Ontario Renal Plan 4

2024 - 2028

Ontario Health
Ontario Renal Network

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Ontario Health is an agency created by the Government of Ontario to connect, coordinate and modernize our province's health care system. We work with partners, providers and patients to ensure everyone in Ontario has equitable access to high-quality care, when and where they need it.

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Introduction

For the past 15 years, multi-year provincial renal plans have provided a roadmap to improve the performance of the kidney care system in Ontario. This plan, the fourth, builds on a solid foundation of work led by the Ontario Renal Network that has led to progressive advancements in the way kidney care services are delivered and managed in the province. The Ontario Renal Plan ensures that there is a system in place dedicated to providing high-quality kidney care when and where people in Ontario need it.

Ontario Renal Plan 4 clearly identifies our key priorities and what we need to accomplish with the Regional Renal Programs and our many health system partners over the next four years. The plan provides clinical advice and expertise to government on major initiatives that will improve health outcomes for Ontarians.

This plan is more than a refresh of our third renal plan, as much has changed in the health system since its release in 2019. That year, the Ontario Renal Network transferred into Ontario Health, an agency created by the Government of Ontario to connect, coordinate and modernize our province's health care system. In February 2020, the COVID-19 pandemic struck, with an immediate, profound and lasting impact on the entire health system. Additionally, in 2021, Trillium Gift of Life Network formally integrated within Ontario Health, creating an opportunity to realize a seamless, integrated kidney transplantation system for patients, encompassing both deceased donor and living donor kidney transplants. As a result of shifting priorities within the health system due to the pandemic, our third renal plan was extended to 2024.

Complex, lifelong condition

Chronic kidney disease is a serious, lifelong condition. People with chronic kidney disease often require complex and intensive care from a team of health care providers. This condition can present significant challenges to patients and care partners,*1including physical discomfort, emotional distress, financial difficulties and major lifestyle changes. Navigating the complexities of the kidney care system presents additional challenges for those affected

As the Ontario government's chronic kidney disease advisor, Ontario Health (Ontario Renal Network) is dedicated to improving the lives of people at risk for and living with chronic kidney disease and reducing the burden of chronic kidney disease on individuals and the health care system. Our aim is to create a system that provides person-centred and effective kidney care services in a safe, efficient, equitable and timely manner throughout every phase of the kidney care continuum (see Figure 1).

* Care partners are individuals who provide unpaid essential and on-going personal, social, psychological and/or physical support and care, as deemed important to the person requiring care. This may include support in decision-making, care coordination, care delivery and continuity of care. The term implies a two-way relationship with a shared purpose, and it includes people who are identified as family, chosen family, an informal caregiver, or a friend.

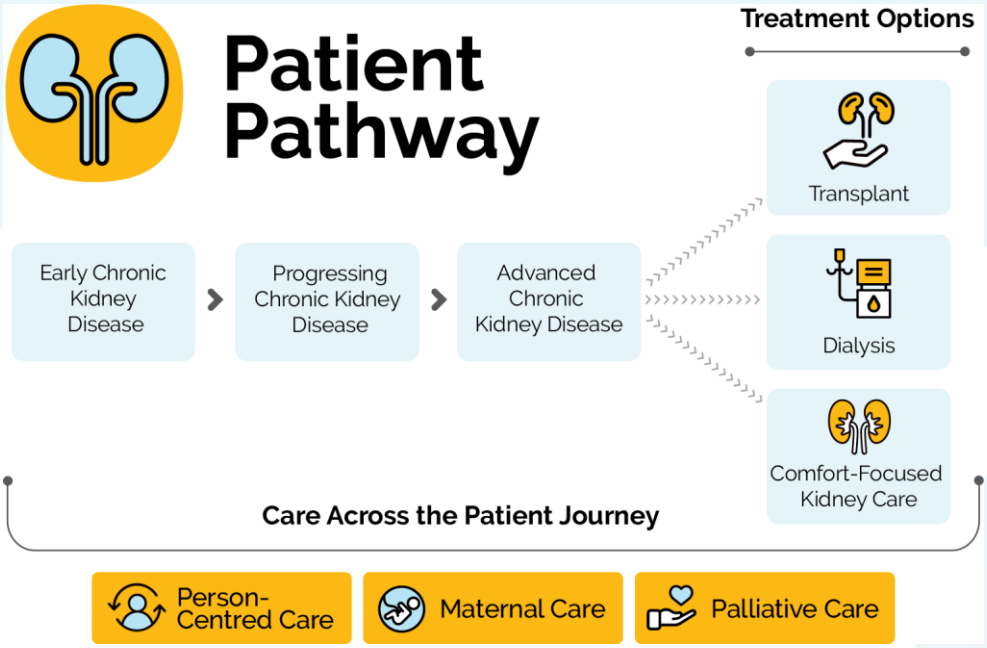


Figure 1: Kidney Care Continuum

About this plan

The Ontario Renal Plan is a roadmap for the way Ontario Health (Ontario Renal Network) will work together with Regional Renal Programs, transplant programs, nephrologists, other health care providers, patient and family advisors, health system partners and the provincial government to develop and deliver kidney care services through to 2028. This plan builds on the achievements of previous Ontario Renal Plans to sustain and enable improvement in Ontario's kidney care system (see Our Progress Together, page 24).

The goals and strategic objectives in the plan will help to:

- Ensure patients and their care partners are involved in their care
- Identify key priorities to guide our work at all levels
- Focus our efforts where they are most needed
- Advise the government on major initiatives and funding decisions
- Support and develop program-level strategic plans
- Bring together many partners within our complex health system

Developing this plan

Ontario Health (Ontario Renal Network) consulted with more than 500 people from our network, including clinical leaders, administrators, patients and care partners, health system partners across Ontario and teams across Ontario Health. The engagement process resulted in valuable insights into the patient and care partner experience, system strengths and areas of improvement.

The Ontario Renal Plan not only reflects input received from consultations but also considers the current health care landscape, including lessons learned during the pandemic and a need to improve health equity and the sustainability of our health system. The plan also leverages and aligns with foundational and transformational work within Ontario Health.

The goals of this plan are also guided by five aims that are critical in the delivery of world-class health care services (known as the Quintuple Aim):

- Enhancing patient experience
- Improving population health
- Improving provider experience
- Improving value
- Advancing health equity

Working together, we will use this plan to increase opportunities to detect and slow the progression of chronic kidney disease and to improve the quality of life and kidney care services for current and future patients.

DR. PETER BLAKE

"In developing this plan, we collaborated with a team of experts including nephrologists and other health care professionals, patients and care partners. This allowed us to take a comprehensive approach to our work, ensuring that we are providing quality care that meets the needs of all patients. Our focus on improving kidney care is evident in our commitment to advancing access to transplantation, dialysis options, palliative care and specialized clinics. We are also dedicated to reducing patient-borne costs, promoting mental health and advocating for environmentally friendly kidney care practices. Our ultimate goal is to ensure that exceptional kidney care is available to everyone."

Dr. Peter Blake is the Provincial Medical Director, Ontario Renal Network, at Ontario Health. He is a nephrologist working in London, Ontario and a professor of Medicine and former chair of the Division of Nephrology at Western University and London Health Sciences Centre.

Plan in action

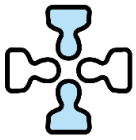
We look forward to working with our partners across Ontario Health, including Trillium Gift of Life Network, and the broader health system, including the Regional Renal Programs, the Ministry of Health, health care providers, patients and care partners throughout the province to drive improved and equitable health outcomes, experiences and value for all.

REBECCA COOPER

"Collaborating with partners across the health system, we are dedicated to delivering meaningful improvements to the comprehensive system of kidney services for those affected by chronic kidney disease throughout every phase of the care continuum."

Rebecca Cooper is the Vice President of the Ontario Renal Network and Trillium Gift of Life Network at Ontario Health.

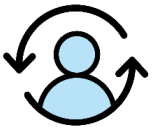
Ontario Renal Plan 4 Goals



Advance health equity in kidney care

Partner with patients and care partners to drive improvements in kidney care

Improve access to timely and effective kidney care



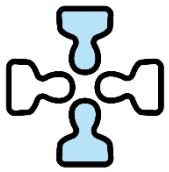
Improve the health of people living with chronic kidney disease

Drive quality and value by supporting a sustainable kidney care system

Each goal is supported by strategic objectives, which are outlined in the plan. A one-page summary of Ontario Renal Plan 4 goals and strategic objectives is available online.

Goals and Objectives

Advance health equity in kidney care



Strategic Objectives

- **Enable equitable care for those impacted by chronic kidney disease, including Black Ontarians, people living with low income, and people living in rural and remote areas**
- **Decrease barriers to kidney care by addressing patient-borne costs**
- **Develop an Indigenous Kidney Health Plan in partnership with First Nations, Inuit, Métis and Urban Indigenous people, their communities and organizations to improve their well-being, enable culturally safe kidney care and reduce the impact of chronic kidney disease on Indigenous people**

Everyone in Ontario should have the ability to access the services they need and should not be disadvantaged because of who they are, where they live or what resources they have. Some people may encounter obstacles in receiving kidney care services due to factors such as geography, finances or cultural barriers. These barriers can negatively affect people's care experience, access, treatment decisions and outcomes.

The Black population in Ontario is disproportionately impacted by chronic kidney disease. They have a 35 per cent higher rate of being on dialysis compared to the rest of the population of Ontario, representing 5.5 per cent of Ontario's population and 7.5 per cent of the population on dialysis. We are working with Black community members, health leaders and academics, in alignment with the Black Health Plan, to reduce disparities in kidney care and advance health equity for Black Ontarians impacted by chronic kidney disease.

For people living in rural and remote areas, accessing kidney services can be challenging due to long distances, lack of support systems near care services, and out-of-pocket expenses for travel and accommodation. These barriers can prevent some people, particularly those with low incomes, from accessing multi-care kidney clinics, transplantation, or dialysis at home or in their home communities. We will work with health system partners to reduce financial and geographic barriers to accessing care.

First Nations, Inuit, Métis and Urban Indigenous people are more likely to live with chronic kidney disease than the general population. They often face significant challenges in accessing care in a way that is culturally safe. To support the unique needs of First Nations, Inuit, Métis and Urban Indigenous people, we will support the delivery of culturally and geographically appropriate kidney care, working in partnership with these communities, health care providers and Regional Renal Programs across Ontario. This work will leverage data, where possible, and be aided by the Indigenous Data Governance principles, which affirms First Nations, Inuit and Métis peoples' rights to self-govern their data.

The work of the Ontario Renal Plan will be guided by Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework. We will prioritize embedding cultural safety principles to ensure people feel empowered and involved in their health care. We will also collaborate to develop strategies and policies that will help break down barriers and provide more equitable care for underserved populations.

BRUCE M.

"I strongly believe that advancing health equity in kidney care is not just a goal; it's a fundamental value in our society. Everyone deserves fair, respectful, and dignified treatment, regardless of where they live or income status. Eliminating barriers, raising awareness, and ensuring accessible kidney care for all are essential steps toward fostering a more positive and inclusive healthcare system."

Bruce M. was diagnosed with glomerulonephritis in 2019 after a year of multiple diagnostic tests. Since then, he has effectively managed his chronic kidney disease and has been an active advocate for early diagnosis and screening.

Partner with patients and care partners to drive improvements in kidney care

Strategic Objectives

- **Understand and improve patients' experience throughout their kidney care**
- **Improve education for patients, care partners and the care team to enable patients to make informed decisions and be active partners in their care**
- **Promote access to virtual kidney care services**

When describing excellent care, people with chronic kidney disease and their care partners consistently emphasize the importance of being seen by health care providers as individuals and as respected, equal partners in their care.

Partnering with patients and care partners is critical to improving their experience and quality of care. By understanding their experiences, we can target areas for improvement with the aim of providing care that is respectful and responsive to patients' needs and preference. We will continue to work with our Patient and Family Advisory Committee to co-design policies, programs and initiatives that affect the delivery of care and patient and care partner experiences.

A person-centred approach relies on effective and compassionate communication between patients, care partners and health care providers. These conversations should cover all aspects of care and begin early, continuing throughout the patient's kidney care journey. These discussions should include goals of care and management of symptoms that can significantly impact the patient's quality of life. Shared decision-making between patients, their care partners and their care team ensures treatment aligns with the individual's preferences, family situation, culture and lifestyle.

Patients and care partners should receive ongoing education on chronic kidney disease from their care team, empowering them to actively engage in their health care. Education not only enables patients to understand chronic kidney disease but also facilitates informed and timely decision-making and treatment plans. Continuous education for health care providers is also critical to ensure they are equipped to offer best practice care and engage patients and care partners in meaningful discussions about their care. A complementary education approach establishes a collaborative, supportive environment, promoting patient self-management and timely decision-making.

Virtual care makes it possible for patients to receive needed care without having to travel long distances. It improves access for those living far from Regional Renal Programs or who may be frail, elderly or socioeconomically disadvantaged. Virtual care can reduce patient and system expenses related to travel and accommodation, as well as reduce time away from home and work. We are committed to advocating for access to virtual kidney care services, ensuring patients can receive care comfortably.

BONNIE F.

"From my own experience, I've learned that partnering with patients and their care partners is essential in improving kidney care. It's not about having treatment done to you; it's about taking responsibility for your own health. Knowledge is empowering, and I believe in providing ongoing education to patients. Patients should be aware of all that is involved in kidney care as a whole and given the opportunity to get involved in their care and other opportunities like advisory groups and research. This can only be a positive thing for all of us."

Bonnie F. was diagnosed with kidney disease in 2004 and has had kidney two transplants. She has been back on nocturnal home dialysis for the past seven years and is doing well.

Improve access to timely and effective kidney care

Strategic Objectives

- **Jointly with Trillium Gift of Life Network, advance an integrated and person-centred approach to improve access to living kidney donation and kidney transplantation**
- **Expand equitable access to home dialysis through innovative models of care**
- **Ensure access to multidisciplinary care to actively manage advanced kidney disease, glomerulonephritis, and reproductive health**
- **Improve the delivery of comprehensive conservative kidney care in partnership with primary care, nephrology care and palliative care teams**

Effective kidney care means that services are based on best evidence and contribute to the best possible outcomes for patients, in alignment with their goals of care.

Kidney transplantation, especially from a living donor, provides the best long-term outcomes for people with end-stage kidney disease. People who receive a kidney transplant have a better quality of life and a reduced risk of dying from kidney disease. Despite these advantages, the annual wait list for patients awaiting a kidney transplant is larger than the number of transplants completed per year, and recipients often wait many years for a transplant. To increase access to kidney transplantation, our focus is on increasing awareness and knowledge about the benefits of living kidney transplantation for health care providers, patients and their care partners. Living donor transplantation can reduce wait times, may lessen the risk of rejection and last longer. In partnership with Trillium Gift of Life Network, we will work with living kidney donor programs, transplant programs and Regional Renal Programs to both improve access to kidney transplantation and also advance a person-centred, integrated kidney transplantation system in Ontario.

Home dialysis, including both peritoneal and home hemodialysis, allows individuals to perform dialysis in their homes, either by themselves or with the help of care partners or health care providers. Home dialysis can provide people with greater flexibility and independence, which may lead to improved quality of life. Over the last decade, efforts have been made to support people who wish to dialyze at home. There has, however, been a decline in the home dialysis rate in Ontario since 2021 due to multiple factors, including health human resource challenges.

We will advance efforts to reduce barriers to home dialysis, including those related to financial barriers. The Home Hemodialysis Dialysis Utility Grant provides financial support to offset the costs of electricity and water, while the Home Dialysis Training Travel Grant offsets the costs of traveling to complete training for home dialysis. Our Home Dialysis Assistance Program will support individuals in

completing dialysis at home by providing access to health care providers who provide the necessary assistance. In addition, we will continue to support patient and care partner education and training to increase the rate of home dialysis across Ontario.

Multidisciplinary care is essential for the management of advanced kidney disease, glomerulonephritis and reproductive health. We will work to ensure access to multi-care kidney clinics and glomerulonephritis clinics. These clinics include a multidisciplinary team of nephrologists, nurses, dietitians, pharmacists and social workers who support patients and care partners in making care decisions based on their goals and in managing their chronic kidney disease.

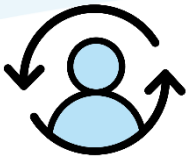
Conservative kidney care is a treatment option that provides care for people with advanced kidney disease without dialysis or a kidney transplant. Health care providers can assist patients, or their Substitute decision-maker(s), to understand conservative renal care and make informed decisions about their care. Our approach for conservative kidney care is aligned with the recommendations in the Palliative Care Health Services Delivery Framework. Our aim is to provide supportive holistic care when needed and increase access to supportive care from primary care providers, nephrologists and the community. Care coordination and navigation with these partners are vital to ensuring that care is seamless and integrated.

CRAIG L.

"Improving access to timely and effective kidney care means creating pathways to a world where people don't have to sacrifice their quality of life to stay alive on dialysis. It's about reducing and removing barriers, customizing support and understanding the unique challenges people face. Whether it's enhancing access to kidney transplants, developing innovative models for supported home dialysis, or providing access to a dedicated care team, it's all about giving individuals the tools and resources they need to manage their kidney health proactively and confidently."

Craig L. was diagnosed with diabetes at age of 30, and his kidneys failed at age of 45. Craig has performed peritoneal dialysis, in-centre hemodialysis and home hemodialysis and has been living well with a kidney-pancreas transplant for 10 years.

Improve the health of people living with chronic kidney disease



Strategic Objectives

- **Improve identification and management of early chronic kidney disease in partnership with primary care to reduce the burden of chronic kidney disease**
- **Integrate mental health services that support the well-being of people with chronic kidney disease**

Early identification and appropriate management of chronic kidney disease are critical to decreasing the incidence of the disease.

As Ontario's population ages, an increasing proportion of Ontarians will be at risk of diabetes, cardiovascular disease, chronic kidney disease and associated risk factors. If kidney disease is caught early using recommended screening tests, then medication management and patient education about lifestyle modifications (including diet) can be effective in slowing, preventing or even reversing disease progression.

Primary care providers play a key role in screening, diagnosing and treating people with chronic kidney disease, as well as ensuring timely referral to nephrology. We will continue to promote the use of the KidneyWise Toolkit, which helps primary care providers identify and manage chronic kidney disease. The toolkit supports primary care providers with guidance on who will benefit from a referral to nephrology, recommendations on ordering appropriate tests to confirm diagnosis, and how to best manage the disease to help prevent further progression and reduce cardiovascular risk.

Dealing with chronic kidney disease goes beyond the physical challenges it presents. Many individuals also grapple with anxiety and depression as they navigate the complexities of managing their health. The demands of treatment, lifestyle adjustments and uncertainties about the future can lead to heightened anxiety levels, while the ongoing nature of chronic kidney disease can contribute to feelings of depression. Recognizing and providing integrated supports for mental health is vital for ensuring a holistic approach to the well-being of those living with chronic kidney disease. Symptom management resources for health care providers and symptom self-management guides for patients provide supports for recognizing and managing symptoms. We will continue to support improved access to mental health care, including through the Mental Health and Addictions Centre of Excellence .

JANET H.

"Chronic kidney disease is often a hidden disease until diagnosis. Early education and awareness play a key role in early diagnosis and management. Primary care providers have a lot on their plate, but kidney health should be higher on their priority list. Kidney disease affects not just the kidneys but also other parts of the body and mental health. In the next four years, our biggest success would be to move the dial on prevention, early screening and spreading awareness about this hidden condition."

Janet H.'s husband was diagnosed with kidney disease in 2006, started peritoneal dialysis in 2009 and received a kidney transplant in 2012 from a deceased donor. His sister was diagnosed with end-stage kidney disease in 2019 and is receiving in-centre hemodialysis three times a week.

Drive quality and value by supporting a sustainable kidney care system

Strategic Objectives

- **Optimize capacity planning and funding models to enable a sustainable kidney care system**
- **Optimize health human resource models to enable the delivery of high-quality kidney care**
- **Advance a learning health system approach through data, knowledge translation, and innovation**

More people are now living with chronic kidney disease in Ontario than ever before. For Ontario's kidney care system to continue to provide the right care at the right time by the right care team, we will work closely with the health system partners to enable efficient, coordinated and integrated care.

We will continue to enable coordinated and integrated care through the Chronic Kidney Disease Quality-Based Procedures. This funding and accountability provide Regional Renal Programs, long-term care homes and home and community care services with the funding to support patients in multiple care settings, including in hospitals, in the community and at home. This one source of funding encourages an integrated care approach across the patient journey.

As the health system continues to experience challenges with access to health human resources, we are committed to optimizing health human resource models that will enable the full care team to deliver high-quality kidney care in partnership with patients and care partners.

We will begin a "green nephrology" approach, recognizing the environmental effects associated with kidney care. Several of the most effective treatments in kidney care align with environmentally friendly practices, including transplantation, home dialysis and the prevention of progressive chronic kidney disease. Our focus is on increasing awareness of the environmental impact of kidney care and supporting environmental sustainability with health system partners.

To maximize existing health system resources and optimize system capacity, we will leverage data to support provincial priorities outlined in this system plan. This information will help us plan and manage capacity with our partners so Ontario will be prepared to provide services for future patients.

An important aspect of this goal – and all our work – is our focus on continually improving how the health system works, based on evidence. As a learning health system, we develop our work based on the experience and expertise of those in the kidney care system: health care providers, patients and care partners. We continually monitor what works and what doesn't, share what we've learned and use the evidence to make the system better.

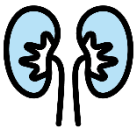
JOSEPH G.

"My experience, having to travel far from home for care, underscores the critical need for care to be accessible and close to home. As a patient, I believe in ensuring the best health outcomes, and for that, we need a quality system with staffing, equipment and funding in place. Sustainability isn't just about sustaining resources; it's about sustaining a system that reaches every patient where they are."

Joseph G. was diagnosed with acute kidney disease secondary to lupus nephritis in his early 20s and underwent treatment with in-centre hemodialysis and plasmapheresis. Upon diagnosis of chronic kidney disease, he transitioned to peritoneal dialysis and recently received a transplant.

Kidney Disease in Ontario

Why we need a renal plan



Understanding current and future trends in chronic kidney disease incidence, prevalence and care helps health planners, policy-makers and health care providers anticipate the resources and costs needed to care for people diagnosed and living with chronic kidney disease.

700,000 adults in Ontario are living with early chronic kidney disease.[2]

The loss of kidney function often starts slowly and silently; left unmanaged, it can progress to end-stage kidney disease. As Ontario's population continues to grow and age, more people are expected to develop diabetes and cardiovascular disease, leading to a projected increase in chronic kidney disease. Through appropriate screening, identification and management, including lifestyle changes and medications, the majority of these individuals can mitigate the risk of additional damage to their kidneys.

13,300 people with advanced chronic kidney disease receive care from multi-care kidney clinics.[3]

People with advanced chronic kidney disease require specialized care and services to manage the many challenges associated with the condition and prepare for end-stage kidney disease. Multi-care kidney clinics empower patients by engaging them in collaborative decision-making, actively managing symptoms, providing education on health and modality options, and aiding in care coordination.

5,000 people with glomerulonephritis (GN) receive specialized multidisciplinary care to manage their disease.[4]

Glomerulonephritis is a group of rare, heterogenous kidney diseases and is a leading cause of end-stage kidney disease. Despite its dynamic nature, GN can be effectively treated by timely and appropriate management. Through improved access to specialized GN care teams, laboratory tests and medications, we aim to improve health outcomes and disease prognosis for those impacted by GN.

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[2] Blake, P., Heale, E., Maclean-Bowman, E., Molnar, A., Nash, D., Padewski, S., Smith, G., Stirling, K., Young, A. (2023). Chronic Kidney Disease in Ontario: Burden and Care Gaps. [Manuscript in preparation]
[3] Based on Ontario Renal Reporting System, retrieved June 1, 2023 data.
[4] Based on Ontario Renal Reporting System, retrieved June 1, 2023 data.

12,400 people with advanced chronic kidney disease require dialysis, with 9,300 of these (76%) using in-facility dialysis units.[5]

To meet the ongoing and future needs of people requiring dialysis treatment, it is essential to efficiently manage capacity in in-facility units.

24% of dialysis patients are completing dialysis at home.[6]

Prioritizing the expansion of home dialysis for Ontarians remains a key focus. At the time of developing this plan, the percentage of people on home dialysis is declining. We will continue working as a system to remove barriers and support patients in receiving dialysis at home, whether through an assistance model, with a health care provider, care partner or independently.

5.6% of individuals treated for end-stage kidney disease receive a kidney transplant, with less than 2% of kidney transplants from living donors.[7]

Kidney transplants, especially from a living donor, provide the best long-term outcomes for people with end-stage kidney disease, improving survival rates and quality of life. Transplantation is also recognized as a more cost-effective treatment than dialysis. In partnership with the Trillium Gift of Life Network, we will work to bridge patient transitions between renal and transplant programs, increase access to kidney transplantation (including living donor kidney transplants) and improve the patient experience with kidney transplantation.

Over 9,000 people are living with kidney transplants.[8]

Ensuring the well-being of individuals with kidney transplants is essential for promoting long, healthy lives. With care and support, individuals can effectively manage their transplants and address any potential decline in kidney function with confidence. In partnership with the Trillium Gift of Life Network, we will drive improvements in post-transplant care and smooth transitions back into kidney care when needed.

660 individuals attending multi-care kidney clinics receive conservative kidney care.[9]

Conservative kidney care embraces a holistic, person-centred approach, prioritizing quality of life, symptom management and kidney function maintenance. Ensuring access to timely supportive care, planning for the future, and enhancing accessibility for support from primary care providers, nephrologists and the community are key aspects of this approach.

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[5] Based on Ontario Renal Reporting System, retrieved November 1, 2023 data.
[6] Based on Ontario Renal Reporting System, retrieved November 1, 2023 data.
[7] Based on Ontario Renal Reporting System, retrieved November 1, 2023; Organ Allocation and Transplant System, retrieved November 1, 2023 data.
[8] Canadian Institute for Health Information. Treatment of End-Stage Organ Failure in Canada, Canadian Organ Replacement Register, 2012 to 2021: End-Stage Kidney Disease and Kidney Transplants — Data Tables. Ottawa, ON: CIHI; 2023.
[9] Based on Ontario Renal Reporting System, retrieved November 1, 2023 data.

JUDY LINTON

"For 15 years, the Ontario Renal Network demonstrated a commitment to improving the lives of people living with chronic kidney disease in Ontario. Ontario Health builds on that legacy. As a single, integrated provincial agency, Ontario Health leverages the collective expertise, skilled resources, innovative solutions and digital programs of all our team members to better connect the health system to drive improved and equitable health outcomes, experiences and value."

Judy Linton is the Acute and Hospital-Based Care Executive Vice-President and Chief Nursing Executive at Ontario Health.

Ontario's Kidney Care System

How we work together

Regional Renal Programs

Ontario Health (Ontario Renal Network) works in close partnership with Ontario's 27 Regional Renal Programs, which are networks of hospitals and other agencies involved in providing kidney services at the local level. The Regional Renal Programs use this provincial plan to develop their regional workplans to address local issues and improve kidney care services within their communities. Their work helps make sure people across Ontario can access high-quality kidney services as close to home as possible.

Ontario Health Regions

Ontario Health's operating model includes six Ontario Health Regions: Central, East, North East, North West, Toronto and West. These regions work closely with Health Service Providers to support planning, design and implementation of provincial strategies and programs, including the Ontario Renal Plan. As people with chronic kidney disease often have complex medical needs beyond their kidney disease, the Ontario Health Regions play an important role in supporting access to broader health care services for people with chronic kidney disease.

Clinical leadership

Clinical Leads, including physicians, nurses and other health care professionals, provide leadership and expert advice to help improve the kidney care system. Their pivotal role involves identifying priorities and advancing system improvements. Many health care professionals from across Ontario participate on expert panels and advisory committees, and as reviewers to support our work including the development of clinical program standards and evidence-based guidelines. Their contributions are essential to achieving our goals.

Patient and care partners

Patients and care providers participated in the development of the Ontario Renal Plan 4. Over 250 individuals provided feedback through a survey, and 230 individuals participated in consultations to share their perspectives on successes and challenges within the kidney care system. Their experiences and advice helped create a kidney plan that better addresses the needs and values of the populations we serve.

Furthermore, as policies, programs and practices are developed to meet the goals of the Ontario Renal Plan, ongoing input from patient and family advisors as well as our Patient and Family Advisory Council will help shape decisions that affect patient care and services. We thank the patients and care partners across Ontario for sharing their lived experiences for the betterment of our kidney care system.

Indigenous Communities and Organizations

Indigenous people face significant challenges accessing culturally safe, high-quality kidney care. To address this, we will partner with First Nations Political Territorial Organizations, the Métis Nation of Ontario, Indigenous health partners, and individual First Nations communities across Ontario to define Nation-specific priorities. Together with Indigenous partners, we will use these priorities to establish an Indigenous Kidney Health Plan, incorporating nation and region-specific action plans to deliver culturally and geographically appropriate kidney care. Ontario Health (Ontario Renal Network) and Regional Renal Programs will work with Indigenous partners to advance provincial and regional goals through local meaningful collaboration with the goal of advancing Indigenous health priorities across the kidney system.

Government and system partners

The Ministry of Health reviews and assesses the Ontario Renal Plan and provides funding for its programs and projects. We advise the ministry about the performance of the kidney care system and regularly report on the results of our work.

Many system partners help develop programs, policies and projects that support the strategic objectives of the Ontario Renal Plan. External partners include provincial agencies, health care organizations, and health care professionals, their colleges and associations.

As Ontario's health system continues to evolve and mature, we look forward to working in an integrated way with system partners, including Ontario Health Teams[ŧ] and home and community services to advance the goals and strategic objectives of this plan. Partnering with Ontario Health Teams will be critical to support other medical needs of people with chronic kidney disease including navigating the broader health system, transitioning between providers and experiencing more coordinated, integrated local care.

[ŧ] Ontario Health Teams (OHTs) provide a new way of organizing and delivering care that is more connected to patients in their local communities. Under Ontario Health Teams, health care providers (including hospitals, doctors, and home and community care providers) work as one coordinated team – no matter where they provide care.

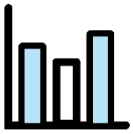
GAIL B.

"The Ontario Renal Plan serves as our compass for navigating local priorities in kidney care. This strategic roadmap empowers us to identify and address priority areas, ensuring that our resources are effectively managed, fostering collaborative partnerships, and delivering comprehensive, patient-focused care. The plan guides impactful change to meet the unique needs of our community and ensures the delivery of high-quality care at each Regional Renal Program. By incorporating the voices and perspectives of patients in its development, it is a testament to our commitment to ensuring their needs, preferences, and experiences are at the heart of everything we do."

Gail B. is a Regional Director at Ontario Renal Network and a Program Director at Halton Healthcare.

Measuring Progress

Accountability and measurement



We are accountable to the Ministry of Health, our partners and the people of Ontario for meeting the priorities outlined in this plan.

Annual business plans submitted to the ministry and detailed internal operating plans set out how initiatives and programs will be developed and put in place to support the plan's goals and strategic objectives.

There is a robust measurement plan, including performance indicators, to measure progress. Progress will be reported in various ways, including:

- Quarterly scorecards
- Insights reports on home dialysis, transplant and multi-care kidney clinic care
- Quarterly performance review with all Regional Renal Programs
- Quarterly reports on our accountability and funding agreements

Additionally, we report our progress to the public in Ontario Health's annual reports. We use all of this information to adjust planning and respond to changes.

Our Progress Together

Building on our foundation

This Ontario Renal Plan is built on the progress we have achieved with our many partners over the past 15 years. Together, we have been improving the lives of people at risk for and living with chronic kidney disease by:

- Establishing a province-wide network of 27 Regional Renal Programs that provide integrated and coordinated care for patients across the kidney care continuum.
- Creating and maintaining a comprehensive data system that collects, analyzes and reports on key indicators of chronic kidney disease care, including incidence, prevalence, outcomes and quality of care.
- Implementing Chronic Kidney Disease Quality-Based Procedure funding that enables efficient, high-quality care that is organized around the person.
- Providing detailed forecasting and capacity assessments to support Regional Renal Programs in planning for sufficient space to meet the dialysis needs of current and future patients.
- Developing and disseminating evidence-based standards and guidelines for the identification, management and treatment of chronic kidney disease, including Multi-Care Kidney Clinics Best Practices.
- Advancing person-centred care through engagement and partnership with our Patient and Family Advisory community who provide meaningful contributions to initiatives and programs.
- Supporting quality improvement initiatives and projects in Regional Renal Programs, such as reducing infections, improving vascular access and implementing goals of care conversations.
- Increasing the availability and utilization of home dialysis modalities, including peritoneal dialysis and home hemodialysis, which allows for flexibility and greater independence in the comfort of patients' own homes; this includes supporting patients through the Home Hemodialysis Utility Grant to offset the added electricity and water costs related to this treatment.
- In collaboration with Trillium Gift of Life Network, expanding access to living kidney donation and kidney transplantation, which is the optimal treatment for end-stage kidney disease for eligible patients.

- Improving kidney care services for underserved populations, such as Indigenous communities and individuals living in rural and remote areas.
- Establishing glomerulonephritis clinics, including specialty clinics, across Ontario to provide specialized care for patients closer to home.
- Ensuring access to COVID-19 rapid vaccination campaigns for people with kidney disease, fostering a proactive approach in safeguarding the health of individuals with chronic kidney disease.
- Expanding access to conservative kidney care across Ontario, which provides a holistic, person-centred and active treatment option for people with end-stage kidney disease who are not receiving renal replacement therapy.

Ontario Renal Plan 4 is dedicated to the memory of Mary Beaucage, Patient Advisor Chair of Ontario Renal Plan 4 and founding member of Ontario Health CEO Patient and Family Advisory Group. Mary was instrumental in the development of this plan and made significant contributions to the kidney system through the generous sharing of her lived experience.