

CE LHIN 3 Early Chronic Kidney Disease (CKD) Initiatives

Presentation to the Central East LHIN Board

April 20, 2010

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Objectives

- Provide overview of project scope and key drivers
- Demonstrate the CKD alignment within the broader system goals
- Highlight early intervention deliverables for the three initiatives
- Share stories to demonstrate project impact
- Identify Lessons Learned
- Propose next steps for moving towards 2013

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Project Charter Committee

- Jeanne Thomas, Jenny Greensmith CE LHIN
- Liz Hawthorne, Linda Hewitt, Debbie Wilson- Peterborough Regional Health Centre
- Denise Ashton, Dr. Ashton- HarbourFront Health
- Emily Harrison, Ethel Doyle, Ines Jowitt - Lakeridge Health
- Linda Kloosterman, Tracey Skov, Barb Bunker-Baxter Canada
- Gail Chan –Carefirst Seniors and Community Services Association
- Janet Bick- The Kidney Foundation of Canada- Ontario Chapter
- Jay Wilson- The Scarborough Hospital

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Project Scope

To develop and implement a sustainable Chronic Disease Model for the CE LHIN, replicated as a whole or in parts across other LHINS.

The model includes several initiatives that address care elements across the spectrum of Chronic Kidney Disease (CKD):

- Early identification of those at risk for CKD
- Treatment of patients with End Stage Renal Disease (ESRD)
- Support for dialysis patients throughout the transitions of care
- Promoting home dialysis modalities
- Supporting education and patient self management
- Improving clinical, program and economic outcomes

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Drivers

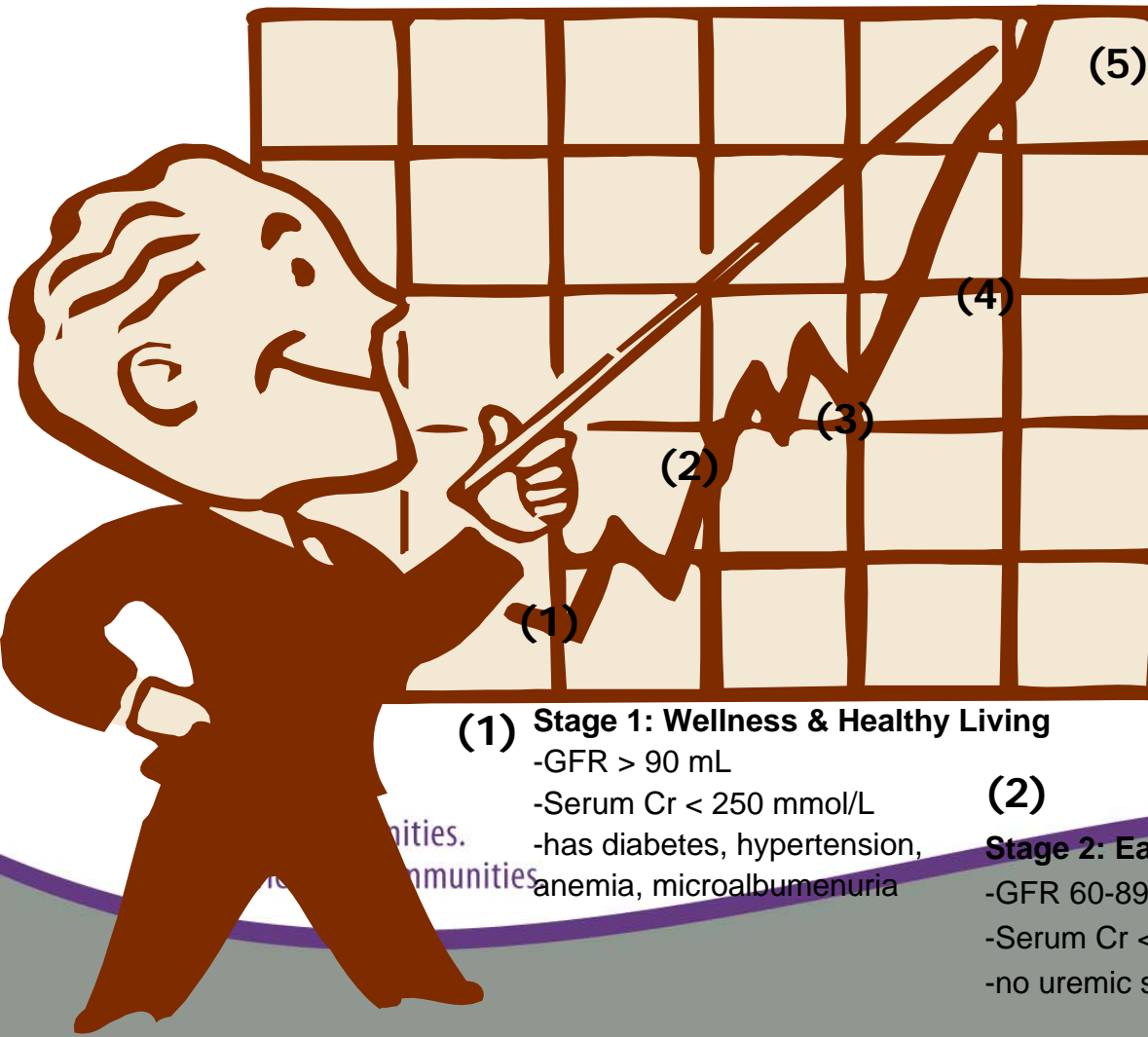
- CE LHIN IHSP (2006) identified Chronic Disease Prevention and Management (CDPM) as one of its strategic priorities

CKD and Diabetes were a priority focus area within CDPM.

- The CE LHIN has the second highest growth/prevalence of CKD in Ontario, with significant at risk populations including Asian and Aboriginal groups
- Diabetes is one of the leading causes of CKD
- Patients living with CKD often have multiple co-morbid conditions that require frequent intervention and support
- The progression of CKD if detected early can be delayed

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New Stages for the CKD Program



(1) Stage 1: Wellness & Healthy Living

- GFR > 90 mL
- Serum Cr < 250 mmol/L
- has diabetes, hypertension, anemia, microalbuminuria

(2)

Stage 2: Early Renal Failure

- GFR 60-89 mL
- Serum Cr < 250 mmol/L
- no uremic symptoms

(4) Stage 4: Modality Review & Selection

- GFR 15-29 mL
- Serum Cr > 250 mmol/L
- Presence of uremic symptoms

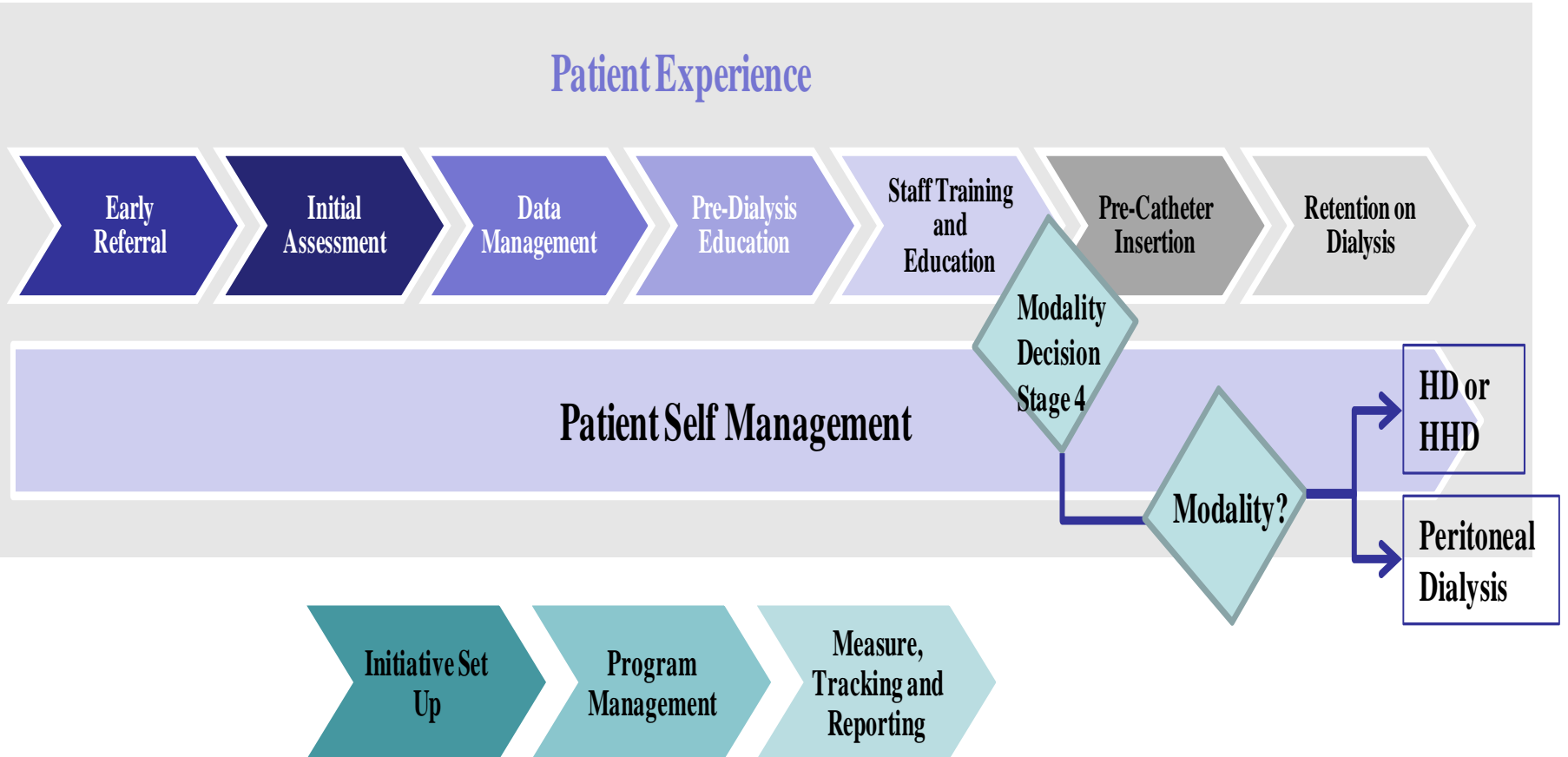
(5) Stage 5: Preparation for Dialysis Access

- GFR < 15 mL
- Serum Cr > 250 mmol/L

(3) Stage 3: Modality Teaching

- GFR 30-59 mL
- Serum Cr > 250 mmol/L
- Patient asymptomatic
- Modality training and Arrangement for access

CKD Care Across the Continuum



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CKD Initiative Alignment with Broader System Goals

Ministry of Health Goals

- Reduce wait time in ER departments

- Reduce time in ALC beds

- Improve access to integrated Diabetes services

Ontario Renal Network

- Establish a regional model for planning and coordinating delivery of services

- Promote home modality where appropriate; encourage and support self-management and autonomy

- Improve quality and access for the CKD population

CE LHIN Goals, by 2013:

Save 1 million hours patients spend in ER departments

Reduce the impact of vascular disease by 10%

The Triple Aims

Value for money

Enhance population health outcomes

Improved patient experience

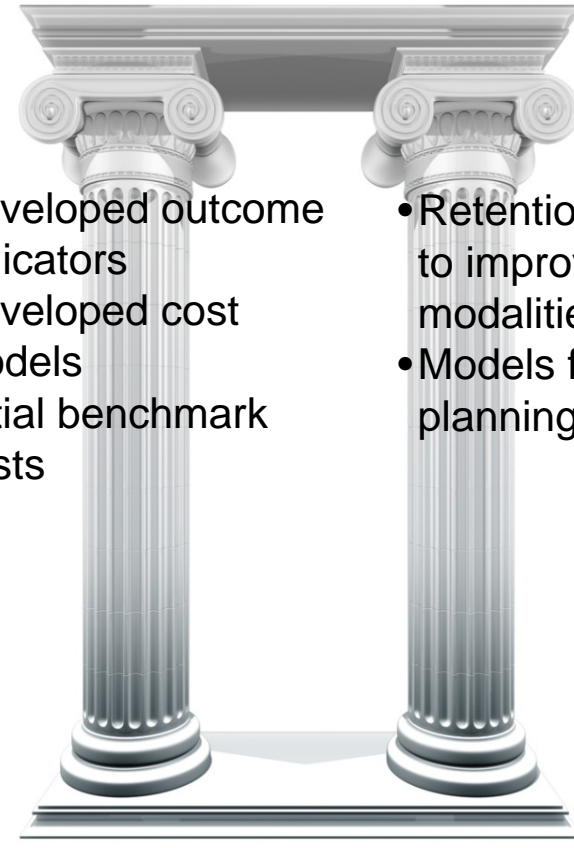
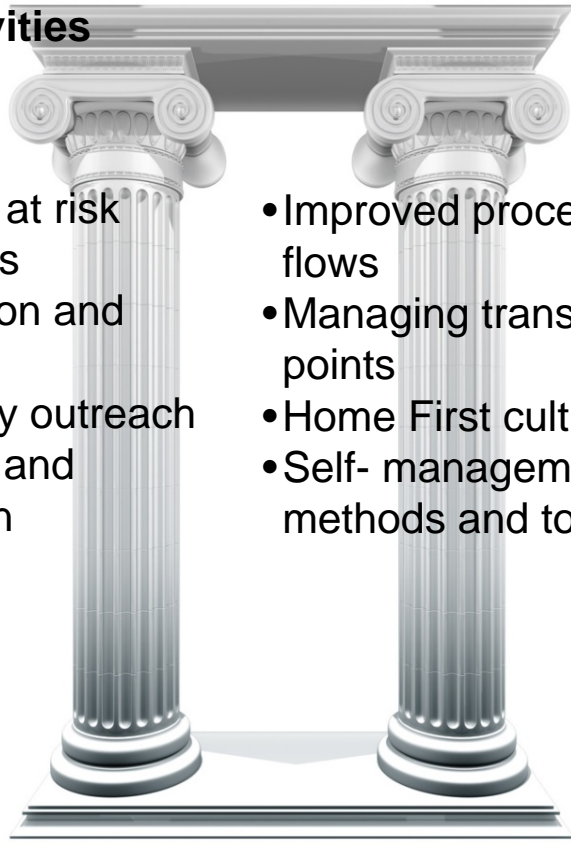
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The 3 CKD Initiatives support the ORN Pillars of Care

Model of CKD Care – CE LHIN

**Continuum of Care
Improved Patient Experience
Patient Self-Management**

CKD Activities



- Screening at risk populations
- Identification and referral
- Community outreach
- Education and information

- Improved process flows
- Managing transitions points
- Home First culture
- Self- management methods and tools

- Developed outcome indicators
- Developed cost models
- Initial benchmark costs

- Retention strategies to improve home modalities
- Models for resources planning

Eng:

Prevention

Quality

Cost
Effectiveness

Proactive Planning

CareFirst/The Scarborough Hospital - Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
Carefirst/SRDP Chronic Kidney Disease Early Intervention & Outreach	<p>1. To improve the quality of care for individuals at high risk for CKD through: prevention, early detection, enhanced referrals, timely diagnosis</p> <p>2. To provide education and support towards CKD and self management</p>	<p>Community Outreach</p> <ul style="list-style-type: none"> • Outreach to 31 agencies serving immigrant groups • Outreach screening at 71 locations in Scarborough • Service to groups speaking 13+ languages <p>CKD Risk Factor Screening</p> <ul style="list-style-type: none"> • 129 screening clinics • 3747 patients screened • 38% demonstrated risk factors <p>Patient/Community Education</p> <ul style="list-style-type: none"> • 90 pre-screening workshops-CKD awareness • 3 curriculum based intensive workshops-offered for people with identified risks • 3,7190 copies of project brochures disseminated • Kidney Foundation pamphlet translated and printed in Chinese, Tamil, Punjabi • 11,217 tracks of Kidney Health education disseminated 	<p>Screening tool: questionnaire, BMI, BP, urine dip stick</p> <p>Outreach database tool</p> <p>CKD screening project brochure template</p> <p>“Am I at Risk Pamphlet (English, Chinese, Tamil, Punjabi)</p>

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CareFirst/The Scarborough Hospital - Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
<p>Carefirst/SRDP Chronic Kidney Disease Early Intervention & Outreach</p>	<p>2. To provide education and support towards CKD and client self management/patient empowerment</p> <p>3. To develop an integrated model that can be replicated in other geographical areas</p>	<p>Patient Follow-up</p> <ul style="list-style-type: none"> •1,300 patients identified at risk followed up via telephone calls • 935 patients reached, •70% (653) patients returned to see family physician • 14% being followed by specialist care •18% referred for Diabetes Education •71% express interest in more CKD education 	<p>Kidney foundation education material</p> <p>CDA education material</p> <p>CKD education series (power point presentations and video)</p> <p>Telephone follow up questionnaire and guideline</p> <p>Data collection tracking sheet</p>

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Peterborough Health/First Nations - Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
<p>Peterborough Regional Health Centre/First Nations Chronic Kidney Disease Early Intervention Initiative</p> <p>First Nations</p> <ul style="list-style-type: none"> •Alderville •Curve Lake •Hiawatha 	<ol style="list-style-type: none"> 1. To deliver culturally sensitive CKD screening and treatment to First Nations and Seniors 2. To provided education and support towards CKD and client self management 3. To develop an integrated care model that can be replicated 	<ul style="list-style-type: none"> •Cultural sensitivity training for 65 staff •1,000 CKD awareness pamphlets distributed •Screened 555 clients (total >19 =670) •258 clients identified at risk for CKD •18 clients with eGFR less than 60 (stage 3) •5 clients had an eGFR between 15-29 (stage 4) •86 clients referred for Nephrology consultations •90 at risk clients participated in CKD educational sessions •1,000 CKD awareness pamphlets distributed 	<p>CKD screening tool</p> <p>“Do I have CKD” pamphlet</p> <p>Referral decision algorithm for follow up to GP and Nephrologists</p> <p>Medical Directive for blood sampling in community</p> <p>CKD awareness video –target audience Caregivers</p>

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Lakeridge Health/Baxter Canada - Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
Lakeridge Health	<p>1. To promote patient empowerment through Self Management</p> <p>2. To develop a comprehensive Education program that supports CDPM and Self Management</p>	<ul style="list-style-type: none"> •Baxter -Self management support workshops (65 attended) •Established community partnerships to support self-management (ADEC, DRDN) •Electronic intranet link for staff to access external links (Kidney Foundation, Lifeline) •One Patient peer leader trained in self management •Patient education curriculum •Tools available electronically for patient access 	<p>Renal Health Care Diary</p> <p>Food for thought: Kidney Friendly Nutrition manual</p> <p>Sleep hygiene pamphlet, Medication pamphlets, Transition pamphlets e.g. KCC to PD, PD to HD</p> <p>On line documentation tool to track modality education, access creation, dialysis starts (Meditech)</p>

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Lakeridge Health/Baxter Canada - Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
Lakeridge Health	3.To maintain/increase home therapy utilization	<ul style="list-style-type: none"> •Culture shift to Home First Philosophy •Surpassed MOH targets for PD and HHD prevalence. PD maintained at 30%, HHD growth from 1% (2003) to 10% •Dedicated OR block for PD catheter insertions. •Creation of Dialysis Access committee •Developed and tested strategies for Growing a Home Dialysis Program 	<p>Algorithm modality</p> <p>Home Hemodialysis check list</p> <p>Peritoneal Dialysis checklist</p> <p>On line documentation tool to track modality education, access creation and dialysis starts</p>

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Lakeridge Health/Baxter Canada - Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
Lakeridge Health	<p>4. To promote seamless patient coordination as nephrology patients transition throughout the health care system</p> <p>5. To provide proactive patient care with a focus on co morbidity prevention and management</p>	<ul style="list-style-type: none"> •Staff workshops to identify, prioritize transition points,- 30 staff attended •5 Process flow maps created for transition points •3 follow-up workshops utilizing PDSA approach for solution building •30 process flow diagrams created (processes within programs and between programs)-includes education materials •Developed Risk Stratification tool for Home Hemodialysis (HHD), Peritoneal Dialysis (PD) (Simple Patient score identifies risk index for admission, ER visit, death) •In centre HD tool to roll out early 2010 •Community wide schedule module provides print out of patient Admissions/ER visits last 120 days, Facilitates proactive planning of needed patient supports to prevent reoccurrences 	<p>Process flow maps</p> <p>Dialysis Co morbidity Severity Index</p>

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Lakeridge Health/Baxter Canada- Early Intervention Deliverables

Initiative	Objectives	Deliverables Achieved	Tools to be Shared
Lakeridge Health	<p>6. To provide CQI initiatives designed to maintain and/or improve patient clinical outcomes and quality of life</p> <p>7. Increase provider and patient satisfaction through the implementation of the CDPM program</p>	<ul style="list-style-type: none"> •Developed quality framework (incorporates business, operational and clinical outcome measures) •Identified and track clinical indicators – benchmark against best practice •Implemented combination Kidney care/Endocrinology clinic (expect improved management of stage 3, 4 CKD) •Developed quarterly outcome indicator report •Cost efficiency related to #peritonitis cases- \$82K •Time saved with improved process for providing diet education-35 min/patient= \$29K/yr •Cost avoidance –line infections \$27K •KDQOL survey completed for aliquot sample •“Patient Assessment of Chronic Illness Care” McColl Institute for Health Care Innovation- N=253, Satisfaction ~70% 	<p>Quality framework</p> <p>Outcome indicator template</p> <p>KDQOL survey tool McColl assessment tool</p>

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Patient and Caregiver Stories

- Mr. M finds CKD screening and education session so helpful-organizes screening for his condo residents (58 people screened, 20% demonstrated high blood pressure, 10% showed protein in their urine.
- Mrs. R –teacher who was overseeing her class being screened. She decides to be screened- high BMI, sugar in urine, POC BS elevated->Diabetic, Oral Hypoglycaemic, Referred to community Diabetes Education

Patient and Caregiver Stories

Gail Chan- Carefirst/The Scarborough Hospital Project Lead

“What impacts me the most is how many people are walking out there in the community who need attention to health care, but without knowing they need attention.....We were able to help people to learn that they can take care of themselves and live a healthy life style at an earlier stage as much as possible. This will benefit the whole health system”

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Patient and Caregiver Stories

Jack Pine- Traditional Healer

"It is hard for people to make changes. It is so simple in life to do things, but a lot of people have a hard time with it. The way I look at life we have one chance at this life. Do we want to be happy and healthy; everything out there we see is good, nothing bad, but it is the human beings choice. Even though we make mistakes there is a chance of coming back, there is always a good chance, because now we have learnt something about what makes us sick and we can make changes"

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Patient and Caregiver Stories

Bill Crowe- Alderville First Nations

"The First Nations people, we have a high incidence of diabetes, that translates into a lot of other things, kidney disease being one of them. It is wise to have the kidney screening. If you can catch it a lot earlier you certainly can do something about it"

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Patient and Caregiver Stories

Pam Stevenson- Community Health Nurse Alderville

"For me the most important part of the project besides the screening that helped to identify those at risk was pulling clients into programs and services that already existed in the community. It is always a struggle to try to get people engaged; however when they came for screening we were able to talk to them about the chiropody clinic, the dietician clinic, the diabetes education support group and we saw a real increase in utilization of services that we offer"

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Patient and Caregiver Stories

Pat Howell –Peer Support leader

“The project really encouraged Patients to advocate for themselves. Through the chronic disease prevention management program, people are encouraged to share, and through the peer support group, people are becoming more able to advocate for themselves. I’ve learned that I need to look after myself. I am the one that needs to be aware of what I need. The program really helped me see this”

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Patient and Caregiver Stories

Emily Harrison- Lakeridge Health/Baxter Canada Project Lead

"Staff would come to me with ideas. To be able to say yes let's see what we can do to help make this happen and see the ideas come to life, and then see the staff beam when their ideas came to life, was very rewarding for me. It has been a tremendous experience for me to be able to share some data with staff and show how things have improved over time. You can never communicate enough with front line staff. You think you share well with front line staff, but truly one of the things that the project did was open those communication lines even more"

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Patient and Caregiver Stories

“Working with the Scarborough Hospital and Peterborough Health Centre for the CKD project has been a wonderful experience. It helps you realize that we all have the same issues even though we have unique ones as well. It is a shame to create things in isolation without working together, because we are all trying to do the same thing just in a different way, so by coming together at one table we can share ideas. From the patient experience if they happen to go from hospital to hospital they are going to get more of the same type of care and it will be more comfortable for them”

“From a partnership point of view working with all different levels of people, organizations and Patients, is a tremendous value to me. It is what we are here for, to look after the Patients and make their experience as easy as possible” Emily Harrison

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Lessons Learned

- The model of care is changing
- Patient self-management is an achievable goal
- Internal Leadership is paramount to effective change management
- Internal process and transition management is key to seamless coordination for the Patient
- Strong coalitions support improved Healthcare outcomes
- Integration is key to optimize results
- Measuring outcomes directs resources and effort more effectively
- Funding indicators can be better estimated and support planning
- Project Management integrates “all the moving parts”

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Moving Towards 2013

- Integrate PRHC initiative into the Vascular Health Network project
- Identify opportunities for building coalitions to align with key LHIN priorities 2010-2013
- Extend Carefirst /Scarborough initiative- Cardio Metabolic Chronic Disease Prevention & Management Center. HSIP proposal.
- Lakeridge Health- project extension until 2012: focus on developing electronic database, quality, cost effectiveness
- Continue to incorporate Self Management into initiatives
- Continue work of CE LHIN Renal Network
- Continue advocacy with Ontario Renal Network. Position CKD initiatives, as magnet for other renal programs/ LHINS across the province.

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Current Opportunities with the Ontario Renal Network

- Build a Community of Practice –ORN web link to Report/Field Guide
- Incorporate Dialysis Co morbidity Severity Index® tool across LHINS
- Utilize our CKD CDPM model of care across LHINS
- Move forward with Early detection/Intervention HSIP
- Expand Renal to include Cardio-vascular outcomes

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Acknowledgements

Special thanks to Jeanne Thomas and Jenny Greensmith, CE LHIN

Many Thanks: Dr. Kamilla, Dr. Hanson (PRHC), Dr. Steele, Carol Anderson,(LH) Dr.Tam, Denise Leblanc, Fred Chan (SRDP), Helen Leung (Carefirst), Leon Lau (Kidney Foundation).

Community Partners: Chief Knott, CICS, CCM Centre, Afghan Association of Ontario, Catholic Cross Cultural Services, Harmony Hall Centre, Scarborough Support Services, Carefirst- NTO office, The Scarborough Tamil Seniors Association, South Asian Family Support Services, The Family Services Association of Toronto, Toronto District Board LINC Program, Vasantham Tamil Wellness Centre, West Hill Community Services Association, Working Women Community Services.

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Questions

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