# Improving Collaborative Patient Goal-Setting in Kidney Care: A Worksheet

BCRenal
Provincial Health Services Authority

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| **What** | This is a step-by-step guide with a driver diagram that links ideas to action for improving collaborative patient goal-setting. |
| **Why** | Patients, family members and kidney health professionals recognize setting goals with patients is useful and valuable when it is done well. It helps improve patient and health professional relationships, create more effective tailoring of care, and enhance overall patient experiences and outcomes. More information can be found in *Better Together: A Strategy to Advance Collaborative Patient Goal-Setting in Kidney Care* at bcrenalagency.ca ▶ Health Professionals ▶ Clinical Resources ▶ Self-Management |
| **Who** | This worksheet can be used by health authority renal programs, BC Renal, The Kidney Foundation—BC & Yukon Branch and other organization partners, patients and family caregivers living with kidney disease. |
| **How** | Follow the steps:<br>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.<br>2. As a team, examine potential gaps in collaborative goal-setting and the primary and secondary drivers on the driver diagram (next page), considering the regional and/or local context.<br>3. Define the aim of your improvement effort by specifying the target location and time frame.<br>4. Prioritize the identified areas of improvement based on existing needs and resources.<br>5. On the driver diagram, mark the top areas of improvement your team would like to focus on.<br>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?<br>7. Test the change ideas systematically.<br>8. Evaluate and note the learning (i.e., 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.<br>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.

*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<br>What are we trying to accomplish? | PRIMARY DRIVERS<br>Components which will contribute to achieving the aim. | SECONDARY DRIVERS<br>Major actions within the components which will contribute to achieving the aim. | CHANGE IDEAS<br>What change can we make that will result in improvement? |
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| To enhance and sustain collaborative patient goal-setting between patients and kidney care professionals in<br><br>_____<br>**Location/Setting**<br><br>by<br><br>_____<br>**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 | |