All About YOU Review

Life Planning and Plan of Care Toolkit

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Introduction

The "All About YOU Review" Plan of Care Toolkit has been developed in collaboration with patients, care partners, providers, and renal community partners with the aim of increasing patient engagement and patient-centered care. Care teams should assist patients in development of a Life Plan from which an individualized plan of care is created.

What is the difference between a Life Plan and a Plan of Care?
A life plan is a roadmap to help patients get the things that mean the most to them. A life plan is built around personal goals and dreams. The goals can be things such as going back to school or work, volunteering, traveling to a place they always wanted to visit, or spending time with family. The dialysis care plan is about kidney care and health. The goals focus on things like dialysis routine and treatment choice. The development of an individualized plan of care in which the patient and family members and/or care partners are actively engaged in the process can help to facilitate positive treatment outcomes. Studies have shown that patients who take an active role in their healthcare actually have better health outcomes and can incur less medical costs compared to their unengaged counterpart[2].

Several key patient "engagement" behaviors have been identified and include:
- communication with healthcare professionals;
- making good treatment decisions by gathering information and asking questions about various treatment options,
- participating in treatment, and
- seeking health knowledge[1].

During the development of the toolkit, Patient Subject Matter Experts (SMEs) have emphasized the importance of patients being engaged in their care as part of their care team. Being an engaged member of the care team can help ensure that a patient's Life Plan is being followed and both the Life Plan and Plan of Care for dialysis are adjusted as needed. Patient SMEs shared that most of the time patients do not know it is an option to attend their Plan of Care meetings and if they do, they are not aware what is discussed and why it is important to be involved. There also is no differentiation between their monthly assessments and the actual plan of care. Additionally, they shared that "plan of care" sounds like a technical term pertaining to the care team staff rather than something that is meaningful to individual patients. The intent was to re-brand the plan of care to show patients that it truly is an All About YOU Review, with the patient taking a lead role in discussion about their goals and needs when developing their individualized plan of care with the team. Your All About YOU Review should help you achieve the goals you've set for your life outside of dialysis.

1) Centers for Advancing Health. A new definition of patient engagement: what is engagement and why is it important? (2010). Washington ,D.C.
2) "Health Policy Brief: Patient Engagement," Health Affairs, February 14, 2013

The resources included in the toolkit are meant to be incorporated into your practices as a starting point to re-brand and improve patient engagement in the development of their plan of care. In addition to the resources that were developed, this toolkit also includes an Appendix with other supporting documentation and guidance on conducting successful plan of care meetings with your patients.

Engaging patients through the process of shared decision-making can have a significant impact at your facility—1) engaged patients tend to be more satisfied with their care, which improves your facility's patient satisfaction scores; 2) engaged patients tend to have better health outcomes and have less medical expenses; and 3) the ESRD Core Survey puts a strong emphasis on patient satisfaction and patient involvement in their plan of care.

Thank you for your dedication to the patients you serve and your interest in improving the plan of care process by using the "All About YOU Review" Plan of Care toolkit. We hope that you will find it helpful.

Getting Started

Here is a quick overview of what you need to do to get started to utilize the "All About YOU Review" Plan of Care toolkit to improve patient participation in their plan of care meetings.

- Review the materials in your "All About YOU Review" Plan of Care Toolkit.
- Identify which patients are due for plan of care meetings and begin to use the toolkit resources.
- Host the staff in-service to discuss the project. Provide a copy of the "Getting Off to the Right Start with Plan of Care" staff guide handout for each staff member attending.
- Distribute "All About YOU Review" patient overview flyers to all patients to encourage them to attend in the future.

Monthly

Determine which patients are due for an All About YOU Review (plan of care) each month and write their names down on the Plan of Care Prep Checklist. For each patient due for the plan of care that month, take the following action steps:

1. Provide patient with invitation (even if done chair side).
2. Collect the patient's input at the bottom of the invitation to prepare your team for what the patient wants to discuss.
3. Review patient's most recent KDQoL.
4. Host plan of care meeting, utilizing patient input, and help patient set SMART (Specific, Measureable, Attainable, Realistic, Timely) goals.
5. Deliver and then collect patient's follow up questionnaire.

Discuss and document the progress made during your facility Quality Assurance Performance Improvement (QAPI) team meetings.

Tools & Resources Instructional Overview

Patient Overview Handout

Description

The "All About YOU Review" patient overview is a two-sided marketing flyer to promote the concept of the All About YOU Review to your patients. On the front side, this patient handout breaks down and explains the Who, What, When, and Why of the All About YOU Review. The backside has quotes from the Patient Subject Matter Experts (SMEs) regarding the importance of being engaged in their care and participating in their All About YOU Review.

Instructions

Print and distribute copies of the handout to all of your patients within the first month of implementing the toolkit, even if they are not due for a plan of care that month. You want to bring awareness about this approach to all patients.

Set a Goal to Thrive

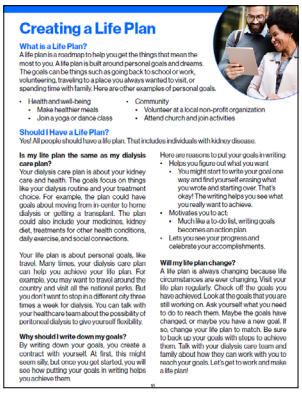
Description

"Set a Goal to Thrive" is a two page patient handout developed to help encourage patients to set goals. The front side explains and provides an example of a S.M.A.R.T. goal and the back side provides space for the development of a personalized S.M.A.R.T. goal.

Instructions

Print and provide a copy of the handout to the patient prior to the plan of care meeting, reviewing the concept of a S.M.A.R.T. goal and how it can benefit them and ensure that their goals are incorporated into their plan of care. Consider using the tool when completing your assessment prior to the plan of care meeting, then incorporating the patient's goal(s) into the Plan of Care document.

Life Planning Handouts



Creating a Life Plan

What is a Life Plan?

A life plan is a roadmap to help you get the things that mean the most to you. A life plan is built around personal goals and dreams. The goals can be things such as going back to school or work, volunteering, traveling to a place you always wanted to visit, or spending time with family. Here are other examples of personal goals.

- Health and well-being
  - Make healthier meals
  - Join a yoga or dance class
- Community
  - Volunteer at a local non-profit organization
  - Attend church and join activities

Should I Have a Life Plan?

Yes! All people should have a life plan. That includes individuals with kidney disease.

Is my life plan the same as my dialysis care plan?

Your dialysis care plan is about your kidney care and health. The goals focus on things like your dialysis routine and your treatment choice. For example, the plan could have goals about moving from in-center to home dialysis or getting a transplant. The plan could also include your medicines, kidney diet, treatments for other health conditions, daily exercise, and social connections.

Your life plan is about personal goals, like travel. Many times, your dialysis care plan can help you achieve your life plan. For example, you may want to travel around the country and visit all the national parks. But you don't want to stop in a different city three times a week for dialysis. You can talk with your healthcare team about the possibility of peritoneal dialysis to give yourself flexibility.

Why should I write down my goals?

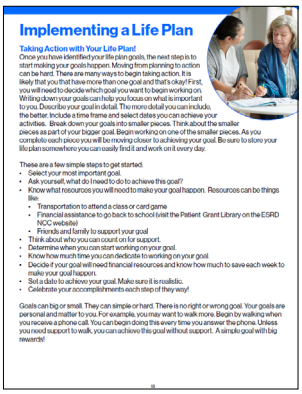
By writing down your goals, you create a contract with yourself. At first, this might seem silly, but once you get started, you will see how putting your goals in writing helps you achieve them.

Here are reasons to put your goals in writing:

- Helps you figure out what you want
  - You might start to write your goal one way and find yourself erasing what you wrote and starting over. That's okay! The writing helps you see what you really want to achieve.
- Motivates you to act.
  - Much like a to-do list, writing goals becomes an action plan.
- Lets you see your progress and celebrate your accomplishments.

Will my life plan change?

A life plan is always changing because life circumstances are ever changing. Visit your life plan regularly. Check off the goals you have achieved. Look at the goals that you are still working on. Ask yourself what you need to do to reach them. Maybe the goals have changed, or maybe you have a new goal. If so, change your life plan to match. Be sure to back up your goals with steps to achieve them. Talk with your dialysis care team and family about how they can work with you to reach your goals. Let's get to work and make a life plan!



Implementing a Life Plan

Taking Action with Your Life Plan!

Once you have identified your life plan goals, the next step is to start making your goals happen. Moving from planning to action can be hard. There are many ways to begin taking action. It is likely that you that have more than one goal and that's okay! First, you will need to decide which goal you want to begin working on. Writing down your goals can help you focus on what is important to you. Describe your goal in detail. The more detail you can include, the better. Include a time frame and select dates you can achieve your activities. Break down your goals into smaller pieces. Think about the smaller pieces as part of your bigger goal. Begin working on one of the smaller pieces. As you complete each piece you will be moving closer to achieving your goal. Be sure to store your life plan somewhere you can easily find it and work on it every day.

These are a few simple steps to get started.

- Select your most important goal.
- Ask yourself, what do I need to do to achieve this goal?
- Know what resources you will need to make your goal happen. Resources can be things like:
  - Transportation to attend a class or card game
  - Financial assistance to go back to school (visit the Patient Grant Library on the ESRD NCC website)
  - Friends and family to support your goal
- Think about who you can count on for support.
- Determine when you can start working on your goal.
- Know how much time you can dedicate to working on your goal.
- Decide if your goal will need financial resources and know how much to save each week to make your goal happen.
- Set a date to achieve your goal. Make sure it is realistic.
- Celebrate your accomplishments each step of they way!

Goals can big or small. They can simple or hard. There is no right or wrong goal. Your goals are personal and matter to you. For example, you may want to walk more. Begin by walking when you receive a phone call. You can begin doing this every time you answer the phone. Unless you need support to walk, you can achieve this goal without support. A simple goal with big rewards!

Staying on Track With Your Life Plan

Now that you have created a life plan and started making your goals happen, it's time to work on staying on track with your life plan goals. Use this resource to select how you will stay on target to meet your life goals and enhance your quality of life.

How am I going to check my progress?

- Use a paper desk calendar or your phone calendar to track milestones
- Set up calendar reminders on your phone for a specific time each week to review
- Make a to-do list to track progress toward your goal and check it regularly
- Make sure your plan is visible to you daily (e.g., taped to your bathroom mirror, on your refrigerator, next to your medicine box, or on your car dashboard)

Who can help me stay on target as I work toward my goals?

Ask someone you trust to discuss your goals with you every few weeks or at least once a month. This person can be a:

- Social worker from the facility
- Close friend or family member
- Peer support group member
- Peer mentor or other dialysis patient at your dialysis facility
- Mental health professional
- Other

How will I know if I need to make changes in my plan or goals?

As your life changes, you may need to change or update your life goals.

- You may experience a major event in your life, like moving, loss of caregiver support, or financial changes
- Feeling like your plan or goal is not something you are looking forward to or it is causing you stress
- If you are struggling to reach your goal.
  - Take a break, review the goal, and change the goal if needed
  - Ask people you trust for their ideas on what you can do

How will I know I've met my goals?

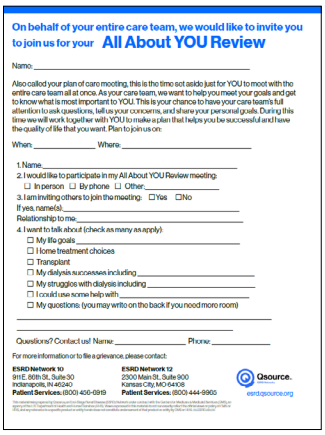
- Assign dates to each goal or each step in achieving a goal
- Once the goal has been met, check it off your to-do-list

What do I do next?

- Celebrate!
- Share your success with others
- Come up with new goals you want to work toward
- Encourage others to set life plan goals (i.e., your caregiver)

Encourage patients to work on a Life Plan to ensure their goals outside of dialysis can be taken into account when it's time for the care team to discuss the Dialysis Plan of Care. Use these resources and provide support for patients working on their Life Plans.

Patient Invitation



On behalf of your entire care team, we would like to invite you to join us for your **All About YOU Review**

Name: _____

Also called your plan of care meeting, this is the time set aside just for YOU to meet with the entire care team all at once. As your care team, we want to help you meet your goals and get to know what is most important to YOU. This is your chance to have your care team's full attention to ask questions, tell us your concerns, and share your personal goals. During this time we will work together with YOU to make a plan that helps you be successful and have the quality of life that you want. Plan to join us on:

When: _____ Where: _____

1. Name_____
2. I would like to participate in my All About YOU Review meeting:
   ☐ In person ☐ By phone ☐ Other: _____
3. I am inviting others to join the meeting: ☐ Yes ☐ No
   If yes, name(s)_____
   Relationship to me_____
4. I want to talk about (check as many as apply):
   ☐ My life goals _____
   ☐ Home treatment choices
   ☐ Transplant
   ☐ My dialysis successes including _____
   ☐ My struggles with dialysis including _____
   ☐ I could use some help with _____
   ☐ My questions (you may write on the back if you need more room)

Questions? Contact us! Name: _____ Phone: _____

For more information or to file a grievance, please contact:

ESRD Network 10
9115 86th St., Suite 90
Indianapolis, IN 46240
Patient Services. (800) 466-0919

ESRD Network 12
2300 Main St., Suite 900
Kansas City, MO 64108
Patient Services. (800) 444-9905

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Description

This invitation is a template for you to inform your patients of their upcoming All About YOU Review (aka plan of care). In addition to being an invitation, this also serves as a patient input form for patients to indicate how they want to participate and what they would like to address. This gives them an opportunity to help set the agenda for the discussion and assists the care team in preparing to address their concerns and questions.

Instructions

Step 1) Determine which patients are due for their All About YOU Review that month.

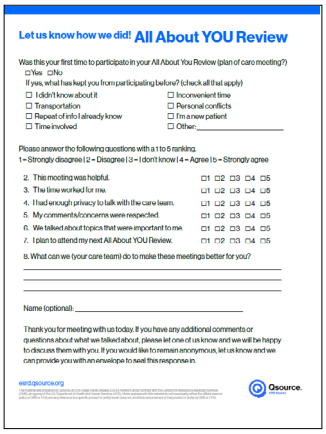
Step 2) Customize an invitation for each patient.

Step 3) For in-center patients, approach the patient toward the beginning of their treatment and explain how they have an All About YOU Review coming up and you would like to get feedback from them to help the care team prepare for the discussion. Present the patient with their invitation and let them know that someone will be back before their treatment ends to collect the bottom half of the form (this was recommended by our Patient SMEs so that patients do not have the opportunity to lose the form or forget to fill it out).

State Surveyors have shared with the Network that those facilities that have established expectations from the beginning for patients to participate in their plan of care have patients that consistently show up to participate. The expectation is that the plan of care is just as important as any other scheduled appointment.

Step 4) Collect the input form from the patient and include it with your plan of care documentation. Use the information to prepare the agenda to keep the discussion focused and on target.

Follow-Up Questionnaire



Let us know how we did! **All About YOU Review**

Was this your first time to participate in your All About You Review (plan of care meeting?)
☐Yes ☐No
If yes, what has kept you from participating before? (check all that apply)

☐ I didn't know about it	☐ Inconvenient time
☐ Transportation	☐ Personal conflicts
☐ Repeat of info I already know	☐ I'm a new patient
☐ Time involved	☐ Other: _____

Please answer the following questions with a 1 to 5 ranking.
1 – Strongly disagree | 2 – Disagree | 3 – I don't know | 4 – Agree | 5 – Strongly agree

2. This meeting was helpful. ☐1 ☐2 ☐3 ☐4 ☐5
3. The time worked for me. ☐1 ☐2 ☐3 ☐4 ☐5
4. I had enough privacy to talk with the care team. ☐1 ☐2 ☐3 ☐4 ☐5
5. My comments/concerns were respected. ☐1 ☐2 ☐3 ☐4 ☐5
6. We talked about topics that were important to me. ☐1 ☐2 ☐3 ☐4 ☐5
7. I plan to attend my next All About YOU Review. ☐1 ☐2 ☐3 ☐4 ☐5

8. What can we (your care team) do to make these meetings better for you?

_____
_____
_____

Name (optional): _____

Thank you for meeting with us today. If you have any additional comments or questions about what we talked about, please let one of us know and we will be happy to discuss them with you. If you would like to remain anonymous, let us know and we can provide you with an envelope to seal this response in.

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Description

This questionnaire is to be used to assess the individual barriers preventing patients from attending their All About YOU Review and to identify the strengths and weaknesses of the meeting from the patient's perspective. Through this mini-evaluation, staff can gain a better understanding of what practices are working well with their patients and what areas could use some improvement.

Instructions

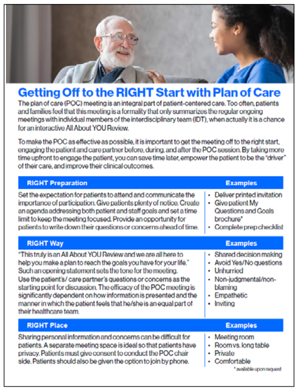
Step 1) After you conduct the All About YOU Review with a patient (either in person or by phone), provide him/her with a copy of this questionnaire. Present it to the patient in a manner that shows you really want these meetings to be beneficial for the patient. Inform the patient that you want to know how the care team did and what you can do to make it even better. The patient has the right to refuse to complete it, but your presentation is imperative in order to get a high completion rate. If a patient refuses, have them sign their refusal.

Step 2) Before collecting the questionnaire, offer the patient the option to remain anonymous. If they would prefer to remain anonymous, provide him/her an envelope to seal it in.

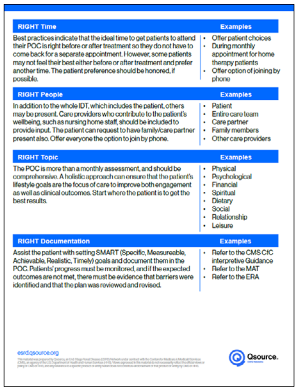
Step 3) Collect the questionnaire immediately following the All About YOU Review to avoid patients losing it or forgetting to return it.

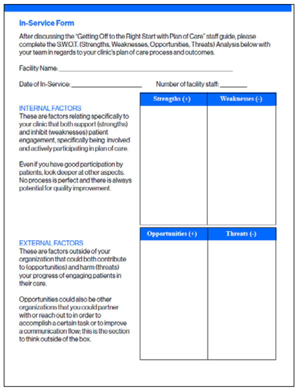
Step 4) Review the patient questionnaires and discuss results with your QAPI team monthly. Identify areas for improvement and congratulate staff on what the team is doing well.

Staff Guide Handout and In-Service



Getting Off to the RIGHT Start with Plan of Care





In-Service Form

Description

"Getting Off to the Right Start with Plan of Care" is a staff guide to examine the RIGHT elements of conducting a plan of care (All About YOU Review) to ensure that it is successful, effective, and meaningful to the patient involved. This is a compilation of best practices identified by both professionals and patients involved in the LAN that positively impact the plan of care process and outcomes.

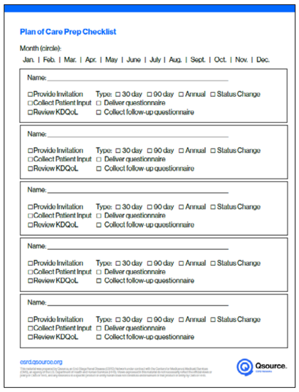
Instructions

Step 1) Print and distribute copies of the handout to all care team staff at your next staff meeting/in-service and discuss all of the elements with your team. Do a quick overview of the resources included in the "All About YOU Review" Plan of Care Toolkit and how your team will begin incorporating them.

Step 2) Complete the In-Service Form by conducting a S.W.O.T. analysis of your plan of care processes and outcomes and review it with your QAPI team.

Step 3) Continue to use the staff guide and reference it with staff periodically. Consider printing an over-sized copy and hanging it in a common staff area.

Prep Checklist



Plan of Care Prep Checklist

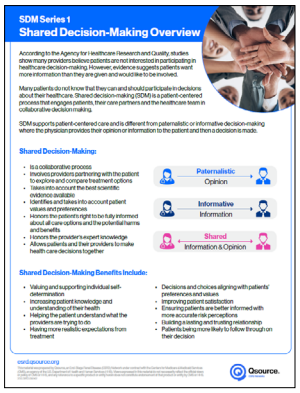
Description

This checklist is to be used to keep track of the patients that are scheduled to have an All About YOU Review each month and the action steps to be completed in preparation for and at the conclusion of each meeting.

Instructions

Identify a staff member to be responsible for completing the checklist each month. The staff member will list the patients that are due for an All About YOU Review that month
and check off each activity as it is completed.

Shared Decision-Making


SDM Series 1
Shared Decision-Making Overview

According to the Agency for Healthcare Research and Quality, studies show many providers believe patients are not interested in participating in healthcare decision-making. However, evidence suggests patients want more information than they are given and would like to be involved.

Many patients do not know that they can and should participate in decisions about their healthcare. Shared decision-making (SDM) is a patient-centered process that engages patients, their care partners and the healthcare team in collaborative decision making.

SDM supports patient-centered care and is different from paternalistic or informative decision-making where the physician provides their opinion or information to the patient and then a decision is made.

Shared Decision-Making:

- Is a collaborative process
- Involves providers partnering with the patient to explore and compare treatment options
- Takes into account the best scientific evidence available
- Identifies and takes into account patient values and preferences
- Honors the patient's right to be fully informed about all care options and the potential harms and benefits
- Honors the provider's expert knowledge
- Allows patients and their providers to make health care decisions together

Paternalistic: Opinion

Informative: Information

Shared: Information & Opinion

Shared Decision-Making Benefits Include:

- Valuing and supporting individual self-determination
- Increasing patient knowledge and understanding of their health
- Helping the patient understand what the providers are trying to do
- Having more realistic expectations from treatment
- Decisions and choices aligning with patients' preferences and values
- Improving patient satisfaction
- Ensuring patients are better informed with more accurate risk perceptions
- Building a lasting and trusting relationship
- Patients being more likely to follow through on their decision

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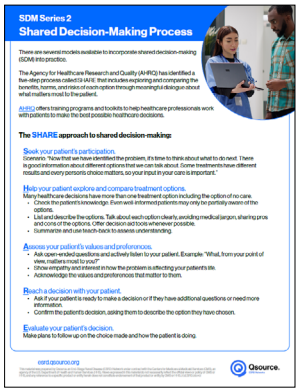
SDM Series 2
Shared Decision-Making Process

There are several models available to incorporate shared decision-making (SDM) into practice.

The Agency for Healthcare Research and Quality (AHRQ) has identified a five-step process called 3-A-I-R-E that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient.

AHRQ offers training programs and toolkits to help healthcare professionals work with patients to make the best possible healthcare decisions.

The SHARE approach to shared decision-making:

Seek your patient's participation.
Scenario: "Now that we have identified the problem, it's time to think about what to do next. There is good information about different options that we can talk about. Some treatments have different results and every person's choice matters, so your input in your care is important."

Help your patient explore and compare treatment options.
Many healthcare decisions have more than one treatment option including the option of no care.

- Check the patient's knowledge. Even well-informed patients may only be partially aware of the options.
- List and describe the options. Talk about each option clearly, avoiding medical jargon, sharing pros and cons of the options. Offer decision aid tools whenever possible.
- Summarize and use teach-back to assess understanding.

Assess your patient's values and preferences.

- Ask open-ended questions and actively listen to your patient. Example: "What, from your point of view, matters most to you?"
- Show empathy and interest in how the problem is affecting your patient's life.
- Acknowledge the values and preferences that matter to them.

Reach a decision with your patient.

- Ask if your patient is ready to make a decision or if they have additional questions or need more information.
- Confirm the patient's decision, asking them to describe the option they have chosen.

Evaluate your patient's decision.
Make plans to follow up on the choice made and how the patient is doing.

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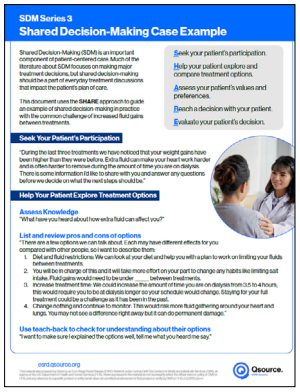
SDM Series 3
Shared Decision-Making Case Example

Shared Decision-Making (SDM) is an important component of patient-centered care. Much of the literature about SDM focuses on making major treatment decisions, but shared decision-making should be a part of everyday treatment discussions that impact the patient's plan of care.

This document uses the SHARE approach to guide an example of shared decision-making in practice with the common challenge of increased fluid gains between treatments.

Seek your patient's participation.
Help your patient explore and compare treatment options.
Assess your patient's values and preferences.
Reach a decision with your patient.
Evaluate your patient's decision.

Seek Your Patient's Participation

"During the last three treatments we have noticed that your weight gains have been higher than they were before. Extra fluid can make your heart work harder and is often harder to remove during the amount of time you are on dialysis. There is some information I'd like to share with you and answer any questions before we decide on what the next steps should be."

Help Your Patient Explore Treatment Options

Assess Knowledge
"What have you heard about how extra fluid can affect you?"

List and review pros and cons of options
"There are a few options we can talk about. Each may have different effects for you compared with other people, so I want to describe them.

1. Diet and fluid restrictions. We can look at your diet and help you with a plan to work on limiting your fluids between treatments.
2. You will be in charge of this and it will take more effort on your part to change any habits like limiting salt intake. Fluid gains would need to be under ____ between treatments.
3. Increase treatment time. We could increase the amount of time you are on dialysis from 3.5 to 4 hours, this would require you to be at dialysis longer so your schedule would change. Staying for your full treatment could be a challenge as it has been in the past.
4. Change nothing and continue to monitor. This would risk more fluid gathering around your heart and lungs. You may not see a difference right away but it can do permanent damage."

Use teach-back to check for understanding about their options
"I want to make sure I explained the options well, tell me what you heard me say."

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Description

Many patients do not know that they can and should participate in decisions about their health care. Shared decision-making (SDM) is a patient-centered process that engages patients, their care partners and the health care team in collaborative decision-making.

Shared Decision-Making

- Is a collaborative process
- Involves providers partnering with the patient to explore and compare treatment options
- Takes into account the best scientific evidence available
- Identifies and takes into account patient values and preferences
- Honors the patient's right to be fully informed about all care options and the potential harms and benefits
- Honors the provider's expert knowledge
- Allows patients and their providers to make healthcare decisions together

For more information on shared decision-making and case examples, please visit our website at esrd.qsource.org.

Downloadable Patient Resources

“All About YOU Review”

What’s in it For You

Who

YOU, your entire care team, and anyone else that you would like to invite as part of your support team (family, care partner, friend)

What

Also known as your plan of care meeting, this is the time designated just for YOU to work together with your care team to create goals for your life and health. This is not a meeting to summarize what you have already heard during other regular ongoing meetings with each member of your care team. It truly is an All About YOU Review where you can help lead the discussion.

When

If you are a new patient, this takes place at 30 and 90 days after you start dialysis to help you adjust to your new lifestyle. From there, the All About YOU Review takes place at least once a year, but your care team can set up additional meetings if you have any changes in your health or life.

Why

YOU are the key member of your healthcare team. By becoming more engaged in your care, your care team will have a better understanding of your personal needs and can make your care more individualized. This is your chance to ask questions, tell them your concerns, and share your personal goals with your entire care team all at once. By working together, your care team can offer support and help YOU make a plan to do and achieve what is most important to YOU.

What patients have to say about being engaged in their care and attending their All About YOU Review

Most patients want more control over their care. Working closely with your care team on a customized plan that fits your individual needs can make a difference. During the All About YOU Review, the clinical team takes the time to listen to both the patient and their care partner to make sure they get the attention and educational information they deserve.

Yvonne | Patient from Missouri

The annual plan of care meeting (All About YOU Review) is important because patients get a chance to review all medical information in one setting with the doctor, nurse, dietician, and social worker. It is important that patients actively participate in their dialysis care because we are the one person who ties our care together. Dialysis is happening to us. We need to take charge of our medical care.

Elzada | Patient from Kansas

The All About YOU Review gives you the opportunity to take more control of your care by asking questions and sharing concerns with your treatment team. The All About YOU Review is important because the entire treatment team is together to discuss your health, your treatment, your concerns and your goals.

Dave | Patient from Missouri

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Set a Goal to Thrive

Being physically and socially active can make your overall quality of life better. Setting a SMART goal (Specific, Measurable, Achievable, Realistic and Time-Based) can help you be successful. You can start small and build up to your goals! Read the example below. Use page two to write your own goal to thrive!

S	M	A	R	T
Specific The goal will focus on one idea.	**Measurable** You can track the goal to see your progress.	**Achievable** You can make this goal happen.	**Realistic** The goal will take effort, but you can reach it.	**Timely** Set dates that will help you meet your goal.

Goal: "I want to be healthier."

S **Who? What? Where? How? When? |** "I will take a 15-minute walk around my neighborhood three days a week on non-dialysis days."

M **How will I know I've reached my goal? |** "I will write on my calendar every month the time each day I walk."

A **What do I need to meet my goal? Time? Support? |** "I will go farther every week. I will ask a friend to walk with me."

R **Why do I want to reach this goal? |** "Right now I can walk two blocks without getting tired. I want to be able to walk four blocks."

T **I will reach my goal by _____. |** "One month from today, I will be able to walk 15 minutes, three times a week."

Before getting started, talk to your doctor about how to safely start increasing your physical activity.

My Goal to Thrive

Name: _____

Date: _____

S
Specific

M
Measurable

A
Achievable

R
Realistic

T
Time-Based

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Creating a Life Plan

What is a Life Plan?

A life plan is a roadmap to help you get the things that mean the most to you. A life plan is built around personal goals and dreams. The goals can be things such as going back to school or work, volunteering, traveling to a place you always wanted to visit, or spending time with family. Here are other examples of personal goals.

- Health and well-being
  - Make healthier meals
  - Join a yoga or dance class
- Community
  - Volunteer at a local non-profit organization
  - Attend church and join activities

Should I Have a Life Plan?

Yes! All people should have a life plan. That includes individuals with kidney disease.

Is my life plan the same as my dialysis care plan?

Your dialysis care plan is about your kidney care and health. The goals focus on things like your dialysis routine and your treatment choice. For example, the plan could have goals about moving from in-center to home dialysis or getting a transplant. The plan could also include your medicines, kidney diet, treatments for other health conditions, daily exercise, and social connections.

Your life plan is about personal goals, like travel. Many times, your dialysis care plan can help you achieve your life plan. For example, you may want to travel around the country and visit all the national parks. But you don't want to stop in a different city three times a week for dialysis. You can talk with your healthcare team about the possibility of peritoneal dialysis to give yourself flexibility.

Why should I write down my goals?

By writing down your goals, you create a contract with yourself. At first, this might seem silly, but once you get started, you will see how putting your goals in writing helps you achieve them.

Here are reasons to put your goals in writing:

- Helps you figure out what you want
  - You might start to write your goal one way and find yourself erasing what you wrote and starting over. That's okay! The writing helps you see what you really want to achieve.
- Motivates you to act:
  - Much like a to-do list, writing goals becomes an action plan.
- Lets you see your progress and celebrate your accomplishments.

Will my life plan change?

A life plan is always changing because life circumstances are ever changing. Visit your life plan regularly. Check off the goals you have achieved. Look at the goals that you are still working on. Ask yourself what you need to do to reach them. Maybe the goals have changed, or maybe you have a new goal. If so, change your life plan to match. Be sure to back up your goals with steps to achieve them. Talk with your dialysis care team and family about how they can work with you to reach your goals. Let's get to work and make a life plan!

Creating a Life Plan Worksheet

Steps to Creating a Life Plan	Questions to Ask Myself
Step 1 Identify Your Personal Goals	• What are my personal goals? What have I always wanted to do and keep putting off? • What do I want to achieve in my life? Why do I want to do this? • What is the benefit of reaching my goals? • What is stopping me from achieving my goals? • Are my goals realistic?
Make notes here:	
Step 2 Figure Out How to Reach Your Goals	• Do I know what it will take to reach my goals? What steps do I need to take? • Who can help me? • What things might slow me down? • How do I want my goals to look when they are complete?
Make notes here:	
Step 3 Define the Time	• When am I going to start working on my goals? • When do I want to reach these goals?
Make notes here:	
Step 4 Stay on Target	• How am I going to check my progress? • Who can help me stay on target as I work toward my goals? • How will I know if I need to make changes in my plan or goals? • How will I know I've met my goals?
Make notes here:	
Step 5 Celebrate Your Success	• Who has helped me reach my goals? Who can I invite to celebrate my success?
Make notes here:	
Step 6 Always Keep Making New Goals	• What are new goals to add to my life plan? • How can I help others create a life plan, so they too can achieve their goals?

Implementing a Life Plan

Taking Action with Your Life Plan!

Once you have identified your life plan goals, the next step is to start making your goals happen. Moving from planning to action can be hard. There are many ways to begin taking action. It is likely that you that have more than one goal and that's okay! First, you will need to decide which goal you want to begin working on. Writing down your goals can help you focus on what is important to you. Describe your goal in detail. The more detail you can include, the better. Include a time frame and select dates you can achieve your activities. Break down your goals into smaller pieces. Think about the smaller pieces as part of your bigger goal. Begin working on one of the smaller pieces. As you complete each piece you will be moving closer to achieving your goal. Be sure to store your life plan somewhere you can easily find it and work on it every day.

These are a few simple steps to get started:

- Select your most important goal.
- Ask yourself, what do I need to do to achieve this goal?
- Know what resources you will need to make your goal happen. Resources can be things like:
  - Transportation to attend a class or card game
  - Financial assistance to go back to school (visit the Patient Grant Library on the ESRD NCC website)
  - Friends and family to support your goal
- Think about who you can count on for support.
- Determine when you can start working on your goal.
- Know how much time you can dedicate to working on your goal.
- Decide if your goal will need financial resources and know how much to save each week to make your goal happen.
- Set a date to achieve your goal. Make sure it is realistic.
- Celebrate your accomplishments each step of they way!

Goals can big or small. They can simple or hard. There is no right or wrong goal. Your goals are personal and matter to you. For example, you may want to walk more. Begin by walking when you receive a phone call. You can begin doing this every time you answer the phone. Unless you need support to walk, you can achieve this goal without support. A simple goal with big rewards!

Ask for Support

- Share your life plan goals and timeline with family members or a friend. Let them know what else you need to do to meet your goal.
- Ask family or friends to help you stay motivated as you work toward your goal. Invite them to celebrate your success with you.
- If you're having trouble staying on track, ask a friend or a family member to help you stay on track. This can assist you with achieving your life plan goals.[1]
- Asking for help from others to keep yourself on track, even signing up for free newsletters or joining social media groups are ways you can get ongoing support.

For example, if you want to lose weight, ask a friend or family member to walk with you several times a week. Maybe there is a chair yoga class at your community center. Ask a friend to help you find one and to join you in the class. Establish a routine and ask family or friends to be part of it.

Sharing your life plan goals with your care team is also important. Your care plan should always support your life plan goals. For example, if your life plan goal is to continue working, ask your care team about your home dialysis and transplant options. Ask yourself what resources you need to make your plans stick. Check with your care team about available resources and use those resources in your life plan.

In Review

- Write your goals down
- Keep your goals in a safe place that you frequently check
- Tell family and friends your goals and ask then to support you
- Share your life plan goals with your care team

Be sure to check-in with yourself on a regular basis. You will want to be sure you're sticking to your goals. If you find yourself drifting away from your goals, reach out to a friend or family member and let them help you stay on track.

If you miss a goal or it takes longer, don't give up. Revise your life plan and adjust as necessary. Most important, celebrate your success, and reward yourself for meeting a goal.

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Staying on Track With Your Life Plan

Now that you have created a life plan and started making your goals happen, it's time to work on staying on track with your life plan goals. Use this resource to select how you will stay on target to meet your life goals and enhance your quality of life.

How am I going to check my progress?

- Use a paper desk calendar or your phone calendar to track milestones
- Set up calendar reminders on your phone for a specific time each week to review
- Make a to-do list to track progress toward your goal and check it regularly
- Make sure your plan is visible to you daily (e.g., taped to your bathroom mirror, on your refrigerator, next to your medicine box, or on your car dashboard)

Who can help me stay on target as I work toward my goals?

Ask someone you trust to discuss your goals with you every few weeks or at least once a month. This person can be a:

- Social worker from the facility
- Close friend or family member
- Peer support group member
- Peer mentor or other dialysis patient at your dialysis facility
- Mental health professional
- Other

How will I know if I need to make changes in my plan or goals?

As your life changes, you may need to change or update your life goals.

- You may experience a major event in your life, like moving, loss of caregiver support, or financial changes
- Feeling like your plan or goal is not something you are looking forward to or it is causing you stress
- If you are struggling to reach your goal:
  - Take a break, review the goal, and change the goal if needed
  - Ask people you trust for their ideas on what you can do

How will I know I've met my goals?

- Assign dates to each goal or each step in achieving a goal
- Once the goal has been met, check it off your to-do-list

What do I do next?

- Celebrate!
- Share your success with others
- Come up with new goals you want to work toward
- Encourage others to set life plan goals (i.e., your caregiver)

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On behalf of your entire care team, we would like to invite you to join us for your All About YOU Review

Name: _____

Also called your plan of care meeting, this is the time set aside just for YOU to meet with the entire care team all at once. As your care team, we want to help you meet your goals and get to know what is most important to YOU. This is your chance to have your care team's full attention to ask questions, tell us your concerns, and share your personal goals. During this time we will work together with YOU to make a plan that helps you be successful and have the quality of life that you want. Plan to join us on:

When: _____ Where: _____

1. Name:_____
2. I would like to participate in my All About YOU Review meeting:
   ☐ In person ☐ By phone ☐ Other:_____
3. I am inviting others to join the meeting: ☐Yes ☐No

If yes, name(s):_____

Relationship to me:_____

4. I want to talk about (check as many as apply):
   - ☐ My life goals _____
   - ☐ Home treatment choices
   - ☐ Transplant
   - ☐ My dialysis successes including _____
   - ☐ My struggles with dialysis including _____
   - ☐ I could use some help with _____
   - ☐ My questions: (you may write on the back if you need more room)

_____

_____

Questions? Contact us! Name: _____ Phone: _____

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Let us know how we did! All About YOU Review

Was this your first time to participate in your All About You Review (plan of care meeting?)

☐Yes ☐No

If yes, what has kept you from participating before? (check all that apply)

- ☐ I didn't know about it
- ☐ Transportation
- ☐ Repeat of info I already know
- ☐ Time involved
- ☐ Inconvenient time
- ☐ Personal conflicts
- ☐ I'm a new patient
- ☐ Other:_____

Please answer the following questions with a 1 to 5 ranking.

1 = Strongly disagree | 2 = Disagree | 3 = I don't know | 4 = Agree | 5 = Strongly agree

1. This meeting was helpful. ☐1 ☐2 ☐3 ☐4 ☐5
2. The time worked for me. ☐1 ☐2 ☐3 ☐4 ☐5
3. I had enough privacy to talk with the care team. ☐1 ☐2 ☐3 ☐4 ☐5
4. My comments/concerns were respected. ☐1 ☐2 ☐3 ☐4 ☐5
5. We talked about topics that were important to me. ☐1 ☐2 ☐3 ☐4 ☐5
6. I plan to attend my next All About YOU Review. ☐1 ☐2 ☐3 ☐4 ☐5

What can we (your care team) do to make these meetings better for you?

_____

_____

_____

Name (optional): _____

Thank you for meeting with us today. If you have any additional comments or questions about what we talked about, please let one of us know and we will be happy to discuss them with you. If you would like to remain anonymous, let us know and we can provide you with an envelope to seal this response in.

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Downloadable Patient Resources in Spanish

“En su revisión All About YOU”

¿Por cual razón?

Por Quién

Por USTED mismo, todo su equipo de atención y cualquier otra persona a laque le gustaría invitar como parte de su equipo de apoyo (familia, compañero de cuidado, amigo).

¿Qué?

También se conoce como reunión del plan para su atención, esta es la hora designada para que USTED trabaje junto con su equipo de atención y crear metas para su vida y salud. Esta no es una reunión para repasar o repetir lo que ya escuchó en otras reuniones con su equipo de atención. Realmente es una examinación de USTED mismo para USTED mismo en la que puede ayudar a dirigir la discusión.

Cuándo

Si es un paciente nuevo, esto ocurre a los 30 y 90 días después de comenzar diálisis para ayudarlo a adaptarse a su nuevo estilo de vida. A partir de ahí, esta examinación se realiza al menos una vez al año, pero su equipo de atención puede cambiar y adaptar de acuerdo con su salud o cambio en su vida.

¿Por Qué?

USTED es el miembro clave y más importe de su equipo de atención médica. Al volverse más involucrado en su cuidado, su equipo comprenderá mejor sus necesidades personales y puede hacer su atención más individualizada. Esta es su oportunidad de hacer preguntas, hablar de sus ansiedades y compartir sus metas con todo su equipo de atención al mismo tiempo. Trabajando juntos, su equipo puede apoyarlo y ayudarlo hacer un plan y lograr lo más importante para USTED.

Qué tienen que decir los pacientes sobre su participación en su atención y asistiendo a su revisión All About YOU

La mayoría de los pacientes quieren tener más control sobre su cuidado. Trabajando con su equipo de atención en un plan personalizado que se adapta a su necesidades individuales pueden hacer una diferencia. Durante el revisión “All About YOU” el equipo clínico lo escucha tanto el paciente como a su cuidadores para asegurarse de que reciben la atención e información educativa que merecen.

Yvonne | Paciente de Missouri

La reunión anual del plan de atención (Revisión All About YOU) es importante porque los pacientes tienen la oportunidad de repasar toda la información médica en un solo lugar con el médico, enfermera, dietista y trabajadora social. Es importante que los pacientes participen activamente en su atención de diálisis porque somos las únicos persona que une nuestro cuidado. Estamos tomando diálisis. Necesitamos hacernos cargo de nuestra atención médica.

Elzada | Paciente de Kansas

La revisión All About YOU le da la oportunidad para tomar más control de su atención al hacer preguntas y compartir inquietudes con su equipo de tratamiento. La revisión All About YOU es importante porque todo el equipo de tratamiento juntos esta para discutir su salud, su tratamiento, sus preocupaciones y sus metas.

Dave | Paciente de Missouri

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Establezca una meta para mejorar.

La actividad física y social puede mejorar su calidad de vida en general. Configurar metas puede ayudarlo a tener éxito.¡Puede comenzar poco a poco y desarrollar sus metas! ¡Lea el ejemplo a continuación y luego use la página para escribir su meta y mejorar!

S — **Específico**
El objetivo se centrará en una idea.

M — **Medible**
Usted puede dar seguimiento a su progreso.

A — **Alcanzable**
Usted puede cumplir con su meta.

R — **Realista**
La meta requiere esfuerzo, pero puede alcanzarla.

T — **Basado en el Tiempo**
Establecer fechas que ayudará cumplir con su meta.

Objetivo/Meta: "Quiero ser más saludable."

S **¿Quién? ¿Qué? ¿Dónde? ¿Cómo? ¿Cuándo?** "Daré una caminata de 15 minutos tres días a la semana en mi vecindario los días cuando no tenga diálisis."

M **¿Cómo sabré que he alcanzado mi objetivo?** "Escribiré en mi calendario todos los días que camino."

A **¿Qué necesito para alcanzar mi objetivo? ¿Hora? ¿Apoyo?** "Iré más lejos cada semana. Le pediré a un amigo que camine con migo."

R **¿Por qué quiero alcanzar este objetivo?** "Ahora mismo puedo caminar dos cuadras sin cansarme. Quiero para poder caminar cuatro cuadras."

T **Alcanzaré mi meta en _____.** "Dentro de un mes, podré caminar 15 minutos, tres veces a la semana."

Antes de comenzar, hable con su médico sobre cómo comenzar a aumentar su actividad física de manera segura.

Mi meta para mejorar

Nombre: _____

Fecha: _____

S
Específico

M
Medible

A
Alcanzable

R
Realista

T
Tiempo

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Crear un plan de vida

¿Qué es un plan de vida?

Un plan de vida es una guía para ayudarle a conseguir las cosas más importantes para usted. Un plan de vida se crea teniendo en cuenta sus metas y sueños personales. Las metas pueden ser, por ejemplo, volver a estudiar o trabajar, ofrecerse como voluntario, viajar a un lugar que siempre quiso visitar o pasar tiempo con su familia. A continuación, se incluyen otros ejemplos de metas personales.

- Salud y bienestar
  - Consumir comidas más saludables
  - Inscribirse en una clase de yoga o de baile
- Comunidad
  - Ofrecerse como voluntario en una organización local sin fines de lucro
  - Asistir a la iglesia y sumarse a las actividades

¿Debería tener un plan de vida?

¡Sí! Todas las personas deben tener un plan de vida. Eso incluye a quienes padecen una enfermedad renal.

¿Mi plan de vida es lo mismo que mi plan de atención de diálisis?

Su plan de atención de diálisis se ocupa de la atención y la salud de los riñones. Las metas se concentran en cosas tales como su rutina de diálisis y su elección del tratamiento. Por ejemplo, el plan podría tener como metas pasar de diálisis en el centro a diálisis en el hogar, o conseguir un trasplante. El plan también podría incluir sus medicamentos, dieta para pacientes renales, tratamientos para otras enfermedades, ejercicio diario y conexiones sociales. Su plan de vida gira en torno a sus metas personales, como viajar. Muchas veces, su plan de atención de diálisis puede ayudarle a lograr su plan de vida. Por ejemplo, quizás desee viajar por el país y visitar todos los parques nacionales. Pero no desea detenerse en ciudades diferentes tres veces por semana para recibir la diálisis. Puede hablar con su equipo de atención médica sobre la posibilidad de recibir diálisis peritoneal, lo cual le brindará flexibilidad. family about how they can work with you to reach your goals. Let's get to work and make a life plan!

¿Por qué debo escribir mis metas?

Al escribir sus metas, crea un contrato con usted mismo. Al principio podría parecer tonto, pero una vez que comience, verá que poner sus metas por escrito le ayuda a lograrlas. Estos son los motivos por los cuales debe poner sus metas por escrito:

- Le ayuda a averiguar qué es lo que desea:
  - Quizás comience a escribir su meta de una manera, y luego se descubra borrando lo que escribió y comenzando de nuevo. ¡Eso está bien! Escribir le ayuda a ver qué es realmente lo que desea lograr.
- Le estimula a actuar:
  - Al igual que una lista de cosas pendientes, escribir las metas se convierte en un plan de acción.
- Le permite ver sus avances y celebrar sus logros.

¿Cambiará mi plan de vida?

Un plan de vida cambia todo el tiempo, porque las circunstancias de la vida siempre están cambiando. Revise su plan de vida regularmente. Marque las metas que haya logrado. Analice las metas que aún no haya alcanzado. Pregúntese qué debe hacer para lograrlas. Quizás las metas hayan cambiado, o quizás tenga una nueva meta. En ese caso, cambie su plan de vida para que coincida. Asegúrese de respaldar sus metas con medidas para lograrlas. Hable con su equipo de atención de diálisis y con su familia acerca del modo en que pueden trabajar con usted para que logre sus metas. ¡Pongámonos en marcha y creemos un plan de vida!

Planilla para crear un plan de vida

Pasos para crear un plan de vida	Preguntas que debo hacerme
Paso 1 Identifique sus metas personales	• ¿Cuáles son mis metas personales? ¿Qué es lo que siempre quise hacer y postergué una y otra vez? • ¿Qué quiero lograr en mi vida? ¿Por qué quiero lograrlo? • ¿Cuál es el beneficio de alcanzar mis metas? • ¿Qué es lo que me impide lograr mis metas? • ¿Son mis metas realistas?
Incluya sus notas aquí:	
Paso 2 Averigüe cómo alcanzar sus metas	• ¿Sé lo que necesitaré para alcanzar mis metas? ¿Qué pasos debo dar? • ¿Quiénes pueden ayudarme? • ¿Qué cosas podrían hacerme ir más despacio? • ¿Cómo quiero que se vean mis metas una vez completadas?
Incluya sus notas aquí:	
Paso 3 Defina los plazos	• ¿Cuándo comenzaré a trabajar para lograr mis metas? • ¿Cuándo quiero alcanzar estas metas?
Incluya sus notas aquí:	
Paso 4 No pierda de vista el objetivo	• ¿Cómo voy a verificar mis avances? • ¿Quién puede ayudarme a no perder de vista el objetivo al intentar lograr mis metas? • ¿Cómo sabré si debo hacer cambios en mi plan o en mis metas? • ¿Cómo sabré que he alcanzado mis metas?
Incluya sus notas aquí:	
Paso 5 Celebre su éxito	• ¿Quiénes me han ayudado a lograr mis metas? ¿A quiénes puedo invitar para celebrar mi éxito?
Incluya sus notas aquí:	
Paso 6 Nunca deje de generar nuevas metas	• ¿Cuáles son las nuevas metas que deseo agregar a mi plan de vida? • ¿Cómo puedo ayudar a otras personas a crear un plan de vida, para que ellas también logren sus metas?

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Implementar un plan de vida

¡Haga realidad su plan de vida!

Una vez que haya determinado los objetivos de su plan de vida, el paso siguiente es comenzar a concretarlos. Pasar de la planificación a la acción puede ser difícil. Hay muchas formas de comenzar. ¡Seguramente usted tiene más de un objetivo y eso está bien! Tendrá que decidir cuál de sus objetivos quiere abordar primero. Escribir sus objetivos puede ayudarle a enfocarse en qué es lo más importante para usted. Describa sus objetivos en forma detallada. Cuantos más detalles considere, mejor. Incluya plazos de tiempo y seleccione fechas para concretar sus actividades. Divida sus objetivos en partes más pequeñas. Mire a esas partes más pequeñas como piezas de un objetivo mayor. Comience trabajando en una de estas partes. A medida que complete cada una de ellas, estará más cerca de lograr su objetivo. Guarde su plan de vida en un lugar donde sea fácil encontrarlo, ya que esto le facilitará ponerlo en práctica diariamente.

Estos son algunos pasos simples para comenzar:

- Seleccione su objetivo más importante.
- Pregúntese qué necesita hacer para conseguir ese objetivo.
- Determine qué recursos necesitará para lograr su objetivo. Los recursos pueden incluir por ejemplo:
  - Transporte para asistir a clases o para ir a jugar a las cartas
  - Ayuda económica para reanudar los estudios universitarios (visite la Biblioteca de Subvenciones para Pacientes en el sitio web del ESRD NCC)
  - Amigos o familiares que le ayuden a alcanzar sus objetivos
- Piense con quién puede contar para recibir apoyo.
- Determine cuándo puede comenzar a trabajar en su objetivo.
- Calcule cuánto tiempo puede dedicar a trabajar en su objetivo.
- Decida si su objetivo requiere recursos económicos y determine cuánto debe ahorrar por semana para cumplir su objetivo.
- Establezca una fecha para alcanzar su objetivo. Sea realista.
- ¡Celebre sus logros en cada etapa de su camino!

Los objetivos pueden ser grandes o modestos. Pueden ser simples o difíciles. No hay objetivos correctos o incorrectos. Sus objetivos son personales y son importantes para usted. Por ejemplo, podría proponerse caminar más. Comience a caminar cuando reciba una llamada telefónica. Puede empezar con esta modalidad cada vez que responda el teléfono. Salvo que necesite apoyo para caminar, es un objetivo que puede lograr solo. ¡Un objetivo simple con una gran recompensa!

Pida ayuda

- Comparta con sus familiares o amigos los objetivos de su plan de vida y los plazos para cumplirlos. Coménteles qué otras cosas necesita para cumplir su objetivo.
- Pida ayuda a su familia o amigos para mantenerse motivado en su camino hacia su objetivo. Invítelos a celebrar juntos cada logro.
- Si tiene dificultades para mantenerse en el camino, pídale ayuda a un amigo o a un familiar. Esto puede ayudarle a alcanzar los objetivos de su plan de vida.[1]
- Pedir ayuda a los demás para mantenerse encaminado, así como suscribirse a boletines informativos gratuitos o integrar algún grupo en redes sociales, son formas de contar con un apoyo permanente.

Por ejemplo, si quiere bajar de peso, pídale a un amigo o a un familiar que salgan juntos a caminar varias veces a la semana. Es posible que haya clases de yoga en silla en su centro comunitario. Pídale ayuda a un amigo para encontrar un centro e invítelo a ir con usted a la clase. Establezca una rutina e invite a participar a familiares o amigos.

También es importante que comparta los objetivos de su plan de vida con su equipo de atención. Su plan de atención siempre debe apoyar los objetivos de su plan de vida. Por ejemplo, si un objetivo de su plan de vida es continuar trabajando, pregúntele a su equipo de atención sobre sus opciones de diálisis en el hogar y de trasplante. Pregúntese qué recursos necesita para no desviarse de sus planes. Consulte a su equipo de atención sobre los recursos disponibles y aproveche esos recursos en su plan de vida.

En resumen

- Escriba sus objetivos
- Mantenga sus objetivos en un lugar seguro que revise con frecuencia
- Hable con su familia y amigos sobre sus objetivos y pídales apoyo
- Comparta los objetivos de su plan de vida con su equipo de atención

Controle regularmente si sigue en camino, ya que debe evitar desviarse de sus objetivos. Si ve que se aparta de sus objetivos, recurra a un amigo o a un familiar y déjelos que le ayuden a recuperar el rumbo.

Si no llegara a cumplir un objetivo o tarda más en hacerlo, no se desanime. Revise su plan de vida y haga los ajustes necesarios. Lo más importante es que celebre sus logros y se premie a usted mismo cada vez que logre un objetivo.

[1]How to Plan Your Life (Cómo planificar su vida): https://www.tonyrobbins.com/importance-time-management/life-planning/ Consultado el 17 de mayo de 2022

Manténgase en el rumbo con su plan de vida

Ahora que creó un plan de vida y ha comenzado a convertir sus metas en realidad, llegó el momento de trabajar para mantenerse en el rumbo hacia esas metas. Este recurso le ayudará a seleccionar la manera en que seguirá el camino para alcanzar sus metas y mejorar su calidad de vida.

¿Cómo voy a verificar mis avances?

- Lleve la cuenta de sus logros en un calendario impreso o del teléfono
- En el calendario de su teléfono, programe recordatorios para hacer revisiones en momentos específicos de cada semana
- Haga una lista de tareas pendientes para llevar la cuenta de sus avances y verifíquela periódicamente
- Asegúrese de tener su plan donde pueda verlo diariamente (p. ej., pegado en el espejo del baño, en el refrigerador, al lado del botiquín de primeros auxilios o en el tablero del automóvil)

¿Quién puede ayudarme a mantener el rumbo hacia mis metas?

Pídale a alguien de confianza que conversen sobre sus metas cada tantas semanas o al menos una vez al mes. Esa persona puede ser, por ejemplo:

- Un trabajador social del centro
- Un amigo cercano o familiar
- Un miembro de un grupo de apoyo
- Un mentor u otro paciente de diálisis en su centro de diálisis
- Un profesional de salud mental
- Otro

¿Cómo sabré si debo hacer cambios en mi plan o en mis metas?

A medida que cambie su vida, quizás le toque cambiar o actualizar sus metas de vida.

- Puede que ocurran eventos importantes en su vida, como mudarse, perder el apoyo de un cuidador o cambios en su situación económica
- Sentir que su plan o meta no le atrae o le causa estrés
- Si le está costando alcanzar su meta:
  - Tómese un descanso, revise la meta y cámbiela si es necesario
  - Pídales a personas de confianza que le den ideas sobre lo que puede hacer

¿Cómo sabré que he alcanzado mis metas

- Fíjese fechas para cada meta o para cada paso hacia el logro de una meta
- Una vez que se haya cumplido la meta, táchela de su lista de tareas pendientes

¿Qué hago a continuación?

- ¡Celebrar!
- Comparta su éxito con otros
- Piense en nuevas metas que quisiera lograr
- Anime a otros (por ejemplo, su cuidador) a fijarse metas de planes de vida)

En nombre de todo su equipo de atención, nos gustaría invitarlo para unirse a nosotros para su revisión "All About YOU"

Nombre: _____

Esta reunión también se llama "plan de atención," este es el tiempo reservado solo para USTED y todo su equipo de atención a la vez. Como su equipo de atención, queremos ayudarlo a alcanzar sus metas y entender lo que le es más importante. Esta es su oportunidad de hacer preguntas a su equipo de atención, contarnos sus inquietudes y compartir sus metas personales. Durante esto tiempo trabajaremos junto con USTED para hacer un plan que lo ayude a tener éxito y a tener la calidad de vida que desea. Únase a nosotros:

Cuando: _____ Donde: _____

1. Nombre:_____
2. Me gustaría participar en mi reunión de revisión All About YOU:
   ☐ En persona ☐ Por teléfono ☐ Otro:_____
3. Estoy invitando a otras personas a la reunión: ☐Sí ☐No

NoEn caso afirmativo, nombre (s):_____

Relación:_____

4. Quiero hablar sobre (marque todos los que correspondan):
   - ☐ Mis metas _____
   - ☐ Opciones de tratamiento en el hogar
   - ☐ Trasplante
   - ☐ Mis éxitos de diálisis, incluyendo _____
   - ☐ Mis luchas con la diálisis, incluyendo _____
   - ☐ Me vendría bien un poco de ayuda con _____
   - ☐ Mis preguntas: (puede escribir en la parte de atrás si necesita más espacio)

_____

_____

¿Preguntas? ¡Contáctenos! Nombre:_____ Teléfono:: _____

Para obtener más información o presentar una queja, comuníquese con:

ESRD Network 10
911 E. 86th St., Suite 30
Indianapolis, IN 46240
Patient Services: (800) 456-6919

ESRD Network 12
2300 Main St., Suite 900
Kansas City, MO 64108
Patient Services: (800) 444-9965

Qsource® ESRD Networks
esrd.qsource.org

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¡Háganos saber cómo lo hicimos! Todo sobre la revisión "All About YOU" Review

¿Fue la primera vez que participó en su revisión "All About YOU" (reunión de plande atención?) ☐Sí ☐No

Si es sí, ¿qué le ha impedido participar antes? (marque todo lo que corresponda)

- ☐ No lo sabía
- ☐ Transporte
- ☐ Repetición de información que ya sé
- ☐ Tiempo involucrado
- ☐ Tiempo inconveniente
- ☐ Conflictos personales
- ☐ I'm a new patient
- ☐ Otro: _____

Responda las siguientes preguntas con clasificación de 1 a 5.

1 = Totalmente en desacuerdo | 2 = En desacuerdo | 3 = No lo sé | 4 = De acuerdo | 5 = Totalmente de acuerdo

1.	Esta reunión fue útil.	☐1	☐2	☐3	☐4	☐5
2.	El tiempo funcionó para mí.	☐1	☐2	☐3	☐4	☐5
3.	Tuve privacidad suficiente para hablar con el equipo deatención.	☐1	☐2	☐3	☐4	☐5
4.	Se respetaron mis comentarios / preocupaciones.	☐1	☐2	☐3	☐4	☐5
5.	Hablamos sobre temas que eran importantes para mí.	☐1	☐2	☐3	☐4	☐5
6.	Planeo asistir a mi próxima revisión "All About YOU".	☐1	☐2	☐3	☐4	☐5

¿Qué podemos hacer nosotros (su equipo de atención) para mejorar estas reunionespara usted?

_____

_____

_____

Nombre: (Opcional): _____

Gracias por reunirse con nosotros hoy. Si tiene comentarios o preguntas adicionales acerca de lo que hablamos, háganoslo saber a uno de nosotros y estaremos encantados de discutir con usted. Si desea permanecer anónimo, háganoslo saber y podemos proporcionarlo con un sobre para sellar su respuesta.

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Downloadable Staff Resources

Getting Off to the RIGHT Start with Plan of Care

The plan of care (POC) meeting is an integral part of patient-centered care. Too often, patients and families feel that this meeting is a formality that only summarizes the regular ongoing meetings with individual members of the interdisciplinary team (IDT), when actually it is a chance for an interactive All About YOU Review.

To make the POC as effective as possible, it is important to get the meeting off to the right start, engaging the patient and care partner before, during, and after the POC session. By taking more time upfront to engage the patient, you can save time later, empower the patient to be the "driver" of their care, and improve their clinical outcomes.

RIGHT Preparation	Examples
Set the expectation for patients to attend and communicate the importance of participation. Give patients plenty of notice. Create an agenda addressing both patient and staff goals and set a time limit to keep the meeting focused. Provide an opportunity for patients to write down their questions or concerns ahead of time.	• Deliver printed invitation • Give patient My Questions and Goals brochure* • Complete prep checklist

RIGHT Way	Examples
"This truly is an All About YOU Review and we are all here to help you make a plan to reach the goals you have for your life." Such an opening statement sets the tone for the meeting. Use the patient's/ care partner's questions or concerns as the starting point for discussion. The efficacy of the POC meeting is significantly dependent on how information is presented and the manner in which the patient feels that he/she is an equal part of their healthcare team.	• Shared decision making • Avoid Yes/No questions • Unhurried • Non-judgmental/non-blaming • Empathetic • Inviting

RIGHT Place	Examples
Sharing personal information and concerns can be difficult for patients. A separate meeting space is ideal so that patients have privacy. Patients must give consent to conduct the POC chair side. Patients should also be given the option to join by phone.	• Meeting room • Room vs. long table • Private • Comfortable

* available upon request

RIGHT Time	Examples
Best practices indicate that the ideal time to get patients to attend their POC is right before or after treatment so they do not have to come back for a separate appointment. However, some patients may not feel their best either before or after treatment and prefer another time. The patient preference should be honored, if possible.	• Offer patient choices • During monthly appointment for home therapy patients • Offer option of joining by phone

RIGHT People	Examples
In addition to the whole IDT, which includes the patient, others may be present. Care providers who contribute to the patient's wellbeing, such as nursing home staff, should be included to provide input. The patient can request to have family/care partner present also. Offer everyone the option to join by phone.	• Patient • Entire care team • Care partner • Family members • Other care providers

RIGHT Topic	Examples
The POC is more than a monthly assessment, and should be comprehensive. A holistic approach can ensure that the patient's lifestyle goals are the focus of care to improve both engagement as well as clinical outcomes. Start where the patient is to get the best results.	• Physical • Psychological • Financial • Spiritual • Dietary • Social • Relationship • Leisure

RIGHT Documentation	Examples
Assist the patient with setting SMART (Specific, Measureable, Achievable, Realistic, Timely) goals and document them in the POC. Patients' progress must be monitored, and if the expected outcomes are not met, there must be evidence that barriers were identified and that the plan was reviewed and revised.	• Refer to the CMS CfC interpretive Guidance • Refer to the MAT • Refer to the ERA

In-Service Form

After discussing the "Getting Off to the Right Start with Plan of Care" staff guide, please complete the S.W.O.T. (Strengths, Weaknesses, Opportunities, Threats) Analysis below with your team in regards to your clinic's plan of care process and outcomes.

Facility Name: _____

Date of In-Service: _____ Number of facility staff: _____

INTERNAL FACTORS

These are factors relating specifically to your clinic that both support (strengths) and inhibit (weaknesses) patient engagement, specifically being involved and actively participating in plan of care.

Even if you have good participation by patients, look deeper at other aspects. No process is perfect and there is always potential for quality improvement.

Strengths (+)	Weaknesses (-)

EXTERNAL FACTORS

These are factors outside of your organization that could both contribute to (opportunities) and harm (threats) your progress of engaging patients in their care.

Opportunities could also be other organizations that you could partner with or reach out to in order to accomplish a certain task or to improve a communication flow; this is the section to think outside of the box.

Strengths (+)	Weaknesses (-)

Now that you and your team have identified the elements of your S.W.O.T analysis, identify at least one goal that your clinic would like to accomplish in regards to improving the plan of care process. The goal should be specific and measurable.

Set a goal date and review your progress monthly with the key plan of care team members until completed. Consider conducting the S.W.O.T analysis annually to continuously look for new opportunities to improve the process and maximize the benefit of the strengths.

Clinic Goal:

Plan of Care Prep Checklist

Month (circle):

Jan. | Feb. | Mar. | Apr. | May | June | July | Aug. | Sept. | Oct. | Nov. | Dec.

Name: ____

☐Provide Invitation Type: ☐ 30 day ☐ 90 day ☐ Annual ☐ Status Change
☐Collect Patient Input ☐ Deliver questionnaire
☐Review KDQoL ☐ Collect follow-up questionnaire

Name: ____

☐Provide Invitation Type: ☐ 30 day ☐ 90 day ☐ Annual ☐ Status Change
☐Collect Patient Input ☐ Deliver questionnaire
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Name: ____

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☐Provide Invitation Type: ☐ 30 day ☐ 90 day ☐ Annual ☐ Status Change
☐Collect Patient Input ☐ Deliver questionnaire
☐Review KDQoL ☐ Collect follow-up questionnaire

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SDM Series 1

Shared Decision-Making Overview

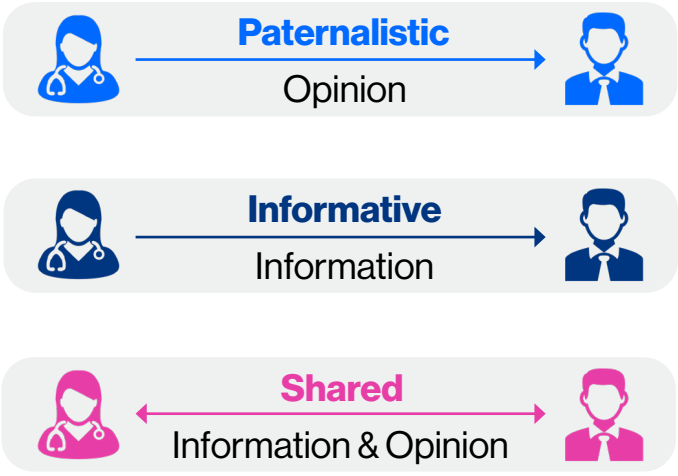
According to the Agency for Healthcare Research and Quality, studies show many providers believe patients are not interested in participating in healthcare decision-making. However, evidence suggests patients want more information than they are given and would like to be involved.

Many patients do not know that they can and should participate in decisions about their healthcare. Shared decision-making (SDM) is a patient-centered process that engages patients, their care partners and the healthcare team in collaborative decision making.

SDM supports patient-centered care and is different from paternalistic or informative decision-making where the physician provides their opinion or information to the patient and then a decision is made.

Shared Decision-Making:

- Is a collaborative process
- Involves providers partnering with the patient to explore and compare treatment options
- Takes into account the best scientific evidence available
- Identifies and takes into account patient values and preferences
- Honors the patient's right to be fully informed about all care options and the potential harms and benefits
- Honors the provider's expert knowledge
- Allows patients and their providers to make health care decisions together



Shared Decision-Making Benefits Include:

- Valuing and supporting individual self-determination
- Increasing patient knowledge and understanding of their health
- Helping the patient understand what the providers are trying to do
- Having more realistic expectations from treatment
- Decisions and choices aligning with patients' preferences and values
- Improving patient satisfaction
- Ensuring patients are better informed with more accurate risk perceptions
- Building a lasting and trusting relationship
- Patients being more likely to follow through on their decision

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SDM Series 2

Shared Decision-Making Process

There are several models available to incorporate shared decision-making (SDM) into practice.

The Agency for Healthcare Research and Quality (AHRQ) has identified a five-step process called SHARE that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient.

AHRQ offers training programs and toolkits to help healthcare professionals work with patients to make the best possible healthcare decisions.

The SHARE approach to shared decision-making:

Seek your patient's participation.

Scenario: "Now that we have identified the problem, it's time to think about what to do next. There is good information about different options that we can talk about. Some treatments have different results and every person's choice matters, so your input in your care is important."

Help your patient explore and compare treatment options.

Many healthcare decisions have more than one treatment option including the option of no care.

- Check the patient's knowledge. Even well-informed patients may only be partially aware of the options.
- List and describe the options. Talk about each option clearly, avoiding medical jargon, sharing pros and cons of the options. Offer decision aid tools whenever possible.
- Summarize and use teach-back to assess understanding.

Assess your patient's values and preferences.

- Ask open-ended questions and actively listen to your patient. Example: "What, from your point of view, matters most to you?"
- Show empathy and interest in how the problem is affecting your patient's life.
- Acknowledge the values and preferences that matter to them.

Reach a decision with your patient.

- Ask if your patient is ready to make a decision or if they have additional questions or need more information.
- Confirm the patient's decision, asking them to describe the option they have chosen.

Evaluate your patient's decision.

Make plans to follow up on the choice made and how the patient is doing.

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SDM Series 3

Shared Decision-Making Case Example

Shared Decision-Making (SDM) is an important component of patient-centered care. Much of the literature about SDM focuses on making major treatment decisions, but shared decision-making should be a part of everyday treatment discussions that impact the patient's plan of care.

This document uses the **SHARE** approach to guide an example of shared decision-making in practice with the common challenge of increased fluid gains between treatments.

Seek your patient's participation.

Help your patient explore and compare treatment options.

Assess your patient's values and preferences.

Reach a decision with your patient.

Evaluate your patient's decision.

Seek Your Patient's Participation

"During the last three treatments we have noticed that your weight gains have been higher than they were before. Extra fluid can make your heart work harder and is often harder to remove during the amount of time you are on dialysis. There is some information I'd like to share with you and answer any questions before we decide on what the next steps should be."

Help Your Patient Explore Treatment Options

Assess Knowledge

"What have you heard about how extra fluid can affect you?"

List and review pros and cons of options

"There are a few options we can talk about. Each may have different effects for you compared with other people, so I want to describe them:

1. Diet and fluid restrictions: We can look at your diet and help you with a plan to work on limiting your fluids between treatments.
2. You will be in charge of this and it will take more effort on your part to change any habits like limiting salt intake. Fluid gains would need to be under _____ between treatments.
3. Increase treatment time: We could increase the amount of time you are on dialysis from 3.5 to 4 hours; this would require you to be at dialysis longer so your schedule would change. Staying for your full treatment could be a challenge as it has been in the past.
4. Change nothing and continue to monitor: This would risk more fluid gathering around your heart and lungs. You may not see a difference right away but it can do permanent damage."

Use teach-back to check for understanding about their options

"I want to make sure I explained the options well, tell me what you heard me say."

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ASSESS Your Patient's Values and Preferences

Encourage your patient to talk about what matters most

"As you think about your options, what matters most to you? Which of the potential side effects worries you the most?

Ask open-ended questions, show empathy and interest

"Which of the options fit best with the treatment goals we've discussed? How would each of these options affect your daily life?"

Listen actively to your patient

"I'm having trouble making changes in my diet, and I don't make my own food. I also do a lot of work outside, which makes me thirsty. Increasing my treatment time worries me because of transportation, and I already get anxious when I'm on the machine. I am not feeling too bad right now, but I don't want to start feeling out-of-breath. My time outside of dialysis is more important to me than limiting my fluids. I think I could get the amount down over time."

Acknowledge the values and preferences that matter to your patient

"It sounds like having more time away from dialysis is more important to you and worth the extra effort it will take to manage your fluid intake better."

REACH a Decision With Your Patient

Help your patient move to a decision

Staff: "What additional questions do you have, or are you ready to make a decision about your next step?" Are there any other people you would like to involve in the discussion? Now that we've had time to discuss the options, which do you think is right for you?"

Patient: "I'd like to work on my diet and how much I drink more closely, keeping my fluid gain at less than _____ between each treatment."

Verify the decision and next steps to be taken

"We'll plan to continue to monitor for the next few weeks to see how you are doing with decreasing the gains between treatments."

EVALUATE your patient's decision

Continue to follow up assisting in managing barriers to success

"Let's plan on reviewing the decision next month to see how it is going for you."

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Additional Plan of Care Resources for Reference

- Evidence of Recognizing and Addressing (ERA) Interdisciplinary Clinical Care of the Individual Patient
- Measuring Dialysis Patients' Health-Related Quality of Life with the KDQoL-36
- ESRD Interpretive Guidance

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