Home Modality
Meeting Patients Where They are to Empower Choice

Introduction

It is important to educate patients on all their options for treatment, especially when it comes to dialyzing at home. The benefits of dialyzing at home can help a patient's physical, social, and mental health. It allows the patient to be engaged in their healthcare and adds to their quality of life.

Qsource ESRD Networks, and the members of our Home Modality Community Coalition, believe that an important strategy for effective conversations about choice of modality is meeting patients where they are when it comes to each individual choosing the right modality for their current lifestyle. Patients who have already started dialysis in an in-center hemodialysis clinic may not have been educated about home dialysis prior to starting hemodialysis, or they may not have been in a good headspace to give home modalities proper consideration. This booklet has been developed with home modality discussions in mind; however, the skills in this booklet are flexible and can be used by the dialysis care provider as needed to assist in other care decisions with the patient.

Section I
Stages-of-Change Method

Meeting a patient where they are means understanding the Stages-of-Change Model. During a smoking cessation study in 1983, researchers James Prochaska and Carlo DiClemente created the Stages-of-Change Model to illustrate the different phases of health-related behavior changes. The framework is one part of their Transtheoretical Model of Behavior Change and the model assesses the person's readiness to act and includes strategies to guide individuals through each stage. *

The 5 Stages

1 Precontemplation	2 Contemplation	3 Preparation	4 Action	5 Maintenance
• I won't do this. • I am not going to do this.	• I may do this in the next six months. • I am thinking about it.	• I will do this in one month. • I am planning how to do this.	• I am currently doing this.	• I am already doing this (for over six months).

All patients have a right to make informed decisions about their treatment options. Each patient should be treated as a unique individual with the opportunity to choose what is best for them. Individuals will be in different stages of readiness to take a behavior. Many people are not yet ready to start. A patient's readiness can change over time, meaning that they can get more or less motivated as they move through the stages, which are not always linear. It is important to assess the stage and encourage small steps toward the overall goal.

Meeting a Patient in Precontemplation

Patients in precontemplation will not find a discussion about home modality choice as a priority. They will see no pros to taking action and they won't want to talk about it. They will have limited beliefs on the topic or feel hopeless in the possibility of transitioning. They will appear uncomfortable or resistant and they may ignore education completely.

Meeting a Patient in Contemplation

A patient who is in the contemplation stage may see that transitioning to home is a good thing, but they will see as many pros as they see cons. A patient may stay in this stage indefinitely. There will be no urgency to change.

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*Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51(3), 390–395.

Meeting a Patient in Preparation

Patients in the preparation stage will believe that making the choice to transition to a home modality is a good thing and they will be trying to figure out how to overcome their barriers. They may not know where to turn next and will need some guidance. They will be eager for more information and engaged in discussion.

Meeting a Patient in Action

A patient who has reached the action stage will be proud and excited about their decision to transition toward home dialysis. They may not be fully certain of their success and will need encouragement, so they do not slip back into the preparation stage.

Meeting a Patient in Maintenance

Once a patient has reached the maintenance stage they want to share their experience. They know how to overcome barriers and who to ask for help. They want to learn more to continue to accomplish their goals and maintain their choice.

Remember:

- Traditional education is action-oriented (Asking you to make a decision or take action today)
- Patients in earlier stages will look uncomfortable, resist, or ignore education
- It is best to tailor education by the stage of the patient
    - Motivate individuals to shift one stage only, not straight into action
    - Recommend small changes vs. one big ones

Stages of Behavior Change

	Pre-contemplation	Contemplation	Preparation	Action	Maintenance
Definition	Not considering taking actions in the next six months toward a personal or health goal	Considering taking actions in the next six months to pursue a personal or health goal	Preparing to take actions in the next 30 days to pursue the goal	Taking actions to pursue the goal	Behavior change has been sustained for more than six months

Orientation	• Behavior change is not a priority
	• Undervalue pros and overvalue cons
	• Not confident
	• Doesn't want to talk about it
	  • Feels hopeless
	  • Will look uncomfortable
	  • Ignore or resist education
		• "On the fence" with equal value seen in pros and cons
		• Can stay in this stage indefinitely
		• No urgency to change
			• Pros of decision outweigh cons
			• Thinking through/problem-solving how to get started
			• More confident
				Taking actions, but could give up if problems arise	Has intent to maintain the behavior change going forward

Tailoring Approach	• Plant the seed • Provide gentle support to honor where the person is	• Shift ambivalence • Help patients think about pros and what is important to them • Does the goal fit with their lifestyle?	Help patients develop a plan and take the first step	• Support patients continuing the behavior • Problem-solve common barriers • Celebrate progress	Provide reminders and cues that support and encourage maintenance of the positive change
Recommended Small Steps	• Generally talk about the possibility of the decision • Provide education for future use	• Learn more about the topic/goal • Provide educational materials to share with others about the topic/goal	• What would a small step look like? • When do you think you could start? • How could I help you?	• What would the next step be? • Who could help you with your goal?	• Continue positive feedback • Provide support if a barrier is anticipated

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Patient Steps for Change

Are you ready for change?
Use this handout created by patients for patients to help you take small steps to make big changes for better health.

Content

Not thinking about making a change anytime soon.

"I'm doing ok. I'm happy with how I'm doing and how I feel."

Thinking

Thinking that something may need to change to meet my goals.

"I met another patient who does home hemodialysis and it made me want to learn more to see if it would be a good fit for me. I started asking for more information."

Acting

Setting my plan to meet my goal for change.

"I want to get a transplant. I called the transplant center to learn more and scheduled an appointment to get my evaluation started."

Achieving

Moving forward on steps and reaching my goal.

"I started my home training this week and am already noticing a difference in how I feel."

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Section II
Motivational Interviewing

Motivational Interviewing (MI) is a collaborative, goal-oriented method of communication or approach that helps people make change. Motivational Interviewing plays a big role in positive behavioral changes to support better health. The approach upholds four principles:

1. Expressing empathy and avoiding arguing
2. Developing discrepancy
3. Rolling with resistance
4. Supporting self-efficacy (patient's belief they can successfully make a change)

The goal is to avoid creating resistance — no arguments, shaming, persuasion, warnings, or unsolicited advice. It is important to get the person to elicit their own self-motivating statements as to why this change is important to them.

In the following example, a patient has expressed concern that their current modality is like a part-time job. With treatment and travel to and from the clinic three times per week, they feel like their time enjoying hobbies and spending time with family is limited. Part of their life plan is to find more time for things they enjoy. They've heard about home dialysis, but they are not sure if they would be able to do it.

EXAMPLE:
- "I don't feel like I have time to do a lot of the things I used to enjoy."

Create a discrepancy between the current state and the person's goals and values.

EXAMPLE: "Traveling to dialysis three times a week takes a lot of time away from things you'd rather be doing, like spending time with your family."

Elicit Change Talk

EXAMPLES:
- "Tell me what you know about home modalities."
- "What concerns do you have about your ability to do your treatment at home?"
- "What would be the best thing that could happen if you decided that home dialysis was best for you?"

List the pros and cons of behavior change. Assess how important a change is to the person and how confident they are that they can succeed. Look back at what worked in the past.

EXAMPLE:
- Have you ever had to make a big decision like changing careers or jobs?
- How did you do it?

Look forward. Ask these questions:
- What do you hope would happen in the future if you made this change?
- What could you do now?
- What are the best results you could imagine if you made this change?

Explore goals. Assess the match between the person's current modality and future goals. Explore how realistic their goals are. Look for discrepancies between current state and future goals.

EXAMPLE:
- "It's important for me to be here for my family, but spending so much time out of the house gets in the way of that."

Listen and Reflect
Restate the person's change talk from above, helping them feel understood and heard. Use MI Reflection Stems to help restate the change talk.
- Sounds like...
- You're saying that...
- You're feeling like...
- This has been totally ______ for you.
- Almost as if...
- Like a...
- For you, it's a matter of...
- From your point of view...You really ...
- Through your eyes...
- You believe...
- Your concern is that...
- Your fear is that...
- It seems that...
- You're not terribly excited about...
- You're not much concerned about...
- It's really important to you that...
- You're not really...
- You feel as though...
- What I heard you say was...

Empathy is saying more than the person said but not more than the person meant.

What To Do and What to Avoid When Using MI

Express empathy. Listen and reflect on what the person said. Develop discrepancies.

EXAMPLE: On the one hand, having your dialysis treatment is important to your health. On the other hand, you want to make more time to get back to doing things you enjoy.

Avoid arguments. You never want to be arguing for change while the person is arguing against the change. Roll with person's resistance to the plan of care, treatment, or behavior change. Support the person's self-efficacy to change.

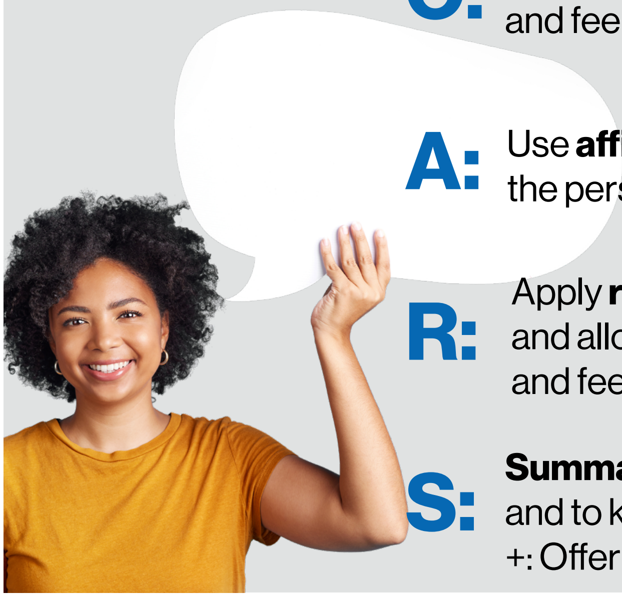
Avoid telling the person they **ought** and/or **want** to change. Don't assume the person's health is the primary motivating factor for him or her. They may be motivated by something else. Make sure you are developing a life plan with your patients, from which the dialysis plan of care can be created. This includes discussions about modality choice.

If the person does not decide to change, do not consider that as your failure as their care provider. Conveying "I'm the expert — the person must follow my advice" is not in the spirit of Motivational Interviewing or Shared Decision Making. The "tough love" approach is not always best. Negotiation is not always the best strategy if a person is not ready to make a change. Learn more about Change Theory in the next section.

Set Up a Plan

Consider and present different options. Try to match the person with the best option for their case but recognize they may not choose the "right" strategy and prepare the person for this possibility. Establish a goal

Motivational Interviewing Using the OARS+ Model



O: Ask open questions to encourage exploration of thoughts and feelings.

A: Use **affirmations** to acknowledge and build confidence in the person's innate capabilities.

R: Apply **reflective** listening to clarify your understanding and allow the person to hear their own words, thoughts, and feelings reflected to them.

S: **Summarize** to let the person know they are being heard and to keep the discussion active and moving forward.

+: Offering information and/or advice with permission.

Motivational Interviewing Four-Part Course | Mini-Lessons

A person's ability and/or willingness to change their behavior has a direct impact on how effective a treatment may be. During this four-part course participants are provided with an overview of using motivational interviewing. The lessons outline key concepts and techniques of motivational interviewing, how to recognize ambivalence, roll with resistance and elicit change talk.

- Part 1
- Part 2
- Part 3
- Part 4

Section III
Shared Decision-Making

Shared decision-making is a collaborative process between patients and healthcare providers aimed at reaching consensus on treatment plans that best suit the patient's individual needs and preferences. It involves sharing information, discussing treatment options, and considering the patient's values and goals.

Through shared decision-making, patients gain a deeper understanding of their health conditions, treatment options, and potential outcomes, empowering them to actively participate in decision-making processes regarding their care. This approach not only enhances patient satisfaction and trust in healthcare providers, but also promotes better adherence to treatment plans and improved health outcomes.

By engaging patients as partners in their healthcare journey, shared decision-making ensures that treatments are aligned with patients' preferences and values, leading to more personalized and effective care experiences.

SDM Series 1

Shared Decision-Making Overview

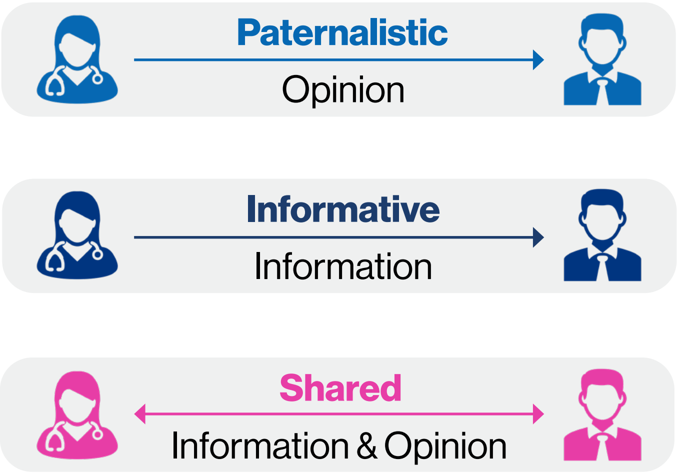
According to the Agency for Healthcare Research and Quality, studies show many providers believe patients are not interested in participating in healthcare decision-making. However, evidence suggests patients want more information than they are given and would like to be involved.

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 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.

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."

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."

Section IV

Improving Communication

The bridge for communication is built on the relationship between staff and patients. When speaking to patients about any change, including consideration of home modalities, communication pathways must be optimized. Many times, these conversations start at the level of the patient care technician, as these team members typically spend the most time interacting with the patients during treatment. Building the bridges of communication is an important skill that is relevant to all team members.

Many facilities have daily team huddles as a way to communicate and share information with staff. The Huddle Up resources have been developed to provide a visual reminder to discuss key concepts during a quick team “huddle”. The information shared can be used for staff training, shared at your facility “huddle” and/or posted for staff review.

Huddle Up
Communication Series #1

Four Rules of Active Listening

1 Seek to understand before you seek to be understood.

Restate: Paraphrase what you think the person has said.
Summarize: Bring together the facts and pieces of the problem to check understanding.

2 Be non-judgmental

Set aside your judgment and withhold blame and criticism in order to fully understand someone. You don't have to like them or agree with their ideas, values, or opinions.

3 Give your undivided attention to the speaker.

Focus fully on the speaker. If you are distracted, you may not notice body language, tone of voice, and other nonverbal cues that may tell you what the speaker is feeling. Show your interest in what is being said. Use brief, positive prompts to keep the conversation going and show you are listening (such as "yes" or "oh?").

4 Use silence effectively.

Silence is a very valuable tool, especially when used to gather information. You can learn a lot by just being silent and listening. Allow for comfortable silences to slow down the conversation. It is important to give a person time to think as well as talk. Deliberately pause at key points for emphasis. This will tell the person you are saying something that is very important to them.

Active Listening

The most common communication problem is when one or more of the people involved are not listening. To listen effectively, we have to do more than just hear what is being said. We must be engaged and practice active listening.

Using active listening in your everyday interactions can help you communicate more effectively. Active listening can help you to:

- build rapport
- increase understanding
- create trust

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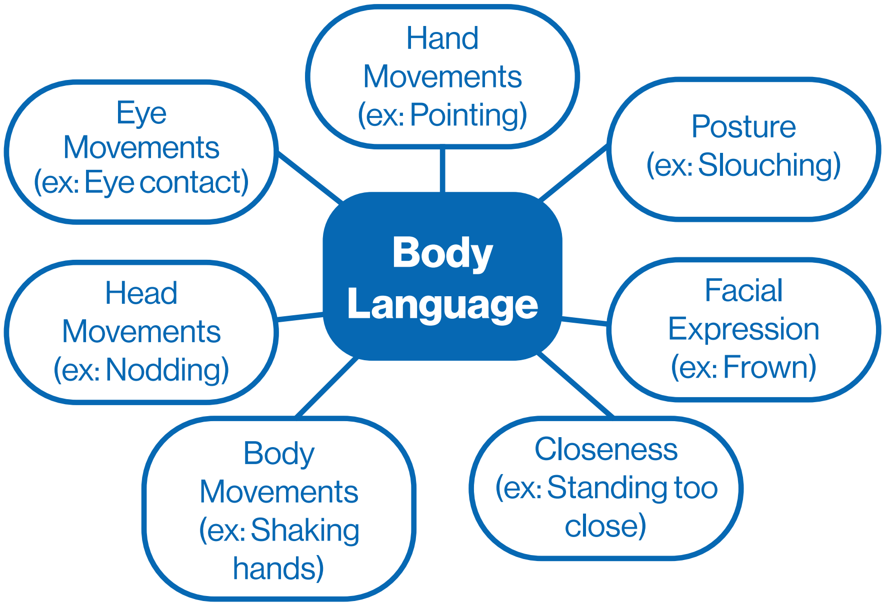
Huddle Up
Communication Series #2



Body Language

- Eye Movements (ex: Eye contact)
- Hand Movements (ex: Pointing)
- Posture (ex: Slouching)
- Head Movements (ex: Nodding)
- Facial Expression (ex: Frown)
- Body Movements (ex: Shaking hands)
- Closeness (ex: Standing too close)

Body Language

Body language is an important part of communication. Non-verbal communication can constitute 50% or more of what we are communicating.

This includes facial expressions, body movement and gestures, eye contact and posture. The way you look, listen, move and react to another person tells them more about how you are feeling than words alone ever can.

Developing the ability to understand and use non-verbal communication can help you connect better with patients, express what you really mean, navigate challenging situations and build better relationships. Ultimately you want to make sure all the non-verbal signals you are sending are giving the same message as your words. Below are some general positive and negative examples of body language to consider.

Positive Body Language*

+ Arms uncrossed
+ Standing with an open stance
+ Sitting at chair level
+ Maintaining eye contact
+ Smiling
+ Facing the patient
+ Slowing down, breathing regularly
+ Nodding
+ Leaning in closer

Negative Body Language*

- Crossed arms or legs
- Standing with hands on hips
- Slouching
- Looking away or rolling eyes
- Avoiding eye contact
- Frowning
- Pointing
- Tapping foot
- Looking at watch or phone
- Moving or leaning away from
- Standing over someone

*May vary based on age, culture, religion, gender and emotional state.

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Huddle Up
Communication Series #3

Being aware of and controlling your emotions requires effort. Here are a few questions to ask yourself to increase your awareness and ways you can manage stress, so you can stay in control of your emotions.

What Emotions Am I Feeling?

- What am I thinking about?
- Am I thinking about what is happening now, or am I preoccupied with something else?
- Are my thoughts positive or negative?
- Did I just hear something that made me angry or sad?
- What is my body telling me?
- Are my muscles or stomach tight?
- Are my hands clenched?
- Is my breathing shallow?
- Am I forgetting to breathe?
- What am I doing?
- Am I engaged in the conversation?

Quick Ways to Manage Stress and Stay in Control of Your Emotions:

Take a few deep breaths

Count to 10

Tighten then relax your muscles

Think of a soothing image

If you are unable to remain calm, it may be better to remove yourself from the situation politely.

Emotional Awareness

Emotional awareness is being aware of your thoughts and feelings. It is important to be aware of the emotions and attitudes you are displaying when interacting with others, so they do not get in the way of the message you are trying to communicate.

Self-awareness increases your ability to identify what underlying emotions may be impacting the patient's words and actions.

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Huddle Up
Communication Series #4

Do:

Focus on the Positive. Give praise and compliments. Who doesn't like when someone acknowledges their efforts? Managing life on dialysis is hard. Try to offer at least one positive with any negative piece of information you share.

Emphasize strengths not weaknesses. "You've been doing a great job coming to all your treatments. Staying for your full treatment will help you get to your dry weight."

Use a neutral tone of voice. "Are the words you are saying being delivered in an appropriate tone of voice? Does your message match your tone?

Use a formal name when first meeting someone. "Use Mr./Mrs./Ms. versus first names. Ask how they would prefer to be addressed before calling them by their first name.

Don't:

Use acronyms and medical jargon. Healthcare is full of acronyms that we often assume patients understand.

Get defensive. When a patient asks, "Did you change your gloves?"...instead of "of course I did" say "Yes, I did, thank you for asking. I know how important it is to your safety." or "You're right, thanks for reminding me."

Words Matter

Word choice and non-verbal cues can positively or negatively impact communication between patients and staff. The words we choose to use are important, because words shape our beliefs and impact our actions.

Words do matter–make sure the words you choose get the intended and desired result.

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Huddle Up

Communication Series #5

Showing respect is a key piece to effective communication. Here are some quick tips to review to make sure you are communicating respectfully.

Recognize that people are different from you and each other.

Be mindful of their time. Avoid making someone wait.

Be aware of individual differences. It's important to take age, culture, religion, gender and emotional state into account.

Be attentive and acknowledge that you have heard them and when you will be able to address their concern. Do not ignore.

Know if the person prefers to be called by their first, last or nickname, and use the preferred method to address them.

Be polite and do not interrupt. Wait for others to finish speaking before sharing your own thoughts.

Nod, smile and respond in a manner that lets them know you are paying attention.

Genuinely encourage their ideas.

Make eye contact (see body language huddle).

Do not assume anything.

Show Respect

All patients have the right to be treated with respect and dignity. We all have our own ways of defining respect and expressing respect for others.

It is important to keep in mind that each patient is an individual that has a life outside of dialysis, a history before dialysis and an experience with healthcare that should be recognized and valued.

All of this impacts their interactions and expectations for how professionals should treat them.

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Relationship-Centered Care

Relationship-Centered Care (RCC) can be defined as care in which patients, families and healthcare providers appreciate the importance of their relationships with one another. In RCC, the patient is the central concern, but is not considered in isolation of all others. The staff is mindful of the contribution of the family, the care team, their organizations and the community.

RCC involves the following principles:

1. Relationships in healthcare ought to include dimensions of personhood as well as roles.
   - Both the patient and providers are unique individuals with their own sets of experiences, values and perspectives.
   - Providers remain aware of their own emotions, reactions and biases and monitor their own behavior.
2. Affect and emotion are important components of relationships in healthcare.
   - Providers should not be detached.
   - Providers are encouraged to empathize with the patient, as it may help patients to experience and express their emotions thereby helping staff understand and serve the patient's needs and improve the patient's experience.
3. All healthcare relationships occur in the context of reciprocal influence.
   - Health and health-related actions do not occur in isolation but are related to one another.
   - Acknowledges that the providers also benefit from serving the patient.
4. The formation and maintenance of genuine relationships in healthcare is morally valuable.
   - Humans are more morally committed to those whom they are in a personal relationship with.
   - As a human participant, the provider behaves more genuinely than if he/she were acting out a role.

After discussing the principles of relationship-centered care with your team, review the A.R.T. (Ask-Respond-Tell) of Communication as a strategy to incorporate RCC into your clinic's workflow.

Outcomes of Relationship-Centered Care (RCC)

The anticipated outcomes of RCC include:

- increased patient engagement in their care;
- patients feel honored, respected and satisfied with care;
- patients have lower anxiety and a higher degree of trust in providers;
- a greater agreement on treatment plans and increased adherence to treatment;
- a better understanding of their illness and informed decision making adds depth to the interaction;
- provider becomes support for the patient and the patient becomes source of professional gratification;
- decreased provider burn-out.

Source: *Beach, M., Inui, T., and the Relationship-Centered Care Research Network. Relationship –Centered Care, A Constructive Reframing., J Gen Intern Med. 2006 Jan; 21(Suppl 1): S3–S8.*

The A.R.T. of Relationship-Centered Care (RCC)

Good communication is essential to providing relationship-centered care.

RCC recognizes reciprocal influence between patients/staff; acknowledges the importance of affect and emotion on relationships; and emphasizes genuineness in relationships.

The A.R.T. (Ask-Respond-Tell) technique can help providers to effectively communicate and build their relationships to improve patient and staff satisfaction and outcomes.

Source: *"Academy of Communication in Healthcare." ACH, www.ACHonline.org/. Accessed 16 Nov. 2023.*

"Ach Book Communication Rx." ACH Book Communication RX, www.CommunicationRX.org/. Accessed 16 Nov. 2023.

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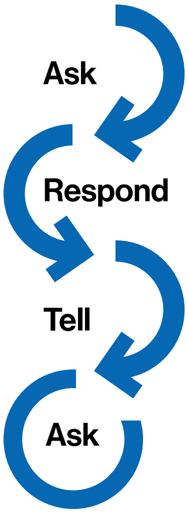
Using A.R.T. for RCC



Ask for the other's perspective (Give time to answer and don't interrupt). "We need to review your medications to make sure they are still working for you. What medications do you take and what do you take them for?"

Respond with empathy (See PEARLS below). "Managing all your medicines can be overwhelming and confusing, but they are all important to your health. We want to support you and will work together to find a plan."

Tell your perspective. "Understanding why you take all your medications is important. Keeping a current list of your medications can help you talk about them with your doctor."

Ask "What are some things you can do to keep track of your medications and help you take them as prescribed by your doctor?"

A.R.T. Loops

- Turns monologue into dialogue
- Elicit patient preferences, goals and barriers
- Ensures clarity and maximizes adherence

Use A.R.T to Summarize and Clarify Teachback

Ask the patient to summarize. "I've spoken a lot: can you tell me in your own words what we've decided on? Or "When you speak with your family member, what will you tell them we discussed?"

Respond: "Sounds like a good summary."

Tell additional points, as needed.

Respond with Empathy

Partnership: "Let's work on this together."

Emotion: "You say you're frustrated."

Apology & Appreciation: "I'm sorry that I upset you." Respect: "I give you a lot of credit for getting through this as you have."

Legitimization: "Most people in your position would feel this same way."

Support: "I'm going to stick with you through this."

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Huddle Up
Coaching

What Type of Coach Are You?

When addressing a challenging situation, it is important to take a step back and evaluate the situation. The underlying reasons or "root cause" for the undesired behavior(s) need to be identified and evaluated with a patient-centered focus. This includes considering how staff beliefs and reactions may be affecting a patient's behavior. Visualizing yourself as a coach can be helpful when thinking of being patient-centered. "A coach is a collaborative partner who works with the learner to help them achieve goals, solve problems, learn and develop."[1]

Do you remember your "best" and "worst" experience with a coach? What did they do and say to make you want to follow them? Did they build you up? Did they focus on all that you were doing wrong or did they focus on the positive and help you to identify what you could do differently to improve? How patients feel they are treated by staff can impact their response, just like someone responding to a coach. It can be a positive or negative experience.

Review the following do's and don'ts of "coach qualities" and assess how they can relate to your work with dialysis patients.

DO

Focus on the positive.
Notice and give praise to patients when they come in on time, stay their full treatment, or keep their fluid gains down. "Good" coaches help identify when something worked well and how you can replicate it for success.

Be respectful.
Good coaches earn their respect on a daily basis, based on how they conduct themselves and interact with patients and coworkers.

Be patient-centered.
Make it your mission to provide individualized care. Teach and help them adjust to and live better with dialysis as part of their life.

Be discreet.
Address any concerns with the patient in a discreet and private manner.

Treat all patients fairly.
Always maintain appropriate professional boundaries.

Encourage patients to share their concerns.
All complaints are opportunities to improve.

DO NOT

Focus on the negative.
"Bad" coaches tear down self-esteem rather than building it up. They use fear, humiliation and demeaning, disrespectful behaviors as "teaching" tools.

Be disrespectful.
Do not talk down to patients. Do not ignore them or dismiss their concerns or needs.

Publicly shame.
It can be humiliating to have your "failures" pointed out in public.

Play favorites.
Don't operate with two different sets of rules for patients you prefer to work with and those you may struggle with.

Discourage patients from sharing concerns.

Focus only on meeting ESRD QIP outcomes and corporate goals
Do not tell a patient they're affecting the clinic's numbers.

For more information, contact:
ESRD Network 10: 800-456-6919
ESRD Network 12: 816-880-9990

esrd.qsource.org

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[1] J Caplain (2003) Coaching for the future how smart companies use coaching and mentoring. London CIPD

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Huddle Up
Teach-Back

Teach-Back Basics:

- Use plain language and explain any new words or acronyms when teaching.
- Break down information into short statements.
- For more than one concept, teach the 2-3 main points for the first concept and check for understanding before going to the next concept.
- Be careful NOT to ask questions that can be answered with a Yes or No response, such as: "Do you understand?" or "Do you have any questions?"
- Ask for Teach-Back in a non-shaming tone. It's not a test of the patient, but a check on how well you explained the ideas and what the patient understood.

Teach-Back in Action

1 **Ask the patient to demonstrate understanding, using their own words.**
"We covered a lot of information about your blood pressure today. I want to be sure I explained everything clearly. Can you please explain it back to me, or tell me in your own words what we talked about?"

2 **Listen to the patient's answer. If the patient does not repeat the information accurately, rephrase the information.**
"It sounds like you understand why it's important to control your blood pressure. Before we move on, I'd like to talk more about your blood pressure medications."

3 **Ask the patient to teach back the information again, using their own words, until you are comfortable they really understand it.**
"What will you tell your spouse about the changes we made to your blood pressure medicines today?"

4 **If they still do not understand, consider other strategies.**

Teach-Back

Research shows that patients remember and understand less than half of what healthcare providers explain to them.

This lack of understanding can cause numerous problems and impact safety. Asking patients to recall and restate what they have been told is a top patient safety practice.

Teach-back is an effective method to check for understanding. It creates an opportunity for dialogue in which the provider gives information, then asks the patient to respond and confirm understanding before adding any new information. This also allows the provider to determine if reteaching is necessary.

For more information, contact:
ESRD Network 10: 800-456-6919
ESRD Network 12: 816-880-9990
or visit esrd.qsource.org

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Section V

Home Dialysis Resources

The following list of resources are available online. Utilize these resources to learn more about home modalities and to help educate patients about the possibilities of dialyzing at home.

Qsource ESRD Network Resources

- Home Dialysis Poster
- Home Dialysis Myth Busters
- Explore Your Kidney Treatment Options
- Home Hemodialysis Handout
- Home Dialysis is Possible
- Benefits of Home Dialysis Word Search
- Is Home Dialysis Right for Me?
- Home Dialysis Passport

Bulletin Board Kits

- Home Dialysis Bulletin Board Kit
- Harvest the Benefits of Home Dialysis
- Tis the Season to Learn About Home Dialysis

Partner Resources

- Home Dialysis Central
- MATCH-D
- My Kidney Life Plan English | Spanish
- End-Stage Renal Disease National Coordinating Center
- The Kidney Hub

Section VI
Life Planning Goal Setting Worksheets

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, which may include review of their current modality and consideration for change. Use these resources and provide support for patients working on their Life Plans.

"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.

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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[1] How to Plan Your Life: https://www.tonyrobbins.com/importance-time-management/life-planning/ Accessed May 17, 2022

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)

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?

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.

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[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)

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

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

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911 E. 86th St., Ste. 30 | Indianapolis, IN 46240
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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	M	A	R	T
Específico	**Medible**	**Alcanzable**	**Realista**	**Basado en el Tiempo**
El objetivo se centrará en una idea.	Usted puede dar seguimiento a su progreso.	Usted puede cumplir con su meta.	La meta requiere esfuerzo, pero puede alcanzarla.	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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