MY DIALYSIS PLAN™

My Dialysis Plan™, also known as person-centered care planning, helps care teams align dialysis care with patient needs and priorities. The goal of My Dialysis Plan™ is to improve patient health through increased communication, shared decision-making, and close follow-up.

MY DIALYSIS PLAN™

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OVERVIEW

Person-centered dialysis care planning aligns care with what matters most to individual patients. My Dialysis Plan™ aims to shift care planning from a problem-based approach to a priority-based approach.

Key program components:

- Learn about patient priorities and challenges to achieving personal goals
- Engage in shared decision-making to create an action plan
- Follow up and reevaluate patient priorities and challenges over time

Key program outcomes:

- Individualized care plans that help patients achieve their personal goals and better health
- Greater trust and satisfaction among patients and care teams

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Person-centered care planning is a collaborative process in which patient-identified needs and priorities guide health care decision-making and inform development of an individualized plan of care.

In dialysis care planning, this involves linking patient-identified priorities to care plan components like bone-mineral disease, anemia, pain management, among others. By collaborating as equal partners, the patient and care team agree upon action steps to reach identified goals, establish benchmarks for progress, and outline plans for follow-up.

In the end, **the care plan should be a personalized map** to help patients achieve their personal goals and get where they want to be.

Current Approach

PROBLEM-BASED

Step 1 Review the same generic, unprioritized problem list with all patients.

Step 2 Discuss all problems whether they are important to patients or not.

Step 3 **END** care plan meeting without follow-up plans and often without asking about patient priorities.

Care Planning Paradigm Shift

My Dialysis Plan™

PRIORITY-BASED

Step 1 **START** care plan meeting by asking about patient priorities.

Step 2 Discuss challenges associated with patient-identified priorities and any remaining care team concerns.

Step 3 Work with patients to make care decisions and prepare follow-up plans.

EVIDENCE SUPPORTING THIS APPROACH [a,b,c]

Studies have shown that person-centered (or individualized) care planning:

- Enhances patient experiences and provides a more meaningful context to care
- Promotes patient engagement and self-efficacy
- Improves clinical outcomes
- Improves teamwork and increases care team satisfaction
- Creates shared responsibility between patients and care teams

a. Mold, J. (2017). Goal-Directed Health Care: Redefining Health and Health Care in the Era of Value-Based Care. Cureus, 1043.

b. Pirhonen, L., Olofsson, E. H., Fors, A., Ekman, I., & Bolin, K. (2017). Effects of person-centred care on health outcomes — A randomized controlled trial in patients with acute coronary syndrome. Health Policy, 121(2), 169–179.

c. Pol-Grevelink, A., Jukema, J., & Smits, C. (2011). Person-centred care and job satisfaction of caregivers in nursing homes: A systematic review of the impact of different forms of person-centred care on various dimensions of job satisfaction. International Journal of Geriatric Psychiatry, 27(3), 219–229.

THE CARE PLANNING APPROACH

Person-centered dialysis care planning involves some preparation:

- Invite patients to participate and identify their preferences for meeting time, location, and guests.
- Schedule care plan meetings according to patient preferences and notify care team members of care plan meetings in advance.
- At least one week prior to the meeting, share the care planning video and brochure with patients so they have an opportunity to prepare.
- Before meeting with the patient, huddle with the care team to discuss assessments and relevant information.
- Use the step-by-step conversation guide to elicit patient needs and priorities during the care plan meeting and develop an individualized care plan.

TIPS

Be patient during this process as it may feel unfamiliar initially.

STEP-BY-STEP CONVERSATION GUIDE FOR THE CARE PLAN MEETING

Step 1.

Ask open-ended questions about the patient's life such as...

- What kinds of things do you do on a typical day? What about on a non-dialysis day?
- What does a good day look like for you?
- What is important to you? What matters to you?
- What would you be doing if you weren't on dialysis?
- What would you like to be able to do that you can't do now?

Step 2.

Clarify by asking for additional information, if needed.

- Could you tell me more about that?
- What do you mean by that?

Step 3.

Identify any barriers that may exist for the patient by asking...

- What is getting in the way of that?
- How does dialysis influence that?

Step 4.

Work with the patient to prioritize their identified needs. Use questions such as...

- What would you like to focus on now?
- What do you see as the next steps to get you there?
- What things would you like to address in the long-term?

Step 5.

Develop a care plan through shared decision-making, designating who is responsible for each action item. Ask questions like...

- How can we help you with that?
- What do you need to make this happen?
- What do you think would work for you?

Step 6.

Summarize the care plan at the end of the meeting to ensure accurate understanding and interpretation by everyone.

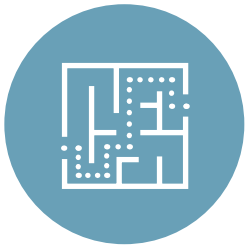
Step 7.

Give the patient a copy of the care plan to take home.

TIPS

- **Make time and space for questions.**
- **Take notes during the meeting, rather than afterward.**
- **Ask if there is anything else to discuss before closing.**

EXAMPLES OF PATIENT PRIORITIES, BARRIERS, AND POSSIBLE CARE PLAN ACTIONS



Sometimes, patient priorities may seem out of scope or unrelated to dialysis. However, there are often creative ways to align the dialysis care plan with patient priorities.

PATIENT PRIORITY	POTENTIAL BARRIER	POSSIBLE CARE PLAN ACTIONS
Get on the transplant list	Ineligible due to frail status and comorbid disease burden	• Refer to physical therapy for an exercise program for strengthening. • Refer to a primary care clinician for better management of comorbidities. • Refer to another transplant center for repeat evaluation.
Shorten dialysis treatment time	Large interdialytic weight gains	• Identify action steps for diet and lifestyle modifications. • Establish a timeline for completion and follow-up. • Designate a time to assess progress and reevaluate patient priorities.
Spend more time with grandchildren	Long recovery time because of post-dialysis fatigue	• Perform a time-limited trial of shorter dialysis or nocturnal dialysis (if available). • Conduct formal time to recovery assessments weekly to see if post-dialysis fatigue improves.
Homeschool children	In-center, thrice weekly treatment	• Discuss options like nocturnal dialysis (if available), home dialysis, and peritoneal dialysis.
Maintain work as a part-time employee with an irregular work schedule	Tuesday, Thursday, Saturday treatment schedule interferes with inconsistent work shifts	• Modify treatment schedule to allow for consistent Saturday work shifts to maintain part-time status. • Elect a care team member to review the monthly work schedule with the patient to determine other helpful changes.

POTENTIAL CHALLENGES AND SOLUTIONS

There may be some challenges with implementing person-centered care planning. Often, these can be resolved with strategic planning, patient empowerment, and transparent communication.

POTENTIAL CHALLENGE	POTENTIAL SOLUTIONS
Past experiences with care planning may influence patients' communication and/or willingness to participate.	• Empower patients with preparation materials (video and brochure), and answer their questions. • Explain how this approach may improve their dialysis experience. • Schedule the meeting in alignment with patient preferences (location, timing, guests) to demonstrate that you are listening.
Each day is already busy, so it may be difficult to balance care team responsibilities with additional patient follow-up.	• Establish a follow-up plan collaboratively with patients and work together to delegate action items among care team members and patients. • Encourage patients to follow up with the care team. **For Example** A patient may be interested in more frequent follow-up, which may best be performed by a clinic staff member rather than a medical provider.
It may feel overwhelming to imagine this approach in bigger clinics.	• Stagger care plan meetings evenly over the year, even if some are performed before their annual due dates. • Review the calendar in advance to prevent scheduling conflicts and facilitate entire care team involvement.
Patient priorities may conflict with traditional care plans. **For Example** Patients may want shorter treatment time to get home earlier to see family. However, shortening treatments may lead to inadequate clearance and/or fluid balance.	• Provide education and offer choices. • Use shared decision-making. • Incorporate care trade-off discussions. **For Example** If care teams explain that shortening treatment time may be detrimental for other reasons (faster fluid removal and potentially greater fatigue), the patient may request information about other options to maximize quality time at home.

Funded by the American Institutes for Research (AIR), with support from the Robert Wood Johnson Foundation (RWJF), for a Patient-Centered Measurement Pilot.