BCRenal
Provincial Health Services Authority

Better Together:
A Strategy to Advance Collaborative Patient Goal-Setting in Kidney Care

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This document and related resources are available at:
BCRenalAgency.ca → Health Professionals → Clinical Resources → Self Management

IMPORTANT INFORMATION
For information about the use and referencing of BC Renal guidelines/resources, refer to http://bit.ly/28SFr4n.

BC Renal
Phone: 604-875-7340
Email: bcpra@bcpra.ca
Web: BCRenalAgency.ca
Facebook.com/BCRenalAgency
@BCRenalAgency
Youtube.com/BCRenalAgency

About BC Renal

BC Renal plans and monitors the delivery of kidney care services to a diverse population living in various settings and communities across BC. As a provincial network, we operate on the unceded traditional and ancestral land of many Indigenous peoples, including First Nations, Métis and Inuit people. Our main office is located on the traditional and ancestral territories of the Musqueam, Squamish and Tsleil-Waututh Nations, and the Métis Chartered Community of the Lower Mainland Region.

Acknowledgments

This strategy is a testimony to the commitment of many people. Its development is informed by various perspectives gathered at a series of focus groups, a provincial workshop and meetings with health professionals, administrators, patients and family members living with chronic kidney disease in BC, as well as representatives of The Kidney Foundation—BC & Yukon Branch and the Provincial Health Services Authority (PHSA). Special thanks to the leadership of BC Renal committees and health authority renal programs for making the action-planning activities possible.

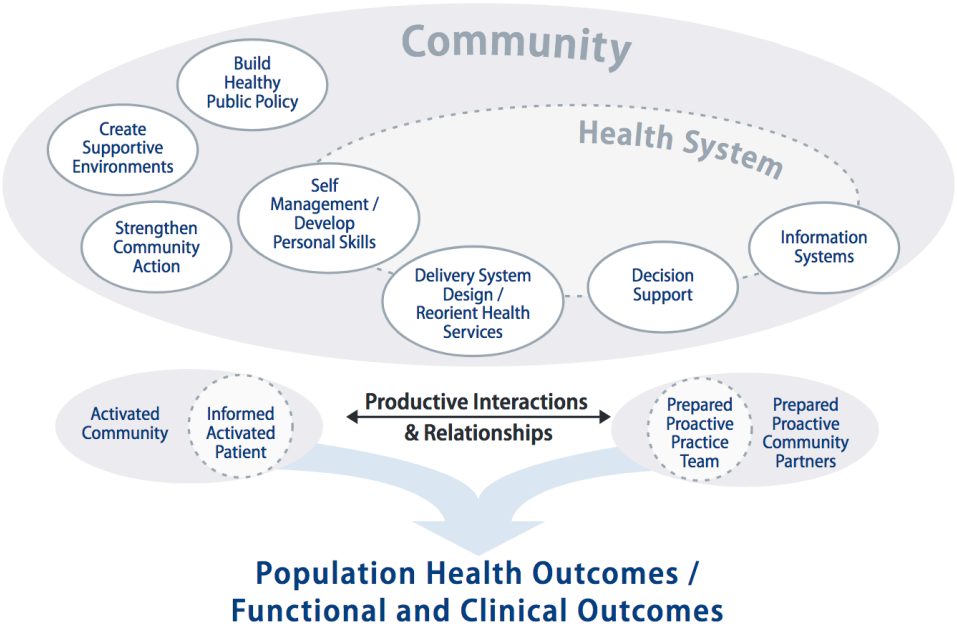
Introduction

This strategy document is intended to be a call to action for various stakeholder groups that form the provincial renal network (health professionals in renal programs, BC Renal, The Kidney Foundation—BC & Yukon Branch and other organization partners, patients and family caregivers living with kidney disease). Together, we can collectively change the culture to one that supports better collaborative patient goal-setting. The document is both a synthesis of relevant resources in BC and a summary review of the discussion at the provincial action-planning workshop in February 2020. It also aims to adapt to the evolving situation of the COVID-19 pandemic that began shortly after the workshop, ensuring that the strategy is applicable during and after the pandemic. The conceptual framework and actionable ideas described are adaptable to the needs of all local kidney care settings and individuals.

Background: The Link to Patient Self-Management

Self-management is a fundamental part of daily life for patients living with chronic kidney disease. It is also an intervention that supports optimal patient outcomes and experiences in line with BC's Expanded Chronic Care Model (Figure 1).

Figure 1: The Expanded Chronic Care Model: Integrating Population Health Promotion



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002). Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" The Milbank Quarterly, 79,(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

As self-management empowers patients in managing their health conditions, self-management support may further activate patients in their care, driving a culture shift for person- and family-centred care. This can be a new concept for some health professionals and people living with chronic conditions.

Self-management relates to the tasks an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management.

Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal-setting, and problem-solving support.

How We Got Here and Why We're Focused on Goal-Setting

Goal-setting is a pivotal element in self-management. It is also one of the five domains that the Patient Assessment of Chronic Illness Care (PACIC), a patient experience survey, evaluates in the context of the Expanded Chronic Care Model.

Over the past decade, BC Renal administered the PACIC three times across the province, and consistently identified goal-setting as an area for improvement across all modalities of kidney care and all health authority renal programs (HARPs). The latest survey reports are available at BCRenalAgency.ca ▶ Health Info ▶ Disease & System Statistics

In Summer 2019, BC Renal and the HARPs organized a series of focus groups with kidney health professionals and patients and family members living with kidney disease across all HARPs to better understand goal-setting from various perspectives, and identify common areas for patient goal-setting improvement across modalities. The focus group report can be found at BCRenalAgency.ca ▶ Health Professionals ▶ Clinical Resources ▶ Self-Management

On February 3, 2020, BC Renal hosted a provincial "What Matters to You" Action Planning Workshop. The goal was to build on the focus group findings and existing evidence and develop a way forward for collaborative patient goal-setting improvement as a provincial renal network. A workshop overview is included in the appendix.

Goal-Setting is defined as the process of acquiring information for and setting of specific, collaborative goals between health professionals and the patient in managing chronic conditions. The focus is on what matters to the patient. The process involves a series of iterative conversations:

- to understand what matters to the patient
- to set an overarching medical and/or non-medical goal
- to break it down into shorter term goals over time with realistic and concrete action plans
- to follow up and provide support if needed

Why is Collaborative Patient Goal-Setting Important?

The 2019 focus groups clearly demonstrated that patients, family members and kidney health professional participants all recognized setting goals with patients as useful and valuable when it is done well. It is a concept that everyone could relate to within and beyond the clinical care setting, i.e., in daily life. The key benefits drawn from the discussions include:

- Patient- and family-specific benefits
  - A greater sense of control and hope
  - Motivated and empowered patients
  - Better understanding of kidney health and care
  - Better health and quality of life
  - Enhanced experience of care
- Health professional-specific benefits
  - Better understanding of their patients
- Mutual benefits
  - Better patient and health professional relationship
  - More effective tailoring of chronic kidney disease care
  - Improved overall patient experience and outcomes

Furthermore, collaborative goal-setting aligns with the principles of person- and family-centred care and corresponds with the BC Ministry of Health and Accreditation Canada's approach to person- and family-centred care. Documenting the process of having collaborative goal-setting conversations and journeying with the patients towards what matters to them can be helpful not only in supporting patients in their care, but also in providing evidence for accreditation surveys. It also supports the values of BC Renal and all provincial and regional health authorities in BC.

A Goal-Setting Conceptual Framework

Authentic and patient-driven goal-setting builds trust and fosters hope among patients,

family and health professionals. Figure 2 summarizes what collaborative goal-setting should entail along with a readily accessible toolbox in the BC kidney care context.

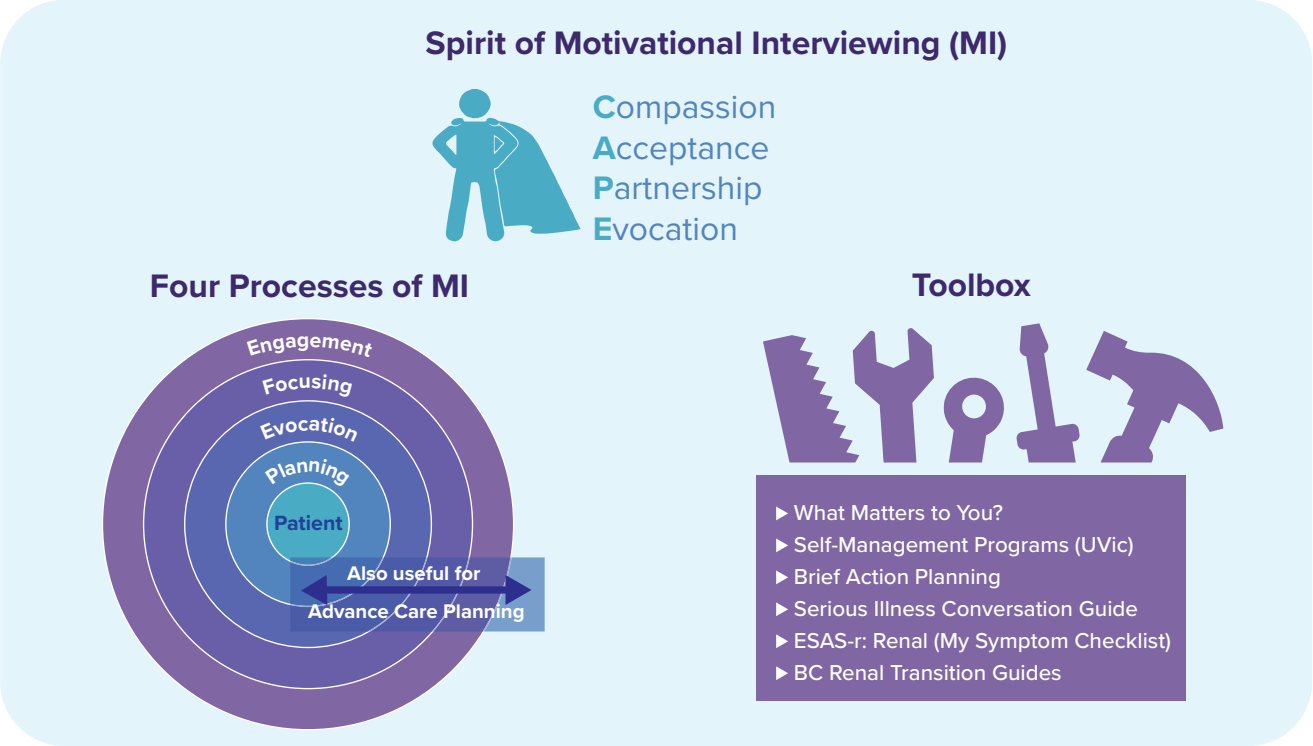
Motivational interviewing (MI) refers to "a collaborative conversation style to strengthen a person's own motivation and commitment to change." As such, motivational interviewing is foundational in collaborative patient goal-setting conversations. Meaningful goal-setting conversations can be guided by the spirit of motivational interviewing (compassion, acceptance, partnership, evocation) with mutual trust and respect as core values.

Spirit of Motivational Interviewing

Compassion: Caring about what is important to another person and feeling moved to help.
Acceptance: Respecting another person and their right to change or not change.
Partnership: Working together with another person and recognizing them as equal.
Evocation: Bringing out another person's ideas, strengths, and knowledge about the situation and themselves. This can include encouraging to explore.

Source: https://centrecmi.ca/wp-content/uploads/2019/11/Spirit_of_MI_2018-11-30.pdf

Figure 2: Goal-Setting Conceptual Framework



Adaptation based on Miller and Rollnick 2012; Motivational interviewing: helping people change, 3rd edition

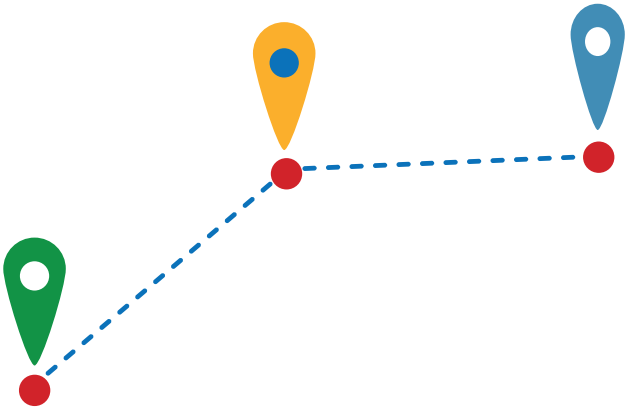
In the context of collaborative goal-setting, the four processes of motivational interviewing are centred around what matters to the patient. They also build the relationship among patients, family caregivers and health professionals to set goals and make corresponding action plans. Flow between the processes is iterative and fluid depending on the needs and circumstances of individual patients. Importantly, the four processes require time and safe space for meaningful conversations between the health professionals and the patient.

Advance care planning conversations are essential in understanding patient values and wishes so as to align health care accordingly when a patient can no longer speak for themselves. Goal-setting conversations and advance care planning conversations may occur in parallel to each other. Even though advance care planning also covers aspects beyond the four processes of motivational interviewing, e.g., communicating about prognosis, the processes are also relevant in fostering the relationship between kidney health professionals and the patient in continuing the conversations and supporting the patient along the way. More about advance care planning can be found at BCRenalAgency.ca ▶ Health Professionals ▶ Clinical Resources ▶ Palliative Care

Four Processes of Motivational Interviewing

Engaging: The process of building and supporting a relationship where trust and respect go both ways.
Focusing: The ongoing process of choosing and keeping a specific direction.
Evoking: Bringing out another's strengths, knowledge and ideas about the situation and themselves. This can include encouraging to explore.
Planning: Being with someone while they form specific actions to take.

Source: https://centrecmi.ca/wp-content/uploads/2019/11/MI_Definitions_and_Four_Processes_2019-11-18.pdf



Goal-Setting Toolbox

The following tools were all captured by the 2019 focus groups. They are all readily available to kidney health professionals, patients and family members living with kidney disease to initiate and sustain collaborative goal-setting conversations and support patients along their kidney journeys. Some of the tools are generic and others are kidney-specific. Almost all are accessible online and free of charge to the users. The icon(s) next to each tool indicates the intended users.

Patient and family

Healthcare providers

What Matters to You?


"What Matters to You?" is a simple and powerful question that encourages meaningful conversations between patients, family caregivers and their health professionals, and ensures that care is aligned with patient preferences. Ultimately, it helps all to move from system- or health professional-centred conversations to person-centred care. More information and resources to support asking, listening and doing what matters: www.whatmatterstoyoubc.ca.

Self-Management Programs

Self-Management BC offers various programs in the community to enable adults in BC to gain knowledge, skills and confidence to manage ongoing health conditions and to assist them in maintaining active and fulfilling lives. All programs currently offered include action planning, problem solving, decision making and dealing with difficult emotions. The programs, sponsored by the BC Ministry of Health, have been delivered by trained lay people in-person across the province. In light of the pandemic, any adults of any age living in BC with one or multiple health conditions may participate online, by telephone or independently. No referral is required. For more information and registration: www.selfmanagementbc.ca For general inquiries, call (toll-free) 1-866-902-3767 or email selfmgmt@uvic.ca.

Brief Action Planning

This is a self-management support technique structured around three core questions to facilitate the development of an action plan

the patient feels confident about. The spirit of motivational interviewing is the foundation of this tool. The BC Ministry of Health sponsors training for BC health authority staff on brief action planning and motivational interviewing through the Centre for Collaboration, Motivation and Innovation (centrecmi.ca). To access the training, contact your regional contact person, check the LearningHub, or e-mail bcpra@bcpra.ca.

Serious Illness Conversation Guide 

This is a communication tool for health professionals to guide advance care planning conversations with patients using a structured format. It helps build trust between health professionals and the patient, understand the patient preference, share information about the illness and explore key things important to the patient, e.g., fears and worries, goals in life. Training workshops are periodically held across the provincial renal network. For more information, and to download the tool: BCRenalAgency.ca ▶ Health Professionals ▶ Clinical Resources ▶ Palliative Care

My Symptom Checklist (ESAS-r: Renal) 

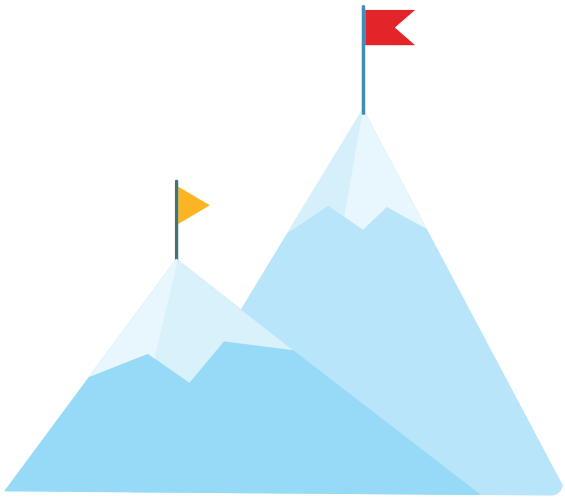
This patient self-reported tool is for systematic assessment of symptoms that are known to be common yet under-reported in patients living with kidney disease. Understanding what is bothersome to the patient may help kidney health professionals to manage those symptoms accordingly. It may also help prioritize what matters to the patient in their care or visits. The checklist is available in English, French, Punjabi, and Traditional and Simplified Chinese. For more information and to download the tool: BCRenalAgency.ca ▶ Health Info ▶ Managing My Care ▶ Symptom Assessment and Management
Health professional resources for supporting its use in clinical settings can be found at BCRenalAgency.ca ▶ Health Professionals ▶ Clinical Resources ▶ Symptom Assessment and Management

BC Renal Transition Guides 

This comprehensive series of Care Team Transition Guides and Patient Transition Guides provides key information to support patients during major transition points in their kidney journeys. These guides provide step-by-step information on what happens during transitions and support the active role patients have in their health care planning and decisions. For more information and to download the guides: BCRenalAgency.ca ▶ Health Professionals ▶ Clinical Resources Transitions in Kidney Care

Further guidance and additional tools on the iterative approach are also described in *Self-management and self-management support: design template and discussion document (2007)*.

So, What's Next in Advancing Collaborative Patient Goal-Setting?



What can be done to practically improve patient goal-setting? Four key requirements or "primary drivers" for improving goal-setting were identified from the 2019 focus group discussions: **Partnership, Awareness, Adaptability, Support** (See focus group report at BCRenalAgency.ca ▶ Health Professionals ▶ Clinical Resources ▶ Self-Management.

Building on those, a number of secondary drivers for improvement were identified and discussed at the 2020 provincial action planning workshop. Here are the top secondary drivers rated by patient, family and health professional participants under the four primary drivers:

Partnership: Harness mutually beneficial partnerships among patients, family caregivers and health professionals

- Foster active listening among health professionals, patients and family caregivers
- Enhance understanding of cultural considerations in ongoing conversations between patients and health professionals
- Ensure shared understanding of what the goal(s) of the patient is (are) among the patient and kidney health professionals

Awareness: Promote awareness and understanding of goal-setting

- Make relevant tools visible to kidney health professionals and patients
- Provide more professional training (e.g., motivational tips, role play)
- Offer various opportunities for education and support among patients and families (e.g., options for group teaching or one-on-one support)
- Enhance awareness in the community via existing communication channels (e.g., The Kidney Foundation's cable TV show PLUGGED IN)

Adaptability: Build adaptable process and safe space to guide effective communication

- Enhance accessibility to online tools
- Release time for having goal-setting conversations
- Designate a 'navigator' for the patient to set goals and action plans with follow-up
- Prioritize appointment based on what matters to the patient

Support: Strengthen continual support along the patient journey

- Document goal(s) in the patient's health record
- Enable the patient to track their own goals while noting individual preference for keeping their own copy (or not)
- Ensure the patient's goals are communicated with their family doctor
- Enable peer support and connections among patients and families

Figure 3 is a driver diagram template that can be used to guide the thought process with respect to targeting certain drivers as deemed relevant and appropriate by individual renal programs and other stakeholder groups. It is also available as a separate, fillable template, titled Improving Collaborative Patient Goal-Setting in Kidney Care: A Worksheet, which can be downloaded for use.

Here are the steps that each kidney care setting, renal program or any of the stakeholder groups may take:

1. Form a working team of key individuals. For example, in a kidney care setting, it may include the manager, frontline clinicians and patient partners with lived experience of care in that setting.
2. As a team, examine potential gaps in collaborative goal-setting and the primary and secondary drivers on the driver diagram, considering the regional and/or local context.
3. Define the aim of your improvement effort by specifying the target location and time frame.
4. Prioritize the identified areas of improvement based on existing needs and resources.
5. On the driver diagram, mark the top areas of improvement your team would like to focus on.
6. Brainstorm specific change ideas that your team would like to attempt for each of the top secondary drivers, i.e., what change can you make that will result in the specific improvement?
7. Test the change ideas systematically.
8. Evaluate and note the learning (e.g., impacts and lessons learned) from each idea you have tested. For example, does the idea actually help patients set and/or accomplish their action plans for better health? The evaluation may include the monitoring of goal-setting conversations that have taken place, documentation of the patient's goals and corresponding action plans as well as the follow-up and progress towards accomplishing the goals.
9. Share your findings with others in the provincial renal network so we can all know what can work (or not) and learn from one another in advancing patient goal-setting!

In improving patient goal-setting, it is important to consider if any target efforts are needed to close the gaps of specific patient populations to ensure equity in care. This may include specific change ideas that address health literacy, Indigenous cultural safety, language and cultural needs, etc.

Figure 3: Driver diagram for improving collaborative goal-setting

Define each part of the following driver diagram in this direction. The change ideas should contribute to what your team is aiming to accomplish.

AIM What are we trying to accomplish?	PRIMARY DRIVERS Components which will contribute to achieving the aim.	SECONDARY DRIVERS Major actions within the components which will contribute to achieving the aim.	CHANGE IDEAS What change can we make that will result in improvement?
To enhance and sustain collaborative patient goal-setting between patients and kidney care professionals in _____ **Location/Setting** by _____ **Timeline**	☐ **Partnership:** Harness mutually beneficial partnerships among patients, family caregivers and health professionals	☐ Foster active listening among health professionals, patients and family caregivers	
		☐ Enhance understanding of cultural considerations in ongoing conversations between patients and health professionals	
		☐ Ensure shared understanding of what the goal(s) of the patient is (are) among the patient and kidney health professionals	
	☐ **Awareness:** Promote awareness and understanding of goal-setting	☐ Make relevant tools visible to kidney health professionals and patients	
		☐ Provide more professional training	
		☐ Offer various opportunities for education and support among patients and families	
		☐ Enhance awareness in the community via existing communication channels	
	☐ **Adaptability:** Build adaptable process and safe space to guide effective communication	☐ Enhance accessibility to online tools	
		☐ Release time for having goal-setting conversations	
		☐ Designate a ‘navigator’ for the patient to set goals and action plans with follow-up	
		☐ Prioritize appointment based on what matters to the patient	
	☐ **Support:** Strengthen continual support along the patient journey	☐ Document goal(s) in the patient’s health record	
		☐ Enable the patient to track their own goals while noting individual preference for keeping their own copy (or not)	
		☐ Ensure the patient’s goals are communicated with their family doctor	
		☐ Enable peer support and connections among patients and families	

Moving Forward Together in Partnership

To change the culture for better collaborative goal-setting between patients and health professionals across the kidney health system in BC, collective commitment is required from each of the following stakeholder groups involved in their unique roles.

Renal program leadership and frontline health professionals

Commitment of the health authority renal programs is paramount to the success of improving collaborative patient goal-setting. Individual programs may take the steps as outlined in the previous section.

Programs may consider using regional renal program (RRP)/ value-add fund for targeted improvement activities. And it is recommended that managers or their designates document the process and outcome of the targeted improvement activities. It will come in handy for upcoming accreditation surveys!

BC Renal

BC Renal will continue to play a facilitative role for better patient goal-setting across the provincial renal network through:

Resource curation: Continuing to curate and keep the renal programs informed of related resources, including tools and training opportunities available across the province.

Strategic alignment: Striving to bridge and align efforts led by the provincial modality committees with this work.

Quality improvement support: Liaising with organization partners, coordinating forums for sharing lessons learned among renal programs and advising on quality improvement approaches and methods as needed.

Knowledge dissemination and communications: Ensuring consistent promotion and messaging of collaborative patient goal-setting, goal-setting tools and resources to be shared via social media, Renal News Express, BC Kidney Days, Province-Wide Rounds and other communication channels.

Evaluation: Evaluating progress provincially by monitoring the uptake of online resources (process measure) and conducting the PACIC survey which will indicate the awareness of goal-setting and whether or not it has taken place in their kidney care (outcome measure). Narratives that capture the improvement experience and impacts will also be captured.

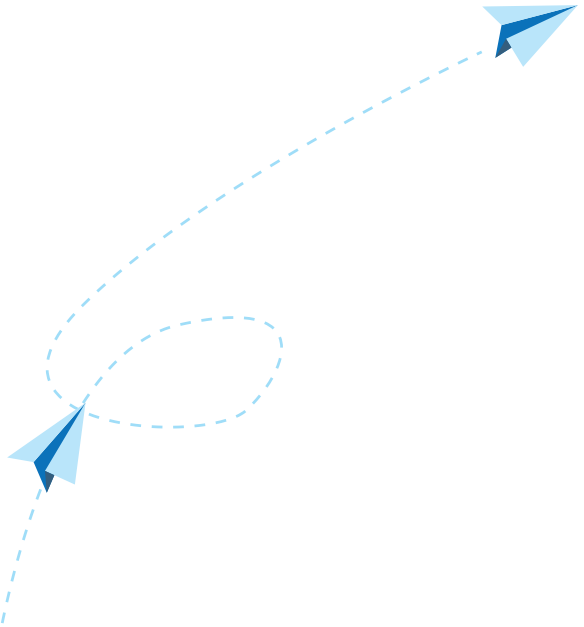
The Kidney Foundation—BC & Yukon Branch

The Kidney Foundation—BC & Yukon Branch plays an important role in promoting awareness of collaborative patient goal-setting and related resources in the community.

Development of peer engagement and support strategies by the branch may also help activate those living with kidney disease in their own care and support each other in individual action planning.

Patients and family caregivers

Individual patients and family caregivers can be ambassadors in helping to enhance awareness of collaborative patient goal-setting among peers. They can also be involved as patient partners within regional renal programs to improve collaborative patient goal-setting in local settings.



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Appendix: "What Matters to You" Action Planning Workshop

Date: Monday, February 3rd, 2020

Time: 8 a.m.- 3 p.m.

Venue: Burrard Ballroom, Century Plaza Hotel, 1015 Burrard Street, Vancouver, BC

Goal: To develop a collective way forward for improved collaborative goal-setting in patients with chronic kidney disease in BC.

Participants: 42 workshop participants include kidney health professionals (19), patients/ family caregivers (10) from all health authority renal programs, BC Renal staff (10 including presenters and facilitators) as well as representatives Provincial Health Services Authority (1) and the Kidney Foundation—BC & Yukon Branch (2). Representation also covers various health care professionals (dietitian, director/manager, nephrologist, nursing staff, pharmacist, social worker), all kidney care settings (kidney care clinic, peritoneal dialysis clinic, home hemodialysis clinic, in-centre and community hemodialysis units) and all BC Renal core committees.

The workshop included territorial welcome (and closing) by Alec Dan (Musqueam Knowledge Keeper), background presentations, as well as group discussions, world café on the key topics identified from the focus groups and rating of actionable ideas.