

# Quality-Based Procedures Clinical Handbook for Chronic Kidney Disease

Ministry of Health and Long-Term Care

January 2016

# Table of Contents

|  |    |
|--|----|
| 1.0 Purpose .....  | 3  |
| 2.0 Introduction .....   | 4  |
| 3.0 Description of Chronic Kidney Disease as a Quality-Based Procedure.....                          | 10 |
| 4.0 How does the Chronic Kidney Disease Quality-Based Procedure Improve<br>Patient<br>Outcomes?..... | 15 |
| 5.0 What Does it Mean for Clinicians?.....   | 18 |
| 6.0 Service Capacity Planning.....   | 19 |
| 7.0 Evaluation and Monitoring .....  | 20 |
| 8.0 Support for Change .....   | 21 |
| 9.0 For more Information .....   | 22 |
| 10.0 Frequently Asked Questions.....   | 23 |
| 11.0 Committees .....  | 27 |

# Quality-Based Procedures Clinical Handbook: Chronic Kidney Disease

## 1.0 Purpose

This clinical handbook has been created to serve as a compendium of the policy framework and implementation approach for the Chronic Kidney Disease (CKD) Quality-Based Procedure (QBP). The Ontario Renal Network (ORN) has played an integral role in the planning and development process and providing advice on best practice care in the delivery of renal services across Ontario. As well, ORN will continue to provide a key leadership role in the implementation of the CKD policy framework while working in close collaboration with the Local Health Integration Networks (LHINs) and all health sectors involved in the provision of CKD services.

The handbook is intended for a clinical audience. It is not, however, intended to be used as a clinical reference guide by clinicians and will not be replacing existing guidelines and funding applied to clinicians. Evidence-informed pathways and resources have been included in this handbook for your reference.

## 2.0 Introduction

Quality-Based Procedures (QBP) are an integral part of Ontario's Health System Funding Reform (HSFR) and a key component of the Patient-Based Funding (PBF). This reform plays a key role in advancing the government's quality agenda and its **Action Plan for Health Care**. HSFR has been identified as an important mechanism to strengthen the link between the delivery of high quality care and fiscal sustainability.

Ontario's health care system has been living under global economic uncertainty for a considerable period of time. At the same time, the pace of growth in health care spending has been on a collision course with the provincial government's deficit recovery plan.

In response to these fiscal challenges and to strengthen the commitment towards the delivery of high quality care, the **Excellent Care for All Act** (ECFAA) received royal assent in June 2010. ECFAA is a key component of a broad strategy that improves the quality and value of the patient experience by providing them with the right care at the right time, and in the right place through the application of evidence-informed health care. ECFAA positions Ontario to implement reforms and develop the levers needed to mobilize the delivery of high quality, patient-centred care.

Ontario's **Action Plan for Health Care** advances the principles of ECFAA reflecting quality as the primary driver to system solutions, value and sustainability.

### 2.1 What are we moving towards?

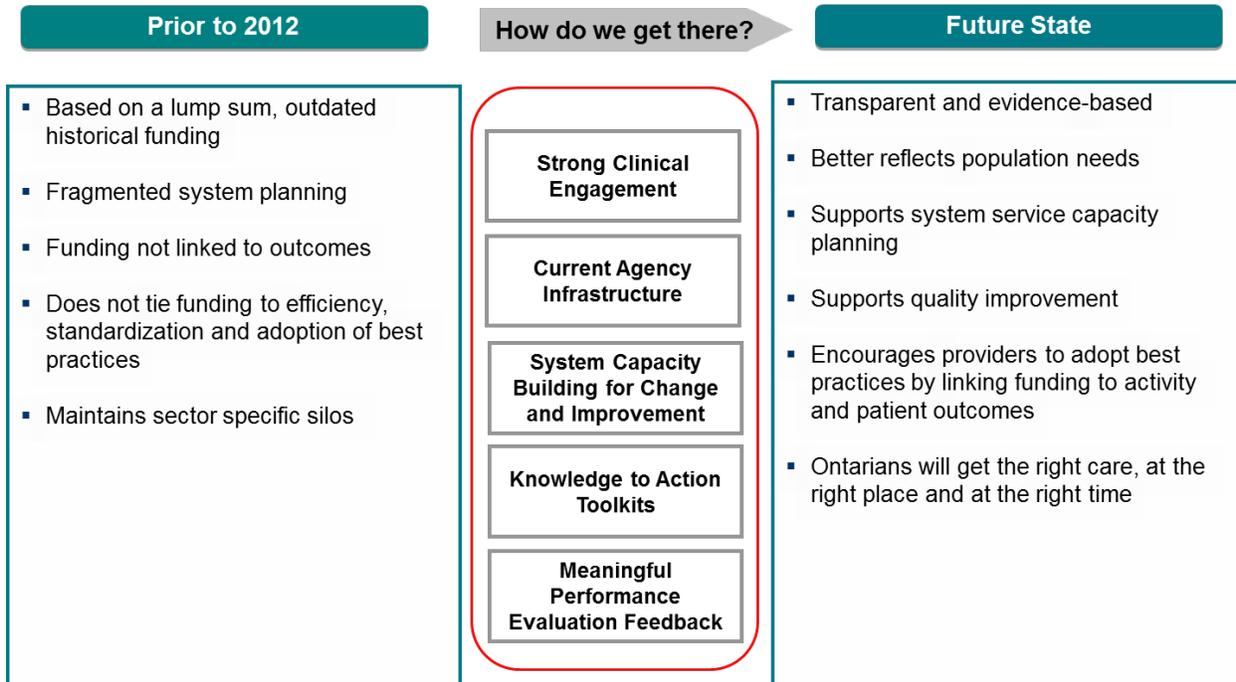
Prior to the introduction of HSFR, a significant proportion of hospital funding was allocated through a global funding approach, with specific funding for some select provincial programs and wait times services. A global funding approach reduces incentives for Health Service Providers (HSPs) to adopt best practices that result in better patient outcomes in a cost-effective manner.

To support the paradigm shift from a culture of 'cost containment' to 'quality improvement,' the Ontario government is committed to moving towards a patient-centred funding model that reflects local population needs and contributes to optimal patient outcomes (Figure 1).

Internationally, PBF models have been implemented since 1983. Ontario is one of the last leading jurisdictions to move down this path. This puts the province in a unique position to learn from international best practices and lessons learned by others to create a funding model that is best suited for Ontario.

PBF supports system capacity planning and quality improvement through directly linking funding to patient outcomes. PBF provides the incentive to health care providers to become more efficient and effective in their patient management by accepting and adopting best practices that ensure Ontarians get the right care, at the right time and in the right place.

Figure 1: The Ontario government is committed to moving towards patient-centred, evidence-informed funding that reflects local population needs and incents delivery of high quality care

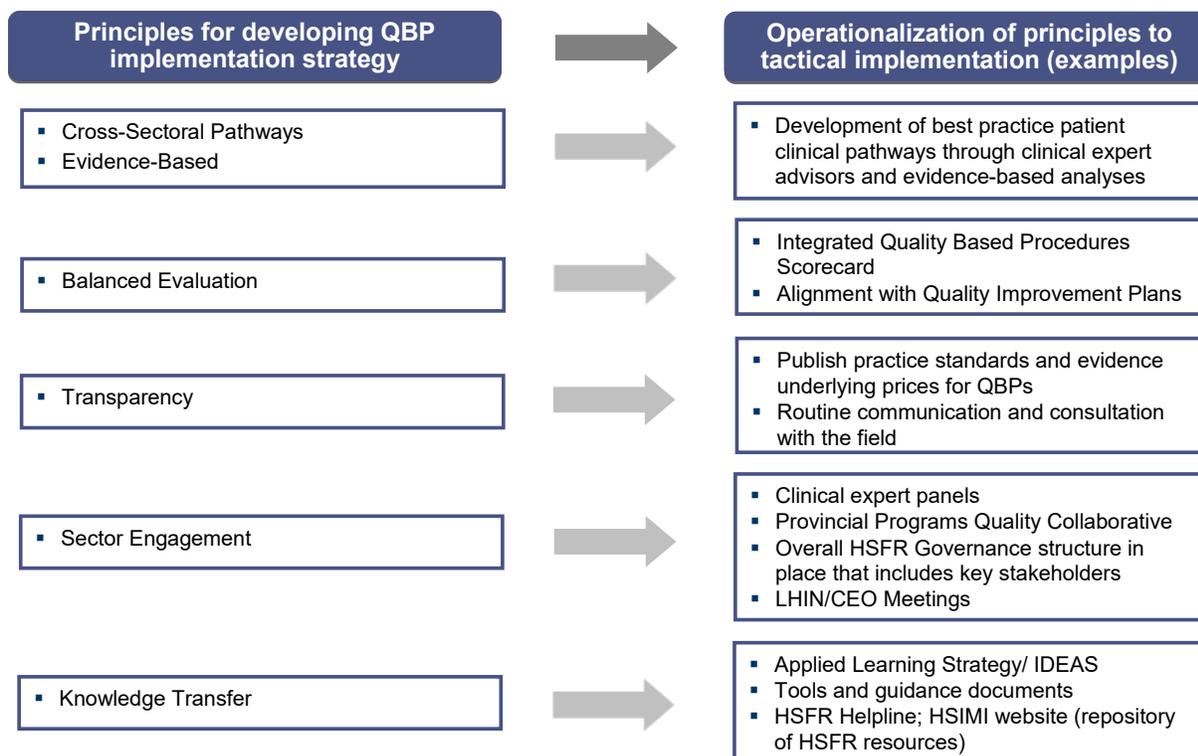


## 2.2 How will we get there?

The Ministry of Health and Long-Term Care (the Ministry) set out with adopted a three-year implementation strategy to phase in successive QBPs and since fiscal year 2012/13, has made incremental funding shifts. A three-year outlook was provided to the field to support planning for upcoming funding policy changes.

The successful transition from the ‘provider-centred’ funding model towards a ‘patient-centred model’ was made possible by a number of key enablers and field supports. These enablers translate to actual principles that guided the development of the funding reform implementation strategy related to QBPs. These principles further translate into operational goals and tactical implementation, as presented in Figure 2.

Figure 2: Principles guiding the implementation of funding reform related to Quality-Based Procedures



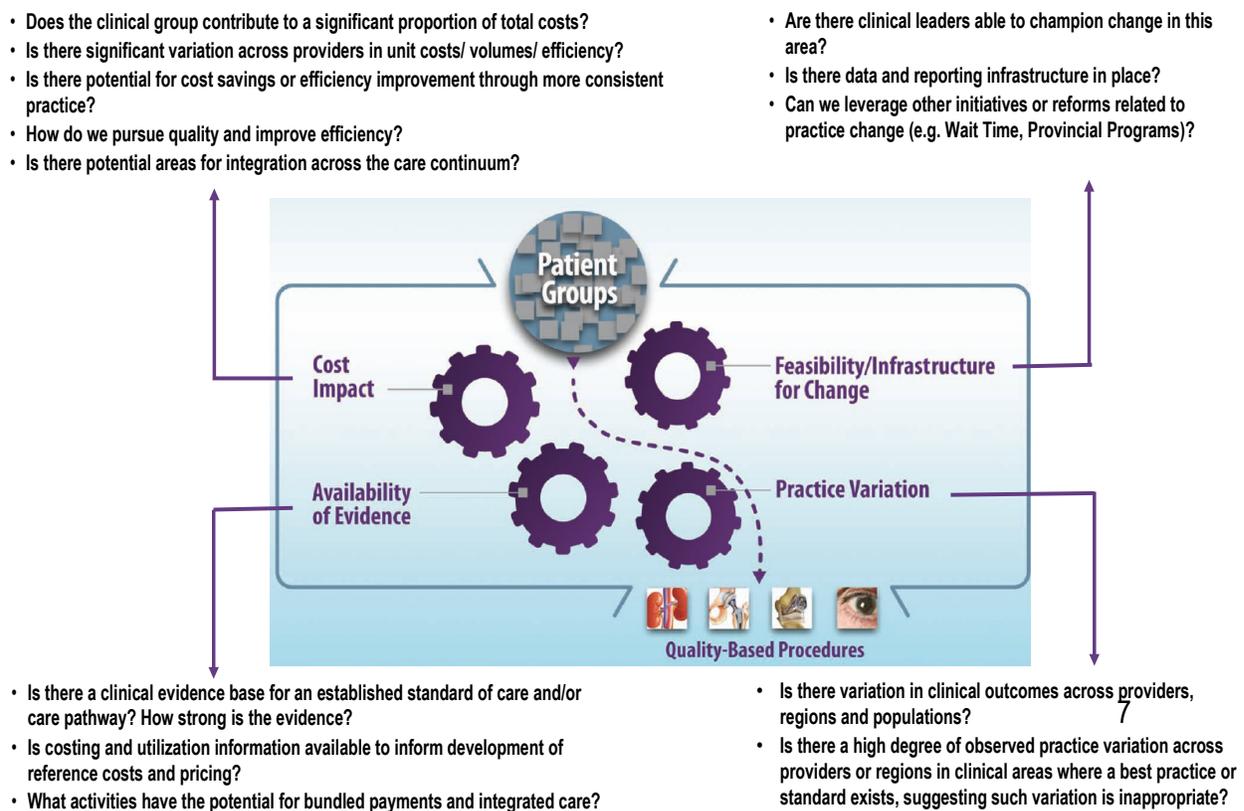
## 2.3 What are Quality-Based Procedures?

QBP's involve clusters of patients with clinically related diagnoses or treatments. Chronic Kidney Disease (CKD) was chosen as a QBP using an evidence and quality-based selection framework that identifies opportunities for process improvements, clinical re-design, improved patient outcomes, and enhanced patient experience and potential cost savings.

The evidence-based framework used data from the Discharge Abstract Database (DAD) adapted by the Ministry for its Health Based Allocation Methodology (HBAM) repository. The HBAM Inpatient Grouper (HIG) groups inpatients based on the diagnosis or treatment responsible for the majority of their patient stay. Day Surgery cases are grouped within the National Ambulatory Care Referral System (NACRS) by the principal procedure they received. Additional data from the Ontario Case Costing Initiative (OCCI) and the Ontario Joint Policy and Planning Committee (JPPC) was used to determine the rate for CKD services at the time of implementation. Evidence such as publications from Canada and other jurisdictions and World Health Organization reports were also used to assist with the patient clusters and the assessment of potential opportunities. Currently, for the CKD QBP, data from the Ontario Renal Reporting System (ORRS) and the Self-Reporting Initiative (SRI) are used to track services.

The evidence-based framework assessed patient groups against four criteria, as presented in Figure 3. This evidence-based framework has identified QBP's that have the potential to both improve quality outcomes and reduce costs.

Figure 3: Evidence-Based Framework



## 1. Practice Variation

The DAD has every Canadian patient discharge, coded and abstracted for the past 50 years. This information is used to identify patient transition through the acute care sector, including discharge locations, expected lengths of stay and readmissions for patients, based on their diagnosis and treatment, age, gender, co-morbidities and complexities and other condition specific data. A demonstrated large practice or outcome variance may represent an opportunity to improve patient outcomes by focusing on evidence-informed practice to reduce variation. A large number of 'Beyond Expected Days' for length of stay and a large standard deviation for length of stay and costs were flags to such variation. Ontario has detailed case costing data for all patients discharged from a case costing hospital from as far back as 1991, as well as daily utilization and cost data by department, day and admission.

## 2. Availability of Evidence

A significant amount of research has been completed both in Canada and globally to develop and guide clinical practice. Working with the clinical experts, best practice guidelines and clinical pathways can be developed for these QBPs and appropriate evidence-informed indicators can be established to measure performance.

## 3. Feasibility / Infrastructure for Change

Clinical leaders play an integral role in this process. Their knowledge of the patients and the care provided or required is essential to assess where improvements can and should be made. Many groups of clinicians have formed and provided evidence and the rationale for care pathways and evidence-informed practice.

## 4. Cost Impact

The selected QBP should have no fewer than 1,000 cases per year in Ontario and represent at least one percent of the provincial direct cost budget. While cases that fall below these thresholds may in fact represent improvement opportunity, the resource requirements to implement a QBP may inhibit the effectiveness for such a small patient cluster, even if there are some cost efficiencies to be found. Clinicians may still work on implementing best practices for these patient sub-groups, especially if it aligns with the change in similar groups. However, at this time, there will be no funding implications. The introduction of evidence into agreed-upon practice for a set of patient clusters that demonstrate opportunity as identified by the framework can directly link quality with funding.

## 2.4 How do QBPs encourage innovation in health care delivery?

Implementing evidence-informed pricing for the targeted QBPs has encouraged health care providers to adopt best practices in their care delivery models, and maximize their efficiency and effectiveness. Moreover, best practices that are defined by clinical consensus are used to assess required resource utilization for the QBPs and further assist in the development of evidence-informed prices. Implementation of a 'price X volume' strategy for targeted clinical areas has incited providers to:

- Adopt best practice standards;
- Re-engineer their clinical processes to improve patient outcomes; and
- Develop innovative care delivery models to enhance the experience of patients.

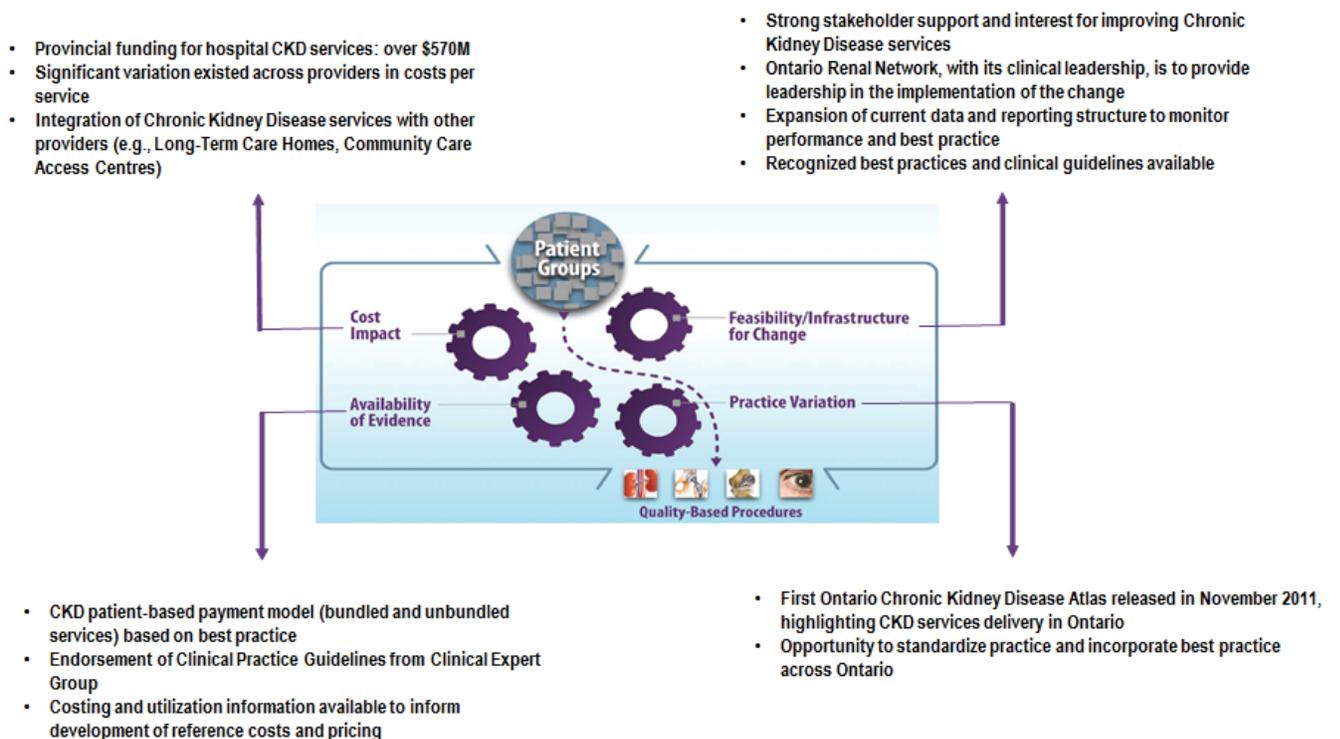
Clinical process improvement may include the elimination of duplicate or unnecessary investigations, better discharge planning, and greater attention to the prevention of adverse events, (e.g. post-operative complications). These practice changes, together with adoption of evidence-informed practices, can improve the overall patient experience and clinical outcomes, and have helped to create a sustainable model for health care delivery.

### 3.0 Description of Chronic Kidney Disease as a Quality-Based Procedure

The Chronic Kidney Disease (CKD) Quality-based Procedure (QBP) is applied to non-pediatric CKD patients based on the nature and progression of their renal impairment. This QBP relates to the provision of multiple services along the continuum of care for CKD patients, from early identification and management to end-stage kidney disease. This includes more than thirty funded services and procedures performed in the hospital, community and home settings. Additional services may be included within this framework in the future.

CKD was identified as a QBP using the evidence-based selection framework, as presented in Figure 4.

Figure 4: Evidence-based framework for Chronic Kidney Disease



The CKD QBP encompasses the management of early stage of CKD, pre-dialysis, body access insertions (abdominal and vascular), and dialysis, but excludes, at present, early detection and prevention of CKD, as well as transplant-related services.

The key objectives of the CKD QBP are to:

- Ensure accountability to CKD patients;
- Improve health outcomes; and,
- Manage the costs of CKD care.

The CKD QBP provides payment that follows the patients to support integration, quality and efficiency throughout the entire patient pathway. Equitable access to care for patients across Ontario remains a strong priority. In addition, the QBP discourages over-provision of services. The QBP provides funding aligned to best practice, appropriate provider reimbursement, and improved accountability for outcomes.

In March 2015, the ORN launched the second Ontario Renal Plan (ORP II), which puts patients at the centre of care at every stage of their kidney care journey. Central to this is the implementation of a home first approach to CKD, and the further development of the CKD QBP.

The quality agenda for the CKD QBP reflects three strategic goals of the ORP II, namely to:

- Empower and support patients and family members to be active in their care;
- Integrate patient care throughout the kidney care journey; and
- Improve patients' access to kidney care.

In 2014/15, in collaboration with the Ministry, the ORN expanded the CKD QBP along the continuum of care to incorporate the provision of dialysis support to peritoneal dialysis (PD) patients in their place of residence. The intention of this initiative was to reduce the care gap for PD patients, improve access to quality care for PD patients, and strengthen integrated care. In 2014/15, CKD became the first QBP to expand along the continuum of care by incorporating funding for the provision of assisted PD by Community Care Access Centres (CCACs) and in Long Term Care (LTC) homes.

The information and reporting systems for CKD services have undergone a steady transition since the CKD QBP was first implemented. The Self Reporting Initiative (SRI) has replaced the Web Enabled Reporting System (WERS) for managing CKD data reporting requirements and provides the financial and utilization data for the purpose of CKD service-based reimbursement. Additionally, the fifth iteration of the Ontario Renal Reporting System (ORRS) will be released in early 2016 to better capture patient modality of care received. ORRS continues to be the key information source for CKD patient-based reimbursement. These changes are part of an overarching strategy to

establish ORRS as the comprehensive source of data required for all CKD patient-based reimbursement.

## 3.1 Hospital-Based Model

The hospital-based model has two components: Patient-based bundled services, and unbundled services.

### Patient-Based Bundled Services

The patient-based bundled services provide a bundled payment, based on best practice, which covers the costs of all services required by a standard patient for a year's worth of a particular CKD treatment. The framework includes seven (7) patient-based payment bundles as follow:

- Bundle A - Pre-dialysis;
- Bundle B.1 - Home PD - Automated PD (APD);
- Bundle B.2 - Home PD - Continuous Ambulatory PD (CAPD);
- Bundle C - Home Hemodialysis (HD) - Daily/Nocturnal;
- Bundle D - Home Hemodialysis - Conventional;
- Bundle E - Chronic In-Facility or Satellite HD Daily/Nocturnal; and
- Bundle F - Chronic In-Facility or Satellite HD Conventional.

The funding bundles, as presented in Figure 5, provide a form of annual reimbursement which follows the patient and discourages over-provision of services.

Bundle A comprises the services for pre-dialysis patients as part of the clinic visits.

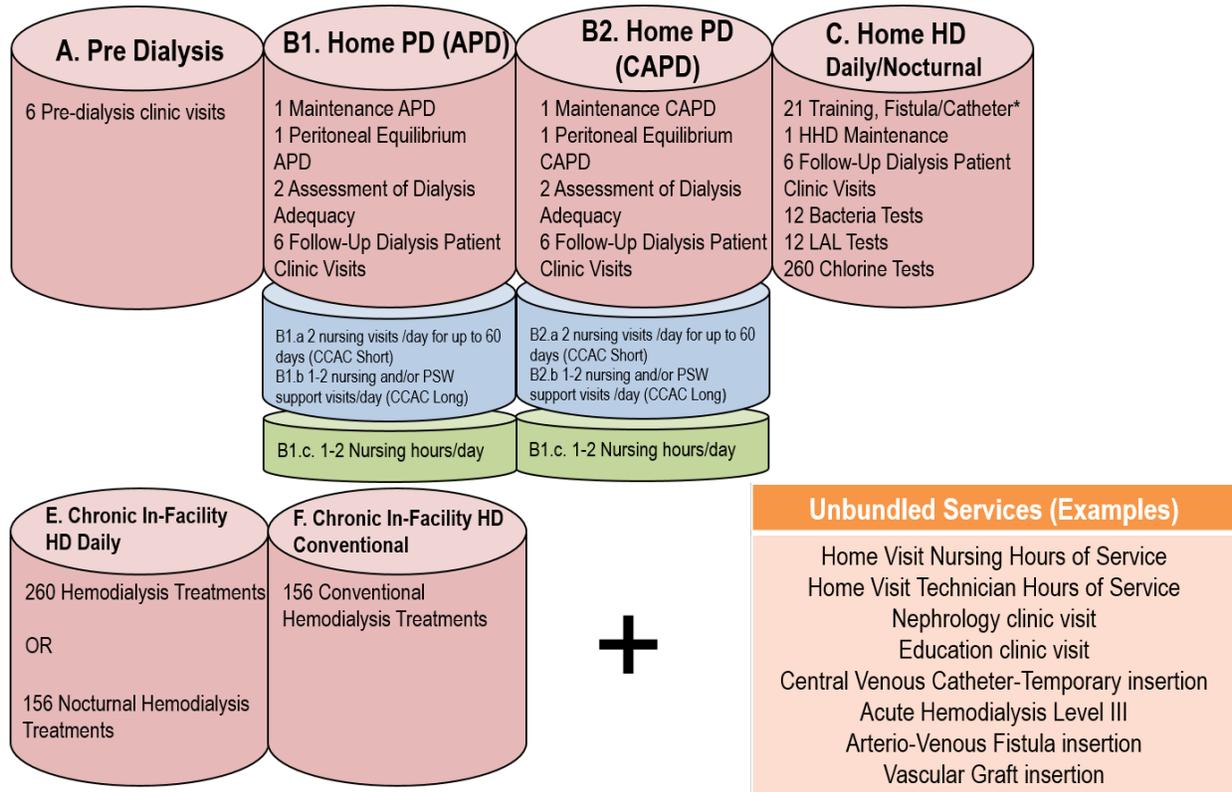
Upon further deterioration of kidney function, patients may move on to renal replacement therapies covered by bundles B1 through F. Bundles B1 and B2 are the groupings of services for PD patients. PD can be classified into two subtypes, APD and CAPD. APD is performed at night while the patient sleeps, and is covered by bundle B1. CAPD involves a series of exchanges performed throughout the day, and is covered by bundle B2.

Bundles C and D are also comprised of services for independent dialysis. Bundle C is the package for patients performing nocturnal or daily HD at home. Bundle D provides services for patients undergoing conventional HD in their home, which is characterized by approximately three daytime HD treatments per week.

The last two packages, Bundles E and F, encompass services for patients receiving chronic in-facility or Satellite HD, either in a hospital-based or community-based facility. Patients who undergo daily or nocturnal in-centre HD, five to six times per week, are covered under Bundle E, while patients who receive conventional HD, three to four times per week, are covered under Bundle F.

Figure 5: CKD QBP bundled and unbundled services

## CKD QBP Bundled and Unbundled Services



### UnBundled Services

Unbundled service funding is a “fee-for-service” model which pays for services that cannot be bundled because their occurrence and/or frequency cannot be predicted. Examples of unbundled services in 2016/17 include:

- Home Visit Nursing Hours of Service;
- Home Visit Technician Hours of Service;
- Nephrology Clinic Visit;
- Education Clinic Visit;
- Central Venous Catheter-Untunneled Insertion;

- Acute HD Level III;
- Arterio-Venous Fistula Insertion; and
- AV Graft Insertion.

## 3.2 Community-Based Model

As per the ORP II, the ORN has a strategic imperative to home first care. CKD home care empowers patients by offering greater comfort and control, at a lower cost to the healthcare system than in-facility dialysis. Almost one quarter of CKD patients currently dialyze at home, however given the patient and system-level benefits, the ORN aims to grow home dialysis by addressing existing barriers to home care.

In 2014/15, the ORN, in collaboration with the Ministry, expanded the CKD QBP along the continuum of care to incorporate community providers. The incorporation of funding for LTC home and CCAC-supported assisted PD will ensure more patients across the province will be able to access their choice of kidney services close to home, as identified in the ORP II.

In 2015/16, with the support of the ORN's CCAC and LTC Working Group and the CKD Funding Panel, the ORN revised the funding model to reduce the care gap that currently exists for LTC home and CCAC-assisted PD clients, and ultimately improve access to quality care for PD clients and strengthen integrated care. Additionally, work is currently underway to explore more seamless and patient-oriented clinical delivery models.

## 4.0 How Does the CKD QBP Improve Patient Outcomes?

At the request of the Ministry, the ORN developed a QBP for accelerating quality improvement and access to CKD services while improving system value. The implementation of the QBP ensures that sufficient healthcare spending is protected for high-quality CKD patient care.

The ORN works in close consultation with clinical, policy, and financial experts to refine and improve this framework to link funding to high-quality and equitable patient care. This framework has been shaped from the work of several separate committees:

### 1. CKD Clinical Advisory Committee

The Clinical Advisory Committee (CAC) was the original contributing body comprised of seven Ontario nephrologists. The primary role of the CAC was to provide advice regarding clinical practice and quality care.

### 2. The Provincial Leadership Forum

The Provincial Leadership Forum (PLF) provides counsel regarding operational practice, system planning, and quality care. The PLF is comprised of fourteen ORN Regional Directors (RDs) for CKD care in Ontario.

### 3. Funding Model Reference Panel

To keep funding policies up to date, a funding panel was established beginning in August 2010 and ending in May 2011. The framework validation for CKD was led by the Funding Model Reference Panel; a diverse committee which included CAC representatives, hospital administrators, RDs, and members of the ORN.

### 4. Funding Model Working Group

The Funding Model Working Group was aligned with the Funding Model Reference Panel, but focused dominantly on framework development. The Working Group was comprised of clinical and administrative leaders (nephrologists, Regional Directors, Ministry representation, and CCO/ORN staff) to guide its work. During Phase 2, CCAC and LTC home representation was added to the Working Group. In recognition that the framework development phase was nearing completion, in

October, 2013, the Funding Model Working Group merged with the CKD Funding Panel to focus primarily on the operationalization of the CKD QBP.

## **5. Regional Renal Steering Committee (RRSC)**

Fourteen RRSCs participate in comprehensive and coordinated planning of CKD services in each respective LHIN. In particular, the responsibility of each RRSC is to ensure that its respective LHIN is responsive to local needs and aligned with the ORN strategies and directions. Other aspects of each RRSC are to ensure optimal delivery of all CKD service levels across its LHIN, making recommendations and providing advice to the ORN to improve access and quality of care related to CKD. There are 14 RRSCs, corresponding to 14 LHINs. Throughout the development and implementation of the CKD QBP, the RRSC memberships have been informed.

## **6. Chronic Kidney Disease Funding and Planning Panel**

The CKD Funding and Planning Panel was established in part to provide an ongoing governance structure focused on the further development and implementation of the CKD QBP. The CKD Funding Panel is chaired by Dr. Peter Magner, and provides expert advice to the ORN on matters related to the funding of CKD services in Ontario, including hospital and community funding allocation, system design, policy and quality of care implications, and related data and reporting issues. The CKD Funding and Planning Panel membership has been updated to support the implementation of the ORP II.

## **7. Body Access Working Group**

The Body Access (BA) Working Group was established in August 2013 to provide expert advice to the ORN on matters related to the funding of BA procedures and services provided to CKD patients in Ontario, including costing, price setting, funding allocation, system design, policy and quality of care implications, and related data and reporting issues.

## **8. Community Care Access Centre Working Group**

The CCAC Working Group was established in August 2013 to provide expert advice to the ORN on matters related to the funding of CCAC services provided to PD patients in Ontario, including service frequency and mix, price setting, funding allocation, system design, policy and quality of care implications, and related data and reporting issues.

## 9. Long Term Care Working Group

The LTC Working Group was established in August 2013 to provide expert advice to the ORN on matters related to the funding of services provided to CKD patients residing in LTC homes in Ontario, including price setting, funding allocation, system design, policy and quality of care implications, and related data and reporting issues. The LTC Working Group serves in an advisory capacity to the ORN's CKD Funding Panel.

## **5.0 What Does it Mean For Clinicians?**

### **5.1 How does the CKD QBP align with clinical practice?**

The CKD QBP provides funding to promote the provision of evidence-informed, best practice care. The exact type and amount of services provided within this clinical pathway will differ among patients. The bundles within the QBP are structured to provide payments aligned to the appropriate level of care for a patient requiring the average quantity of services. In allocating funding for the average level of treatments defined by best practice, the QBP will provide the appropriate counterbalance between patients requiring a greater or lesser amount of care.

### **5.2 Does the CKD QBP have any implications for clinicians?**

The changes associated with QBPs focus on identifying and implementing evidence-informed practice driven by clinical consensus. Clinicians will be tasked with identifying standard treatment protocols within their own practices and pinpointing variances among practices. Collaboration with their hospital and/or community based provider administration will assist both the clinicians in identifying the challenges within the service, opportunities and the feasibility for changes to the treatment protocols.

Clinicians will continue to play an essential role in guiding hospitals and community based providers to the needs of their patient population and ensuring that the highest quality care is provided for all their patients.

### **5.3 Will this change current practice?**

The CKD QBP may have created changes in current practice for certain clinicians in Ontario. Those who are currently delivering services beyond the standards of evidence-informed practice will need to adopt greater efficiency and reduce the over-provision of services. On the other hand, CKD care providers who deliver fewer services than the standards of care, are funded to increase their volumes up to the evidence-informed clinical practice.

## **6.0 Service Capacity Planning**

### **6.1 How will the CKD QBP impact CKD volumes?**

The volumes of CKD services funded in each bundle are based on evidence-informed practice. The seven bundles of the CKD QBP align with the number of services per patient according to the agreed-upon best practice set out in the funding bundles.

In alignment with the ORP II, ongoing refinements to the QBP will be applied in an effort to stimulate and enable the uptake of home care. By increasing the volume of eligible CKD patients who receive home care, hospitals will have greater capacity to serve the needs of complex patients.

### **6.2 How will the new model of budget planning include clinicians?**

Opportunities for clinicians to participate in the development and implementation of the new CKD patient-focused funding model are available at all different levels throughout the province.

Clinical leaders may decide to have active participation on regional and provincial level working groups or within their respective organization.

## 7.0 Evaluation and Monitoring

It is important for the ORN and the Ministry to continually understand the impacts of QBPs to the Ontario healthcare system. Of particular importance is whether changing the way service providers are funded has led to better health outcomes for patients and improved quality and value in the system. In order to better understand and observe these impacts, the ORN has established a Health Systems Performance and Issues Management Guideline (the Guideline) that will help provide quality CKD care that meets the expected outcomes, goals, and objectives of the CKD QBP.

Further, a Ministry QBP Scorecard is being developed, which will involve routine and periodic tracking and reporting of indicators corresponding to relevant outputs, measures of productivity, efficiency, and outcomes of care. The scorecard will include both Quality & Outcomes measures and Services & Funding measures, and will provide an opportunity to track outcomes and explore any variances across the province. The Quality & Outcomes measures are designed to assess whether the QBP has resulted in any unintended consequences or negative impacts on patient outcomes while the funding indicators measure the processes or outcomes that are directly impacted by the funding model.

Finally, as of 2013/14, formal audits have been conducted with CKD Programs. The overall objectives of these audits were threefold:

- 1) To verify that CCO funding was used for direct CKD services, consistent with the ORN Operating Funding Agreements;
- 2) To assess the accuracy of achieved volumes reported by the service provider; and
- 3) To evaluate CCO controllership practices as implemented to achieve accountability for transfer payments.

## 8.0 Support for Change

The ORN provides input on the overarching HSFR strategy for system change and specifically, leads change management related to CKD service delivery.

The Ministry, in collaboration with its partners, is continually deploying a number of tools to support adoption of the funding policy. These supports include the following:

- Committed medical engagement with representation from cross-sectoral health sector leadership and clinicians to champion change through the development of standards of care and the development of evidence-informed patient clinical pathways for the QBPs.
- Dedicated multidisciplinary clinical expert group that seeks to clearly define the purposes, structures, processes, and tools that are fundamental to achieve change.
- Strengthened relationships with Ministry partners and supporting agencies to seek input on the development and implementation of QBP policy, disseminate quality improvement tools, and support service capacity planning.
- Alignment with Performance Improvement Plans (PIPs). PIPs strengthen the linkage between quality and funding and facilitate communication between the hospital and community sectors, administrators, and providers for quality improvement.

## 9.0 For More Information

To obtain more information, please visit:

- Helpline
  - Email: [HSF@ontario.ca](mailto:HSF@ontario.ca)
  - Phone: 416-327-8379
- The Ministry's public website: [www.health.gov.on.ca](http://www.health.gov.on.ca)
- Access the "Health Care Professionals" page
  - Excellent Care For All ([www.health.gov.on.ca/en/ms/ecfa/pro/](http://www.health.gov.on.ca/en/ms/ecfa/pro/))
  - HSFR (<http://www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx>)
- Password protected website for provider: [www.hsimi.on.ca](http://www.hsimi.on.ca)
  - Repository of HSFR resources, including HBAM results and education materials

Ontario Renal Network  
<http://www.renalnetwork.on.ca/>

Cancer Care Ontario  
<https://www.cancercare.on.ca/>

Excellent Care for All Act  
<http://www.health.gov.on.ca/en/ms/ecfa/pro/about/>

Health System Funding Reform  
<http://www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx>

Ontario Medical Association  
<https://www.oma.org/Pages/default.aspx>

Health Quality Ontario  
[www.hqontario.ca](http://www.hqontario.ca)

Canadian Institute for Health Information  
<http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001>

Institute for Clinical Evaluative Sciences  
<http://www.ices.on.ca/>

# 10.0 Frequently Asked Questions (FAQs)

## **Section A: Bundled vs. Unbundled Services, Service Volumes, Service Definitions**

### **What were the criteria against which unbundled services were assessed?**

Unbundled services are those services that will continue to be reimbursed on a fee-for-service basis, similar to the current funding arrangement. Below are the criteria used for unbundling a service:

- Volumes per patient vary considerably across providers (e.g. home nursing visiting hours per home dialysis patient);
- It can't be predicted which patients will be receiving the service (e.g. HD treatments for PD patients, or in-hospital PD exchanges);
- The service tends to take place in facilities that are different from where the patient usually receives dialysis services, making it difficult to align patients and providers of care (e.g. vascular procedures); or,
- Services are provided to patients visiting from other hospitals, but not recorded as transfers (short vacations or admissions to other hospitals).

### **What if a patient requires more services than are defined by best practice?**

The bundles within the CKD QBP are meant to provide payments aligned to the appropriate level of care for a patient requiring the average quantity of services. Certain patients may require more or less of a particular CKD service (or may miss treatments), but the total annual volume of services provided to patients should average out to the number estimated by best practice.

The ORN will continue to monitor the annual number of each CKD service on an on-going basis to determine if the best practice volumes need to be reassessed.

### **What about hemodialysis treatments that are provided to home peritoneal dialysis patients? How are these funded?**

A home peritoneal patient receiving in-facility HD treatments to provide fluid treatment or to address inadequacies is considered a dual modality patient. Providers are reimbursed for an additional 1 in-facility HD treatment per week. The dual modality reimbursement appears under the Home PD Bundle B, as a sub-bundle. These dual modality patients will be measured by count of annualized dual modality CAPD or CCPD (APD) patient and reported in ORRS for reimbursement.

## **If bundled service volumes are not achieved, will funding be clawed back?**

Funding will not be clawed back, the same standard bundle reimbursement rate will be provided for every annualized patient, based upon best practice. Bundled reimbursement is tied to and based upon the count of annualized patients in each bundle, not on the delivery of specific components or services within the bundles. Reported volumes will continue to be monitored. Bundles will continue to be evaluated and refined based upon new and up-to-date data and clinical expertise.

## **Section B: Modality and Location Switching**

### **What happens when patients switch modalities during the year?**

The count of patients in ORRS takes into account modality changes, provider changes, transfer-outs, deaths, and file closures. Prior to May 2012, changes in modality and provider reported only after 30 days. As of May 2012, the ORRS reporting requirement is that all modality and provider switches will need to be reported, including those that took place within less than 30 days.

### **What happens if a patient receives hemodialysis treatments at another facility (outside their Chronic Kidney Disease Program) on a long-term basis? On a short-term basis?**

(i) Patient receiving services from another facility outside their CKD Program on a long-term basis

A patient receiving HD treatments on a long-term basis (8 days or more), at another facility outside their CKD Program, would be treated as a program “transfer”. They would be reported in the ORRS for reimbursement based upon annualized patient count and money would flow to the facility providing the treatment.

(ii) Patient receiving services from another facility outside their CKD Program on a short-term basis

A patient receiving HD treatments on a short-term basis (7 days or less), at another facility outside their host CKD Program, will be treated as a “transfer-in less than 8 days”. Reimbursement is provided to both CKD providers receiving a “transfer-in less than 8 days” patient (receiving providers), and CKD providers whose in-facility or home patients are receiving HD at another facility outside their CKD Program (sending providers). Reimbursement for receiving providers, sending providers of in-facility patients, and sending providers of home patients differs and is outlined in Section 17 of the 2015/16 CKD Funding Guide. The

ORN will calculate reimbursement for short stay treatments based upon ORRS submission.

## **Section C: Reimbursement Rates and Funding**

### **Will reimbursement rates be assessed on an ongoing basis?**

Yes, reimbursement rates will be continuously re-assessed and adjusted to reflect best practice.

## **Section D: Funding for Assisted Peritoneal Dialysis in Long-Term Care Home and Community Care Access Centre**

### **Why did these changes occur?**

The ORN provides overall leadership and strategic direction to effectively organize and manage the delivery of renal services in Ontario in a consistent and coordinated manner. As such, the ORN provides funds for selected CKD Services based on volumes, as set out by the terms in the ORN Operating Funding Agreements. Since 2009, at the request of the Ministry, the ORN has been working in close consultation with clinical, policy, and financial experts to develop a framework that links funding to best practice patient care. In collaboration with the Ministry, the ORN expanded the CKD QBP along the continuum of care to incorporate the provision of dialysis support to CKD patients in their place of residence (home or LTC home). The intention of this initiative is to reduce the care gap that currently exists for assisted PD patients, improve access to quality care for PD patients, and strengthen integrated care.

### **What are the major changes and when are they being implemented?**

The ORN is implementing a staged, 3-year implementation plan, with the aim to strengthen integrated care and improve coordination between patients' Regional CKD Programs, and the CCAC and LTC homes. In the first year of implementation (2014/15) the ORN assumed administrative responsibility for directly funding the provision of PD services by CCACs and LTC homes. The ORN established ORN Operating Funding Agreements with each CCAC and LTC home that provides PD services. In 2014/15, no changes to the current Ministry rates, funding methodology, or reconciliation process were made.

In 2015/16, for CCACs, PD services are funded according to a revised funding formula of \$2,752.93 per unique Short-Stay client (Short-Stay is defined as a "client who will

achieve independence in PD self-management within 60 days” for a total of 43 nursing visits per year) and \$20,566.62 per annualized Long-Stay client (Long-Stay is defined as a “client who will not achieve independence in PD self-management and often requires daily nursing visits most days of the week,” for a total of 299 visits per year). The initial funding allocation for CCACs will no longer be based on a ratio of two-thirds Short-Stay and one-third Long-Stay clients.

For LTC homes, the per diem funding rate has been increased to \$45.21 per assisted PD resident per day to reflect current practice. Initial funding will be allocated based on historical PD service demand (actuals), and input from the Regional CKD Programs and the ORN.

### **What is the volume reconciliation and funding adjustment process?**

For both CCACs and LTC homes, funding is subject to an in-year reconciliation and year-end settlement process, conditional upon the ORN’s receipt of volume funding from the Ministry. For CCACs, the reconciliation process will no longer be based on the application of the funding methodology ratio of one-third Long-Stay and two-thirds Short-Stay clients but rather on the number of actual CCAC PD clients served by the end of the fiscal year. For LTC homes, the year-end settlement process will be based on the total number of actual annualized assisted PD residents. At year end, the ORN will reconcile the allocated CCAC and LTC homes assisted PD volumes against the actual volumes achieved, and the net settlement amount will be the variance between the two (i.e. payout or recovery, as applicable).

### **Is there a governance structure in place?**

ORN-led LTC and CCAC Working Groups comprised of representatives from CCAC and LTC sectors, in addition to clinical and Regional CKD Programs were established in August 2013 to provide expert advice to the ORN on matters related to the funding of services provided to CKD patients receiving CCAC support, or residing in LTC homes in Ontario. The Working Groups serve in an advisory capacity to the ORN’s CKD Funding Panel and Executive Committee.

## 11.0 Committees

### 11.1 Chronic Kidney Disease Clinical Advisory Committee Membership (dissolved)

**Dr. Peter Magner**

Provincial Medical Lead, Funding Policy, ORN  
Regional Medical Lead, Champlain LHIN, ORN  
Associate Professor of Medicine, University of Ottawa  
Head, Division of Nephrology at The Ottawa Hospital  
Director of Hemodialysis, The Ottawa Hospital  
Member, ORN Clinical Advisory Committee

**Dr. Mark Benaroia**

Nephrologist, Grand River Hospital Corp.  
Member, ORN Clinical Advisory Committee

**Dr. Andrew House**

Associate Chair, London Health Sciences Centre, Division of Nephrology Associate  
Professor, University of Western Ontario Member, ORN Clinical Advisory Committee

**Dr. William McCready**

Associate Dean - Faculty Affairs, Senior Associate Dean-West Campus at the Northern  
Ontario School of Medicine Nephrologist, Thunder Bay Regional Hospital Member, ORN  
Clinical Advisory Committee

**Dr. David Berry**

Division Head of Nephrology & Medical Director of the Renal Program, Sault Area Hospital  
Member, ORN Clinical Advisory Committee

**Dr. Paul Tam**

Division Head of Nephrology, The Scarborough Hospital Medical Director, Scarborough  
Regional Dialysis Program Member, ORN Clinical Advisory Committee

### 11.2 Chronic Kidney Disease Funding and Planning Panel

**Dr. Peter Magner**

Provincial Medical Lead, Funding Policy, ORN  
Regional Medical Lead, Champlain LHIN, ORN  
Associate Professor of Medicine, University of Ottawa  
Head, Division of Nephrology at The Ottawa Hospital  
Director of Hemodialysis, The Ottawa Hospital  
Member, ORN Clinical Advisory Committee

**Rick Badzioch**

Regional Director, Hamilton Niagara Haldimand Brant Region, ORN  
Executive Director Renal Programs St. Joseph's Healthcare Hamilton and Niagara Health

**Dr. Phil Boll**

Provincial Medical Lead, Home and Community Care, ORN

**Dr. Chris Rabbat**

Regional Medical Lead, Hamilton Niagara Haldimand Brant Region, ORN  
Associate Professor, Division of Nephrology, Department of Medicine, McMaster University

**Aaron Skillen**

Regional Director, North West Region, ORN

**Dr. Daniel Tascona**

Regional Medical Lead, North Simcoe Muskoka Region, ORN

## 11.3 BA Working Group

**Dr. Jose Aquino**

Radiologist, TOH

**Dr. Vern Campbell**

VA Surgeon, St. Michael's Hospital

**Janet Graham**

Director of Clinical Education and Quality Improvement, ORN

**Dr. Louise Moist**

Provincial Medical Lead, Vascular Access, ORN

## 11.4 CCAC Working Group

**Peter Magner,**

Provincial Medical Lead, Funding Policy, ORN

**Andreas Pierratos**

Provincial Medical Lead, Independent Dialysis, ORN

**Rob Forbes**

Director, Funding and Provincial Corporate Client Initiatives, OACCAC

**Eva Nemeth**

Manager, Client Services, Mississauga Halton CCAC

**Lisa Burden**

Program Director, Chronic Disease Management, Central East CCAC

**Janice McCallum**

Regional Director, South West Region, ORN

**Adrienne Barrett**

Dialysis Access/Independent Dialysis, Health Sciences North

**Sandra Cella,**

Vice President Client Services, Central CCAC

**Barb Frayne**

Director Client Services, Erie St. Clair CCAC

**Tricia Jordan**

Community Care Manager, North West CCAC

**Sonia Rogers**

Branch Operations Lead, Hamilton Branch, Hamilton Niagara Haldimand Brant CCAC

**Susan Hocking**

Client Services Regional Manager, Southwest CCAC

## 11.5 Long Term Care Working Group

**Dr. Andreas Pierratos**

Provincial Medical Lead, Independent Dialysis, ORN

**Julie Girard**

Lead, PD-LTC Initiative, South West LHIN

**Cheryl Lawrence-Holmes**

Executive Director, Stirling Heights LTC

**Emily Harrison**

Patient Care Manager, Nephrology Clinic, Lakeridge Health

**Connie Twolan**

ORN Regional Director, Champlain LHIN

**Mary Ann Murray**

*Advance Practice Nurse*, Home Dialysis Unit

