurse Navigator for each of the 26 Programs

Responsibility for facilitating incident and prevalent patients to start on home dialysis

Answerable to ORN

Meetings to share successes and challenges

(5) CULTURE OF ACCOUNTABILITY

Direct accountability to ORN for home dialysis rate

Based on ORN funding for dialysis, funding for a Regional Director and Regional Medical Lead in each Region and for a Nurse Navigator in each Program

Notion that leaders of Renal Programs are answerable for home dialysis rate

(6) PROVINCE WIDE DATA REPORTING SYSTEM

Same data system in all 26 Programs with common methodology / definitions

Mandatory because funding depends on the same data

Allows easy benchmarking

Initially some resistance but now widely accepted

(7) QUARTERLY MEETINGS WITH BENCHMARKING DATA

Teleconference each quarter with each Program's leadership – administrator + physician

Presentation of prevalent home dialysis league table with breakdown by PD and HD

Benchmarking and discussion of challenges

Subtle pressure approach by a funding agency ("Shame and Blame")

(8) PERITONEAL CATHETERS

Initiative to provide timely access to successful insertion of PD catheters

Increase in Program funding for catheter placement

Centres of Practice for PD catheter insertion – extra (> x2) funding for small number of Programs who have expertise in PD Catheter insertion and who are willing to place catheters for other Programs who have problems

Monitoring of catheter function rates by centre

(9) MENTORING

Sharing of experience between Programs to help those having problems

Expert advice and mentoring where needed

Site visits by ORN leadership and staff

Engagement with senior hospital administrators in struggling programs

(10) ASSISTED HOME PD

Funding of home care agencies to support PD in home

Funding initially directly flowed from ORN to Home Care but now will flow through Programs who can provide home care themselves if they wish

Used by as many as 30% of patients with some coming off or on all the time

Increases cost of PD significantly (c 20%)

(11) LONG TERM CARE HOMES

Initiative in progress to allow Programs to deliver care inside LTC Homes and to provide funding for them to do this

At present few LTC Homes are approved or interested and those that are have large staff turnover so that retraining is constantly required

Might be more cost effective for Programs to do it themselves

5% of dialysis patients live in LTC homes (95% HD)

(12) URGENT PD START

Encouragement and support for Programs who want to initiate this

Defined as the ability to initiate an acute on chronic renal failure on PD within 72 hours of presentation

Optional – some do not seem to need it - now in place in 9 of 26 Programs

(13) PERITONITIS / TECHNIQUE FAILURE INITIATIVES

Just beginning

Standardized data collection by Program

Rate for each Program – benchmarking

Education / Quality Initiative process

(14) FINANCIAL INCENTIVES

Previously ‘bundles’ were based on estimates of actual costs

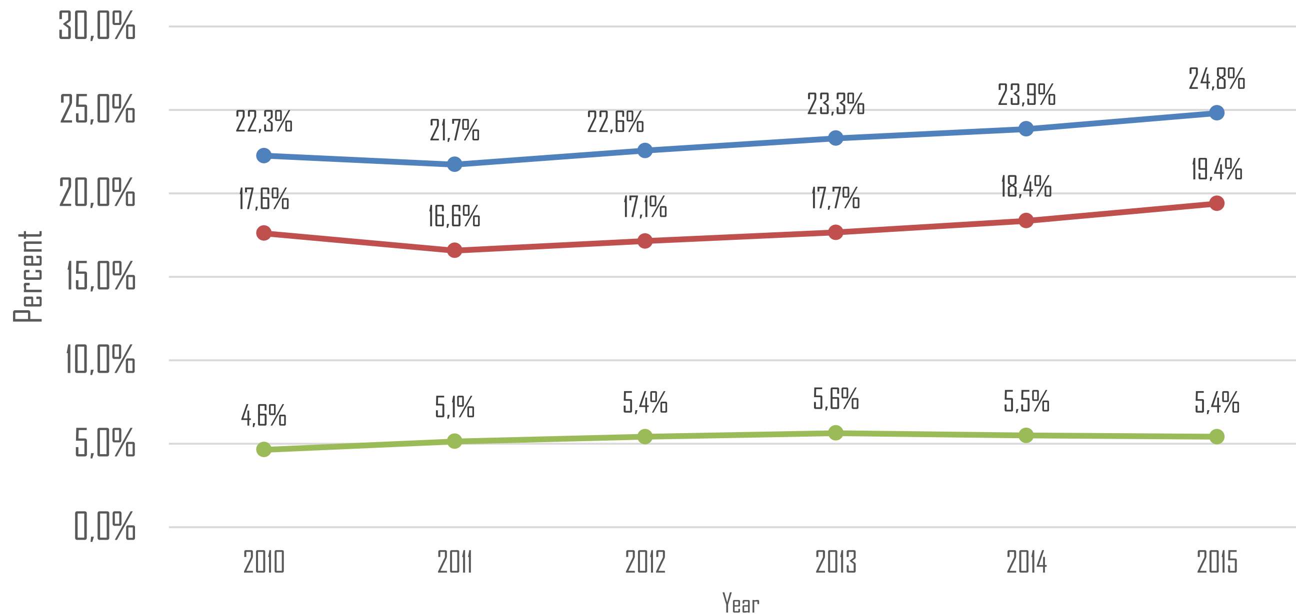
Now as of 2016 there will be modest incentives with funding shift from centre HD to home bundles – 3% increase in home dialysis bundle and 1 % decrease in in centre bundles

Scope to increase this or to cap % of patients that can receive centre HD funding in each Program

Clinical Programs Achievement Highlights

Achievements for Home First

- Achieved 24.8% home dialysis rate in Ontario as of Dec.31st, 2015!
- Introduced target setting approach with funding at risk
- Only 2 CKD Programs may have funding penalty (pending Q4 results)



NUMBERS ON DIALYSIS BY MODALITY ONTARIO mid 2012 – start of 2016

	N Q1 12/13	N Q3 15/16	% change		Prevalent % Q1 12/13	Prevalent % Q3 15/16
Home HD	542	603	+ 11%		5.3%	5.4%
PD	**1,718**	**2,156**	**+ 26%**		**16.9%**	**19.4%**
Total Home	2,260	2,759	+ 22%		22.2%	24.8%
Centre HD	7,924	8,359	+ 5%		77.8	75.2
Total	10,184	11,118	+ 9%		100%	100%

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Home Dialysis Prevalence by Program 2015

	% Home	% PD	% HHD			% Home	% PD	%HHD
UHN	41	22	19		SBK	21	16	5
TDH	37	37	0		SMH	21	18	3
SGH	30	28	2		TOH	21	18	3
LHC	30	20	10		SJH	21	19	2
HRR	30	12	18		PET	20	17	3
OSM	29	25	4		BMH	19	18	1
TBH	28	25	3		MAH	16	12	4
SAH	28	28	0		NHS	16	12	4
JHH	28	19	9		WHD	14	12	2
GRH	26	20	6		OTM	12	8	4
CVH	26	21	5		RVV	11	11	0
NBH	25	25	0		KGH	10	7	3
LHS	25	18	7					
HSN	24	22	2		Total	24.2	18.7	5.5

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WHAT ABOUT HOME HD?

Many of the initiatives mentioned apply to Home HD as well as PD

Accountability, funding, navigators, data feedback

There are additional issues and challenges with HHD

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HHD PREVALENT RATE BY CENTRE

Q3 2014/15

HRR	18.1%		TBH	3.0%	
UHN	17.9%		KGH	2.9%	
LHC	9.7%		PET	2.7%	
JHH	8.5%		SJH	2.4%	
LHS	7.2%		SGH	2.3%	
GRH	5.5%		HSN	2.2%	
CVH	5.3%		WHD	2.1%	
SBK	4.5%		BMH	0.5%	
NHS	4.3%		SAH	0%	
MAH	4.1%		NBH	0%	
OSM	3.7%		RVV	0%	
OTM	3.5%		TDH	0%	
SMH	3.4%				
TOH	3.4%		TOTAL	5.5%	

WHAT ABOUT HOME HD INITIATIVES?

Home helpers for patients not able to take on Home HD themselves – non-RNs – controversial – project underway

Patient borne costs – water and electricity – relocation for training

Funding of simpler machines ('Next Stage') that may increase population capable of taking on HHD

Technique failure project

ORN Home Dialysis Initiative - Conclusions

Working steadily – especially in PD – changing the pattern of the previous decade

Cost savings freeing up funds for other initiatives

What is working?!

Power of benchmarking and close engagement and follow through

Power of fund holding and incentives

Consequences of empowering nephrologists and nurse managers

There are limits to how much home dialysis can grow without compulsion – 30%, 35%, 40%?

Concerns about Home Dialysis Initiative

What if pushing home dialysis too hard leads to ‘bullying’ of patients to do it – the opposite of patient centred care?

What if pushing home dialysis too hard leads to a rise in technique failure rates?

What if all these initiatives increase costs to a point where home dialysis is no longer cost saving?

Need for perspective

Other ORN Initiatives

Palliative care in CKD V and ESRD

Living donor transplant

Vascular access wait times

Patent reported outcomes and experience (PRO and PREs)

Shared Decision Making education tools

Other ORN Priorities

GN Initiative with specialized clinics

First Nations (FNIM)

Primary care

Deferred initiation of dialysis

AKI / Safety