NATIONAL NEPHROLOGY DIRECTOR'S MEETING
WORLD CONGRESS OF NEPHROLOGY
VANCOUVER, BC
APRIL 10, 2011

MINUTES

ATTENDEES: Dr. Andrey Cybulsky, Dr. Kailash Jindal, Dr. Peter Magner, Dr. Brendan Barrett, Dr. Martin Bitzan, Dr. Ted Toffelmire, Dr. Steven Soroka (for final 20 minutes)

REGRETS: Dr. Julian Midgley

CO-CHAIRS: Dr. Nairne Scott-Douglas, Dr. Joanne Kappel

The meeting was called to order at 0700 hours.

Dr. Kappel welcomed everyone to the first National Nephrology Director's Meeting. She explained that the background for this meeting was Dr. Nairne Scott-Douglas' initial organization of a Western Canadian Division Director's meeting in Lake Louise in 2009 with two subsequent teleconferences. It was felt that a national meeting of Nephrology Division Heads would be helpful and that the meeting should be held in conjunction with the CSN meeting. Dr. Tonelli, CSN President asked Drs. Kappel and Scott-Douglas to organize the meeting. Sandra Kelly provided staff support. Division Heads and/or Program leads were contacted – 10 replied.

PROGRAM OVERVIEWS

Everyone present gave a brief overview of their program commenting on clinical service delivery, models of care, funding and administrative structure. Areas/programs of excellence and problems were highlighted.

Dr. Nairne Scott-Douglas

- Physician and administrative lead for Southern Alberta Renal Program, Alberta Health Services
- Division Director University of Calgary
- Envelope funding – have to operate within this envelope of money.
- Clinical service: ~1000 dialysis patients, 800 HD/200+PD, 68 nocturnal HD patients. Have a strong modality-teaching program. Alberta Health Services wanting a strong rural medicine and telemedicine focus.
- Work closely with Northern Alberta Renal Program on protocols ie pain management.

- Current projects: Advanced care planning, PD home assist program, initiatives on First Nation reserves
- Have a central system for triaging new referrals.
- Some challenges: rapid growth in certain areas of southern Alberta, increasing number of geriatric patients

Dr. Ted Toffelmire

- Division Head of Nephrology, Queen's University until retirement in July 2011 – Dr. Ross Morton will be assume the role.
- Number of individuals oversee the program but Division Head is the only voice to senior administration.
- Funding is given to the hospital not directly to the Renal Program. Ministry does review how much/where money is spent and can claw back money.
- Clinical service: ~460 HD patients, 60 PD patients, and 400 transplants with 120 Incentre HD patients with the rest in satellite units. Patients are seen in satellite units.
- A challenge: Division Director does not have a lot of decision-making power as must report to Department of Medicine head.

Dr. Martin Bitzan

- Division Head of Pediatric Nephrology, McGill University
- Clinical service: small ESRD program with 2-5 on HD, 2-6 on PD, waitlist for renal transplantation no more than a few weeks, CKD program follows about 60 patients.
- Major teaching focus with one fellow and 2 international fellows. Also major teaching commitment with the University, and pediatric residency program.
- Four of six medical staff are mainly occupied with research, two with clinical epidemiology research and two with the ISN Sister Dialysis Program in India providing education etc.
- Substantial salary support.

Dr. Peter Magner

- Division Head, University of Ottawa
- 20 nephrologists – 11 fulltime clinical nephrologists. Two smaller hospitals with no ESRD services. Multiple satellite units.
- Clinical service: ~20,000 visits, 800 transplant/650 HD/200 PD. Must cover several hospital sites daily
- Challenges: Nephrologists must cover several sites, which erodes academic time.
- Funding is given to the hospital, which has been reasonably generous. Division Head fairly involved with funding group.
- Department Head more involved now, which may present a problem.

Dr. Andrey Cybulsky

- Division Head, McGill University
- Clinical Service: covers 4 hospitals, services are broad. ~90 transplant pt/~300 HD patients between 2 hospitals/50-60 PD patients. Small home HD program as cannot expand due to lack of funds.
- Nurse Manager runs financial aspect of the Program. There is stable funding but very tight.
- Should be moving into a new hospital. There are 3 satellites with a 4th opening soon.
- Significant teaching component. Four basic sciences labs. Several nephrologists due clinical epidemiological research. Several involved in industry sponsored research.
- A challenge: no provincial dialysis network.

Dr. Brendan Barrett

- Division Head, Memorial University and Provincial Lead for Renal Services
- Funding - no dedicated funds for renal services. Administrator is the Department of Health.
- Teaching is done through hospitals and health regions.
- Major teaching commitment at Memorial University
- Clinical service: Very high numbers of people on dialysis (highest per capita in country). Managed by distance. Telehealth widely used. No transplant program – all done in Halifax
- Some challenges: a lot of travel for nephrologist to satellite units.

Dr. Kailash Jindal

- Acting Director of Nephrology, University of Alberta
- Regional Clinical Program Director, Northern Alberta Renal Program
- Clinical service: Extensive network of CKD clinics. Rural nephrology program has been initiated. Nephrologists travel to rural areas for satellite HD clinics, CKD clinics. Telehealth used for followup.
- Funding similar to SARP.
- Active research group with enough time for same.

Dr. Joanne Kappel

- Division Head, University of Saskatchewan
- Dyad Co-Lead for Renal Services for Northern Saskatchewan
- Funding is given directly to Renal Program and based on volumes. If volumes increase so does funding.
- Clinical service: ~450 transplants/~300 HD/110 PD patients. Small home HD program initiated in May 2010. Large CKD clinic for northern SK. Telehealth very active.
- Major teaching commitment with University of Saskatchewan.

CLINICAL SERVICE DELIVERY

- It was noted that there are a lot of differences between programs but that we could learn more from each other, as there are benefits to information sharing with regards to clinical services, delivery of care, administrative structure etc
- <u>Areas of success that should/could be translated to all programs</u>:
  - Provincial Dialysis Network
  - Pandemic Planning
  - Innovative models of care delivery
    - Using Incentre unit for nocturnal HD program for homeless people in a large urban centre.
    - Using a HD satellite unit in a Long-term care facility for HD of local residents and as a nocturnal unit for those in the LTC facility.

- <u>Areas that need to be further pursued</u>:
  - Nephrology Human Resource (ie; nephrologists) Needs
    - This was felt to be important information for the Training Programs as we have a responsibility to the trainees with regards to accurate information about job opportunities. There is very poor advertising about available jobs in the country.
    - The last CSN manpower survey was done in 2007 by Dr. Barrett (copy attached). Very challenging to do as everyone evaluates "needs" on a different basis.
    - Difficult to determine manpower needs and who should do it? There was discussion whether this was work for the CSN Executive/Council or whether this was an issue for the National Directors. There was no decision.
    - Discussion occurred around how many patients should a nephrologist take care of. Reference was made to Dr. David Hollomby's study several years ago that stated the optimal number of ESRD patients is about 60 per nephrologist. Some nephrologists are taking care of 300 – 400 ESRD pts (financial remuneration is a factor in this). Can the quality of care and patient outcomes be linked to the number of patients per nephrologist? Is there literature on this? What measures of quality of care should be used – Standardized mortality ratio is not one of them. How would this be done?

  - Workload measurement for dialysis staff
    - There is a lot of "downtime" after the patients have been put on HD. Discussion occurred about staggered nurse and patient start times.
    - What is the appropriate RN – patient ratio? Acute: !:2, Chronic 1:4 although it appears that 1:3 is still the standard.

        - What is the role of other members of the multidisciplinary team? Can there be efficiencies in using other individuals – ie LPNs, dialysis technicians. Significant "push back" from nursing union.
        - This is important for small units, which can be very inefficient and expensive to operate.

    - Isolation Protocols
        - Different protocols in the different units despite CDC and previous CSN guidelines on isolation of Hepatitis B and C individuals. Should have universal precautions.
        - This needs to be made clearer.

    - Sharing of Care Protocols
        - See below

- <u>Strategies to Reach High Risk Populations</u>
    - Difficult to engage First Nation's population at times. In order to provide care, need to do a lot of "up front" work and relationship building.
    - Need to take the clinic to the patient – this means the nephrologist has to travel to these rural and remote areas. Not all nephrologists are willing to do this. NARP members regularly travel – may stay overnight and do clinics for 4 days. The philosophy in NARP is that if you promise to deliver rural care you have to deliver it. Travel is used in workload measurement for the nephrologist – ie 4 days of travel is 8 days of work. In Ottawa 4 –5 share coverage and travel 1-2 times per month. In Nfld, all travel and share equally, although this does depend on the goodwill of the nephrologist. In SK, nephrologists do not travel – reason young families.

- <u>Evidence-Based Protocols</u>
    - Some programs have a lot of protocols whereas others have few to none.
    - Protocol development often led by other members of the team such as pharmacists – the number of pharmacists may be a limiting factor.
    - In Ottawa the clinical practice group develops the protocols, a draft is sent to all nephrologists before implementation.
    - Sharing of Protocols would be useful. NARP has an extensive number of protocols and are willing to share. It was agreed that perhaps the CSN website (Members only section) would be the venue for having a national data bank of care protocols. There would need to be a process by which the protocols were dated and had a "user beware" statement.

- Shared services nationally and between regions
  - There was brief discussion about several provinces agreeing to bulk buying of dialysis supplies. Some felt this might be advantageous while others felt this would be too costly.

SUMMARY OF WORK TO BE DONE

- Standardize Isolation Protocols for Hepatitis/HIV
- Standardize patient to nurse ratio by patient's acute needs
- Determine maximal nephrologist to patient ratio
- Determine Canada wide, provincial and local nephrologist manpower needs
- Contact CSN regarding secure use of website for posting and sharing of program protocols.

MEETING WRAP-UP

The attendees felt that the discussion was valuable and that further meetings should be held with one face-to-face meeting per year with perhaps one meeting via video or teleconference. Information sharing is important such as clinical protocols, hot issues, suppliers, use of the CSN website for community practice. It was noted that some programs have more issues than others but instead of reinventing the wheel, we should share what everyone currently has and does.

The meeting was adjourned at 0910 hours.