

BC Renal Agency Balanced Scorecard

	Priority Strategies	Indicators ¹	Status ²	Trend ³	Target	Actual
Clients, Patients & Community	<ul style="list-style-type: none"> Define patient outcomes that rely on integrated services and work with HAs to ensure the best patient and health care system outcomes. Assess education and training needs of professionals, caregivers, and patients with kidney disease and ensure resources and plans are implemented to meet those needs. Expand and enhance province-wide independent care model for dialysis. 	1. One year patient survival rate on dialysis	●	→	≥ 80%	83%
		2. Patient experience	●	N/A	TBD	3.1-3.6
		3. Percentage of patients participating in independent dialysis* (PD and home-based HD)	●	→	≥ 30%	30.6%
Service Coordination & Delivery	<ul style="list-style-type: none"> Improve integration of services for kidney patients within each HA through an increased understanding of the linkages and inter-relationships between acute care services, community services, and primary health care. Build on strength of established Health Authority Renal Programs. Planning for capacity to meet CKD care needs. Continue to facilitate medication best practices across BC renal care community for an estimated cost savings of 5-10% of current renal drug budget. 	4. Level of kidney function (median eGFR) at time of CKD registration	●	→	30-35 mL/min	30.0 mL/min
		5. Occupancy rate by dialysis unit setting	●	→	80%±5%	82%
		6. Rate of catheter-related infections per patient year (HD and PD)	●	→	< 1 / PD yr; <0.5 / HD yr	0.03/PD yr ExS: 0.07/HD yr BaC: 0.05/HD yr
		7. Percentage of incident and prevalent fistulas	●	↑	Incident >20%; Prevalent >60%	Incident: 15.0% Prevalent: 51.3%
		8. Percentage of patients with optimized drug dose per unit of hemoglobin achieved	TBD	→	>70%	Mdn: 27-93 units/g/L
Learning, Growth, & Innovation	<ul style="list-style-type: none"> Continue to modify and implement a consolidated renal/chronic disease data management system (PROMIS). Ensure that education and research endeavors align to enhance care delivery and demonstrate accountability and fiscal responsibility, while ensuring state-of-the-art care for patients with kidney disease. Assess education and training needs of professionals, caregivers, and patients with kidney disease and ensure resources and plans are implemented to meet those needs. Develop and implement recruitment, retention, and succession plans for health care professionals and allied health care professionals. 	9. Percentage of patients with comorbidity assessment available in PROMIS	●	→	≥ 80%	93%
		10. List of new knowledge translation initiatives	●	→	> 0	11
		11. Total funding for research and health outcomes initiatives	●	↑, →	> \$100k per annum	Research = Actual \$136,926 Health Outcomes = Actual \$733,507
		12. Number of educational events in each HA	●	→	> 0 per HA	17-46 per HA
		13. Staff sick leave as a percentage of regular paid hours*	●	→	≤ 4.8%	2.80%
Finance	<ul style="list-style-type: none"> Leverage opportunities for costs savings and value add funding through provincial contracts. Continue to enhance and further develop the Renal Resource Management Model for adult and pediatric patients with kidney disease, which aligns incentives and patient outcomes in a fiscally responsible manner. 	14. Non-MoH revenue as a percentage of total revenues	●	↓	≥ 6.6%	6.43% Q2 Projection 6.69% Budgeted
		15. Net budget surplus (deficit)	●	↓	≥ \$0	(\$1,803,311) Q2 Projection
		16. Budget growth less than population growth	●	→	≤ 11%	Q2 Projections: Pts: 5.18% Funding: 5.40%

* Mandatory indicator as defined by the Government Letter of Expectations/Health System Performance Framework.

¹ Indicators shaded grey do not have updated data available for this report.

² ● = achieving target and/or positive change; ● = close to achieving target and/or questionable change; ● = not achieving target and/or negative change

³ ↑ = improving trend; → = steady/stable trend; ↓ = deteriorating trend

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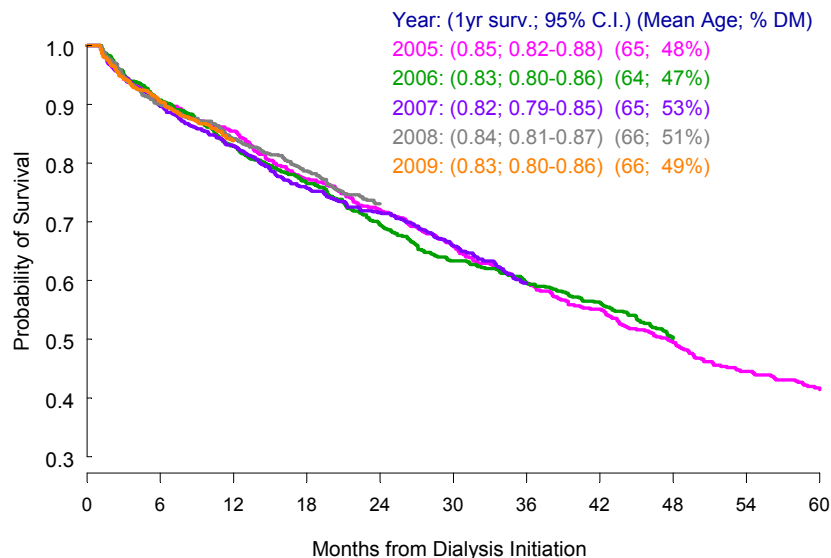
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CLIENTS, PATIENTS, AND COMMUNITY

Updated: November 2010

Status	Trend	Target	Actual
●	→	≥ 80%	83%

1. One-Year Patient Survival Rate on Dialysis



Test for adjusted HR* for Year of Dialysis Initiation: Chi-sq=2.2360, p=0.6924

*Adjusted for age, gender, diabetes, initial modality, HA at dialysis initiation, CKD follow-up

Measure: One-year survival rate by year of dialysis initiation based on product-limit survival estimates (Kaplan-Meier method). Included cases: patients who started dialysis from January 01, 2005 – March 31, 2009. Follow-up duration to October 14, 2010.

Limitations: Unadjusted for comorbidities.

Significance: Survival on dialysis is a measure of the health of a unit. While high mortality rates are expected due to the nature of the disease, tracking of this parameter is important to determine if trends are within acceptable/expected rates.

Drivers: Patient acuity, urgency of dialysis initiation, delivery of adequate dialysis.

PHSA Target: ≥ 80 % survive > 1 year on dialysis.

Benchmarks and Comparators: Annual Canadian mortality ~20% per year.

Trend: There has been no change in the survival rate of BC patients starting dialysis over the past five years, despite a high prevalence of diabetics and an older age at dialysis initiation. Specifically, the one-year survival is 83% with a median survival of 48 months.

Comments: The median survival of 48 months is higher than the national average.

Action Taken: None required.

Source: **BCPRA Health Informatics and Methodology & Analytics;** PROMIS (Patient Record/Registration and Outcomes Management Information System) - Provincial

Registry of Chronic Kidney Patients, data extract October 2010 with SAS data transformations [computer files and programs] Lee Er [producer], Statistician, Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BCPRA Methodology & Analytics.

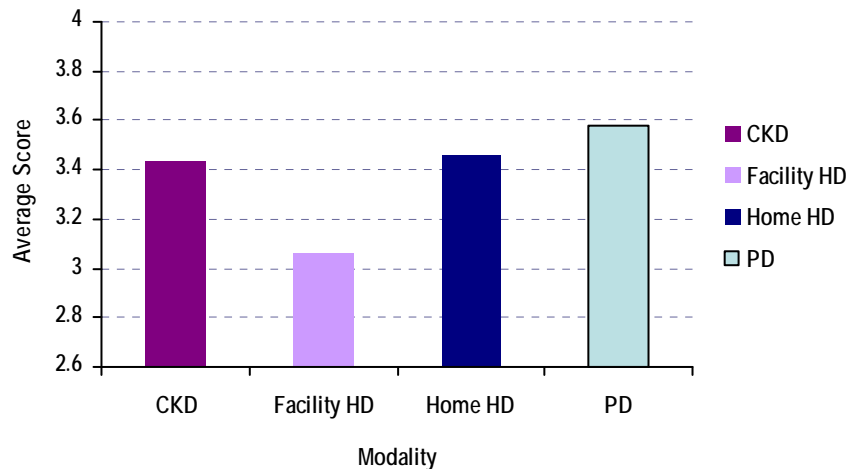
CLIENTS, PATIENTS, AND COMMUNITY

Updated: November 2010

Status	Trend	Target	Actual
●	N/A	TBD	3.1-3.6

2. Patient Experience

Patient Perception of Care



Measure: A validated patient self reporting survey, developed by the McColl Institute to measure the care experience of chronic patients was used to assess patients' perception of their care management and alignment with the chronic care model. 5,000 surveys mailed to the following patients: all hemodialysis patients, all peritoneal dialysis patients and chronic kidney disease patients with 2 visits to a structured, multidisciplinary predialysis clinic in the last 12 months. Numerator is the score on five-level Likert scale, with 5 being maximum score (best). Denominator is the number of respondents to the survey.

Limitations: All surveys are limited by methodology available to ask questions; and by response rate.

Significance: The results of this survey will help the renal community assess the extent that chronic kidney disease patients receive care that aligns with chronic care model. The tool is able to assess the degree to which care is patient centered and the level of proactive care, planned collaborative goal setting, problem solving and follow-up support. Comparisons will be possible across modalities of care (i.e. dependent and independent dialysis, CKD) between HAs, and within and between institutions and programs.

Drivers: Recognition that the patient is a key member of the renal care team. Alignment of care with expanded Chronic Disease Management Model.

PHSA Target: To be determined when survey collection and data analysis complete.

Benchmarks and Comparators: None.

- Trend:** TBD. The survey established baseline results; to be repeated in 2-3 years
- Comments:** Over 5,000 surveys were distributed. Results indicate that independent dialysis patients report a higher level of participation in their own care compared with patients receiving care in hospitals and community dialysis units. The area of care identified by patients as most needing improvement was follow-up care, which received average ratings between 2.76 and 3.23 out of five – the lowest mean scores obtained from the survey. On this measure, patients were asked if they were contacted after a visit or encouraged to attend community-based programs, if they received referrals to a dietician or health educator and about visits with other health care practitioners.
- Action Taken:** In July 2010 the multidisciplinary staff members of the 9 pre-dialysis clinics spread throughout BC were surveyed. Purpose of the survey was to establish a baseline regarding clinic organization, community linkages, PROMIS data entry, level of patient self management support, process for decision support for care goals, and the clinical team design. Data is currently being analyzed. Responses in appropriate domains will be matched to the domains on which pre-dialysis patients commented upon in the original patient survey. These results will drive specific actions/strategies at the regional/program level, although the survey results will influence provincial strategies for maximizing the effectiveness of the pre-dialysis interactions
- Source:** **BCPRA External Networks**; *patient survey* [manual], Donna Murphy-Burke [producer], Lead External Renal Networks, BCPRA External Networks, Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BCPRA External Networks.

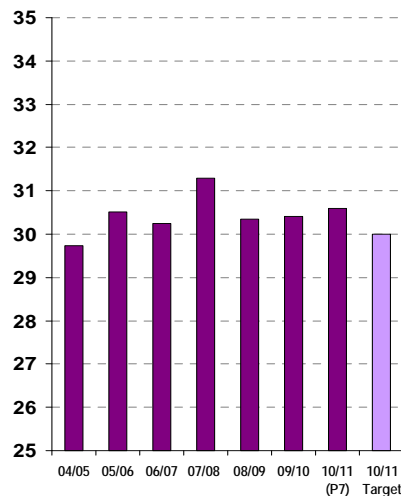
CLIENTS, PATIENTS, AND COMMUNITY

Updated: November 2010

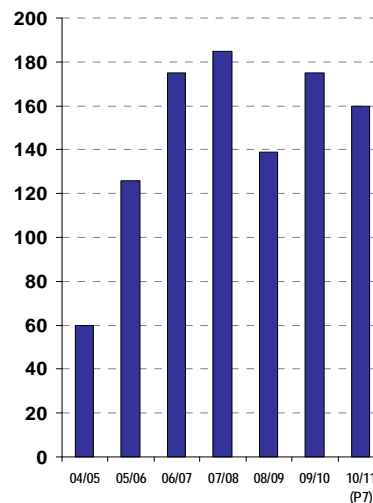
Status	Trend	Target	Actual
●	→	≥ 30%	30.6%

3. Percentage of Patients Participating in Independent Dialysis

Percentage of patients on independent dialysis (Home HD or PD)



Number of patients participating in Home HD



- Measure:** Percentage of patients who are engaged in home-based therapies (peritoneal dialysis and home hemodialysis) in the fiscal year, expressed as percent of all dialysis patients.
- Limitations:** Not all facility-based independent dialysis patients are included at this point (Penticton data not yet integrated), so these are slight underestimates. There are significant fluctuations in numbers of these programs (see drivers below) that cannot be predicted.
- Significance:** Independent dialysis enhances patient quality of life, promotes better individual patient outcomes, and reduces resource utilization, leading to overall savings for the health care system. At the current time the percentage of patients capable of sustained independence is not known, and thus targets may need to be adjusted.
- Drivers:** Interest among patients based on communication/education by care providers; wait time for kidney transplant procedures; lack of nursing resources and inability to have facilities in each community; access to training, and instability of patients' clinical health over prolonged time..
- PHSA Target:** 2008/09 HSPF target is 30% (long-term target is 35%). Internally, 27-30% of all dialysis patients on PD; combined independent Home HD and PD = 30-35% of total dialysis. The targets may appear modest, but are based on significant limitations and drivers.
- Benchmarks and Comparators:** Canadian average for home-based dialysis care < 20%; the PD rate in most provinces is 18-20%, and few have organized independent HD programs.

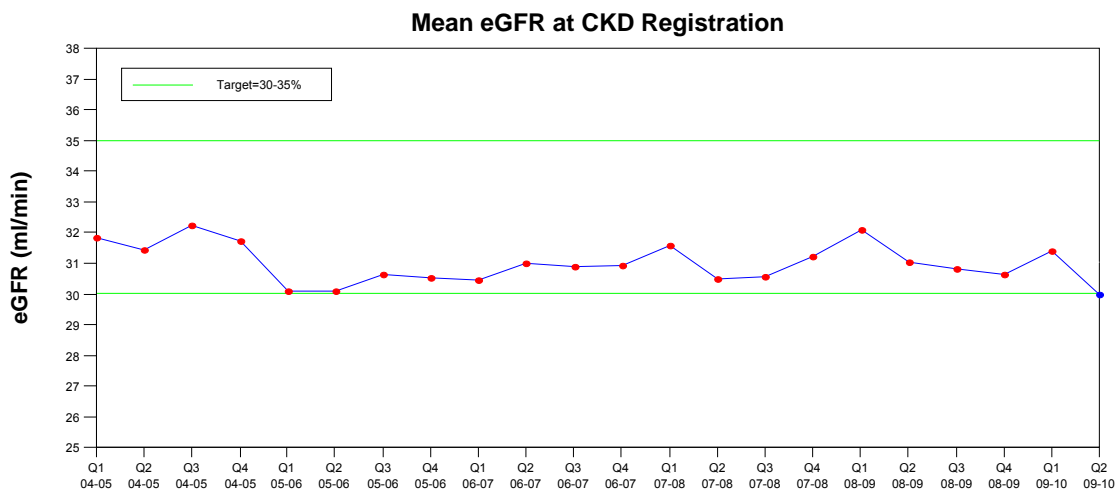
- Trend:** The proportion of patients who commence independent based therapies is steady; however, BC is above the national average but meeting our own targets.
- Comments:** Repeated surveys of patients (both pre-dialysis as well as those on conventional treatment) indicate continued strong interest from patients regarding independent dialysis modalities. Informal discussions with renal staff that work in the dependent settings, as well as pre-dialysis clinics, have illustrated a lack of familiarity regarding many basic aspects of independent therapies. Efforts to change this and enhance broad understanding of independent therapies are being undertaken. The long-term sustainability for the independent therapies will continue to require adequate resources for respite and recognition of changing status of patients.
- Action Taken:** Interest in emulating the “involved care unit” in Penticton grew substantially after representatives from the Fraser and Vancouver Coastal programs conducted a site visit in Sept 2010. In addition, two very successful patient forums about independent therapies were held in New Westminster and Penticton this fall. At BC Nephrology Days (attended by 450+ renal care providers) a plenary session tackled four myths related to independent therapies (infection rates, geographic influences on modality selection, whether partners are needed if dialyzing at home, and mortality rates). PD clinicians from all HAs are working with BCPRA and HSSBC to develop the RFP for the next peritoneal dialysis supply contract (expected to be issued in early 2011).
- Source:** **BCPRA Health Informatics and Methodology & Analytics;** PROMIS (Patient Record/Registration and Outcomes Management Information System) - Provincial Registry of Chronic Kidney Patients, data extract October 2010 with SAS data transformations [computer files and programs] Lee Er [producer], Statistician, Murphy-Burke, Lead External Renal Networks [reviewer], Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BCPRA Methodology & Analytics.

SERVICE COORDINATION AND DELIVERY

Updated: November 2010

Status	Trend	Target	Actual
●	→	30-35 mL/min	30.0 mL/min

4. Level of Kidney Function at Time of CKD Registration



- Measure:** Mean eGFR (level of kidney function) at time of CKD registration.
- Limitations:** None.
- Significance:** The level of kidney function at the time of registration is directly related to outcomes. The ability to delay disease progression and adequately prepare people for replacement therapy (and to promote independent options) requires adequate time. An earlier referral = higher level of kidney function, and thus increased likelihood of successful interventions. Within the province, it's important to ensure the ability to deliver care to patients earlier in their history of kidney disease irrespective of health authority.
- Drivers:** Referral from GP and others, recognition of the condition (i.e. lab strategy), access to nephrologists.
- PHSA Target:** 30-35 mL/min.
- Benchmarks and Comparators:** No province or country has this information available.
- Trend:** There appears to be a plateau in the level of kidney function at the time of registration, after an initial improvement post eGFR reporting implementation. Because the plateau over recent periods might indicate a problem with wait times, a study to capture wait time information was undertaken in late 2009. Results are

currently being analyzed and will inform the development of future strategies. Alternatively, as guidelines currently suggest referral at ~30 ml/min, this would represent an appropriate and steady referral state.

Comments:

BC has made significant positive strides in early identification through the combined GP education and CKD laboratory strategy. With mean eGFR at time of registration up to 30-32 ml/min (i.e., 30-32% of kidney function) compared with 22 ml/min prior to the provincial strategy, there is a possibility that more people will be able to delay progression of their disease, maintain health, or receive non-urgent dialysis starts or pre-emptive transplant. The initiative referenced above re: wait times will inform future strategies.

Action Taken:

The current study re: tracking of nephrology consultation wait times has been undertaken. In addition we have initiated an evaluation of shared care models to determine if the flattening of this curve is due to a saturation issue or a true stability / meeting of the needs of the referring population. A project lead has been identified and project plan, with initial data collection, commenced. A representative period of time and representative practices are being determined to ensure applicability of the data.

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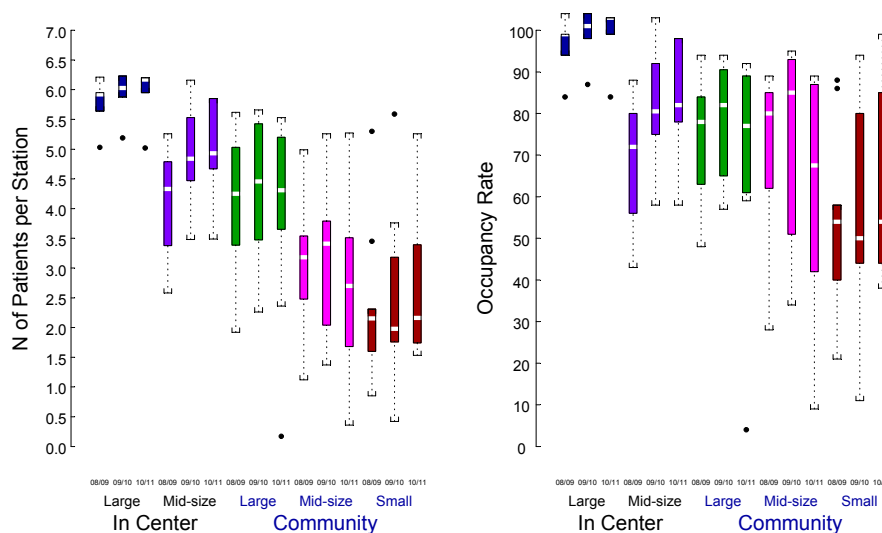
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SERVICE COORDINATION AND DELIVERY

Updated: November 2010

Status	Trend	Target	Actual
●	→	80% ± 5%	82%

5. Occupancy Rate by Dialysis Unit Setting



Measure: Number of chronic HD patients per dialysis station and percent occupancy rate per unit. The maximum occupancy rate is defined as six patients/chair for hospital units and four patients/chair for community units. This is a measure of the ability of units to appropriately operationalize their chairs/capacity to dialyze patients. Due to operational realities that impact occupancy, such as nursing availability and patient variability, the 39 HD units in BC are stratified into five categories based on their setting (a combination of urban/rural and size of the respective communities).

Limitations: The efficiency of any measurement of occupancy (i.e., number of patients receiving dialysis in a unit) may not be reflective of true capacity (i.e., physical chairs available). Occupancy in small/rural units is drastically affected by the loss of 1-2 patients. Occupancy in larger/urban units can also be affected by patient factors, as well as availability of nursing resources to deliver care. As a result, physical capacity does not always translate to actual occupancy. Occupancy rates must be determined based on three key factors: patient population, physical chairs and human resources (nurses, etc.). This measure of occupancy is relative to dialysis units, and needs to be seen within this context.

Significance: Occupancy rates are a measure of organizational effectiveness and the ability to appropriately plan and deliver services. Knowledge of gaps or problems in occupancy informs future planning and strategies.

Drivers: Physical space/chairs; nursing availability; patient demographics and numbers.

PHSA Target: 80% is typically defined as an operational management target for chronic HD units

across Canada. However, given the complexity of the patient population, BC geography, and human resource challenges (among others), we need to explore acceptable variations in occupancy rates. This is why BC PRA has stratified the units into five categories for the purposes of this indicator and analysis.

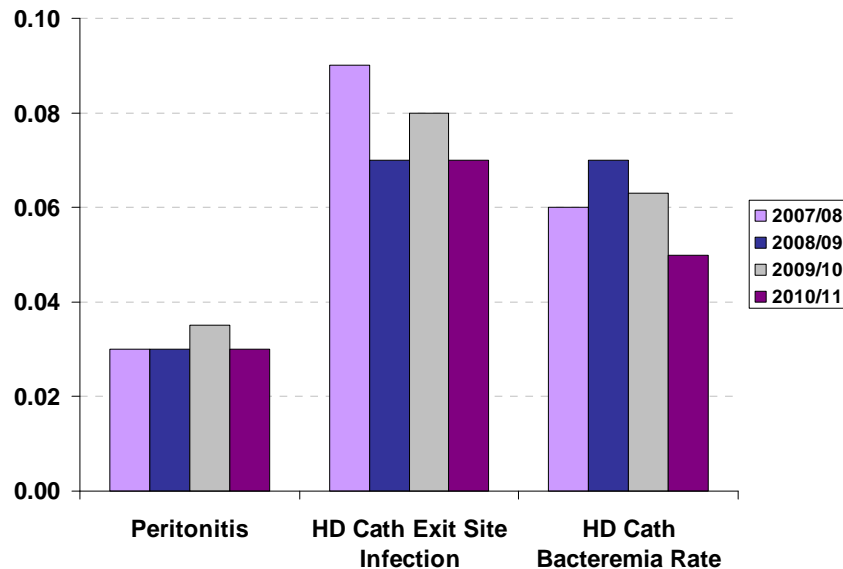
Benchmarks and Comparators:	National and international standards are not well articulated. An average of 4.5 pts/ chair = ~80% occupancy appears to be the national standard, but there is wide variability across provinces.
Trend:	Urban centres tend to be over capacity for most of the time periods, due to increasing demand at the 'initiating centres', and patients with multiple comorbidities who do not have the ability to move or receive care at different locations. Rural centres appear to be vulnerable to nursing shortages and changes in patient numbers. Since November 2009, the occupancy rate has been very stable around 80%.
Comments:	We continue to report trends and support proactive planning. Under consideration and implemented where feasible are new strategies, including: nurse extenders (LPNs), independent facility-based care, and commencement of stable patients in community units, as well as other methods to maximize low occupancy facilities and reduce pressure on crowded units. A project developed at St. Paul's Hospital/Providence Health Care for LPNs who can cannulate has been successfully implemented at the Richmond community unit. The LPN training curriculum developed by PHC has been shared with the other HA renal programs to support wider use of LPNs for HD care in the province, and BC PRA/PHSA is working with the programs to pursue funding through the BC Health Education Fund. In addition, St Paul's is currently planning on expanding dialysis to a fourth overnight shift (from 23:00 to 6:00am).
Action Taken:	Review ongoing trends and innovations re: planning, nursing models, and patient demographics. Support of project managers to facilitate change in culture and facilitation of movement of patients to community units, in addition to potential commencement of dialysis in those units.
Source:	BCPRA Health Informatics and Methodology & Analytics; PROMIS (Patient Record/Registration and Outcomes Management Information System) - Provincial Registry of Chronic Kidney Patients, data extract October 2010 with SAS data transformations [computer files and programs] Lee Er [producer], Statistician [producer], Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

SERVICE COORDINATION AND DELIVERY

Updated: November 2010

Status	Trend	Target	Actual
●	→	< 1/PD yr < 0.5/HD yr	0.03/PDyr ExS: 0.07/HDyr BaC: 0.05/HDyr

6. Rate of Catheter-Related Infections per Patient Year (HD & PD)



Measure: Rate of infections. Numerator is the number of episodes of culture-proven infection; denominator is number of peritoneal dialysis (PD) or hemodialysis (HD) catheter months between April 01, 2007 and September 30, 2010. The rate is derived by calculating the total number of all episodes divided by the number of catheter months in which the episodes occurred.

Limitations: Complete data are not currently available from all renal units. Not always possible to rule out other causes of infection.

Significance: This measure indicates the success of the programs/province in preventing infections. Infections are associated with increased hospitalizations, morbidity and mortality. As such, they may serve as an indicator of population wellness, prior to morbidity and mortality data being available.

Drivers: Vascular access creation rate/ limitations in resources; host factors; delayed referral; break in sterile techniques, environmental factors.

PHSA Target: PD infections < 1/ PD patient year; HD catheter infections < 0.5 HD catheter year.

Benchmarks and Comparators: Canadian averages for PD infection rates are not available; Ontario rates for tube site infection are 0.41/patient year; current guidelines for catheter infections are not

available.

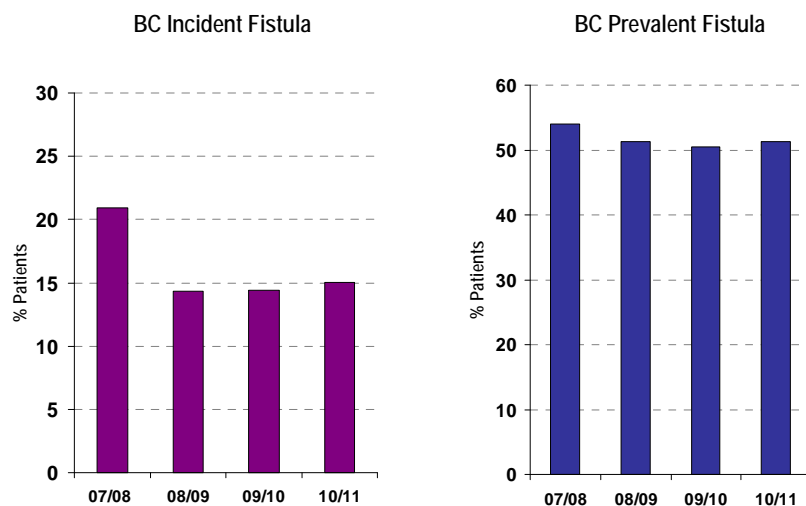
- Trend:** Rates are stable and within the target; they are lower than published data from USRDS.
- Comments:** Infections may be due to patient-related factors that are not controlled by program strategies, as well as factors (specifically cleanliness and catheter care) that are in the control of the program. Nonetheless, the tracking of infections is important for all programs as an indicator of overall wellness of the population, and for tracking of changes that may indicate breaches in technique. The current rates are very low, which likely reflects the excellent patient training and nurse education required to maintain this parameter. As infections have been linked to increase in mortality, the improved survival over other Canadian centres may in part be linked to this.
- Action Taken:** Provincial Vascular Access Services initiative to increase percentage of permanent access (fistulas and grafts) will decrease the rate of infections by decreasing the number of catheters.
- Source:** **BCPRA Health Informatics and Methodology & Analytics**; PROMIS (Patient Record/Registration and Outcomes Management Information System) - Provincial Registry of Chronic Kidney Patients, data extract October 2010 with SAS data transformations [computer files and programs] Lee Er [producer], Statistician, Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

SERVICE COORDINATION AND DELIVERY

Updated: November 2010

Status	Trend	Target	Actual
●	↑	Incident: >20% of all incident Prevalent >60%	Incident: 15.0% Prevalent: 51.3%

7. Percentage of Incident and Prevalent Fistula



Measure: Incident Fistula: Percentage is determined by the number of fistulas used as initial vascular access for incident (new) chronic HD patients.
Prevalent Fistula: Percentage is determined by the number of fistulas used at a particular time point within prevalent (existing) chronic HD patient population.

Limitations: The proportion of acute HD patients and accuracy of differentiation between chronic and acute HD patients may impact the denominator. Thus clarification as to 'chronic' status and incident patients requires further discussion and validation.

Significance: This indicator represents a significant opportunity for practice improvement and impacts patient quality of life and outcomes. Vascular access (VA) is referred to as the patient's lifeline because it allows access to the bloodstream for dialysis. Of the 3 kinds of VA – fistula, graft and catheter – fistulas are considered best practice as they last longer than either grafts or catheters, and tend to have fewer problems such as infections and clotting, which lead to hospitalizations, long term antibiotic use etc. While many European countries have fistula rates above 75%, the US and to a lesser extent Canada lag behind and are working to implement "fistula first" policies and processes.

Drivers: Organization/availability of surgical services; timely identification of CKD patients and planning for dialysis initiation (including fistula creation); proactive monitoring and repairs of fistulas

PHSA Target: >60% prevalent AVF ; >20% all incident

Benchmarks and Comparators:

Reported AVF rates for prevalent patients are 90% in Italy, 84% in Germany, 82% in Spain, 77% in France, and 67% in the UK. Rates in the United States are 31% and a three-year National Vascular Access Improvement Initiative (“Fistula First”) is currently underway to address this issue. Rates in Canada (including BC) are higher than in the US, but significantly lower than in many of the European countries (14 incident fistulas, 50 prevalent fistulas); suggesting opportunities for improvement are possible.

Trend:

Relatively new measure, so trend is only available for last two years, as tracked by BCPRA Provincial Vascular Access Services Team. Appears to be improving though still lagging behind European groups.

Comments:

BC prevalent fistula rate is comparable with reported Canadian data, while incident fistula rate is lower than latest Canadian reported rate (DOPPSII 2005).

Action Taken:

For several years, BCPRA has provided leadership to an integrated, multidisciplinary provincial VA program with local implementation that supports timely identification of patients and appropriate planning for dialysis initiation, coordination of surgical services and proactive monitoring and repairs. Program components include: a provincial committee and working groups; extensive guideline development; PROMIS database support/development; regional VA clinics, nurses and regular rounds; and collaboration with surgeons and radiologists for protected OR and radiology time. Current actions include:

Exploration of fistula creation in ambulatory care settings to address OR wait times (program in IH has proven successful; other HAs exploring similar programs); Development of a clinical scoring system to prioritize patients for VA creation to ensure appropriate use of OR resources, Increasing fistula rates in people who need them and decreasing the number pre-emptively created but not used; Ongoing monitoring of provincial and regional incidence and prevalence rates; and ongoing education activities.

Source:

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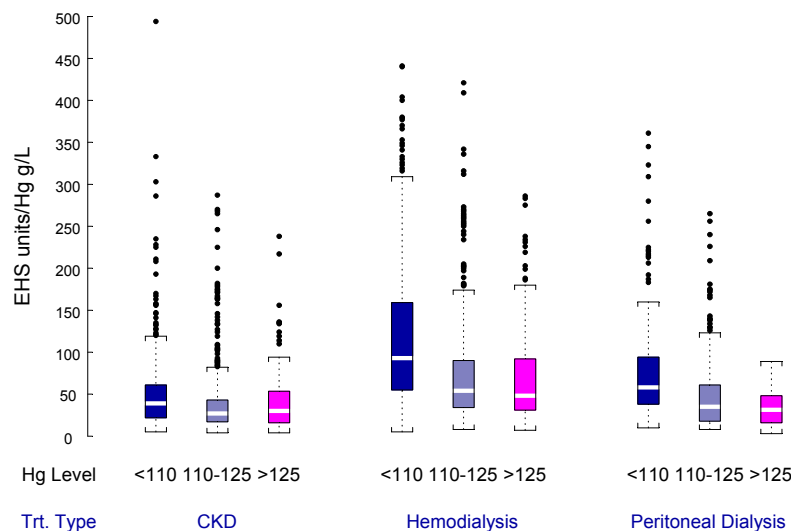
SERVICE COORDINATION AND DELIVERY

Updated: November 2010

Status	Trend	Target	Actual
TBD	→	>70%	Mdn: 27-93 units/g/L

8. Percentage of Patients with Optimized Drug Dose per Unit of Hemoglobin Achieved

ESA Weekly Dose per Hemoglobin Achieved by Treatment Type and Hemoglobin Level



Measure: Percentage of patients receiving optimized drug dose per unit of hemoglobin. Note: an optimum dose has yet to be standardized for incident or prevalent patients; therefore we cannot yet complete the measure and are unable to report percentages. As an interim step, we are reporting median dose/Hgb achieved, as trends have emerged that allow us to evaluate on this basis. The lowest ratio of drug to Hb in target is recommended.

Limitations: Although we know the current prescription patterns, an optimum dose has yet to be standardized, so we cannot yet complete the measure. While dosages continue to be dependent on individual unit prescribing patterns, there is a clear trend towards higher doses in those with lower Hgb; this may be due to starting doses or identifying sicker patients.

Significance: An optimum dose would facilitate medication best practices, namely efficiency of drug utilization and costs for optimum outcomes.

Drivers: Iron usage, patient factors (illness/ hospitalization), and physician practice factors.

PHSA Target: Before a decision can be made re: an appropriate target in terms of percentage of patients, the optimized drug dose associated with patient outcomes must be determined. Review of data and targets will be undertaken for BCPRA Pharmacy and Formulary Review committee, but we are suggesting ~70% of given

populations should have achieved lowest dose/ Hb range.

**Benchmarks and
Comparators:**

Not available.

Trend:

Within the province, we have been stable and see improvements in minimizing doses over time in all patient groups.

Comments:

This is a complex issue requiring more extensive research into best methodology for ensuring that this measure is not susceptible to biases and issues that would make it invalid or unstable. Preliminary results were presented to the Pharmacy committee, who would like to see serial data on this issue to determine stability of the finding and thus develop action plans to address issue of highest dosing in lowest achieved hemoglobin. This is consistent with data in publications, and is likely due to the fact that the sickest patients require the highest doses to achieve, or even approach, targets.

Action Taken:

Ongoing project to determine best methodology to express this value.

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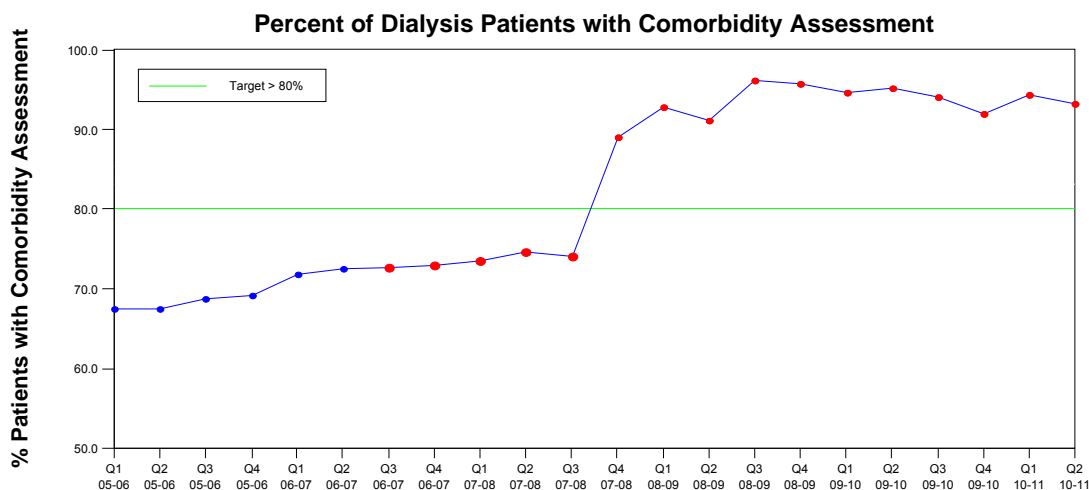
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LEARNING, GROWTH, AND INNOVATION

Updated: November 2010

Status	Trend	Target	Actual
●	→	≥ 80%	93%

9. Percentage of Patients with Comorbidity Assessment Available in PROMIS



Measure: Number of dialysis patients who have comorbidity assessment record entered in the form using categories as a percentage of all prevalent dialysis patients.

Limitations: None.

Significance: Clinically, categorical assessment facilitates communication between health care providers and reduces probability of error and misinterpretation. This measure is essential in interpreting patient outcomes and for planning. It enables adjustments in comparison between HAs and over time. Its presence in the database indicates adherence to data collection directives.

Drivers: User training and re-design of documentation generating processes in renal units.

PHSA Target: ≥ 80%.

Benchmarks and Comparators: Not available.

Trend: There are now over 93% (13% over the target value) of dialysis patients with comorbidity assessments recorded in PROMIS.

Comments: Regular reviews with HAs of CQI/planning data have fostered a better understanding of the importance of accurate/complete data. Increased training and responsiveness to user requirements has supported a steady improvement in data quality. This is a large undertaking, but has resulted in excellent improvement not just in data completion, but more importantly in our ability to more clearly define

outcomes using precise comorbidity data. This data will also allow us to review survival data with appropriate adjustments for age, diabetes and gender, which will improve the interpretability of the information.

Action Taken:

The application was revised (with input of the BCPRA Medical Advisory Committee and users) to increase the number of comorbidities captured, as well as the flexibility and user-friendliness of the application. Ongoing increase of PROMIS users training. The BCPRA Data Management Coordinator facilitates documentation process enhancements in renal units.

Source:

BCPRA Health Informatics and Methodology & Analytics; PROMIS (Patient Record/Registration and Outcomes Management Information System) - Provincial Registry of Chronic Kidney Patients, data extract October 2010 with SAS data transformations [computer files and programs] Lee Er [producer], Statistician, Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

LEARNING, GROWTH, AND INNOVATION

Updated: November 2010

Status	Trend	Target	Actual
●	→	> 0	11

10. List of New Knowledge Translation Initiatives

1. **Independent Hemodialysis Program:** provincially coordinated independent hemodialysis program with local implementation that promotes optimal patient care and system sustainability. This program has been the springboard for the development of independent care within structured settings (please see #8 and #9). Interest in emulating the “involved care unit” in Penticton grew substantially after representatives from the Fraser and Vancouver Coastal programs conducted a site visit in Sept 2010. In addition, two very successful patient forums about independent therapies were held in New Westminster and Penticton this fall. At BC Nephrology Days (attended by 450+ renal care providers) a plenary session tackled four myths related to independent therapies (infection rates, geographic influences on modality selection, whether partners are needed if dialyzing at home, and mortality rates). PD clinicians from all HAs are working with BCPRA and HSSBC to develop the RFP for the next peritoneal dialysis supply contract (expected to be issued in early 2011).
2. **Provincial Vascular Access Services Initiative:** a multidisciplinary, cross-province initiative designed to improve timely access to services and to reduce complications and hospitalizations related to vascular access. Current objectives: exploration of fistula creation in ambulatory care settings to address OR wait times; development of a clinical scoring system to prioritize patients for VA creation to ensure appropriate use of OR resources, increasing fistula rates in people who need them and decreasing the number pre-emptively created but not used; ongoing monitoring of provincial and regional incidence and prevalence rates (additional data is now gathered for all catheter starts; infection rates soon to be tracked); education: ongoing provincial VA rounds via webinar (the series has had strong attendance from surgeons, radiologists, nephrologists and allied disciplines); a 4-hour VA workshop has been offered to over 250 nurses in various centres to increase ability to manage vascular accesses and related complications; ongoing development of guidelines, all of which are posted to the BCPRA website
3. **Integrated Clinics for Complex Patients in SPH and Penticton:** model of care that recognizes the linkages between kidney disease, heart disease and diabetes.
4. **Anemia Management Protocol:** protocol that facilitates the implementation of anemia guidelines in HD patients by non-physician staff supports more efficient use of expensive medications (EHRT) and reduces time required by nephrologists for this aspect of clinical care. Through the implementation of guidelines, average medication dosages have been reduced with the same clinical and patient outcomes.
5. **End of Life Initiative:** the goal is to create a BC model for EOL care that promotes effective, integrated, patient-centered care based on best practices found locally, nationally and internationally. A task group, including experts in this field from outside BC, has finalized a provincial framework and guidelines for patient care. In May 2010, a two-day intensive workshop (attended by over 40 renal EOL champions) focused on patient identification and validated tools, symptom assessment and management with a strong focus on pain management, the role of advanced care planning, linkages with palliative care, and care strategies in the dying stages. Subsequent to the workshop the HA renal programs have reviewed their own structures, with the goal of enhancing EOL care for their renal patients. Current provincial activities include: development of a provincial pain algorithm; integration of an established patient screening tool (Edmonton Symptom Assessment Scale or ESAS) into PROMIS; gathering input from front line staff regarding web based learning tools.
6. **Pharmacoeconomic Review:** this initiative involves a review of the major classes of

medications that the BCPRA funds, with a focus on the major cost drivers (e.g. ESA, non-calcium phosphate binders, cinacalcet) and their efficacy in this complex patient group. An analysis of current processes and procedures, the cost and impact on outcomes, and evaluation of current processes will be undertaken so that a formal cost benefit evaluation can guide further policies.

7. **Peritoneal Dialysis Catheter Insertion Sustainability Project:** The bedside insertion of catheters for renal patients starting peritoneal dialysis (PD) is a cost-effective alternative to having catheters inserted by a surgeon in a hospital operating room. Bedside insertions enable shorter wait times for patients transitioning to PD as they are not subject to the availability of operating rooms. Additionally patients that undergo the bedside procedure require only local anaesthetic and are normally able to go home on the same day. Historically, bedside catheter insertions have only been available for patients in Fraser Health and Vancouver Coastal Health. To advance use of this technique throughout the province, the BCPRA oversaw the development of clinical guidelines, nursing care guidelines and patient information materials, and sponsored training for interested nephrologists and PD nurses. As a result, the procedure is now available for patients at Royal Inland Hospital in Kamloops and at Royal Jubilee Hospital in Victoria. Some surgeons have also expressed interest in learning the procedure and this option will be pursued.
8. **Nocturnal In-Hospital Self Managed Hemodialysis Program:** Nocturnal hemodialysis (NHD) enables patients to receive more dialysis and improve their health outcomes in a cost effective manner. Vancouver General Hospital offers patients the option to dialyze independently at the facility overnight, with 8 patients participating Monday/Wednesday/Friday from 2200 to 0600 hours. These patients are fully trained in all aspects of their care, with staff available for emergency situations only. Further expansion to operate the unit 6 nights per week will be considered over time. Other renal programs have expressed an interest in developing a similar program.
9. **Enhanced Patient Self Management in Structure Settings.** A number of hemodialysis patients are able to manage some, but not all aspects of their care, due to, for example, a difficult vascular access or anxiety about being on their own at home. Two sites in BC are formally providing options for enhanced self-management within structured settings (i.e. owned/leased by the HA, with renal staff). The Northern Health renal program, through the community dialysis unit located in Prince George, has an independent focus where nurses provide care on an “as needed basis” and some flexibility in scheduling is possible. The unit’s patients are trained on the machine used in the Home Hemodialysis Program, so they can transition to complete independence at home if they choose at any time. In February 2010, Interior Health’s Penticton unit launched an “involved care unit” within their in-centre unit. The program features a nurse navigator who works with each patient and the care team to define short and long term goals – from taking vital signs and doing machine checks, through to independent management of dialysis runs. Fully independent patients (currently 8) are integrated into the unit, which encourages and inspires others to work towards their maximum independence.
10. **Medication reconciliation:** A process designed to prevent medication errors at patient transition points and improve patient safety; medication reconciliation is now a requirement for hospital accreditation and is expected to become standard practice for acute care patients across Canada. To our knowledge, it has not been extended to chronic care outpatients anywhere else in the country – despite the fact that chronic renal patients, with their needs for multiple medications (an average of 19), and frequent prescription changes and hospitalizations, are at a higher risk than most patients for medication errors. The BC Provincial Renal Agency is providing provincial leadership for a standardized medication reconciliation process for dialysis patients across the province. The program will further expand to pre-dialysis and transplant patients in later phases. Accomplishments to date include: formation of a provincial, multidisciplinary medication reconciliation leadership group; allocation of additional funding to health authority renal programs to support med rec uptake (through hiring of additional pharmacy technicians); development of a series of reports and forms in the renal clinical

information database (PROMIS), ensuring that the process flows from the outpatient setting through to any hospital in the province; cross-province education sessions and an online tutorial for use of med rec reports and tools in PROMIS; and development of additional med rec support tools, including a patient interview guide. 2010 priorities include setting a provincial standard for frequency of reconciliations and developing med rec timelines for patients on different dialysis modalities. In June, BCPRA received a HEABC Excellence in BC Healthcare Award in the Collaborative Solutions category for the med rec initiative.

11. **General Practitioner Education:** In January 2011, the BC Renal Agency is sponsoring a one-day CME course for family doctors on how to improve care for patients with kidney disease. Topics will include: methods for estimating renal function, management guidelines for CKD, evidence-based treatment for hypertension, when and how to refer patients to a nephrologist and strategies to enhance end-of-life care.

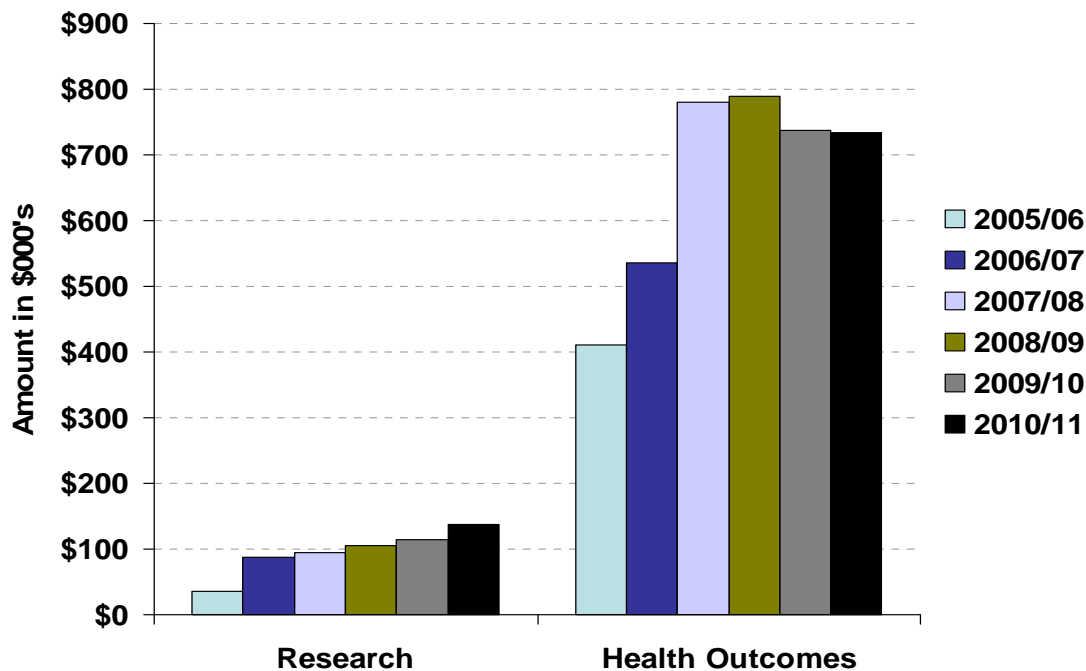
Measure:	Itemization of all initiatives that involve change from existing practice or implementation of new practices to improve care quality, efficiency, effectiveness and outcomes.
Limitations:	Reporting of all activities by HA renal programs is currently not a requirement. Definition of change initiatives may vary by HA or renal program. Current list captures initiatives with significant BCPRA involvement/leadership.
Significance:	By interfacing new knowledge with change in practice, programs can improve care delivery, patient outcomes and system sustainability.
Drivers:	Support structures within institutions or HA to facilitate change; cross-program, cross-HA knowledge sharing and learning.
PHSA Target:	> 0.
Benchmarks and Comparators:	None available.
Trend:	Stable
Comments:	
Action Taken:	Continued support at a provincial level for such initiatives.
Source:	BCPRA Administrative Support; project tracking process [manual], Meganne Sholdice [producer], Project Administrative Coordinator, BCPRA; Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement; Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BCPRA Administrative Support.

LEARNING, GROWTH, AND INNOVATION

Updated: November 2010

Status	Trend	Target	Actual
●	↑, →	> \$100,000 per annum	Research = Actual \$136,926 Health Outcomes = Actual \$733,507

11. Total Funding for Research and Health Outcomes Initiatives



- Measure:** Describes dollar value of current, direct funding that the BCPRA uses to support research activities of the community. Dollar values attributable to these functions are reported.
- Limitations:** Note that funding for projects within the renal community that support change or specific research projects are not necessarily related to BCPRA, but to general groups at the UBC Division of Nephrology and individual researchers at specific institutions and health authorities; as such, the numbers stated in this indicator do not capture total grant dollars.
- Significance:** The direct support of research activities by the BCPRA from the administrative budget describes the true integration of research into the fabric and function of the agency. Grants awarded to members of the renal community (BCPRA constituents) may reflect the importance that funding agencies confer on the BCPRA associated researchers, but would not be a fair reflection of efforts.
- Drivers:** Availability of researchers, availability of research dollars/ industry or other to support initiatives.
- PHSA Target:** > \$100,000 per annum.
- Benchmarks and** Not applicable.

Comparators:

Trend: Slight increase in funding for 2010/11.

Comments: In order to increase applied research within the renal community, BCPRA is funding a part-time methodologist and advisor, as well as statistical support personnel. With respect to health outcomes initiatives, the BCPRA component of this funding is related to organizational support, coordination, and evaluation.

Action Taken: Increasing awareness of the potential for research collaboratively throughout the province; increasing integration of policy and health research by supporting Fellowships in Health Administration directly for nephrology trainees.

Source: **BCPRA Business Planning;** *PeopleSoft extract with excel transformations* [computer files and programs], Eryn Amano [producer], Manager, Financial Planning & Analysis, BCPRA Business Planning; Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

LEARNING, GROWTH, AND INNOVATION

Updated: November 2010

Status	Trend	Target	Actual
●	→	> 0 per HA	17 - 46 per HA

12. Number of Educational Events Held in Each Health Authority

HA	Training/ In-services	Conferences/Workshops/Activities
PHSA (C&W)	8	10 (Annual Dialysis Conference, American Society of Nephrology, BC Nephrology Days, CANNT, Canadian Society of Nephrology, International Pediatric Nephrology Association, International Society of Peritoneal Dialysis, Society of Pediatric Research, Western Society of Pediatric Nephrology, World Congress of the Transplantation Society)
FHA	13	4 (Advance Care Planning Conference, Annual Dialysis Conference, BC Nephrology Days, IHA Renal Education Days)
IHA	19	6 (ANNA National Symposium, BC Nephrology Days, IHA Renal Education Days, World Congress of the Transplantation Society)
NHA	13	7 (BC Nephrology Days, CANNT, Dieticians Conference, Canadian Pharmacy Conference, National Kidney Foundation Conference, International Society of Peritoneal Dialysis, Contegritty Leadership Course for Managers)
PHC	26	20 (American Transplant Congress, ANNA National Symposium, Baxter Symposium, BC Nephrology Days, BCNPA Conference, Canadian Renal Administrators Collaborative, Canadians Society of Nephrology Conference, CANNT, CANSW 31st Annual Conference, Ethel John's Research Forum, Health Care Leaders Conference, IHA Renal Education Days, International Chronic Disease Conference, National Kidney Foundation Conference, Northwest Renal Dietitians Conference, Provincial Renal Transplant Meeting, Renal Update 2010, The Evolution of Psychotherapy Conference, World Diabetes Congress, World Congress of the Transplantation Society)
VCH	14	5 (BC Nephrology Days, CANNT, Decision Support for Patients with CKD, Engaging Learners, Hope Tools that make a difference)
VIHA	19	10 (BC Nephrology Days, CANNT, CANSW, IHA Renal Education Days, Community Dialysis Facility Education Day, North West Renal Dieticians Conference, Disclosure workshop.)

Measure: List of formal events for health care professionals at the provincial, regional, and institutional levels (as available) reported for the period of Q3 2009 through Q2

2010.

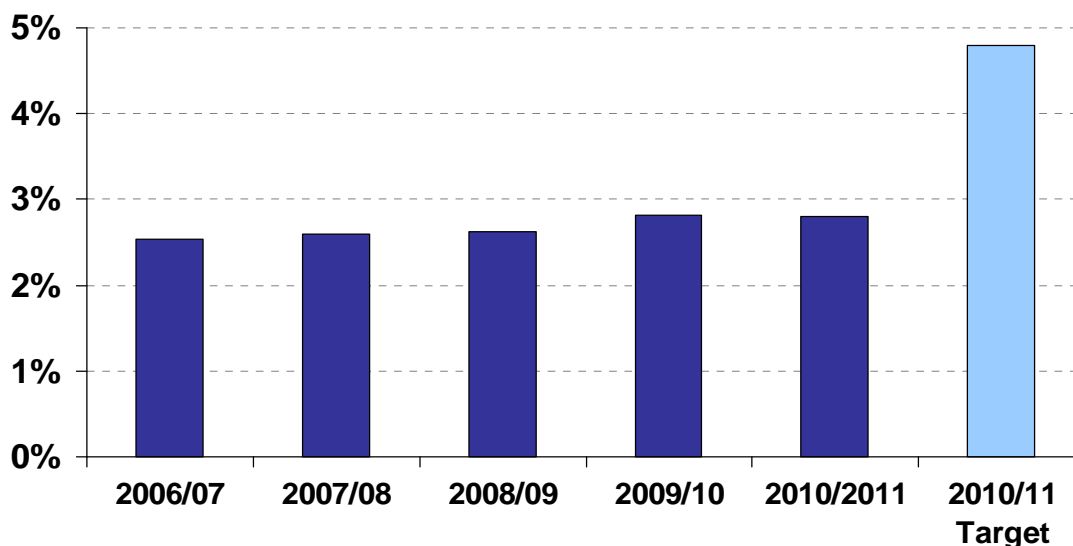
Limitations:	This measure is obtained through renal programs surveys and depends on their capabilities to track and report educational events.
Significance:	This measure is an indicator of commitment to staff education and growth, and may be correlated to improvements in staff morale, care delivery improvements, etc.
Drivers:	Availability of resources to fund educational activities; commitment of senior administration to ensure education is a priority. Critical mass required to be able to ensure attendance does not interfere with clinical work. Smaller communities may be disadvantaged.
PHSA Target:	> 0.
Benchmarks and Comparators:	Not applicable.
Trend:	Average number of events is stable
Comments:	The significant number of events speaks to the value placed on education and knowledge sharing, as well as the vibrancy of the renal care community.
Action Taken:	Continue support and organization of educational events.
Source:	BCPRA Administrative Support ; <i>survey of regional educational activities</i> [manual], Meganne Sholdice [producer], Project Administrative Coordinator, BCPRA; , Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

LEARNING, GROWTH, AND INNOVATION

Updated: November 2010

Status	Trend	Target	Actual
●	→	≤4.8%	2.80%

13. Staff Sick Leave as a Percentage of Regular Paid Hours



Measure:	Paid staff sick hours as a percentage of regular paid hours (regular hours, stats, vacation, sick & other paid leave).
Limitations:	Due to small staff complement at BCPRA (n=34), a high rate of sick leave by one staff member can skew the overall rate.
Significance:	A measure of staff productivity, morale, and commitment to the organization.
Drivers:	Adequate and appropriate staff resources to support the BC Renal Networks, including BCPRA administrative functions, key business areas (finance, IM/IS) and various committees and working groups; staff morale and recognition.
PHSA Target:	To reduce all sick hours by 10%.
Benchmarks and Comparators:	PHSA rates over time: 2005/06 = 5.40%; 2006/07 = 5.42%; 2007/08 = 4.96%; 2008/09 = 5.16%; 2009/10: PHSA Corporate = 4.80%; BCCDC=3.98%; C&W = 5.50%; BCCA = 3.88%; BCTS = 3.05%; RVH = 8.57%; FPSC = 7.65%.
Trend:	Slight decrease since last report, from 2.82 to 2.80%.
Comments:	The current 2010/11 sick leave rate (2.80%) is below the targeted PHSA rate.
Action Taken:	BCPRA continues to provide a supportive and positive environment that fosters commitment and a sense of meaningful contribution.
Source:	Combined payroll reports from Providence Health Care and PHSA HR. PHSA HRTS (Human Resource Technology Solutions) , Peoplesoft-BI Data Warehouse (Extracted April 2010) [computer file and program, manual], Wong, Jeff

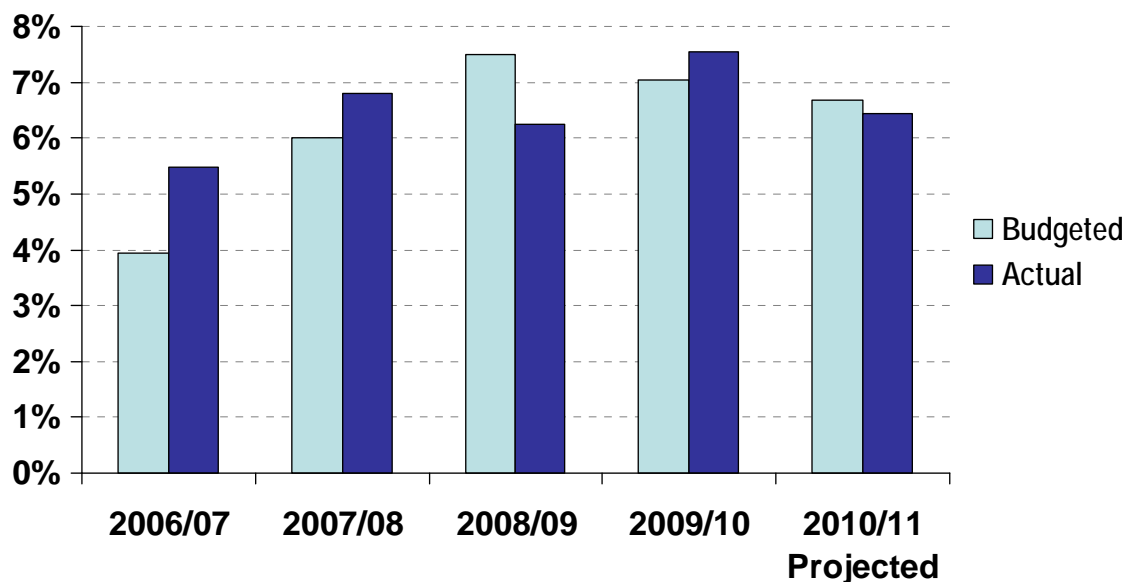
[producer, reviewer, distributor], Specialist – Workforce Metrics, PHSA Human Resources Technology Solutions.

FINANCE

Updated: November 2010

Status	Trend	Target	Actual
●	↓	≥ 6.6%	6.43% Q2 Projection 6.69% Budgeted

14. Non-MoH Revenue as a Percentage of Total Revenues



Measure:	Total Medbuy rebates as a percentage of total revenues (Grant & Rebates).
Limitations:	None.
Significance:	Additional non-MOH revenue reduces overall costs and hence life support funding needs.
Drivers:	Rebates based on actual purchases of medical/surgical supplies and renal medications.
PHSA Target:	2010/11: 6.43%, 14.75% decrease from 7.54% for 2009/10.
Benchmarks and Comparators:	2006/07: BCCDC = 1.22%; BCMHS/Riverview = 1.73%; FPSC = 0.33%; BCTS = 0.18%; C&W = 6.67%. <i>[NB: The calculation used by other PHSA agencies is different than that used for BCPRA due to funding differences, so data may not be exactly comparable.]</i>
Trend:	Non-MOH revenues decreased slightly from 7.54% to 6.43% due to increased budget base (denominator) and relatively same rebate dollars.
Comments:	Non-MOH revenue includes the rebates from provincial contracts for medical/surgical supplies and renal medications. The percentages are based on the MOH grant received at PHSA. The rebates are credited based on expenses incurred by each department (i.e., to each renal unit).
Action Taken:	Ongoing contract monitoring and strategies to increase potential from large

contracts currently in place.

Source:

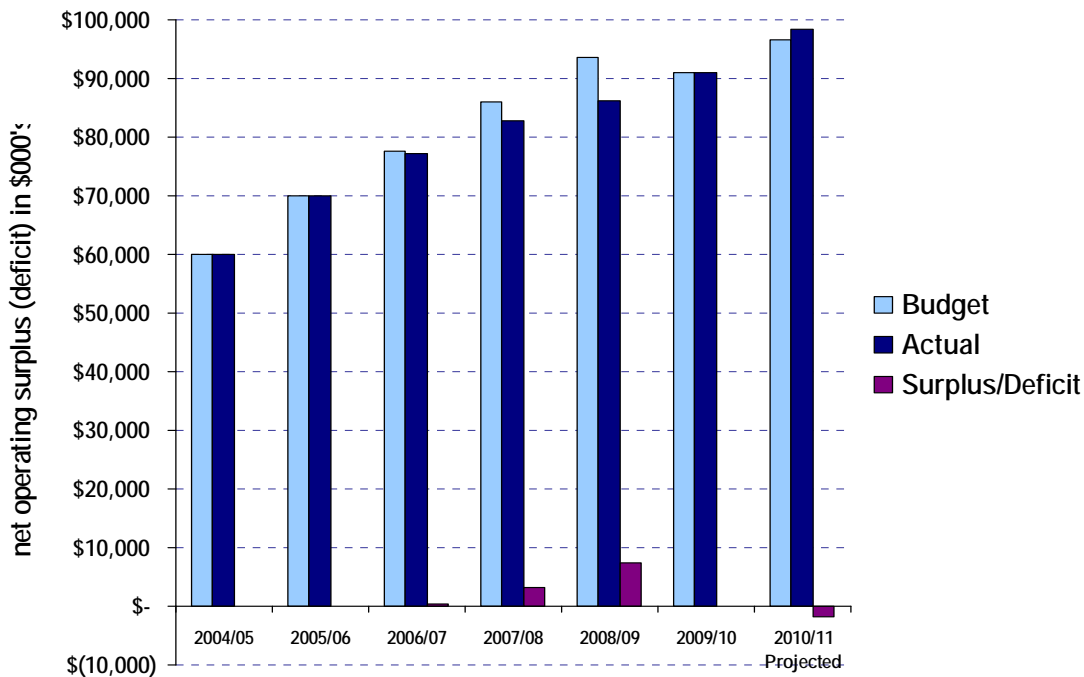
BCPRA Business Planning; *PeopleSoft extract with excel transformations* [computer files and programs], Eryn Amano [producer], Manager, Financial Planning & Analysis, BCPRA Business Planning; Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

FINANCE

Updated: November 2010

Status	Trend	Target	Actual
●	↓	≥ \$0	(\$1,803,311) Q2 Projection

15. Net Budget Surplus (Deficit)



Comments: BCPRA ended the second quarter of 2010/11 with a deficit of 1.181M. To date, actual in-centre dialysis patient volume is higher than budget by 5 pty or 0.8%, while independent dialysis patient volume is lower than budget by 12 pty or 3.1%. Though net referred out to HA is on budget, the actual cost of supplies and medications per patient year is higher than budgeted (10/11 budget being lower than 09/10 actuals, due to budgetary constraints), which results in the year-to-date deficit. BCPRA forecasts a deficit of 1.8M by the end of the fiscal year. In collaboration with the MoHS, PHSA/BCPRA is exploring options to resolve the projected deficit.

Action Taken: Continued analysis of funding model and opportunities for fiscal efficiencies and improvements. Although the BC dialysis growth rate in recent years was below the national average (6-8% vs our 3-4%), the rate is beginning to increase as a percentage of patients who have been able to delay dialysis for a number of years through early intervention ultimately require renal replacement therapy.

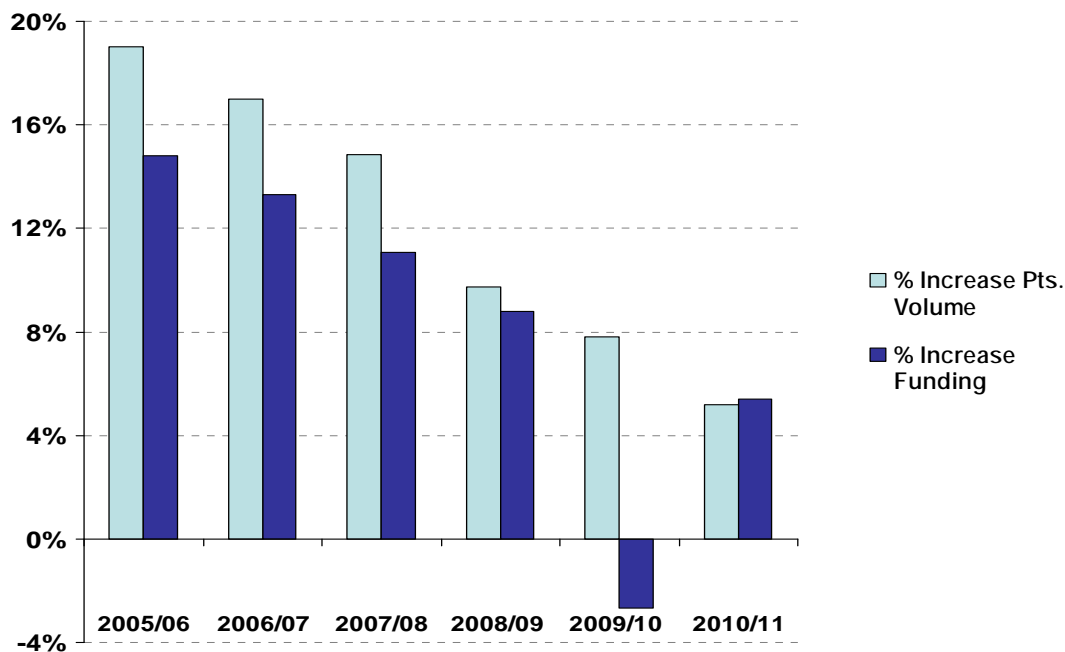
Source: **BCPRA Business Planning;** PeopleSoft extract with excel transformations [computer files and programs], Eryln Amano [producer], Manager, Financial Planning & Analysis, BCPRA Business Planning; Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.

FINANCE

Updated: November 2010

Status	Trend	Target	Actual
●	→	≤11%	Q2 Projections Pt Vol: 5.18% Funding: 5.40%

16. Budget Growth Less than Population Growth



- Measure:** Growth in renal patient years compared to growth in renal life support funding per year.
- Limitations:** Variations in patient volumes and case mix from the funded levels.
- Significance:** The ability of BCPRA to offset volume growth by ensuring efficiencies in care delivery is demonstrated by this statistic. Clearly, as each patient incurs substantial costs for the system, the ability to dissociate funding from volume is an indicator of prudent system management as well as capitalizing on non MOH revenue sources like vendor rebates, to offset costs and reduce the need for MOH funding.
- Drivers:** Patient volumes and case mix; fiscal efficiencies.
- PHSA Target:** ≤ 11%. Cost containment while maintaining high quality care.
- Benchmarks and Comparators:** No other healthcare program in BC or Canada has a comparable funding per patient model.
- Trend:** Patient years have continued to increase at a percentage rate higher than the percentage increase in funding – as of Q2 of 2010/11 actual growth in patient volume (CKD and dialysis) was 5.18%, and the funding was increased by 5.40%. Note also that the percent growth in the total population per year is increasing. The

renal community has worked together to maximize innovation and cost effective patient care.

Comments:

Starting in fiscal year 2009/10, a slow increase in dialysis patients has been noted (from the lowest growth of 1% in 2008/09), which we believe is multi-factorial. Improving survival from cancer, cardiac disease, and other chronic diseases has led to growth in an “at risk for kidney disease population” as well as improving CKD care, which leads to delay of time to dialysis or transplantation. Thus, people starting dialysis have been known in the system, have been maximally cared for, but eventually require dialysis (or transplant) therapy. In the past, these patients may have died before dialysis was required. This ‘success’ in care has led to a growth in patient numbers.

The ability of the renal community to maintain a relatively low growth rate may be a reflection of the province-wide prevention and early detection activities that have been in place for the last 5-7 years. Of note, however, disease progression is delayed by these strategies, not necessarily stopped, so it is not unexpected that BC is now seeing an increased growth in dialysis, which may continue in the years ahead.

Action Taken:

Continued analysis of funding model and opportunities for fiscal efficiencies and improvements.

Source:

BCPRA Business Planning; *PeopleSoft extract with excel transformations* [computer files and programs], Eryn Amano [producer], Manager, Financial Planning & Analysis, BCPRA Business Planning; Gloria Freeborn [reviewer], Director, Strategic Organizational Development and Stakeholder Engagement, Ognjenka Djurdjev [reviewer, distributor], Senior Officer Methodology & Analytics, BC PRA Methodology & Analytics.