INTENSIVE INTERVENTION WITH THE NON-COMPLIANT PATIENT

Guidance & Resources for Dialysis Facility Personnel

End Stage Renal Disease Network of Texas, Inc.
14114 Dallas Parkway #660
Dallas, Texas 75254
972.503.3215 / www.esrdnetwork.org

This guide is meant as a tool for use with the non-compliant patient. It is NOT INTENDED for use with the violent, aggressive, or hostile patient. Those patients require other interventions not covered in this guide.

Table of Contents

The ***Intensive Intervention With The Non-Compliant Patient Guide*** was developed by the ESRD Network of Texas, Inc., Medical Review Board, Executive Committee and Patient Advisory Committee as guide for renal professionals.

Prior to the inclusion or incorporation of these or any other externally reproduced guidelines, the ESRD Network recommends that the governing body, and if applicable legal counsel, review the document for any legal implications.

Published by the ESRD Network of Texas, Inc. under contract with the Centers for Medicare and Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy. Distributed October, 2002.

This guide available at www.esrdnetwork.org.

Non-Compliance Facts

FACT: Almost 30% of all hospital admissions are directly attributable to medication non-compliance

FACT: 125,000 people die each year from non-compliance, twice the number killed in automobile accidents

FACT: Poor compliance with medication regimens costs society $150 billion per year

FACT: Approximately 40% of people entering nursing homes do so because they are unable to self medicate in their own homes

FACT: About one-half of the 1.8 billion prescriptions dispensed annually are not taken correctly, contributing to prolonged or additional illnesses

FACT: At the present time, more than 7 million households have an unpaid "caregiver" who is providing daily assistance to a family member age 50 or older

Sources: Archives of Internal Medicine, 1990, 150: 841-845; Archives of Internal Medicine, October, 1995; Biomedical Business International, January, 1988; Family Circle, 6/25/91.

INTRODUCTION

By Ramiro Valdez, PhD, Patient Services Coordinator

"Non-compliance" is almost a way of life with some Americans. Many people with diabetes, for instance, do not monitor their insulin as they know they are supposed to. A lot of people do not take antibiotics for the full duration (usually ten days) as they have been instructed. Most Americans do not exercise or eat right even though they know they should. Being diagnosed with End Stage Renal Disease seldom changes this pervasive behavior.

Most dialysis patients overload on fluids or "cheat" on their diet from time to time. While this can be a problem, in most cases the staff can see that the patients are making a sincere effort to follow the regimen. There are some patients, however, who flagrantly disregard the medical regimen and make it clear to the staff they have no intention of following it. For these few patients their non-compliance is not only risky, but it also makes it difficult for their doctors and renal staff to continue working with them.

While the temptation may be to dismiss these patients, it is important to recall that their refusal to follow the regimen may be in and of itself a symptom. They may have psychological or emotional problems that will not allow them to develop insight.

They may have psychosocial stressors unknown to the staff that prevents them from cooperating. Or they may have experienced a recent life change event that changed their desire to be healthy or their ability to cope. Finally, some of these patients may not have a good reason for refusing to attend all treatments; they just miss treatments.

Whatever the reason for non-compliance, it is best to do everything possible to eliminate any deterrents to compliance and to enhance those factors that will encourage it. This will take some time and effort but can be extremely rewarding when the staff see a change in the patient's behavior.

The following steps are suggested as a way to intervene with patients who repeatedly skip treatments without a reasonable explanation or who repeatedly sign off before their dialysis treatment is complete. These steps are not all - inclusive and if there is something else a staff member can envision, it should certainly be tried. Also, the *order* of these steps is dynamic; if staff find that doing one step prior to another is more effective, then it should be done this way. Finally, the steps are not absolute; if one particular step does not apply, feel free to skip it.

THE GOAL OF THIS INTERVENTION EFFORT IS A CHANGE IN BEHAVIOR LEADING TO ADEQUATE DIALYSIS AND, THEREFORE, AN IMPROVEMENT IN THE PATIENT'S HEALTH. THIS IS NOT INTENDED AS A DISMISSAL PROCESS.

The ESRD Network of Texas stands ready to consult with any staff member in working with non-compliant patients. Through our combined years of experience it may be that one of us has come up with a solution that your staff has not tried. Please call your Network at (972) 503-3215 and ask for the Patient Services Director, the Quality Management staff, or the Executive Director, and we will be glad to help.

SUGGESTED STEPS IN AN INTENSIVE INTERVENTION WITH NON-COMPLIANT DIALYSIS PATIENTS

- Treatment Team Consensus: The treatment team should discuss the patient's behavior during either care plan review or a QI meeting and reach an agreement that the behavior is a problem and that an Intensive Intervention is needed.

- Complete a focused psychosocial history, with the focus being an assessment of some possible causes of the present problem.

  a. Assess for peripheral contributing problems such as:

     i. Loss of income
     ii. Transportation problems
     iii. Marital discord
     iv. Illness in the family
     v. Conflicting family obligations (i.e., babysitting/care giving)

  b. If any psychosocial problems are found, address immediately.

  c. Evaluate for improvement (See Appendix A for evaluation procedures); if there is no improvement, proceed to another step.

- Rule out significant life change events (LCE):

  a. An LCE is an event that will result in changes in coping or adapting skills for several weeks to several months. Some LCEs are:

     i. Death in the family
     ii. Divorce
     iii. Problems with the police or going to court
     iv. Change in housing
     v. Hospitalization/new illness
     vi. Loss of primary caregiver

  For a more extensive list of LCEs see Appendix B

  b. If any LCEs are identified, help the patient either through a referral for assistance outside the clinic or through staff assistance.

  c. Evaluate for improvement; if there is none, proceed to another step.

- Eliminate (whenever possible) the discomforts of dialysis.

  a. Patients often "hate" to come to dialysis or else cut the treatment short because they are so uncomfortable during the treatment; check for:

     i. Restless Legs Syndrome
     ii. Pain
     iii. Being too cold
     iii. Patient/staff friction
     iv. Need to eat (especially for people with diabetes)
     v. Need to smoke
     vii. Restroom use

  b. Address each of these "discomforts" on a case-by-case basis.

  c. Evaluate for improvement; if there is none, proceed to another step.

- Convene a meeting with the patient and the treatment team to discuss the harm of skipping/shortening treatments. Invite the family if the patient agrees. Wait two or three weeks. If there is still no improvement, proceed to another step.

- Have the social worker or another staff member develop a "therapeutic alliance" with the patient, where the two work together to achieve adherence to the regimen.

  a. Meet with patient *weekly* or every time s/he comes.

     i. Repeat time and again the benefits of dialysis in simple terms. *(For a review of Patient Education Techniques, see Appendix C)*.
     ii. Attempt various techniques in patient education.
     iii. Be certain patient understands consequences of non-compliance.

  b. Evaluate for improvement; if there is none, proceed to another step.

- Mobilize the patient mentor program in your clinic and have a fellow patient meet with the patient to discuss adherence to the regimen.

  a. Before setting up the meeting, ask the mentor if s/he is willing to do this and ask the non-compliant patient is s/he is willing to talk to the mentor. If either refuses, do not do this.

  b. If both agree, facilitate the meeting and offer support and resources to the mentor as usual.

- With the patient's permission, include the patient's family:

  a. If the patient has no immediate family, include any significant other that is listed in the current psychosocial assessment.

  b. The family can be made aware of the seriousness of the patient's inadequate dialysis treatments.

  c. If the patient does not approve of the family or friends being involved, proceed to another step.

- Enter into a *BEHAVIOR CONTRACT* with the patient.

  a. For instructions on writing a contract refer to Nephrology News & Issues, April 2002 (*or call the Network for a copy*).

  b. Assign a staff member to help patient achieve the goal; any staff member can serve in this role. Ideally it would be the doctor, nurse, or social worker, but it can be the dietitian, PCT, or any other staff member.

  c. Monitor over 30, 60, or 90 days.

  d. Evaluate for improvement; if there is none, proceed to another step.

- Have the nurse or social worker write the patient an informal letter of voicing concern that this behavior is self-destructive and could have long-term effects; wait two or three weeks. If there is still no improvement, proceed to another step. *(See Appendix D for an example of such a letter.)*

[This will need to be done verbally with patients who cannot read; patients with limited English-reading skills should receive the letter in their own language if possible or have it translated into their own language.]

  a. With the patient's written permission, send a copy of the letter to the patient's family.

  b. If the patient will not give permission, do not inform the family about this letter.

  c. Wait two or three weeks. If there is no improvement, proceed to another step.

- Review the problem with the entire treatment team in QI or care plan meeting and write a formal letter of warning from the medical director or attending physician *(see Appendix D for an example letter)*; at this time write in bold, capital letters a warning stating that

"Continuation Of This Behavior Could Result In Your Being Placed On Another Shift, And/Or We May Wait Until You Are Actually In The Clinic Before We Set Up Your Machine. This Could Mean As Much As A Half Hour Wait On Your Part And Possibly A Shortened Treatment Since You Will Be Taken Off Dialysis When The Shift Is Over."

[For patients who cannot read, this warning will need to be given verbally. Patients with limited English-reading skills will need to have the letter written in their native language or have it translated for them.] *NOTE: Be sure to take extenuating circumstances (such as transportation) into account. Ask the patient in this letter to meet with the doctor or any member of the treatment team to discuss the problem. Wait another two or three weeks.*

a. With the patient's permission, include the patient's family in this discussion.

b. If the patient's family cannot be included in the discussion, with the patient's permission, inform them of the contents of the letter.

- Discuss the problem a *third time* in QI or care plan meeting and determine if the problematic behavior is totally unacceptable to the staff or disrupts the orderly functioning of the clinic.

a. If the answer to the above is "no", consider changing the patient's dialysis time to another shift.

i. Inform the patient of the team's decision to change times and that s/he will have to wait to have his/her machine set up before each and every treatment.
vi. Do not set up the dialysis machine for the patient until s/he walks in the door (the patient will have to wait).
vii. If the patient shows up late for a treatment and your clinic closes or another shift is scheduled before his/her treatment is complete, stop his/her dialysis at the end of the shift. It was the patient's choice to shorten the treatment.
viii. Continue the therapeutic alliance efforts, as described above, and document the efforts.

b. If the answer to the above is "yes," change the patient's dialysis time as instructed above, contact the ESRD Network and ask for assistance in continued intervention efforts.

APPENDIX A

EVALUATION OF PROGRESS

Evaluating the progress of the **Intensive Intervention** involves both a qualitative and a quantitative measurement. Both need to be considered equally. The qualitative measurement involves the observation by the staff, especially the patient's "ally" if there is one, as to the effort the patient is making. One patient may be cooperative, make an effort, and show a desire to change, but has a hard time achieving the goals. Another may be cavalier about the plan, ignore efforts to help and disregard the suggestions of the staff. Still a third may defy the plan entirely and even blame the staff for not doing their jobs as the reason s/he does not come to dialysis. A crucial factor is to evaluate whether the patient is working with or against the staff. Some patients actually *could* change if they wanted while others just do not want to make the effort. Certainly the patient who shows an attitude of cooperation and willingness to work with the staff should be given every opportunity to do so. On the other hand, the patient who is able but unwilling to change should be moved quickly through the steps of the plan.

The quantitative measurement involves tallying the number of hours of dialysis the patient receives in the present month and comparing this total to the number of hours in the previous month. If the patient has made some gain, remember that even one hour more than the previous month represents progress!

If the patient has made a small progress, one to four hours more than last month, continue on the same step with the same plan. Give the patient lots of praise and positive reinforcement. Brag to fellow staff members about how well the patient is doing. Have the doctor mention it on rounds. Mention to the patient that any change in behavior which is going to last a long time is going to be slow. Continue with the same intervention and encourage the patient to continue with the small but meaningful progress.

If the progress is substantial (four hours more than the previous month, but still short of the prescribed time), stay on the same step but try another intervention. Review the types of patient education techniques (Appendix C) and try a technique other than the one you have been using. The present technique has most likely reaped all the benefits it is going to because it led to a substantial progress. Another technique should be attempted within the same step.

If the patient has become compliant, continue on the same intervention technique, but meet less often with the patient and at different times. Do not meet weekly, as before, but meet at various intervals. Further, if you always met with the patient on a Wednesday, try a Monday or a Friday instead. Change the approach you are taking, but keep the intervention technique the same for at least another month. If the patient continues doing this well after a second month, you can discontinue the Intensive Intervention. The stages of readiness can be assessed and utilized in evaluating progress. *(Appendix F)*

When both the qualitative and the quantitative measurements are made with the patient, the patient who is trying but not succeeding can still feel that s/he has gained some ground. This gain is in the area of *social reinforcement* with the staff recognizing that the patient made a good effort.

APPENDIX B

A LIST OF LIFE CHANGE EVENTS

This list of Life Change Events (LCEs) has been taken from the Holmes and Rahe Social Readjustment Rating Scale. It includes typical LCEs that most people in our society may experience at one time or another in their lives. Most dialysis patients experience some LCEs when they first start dialysis. The initial psychosocial assessment addresses these and helps the patient adjust to life on dialysis. Thus, *this list is intended for those patients who are past their initial adjustment.* The patient who is non-compliant from the start requires intensive patient education and help with adjusting to dialysis, not an assessment for Life Change Events.

Although the LCEs are common, they can still affect our lives in various ways. LCEs may result in an inability to handle daily problems with our usual coping skills. Routines frequently become disrupted and things that were previously important may take a back seat. Doing routine chores, such as making arrangements for a ride, become almost insurmountable. This is due to the extreme stress of some of these events. The stress of any one of these events may continue from a few days to a few weeks. Because our usual coping skills do not work for a short time, other daily stressors, which would usually not disrupt our daily lives, may now do so. It is anticipated that within a few days to a few weeks the stress of the LCE will wear off or the patient will achieve a new level of functioning that will allow him/her to cope once again with daily problems. It usually takes about six weeks for scar tissue to form, both in our bodies and in our emotions! <u>If the stress and inability to cope with the LCE continues longer than a few weeks a referral for psychological help is indicated.</u>

The Holmes and Rahe Social Readjustment Rating Scale can be administered and scored by a professional to determine the level of stress a patient may experience. Most dialysis patients experience some of these events, such as “business readjustment” or “change in financial state,” at the onset of dialysis. **This list does not include a scoring sheet, as it is not intended as a psychological test, but merely a review of some of the events that could affect the daily coping skills of our patients and could result in non-compliance.** The LCEs are listed in order of severity. Most dialysis patients experience some of these events at the onset of dialysis.

APPENDIX B (CONTINUED)

Life Change Events

Death of spouse	Change in responsibilities at work
Divorce	Son or daughter leaving home
Marital separation	Trouble with in-laws
Jail term	Outstanding personal achievement
Death of close family member	Spouse begins or stops work
Personal injury or added illness	Begin or end school
Marriage	Change in living conditions
Fired from job	Revision of personal habits
Marital reconciliation	Trouble with boss
Retirement	Change in work hours or conditions
Change in health of a family member	Change in residence
Pregnancy	Change in schools
Sex difficulties	Change in recreational activities
Gain of new family member	Change in social activities
Business readjustment	Mortgage or loan less than $10,000
Change in financial state	Change in sleeping habits
Death of a close friend	Change in number of family get-togethers
Change to different line of work	Change in eating habits
Change in number of arguments with spouse	Vacation
Mortgage over $10,000	Christmas
Foreclosure of mortgage or loan	Minor violations of the law

Source: Holmes & Rahe, 1967.

APPENDIX C

APPROACHES TO PATIENT EDUCATION

Before trying to teach a patient about the dialysis regimen, it is important to assess the patient's level of learning. Different people learn in different ways! Some learn simply by being told, others by watching television, still others by listening to the radio. Very few learn by reading as very few people are readers. Some patients would rather a staff member sit and explain something and then have an opportunity to ask questions while others want staff to hand them a pamphlet, give them time to read it, then return later for a question and answer session.

Many language barriers exist that present a special challenge in educating patients who speak little or no English. Remember that family is not a preferred choice for the provision of medical translation services. Pamphlets and resources in languages other than English can be obtained by contacting one of the kidney organizations included in the resources in Appendix G.

Even though they may speak English fluently, a large number of Americans have a low literacy level. The average reading level is between eight and ninth grade for the average adult American. Socio-economic status is linked to literacy with one-half to one-third of welfare recipients performing at the lowest literacy levels. Age is also linked to literacy with 44% of those 65 and over in the lowest literacy level. People who are non-readers or poor readers generally try to hide it. The burden is upon the health care professional to assess each patient's status and respond with education that the patient can *understand*. This is especially true when dealing with a patient in an Intensive Intervention. Assessing learning levels can be done by asking a few questions and by making a few observations.

What is the patient's level of education or functional competency level? What is (or was) the patient's profession or skill? Is this a profession that requires a lot of learning of new skills and problem solving? Does the patient read during dialysis or watch television? Does the patient ask more advanced questions ("What is my URR this month?") or simpler questions ("How long do I have to keep doing this dialysis stuff?")? When explaining something to the patient, does it have to be repeated several times before the patient grasps the concept? Most importantly, does the patient even ask questions or does s/he simply accept whatever staff says? Does the patient always direct you to give instructions to a spouse, child or friend? These and many other observations can give one an idea of the patient's learning level and how s/he problem solves, which may indicate the best medium for teaching.

It is safe to say that new techniques will be needed if the usual patient education used in the facility has failed to achieve the desired results. Don't assume that a non-compliant patient is just choosing to ignore what has been said. Consider first that the patient truly does not understand.

References are included for resource books on educating patients. *(Appendix G)*

APPENDIX D

SAMPLE LETTERS

Note: these letters are intended as samples and do not have to be copied word for word. It is best for clinic staff to write their own personalized letters that represent a similar tone and mood, but that contain similar information. Be careful to keep the reading level low.

FIRST LETTER OF CONCERN:

Date

Name and address of patient

Dear _____,

We the staff at _____ Dialysis Clinic want all our patients to be as healthy and strong as possible. This is why we work hard and plan carefully for each patient. The plan that we wrote with your help or input was intended to help you to have as long and healthy a life as possible. For this reason we have a treatment plan that we believe will do this.

We have a problem though. You are not _____. In order for the plan to work you need to_____. If there is anything that is keeping you from _____, we want to know about it. We will work with you to solve any problem that may keep you from reaching your goal of a long and healthy life.

Please stop by and visit with the social worker, _____, if there are any problems we can help you with. You can see the nurse, _____, if there is something about dialysis you don't like or don't understand.

Even if you can't think of anything that could be a problem, stop and see either of us anyway because we would like to talk about your plan of care for a long and healthy life.

See you soon!

Sincerely,

Social Worker

Nurse

SECOND LETTER OF CONCERN:

[Note: Before sending this letter be sure to take extenuating circumstances, such as riding the city bus to get to and from dialysis, into account.]

Date

Patient's name and address

Dear _____,

Recently we wrote you a letter and asked you to talk to our nurse or social worker about the problem of _____. The problem still continues.

We want to do everything possible to help you have a long and healthy life, but to achieve this you would need to _____.

If you continue to_____, we may have to take strong measures to help you help yourself. We do not want to do this, but will be forced to because of the problems your actions create for our clinic. WE WILL HAVE TO CHANGE YOUR TIME OF DIALYSIS TO ANOTHER TIME – ANOTHER DAY AND ANOTHER HOUR THAT WILL CREATE FEWER PROBLEMS IN THE CLINIC. This could be harder on you so please come in and help us work out another solution.

Also, along with changing your shift time WE ARE GOING TO WAIT UNTIL YOU ACTUALLY SHOW UP AT THE CLINIC BEFORE WE SET UP YOUR MACHINE. THIS MEANS YOU MAY HAVE TO WAIT AS LONG AS A HALF HOUR AFTER YOU GET HERE BEFORE YOU START DIALYSIS. IF YOUR TREATMENT RUNS LONGER THAN THE TIME OUR CLINIC CLOSES, OR WHEN ANOTHER SHIFT IS SCHEDULED, YOUR TREATMENT WILL BE CUT SHORT.

We really do not want to do any of this and would rather have you _____ all the time. Please come in and talk to me so we can work this all out.

Sincerely,

Doctor

APPENDIX E

INTENSIVE INTERVENTION TECHNIQUES

1. Personalizing the Treatment Plan

Treatment Plans that include only medical objectives are often very impersonal to patients. A Treatment Plan can be used to set personal as well as medical goals. A patient who has always wanted to see Alaska can include this in the treatment plan. Every time the patient is compliant s/he can reward himself or herself by setting aside a dollar for the "See Alaska Fund." Including familial goals in the Treatment Plan could be helpful. "Take a walk with my wife once a week" is certainly an appropriate personal goal that can find a meaningful place in the Treatment Plan and achieve a medical goal as well.

2. Teaching by telling stories

Many patients will listen to a story before they will listen to a lecture. Telling patients a story about another patient who had a hard time with compliance but managed to overcome it could be very helpful. It is best to use stories that are true without using a patient's name or stories that are a composite of several patients.

3. Teaching through appropriate self-disclosure

Self-disclosure can be a very effective teaching tool but must be used carefully. The staff member must take care not to "unload" on a patient. Sharing a personal experience with a patient on problems with compliance could be a meaningful learning experience. Staff members who used to smoke or who have lost a lot of weight can share how they overcame those problems.

4. Recounting a famous person who overcame obstacles

History is full of examples of people who had handicaps and achieved a lot or persons who overcame great obstacles to achieve their goals. Some patients have personal heroes and may be encouraged to learn that they overcame problems as well.

5. Behavior Modification Techniques

Behavior modification can be an excellent means of changing non-compliant behavior. If there is a staff member who is familiar with contingency management, positive and negative reinforcement, token and social reinforcement, then it can be used effectively. However, learning the techniques takes years of training and using it incorrectly could be a waste of time.

INTENSIVE INTERVENTION TECHNIQUES (CONTINUED)

6. Cognitive Restructuring

Cognitive restructuring involves basically helping a patient change his or her mind about a situation. This involves changing faulty thinking, stopping thoughts before they escalate, replacing thought associations, and other such techniques. Like behavior modification, cognitive restructuring is an excellent tool in the hands of a skilled clinician. However, if there is no one on staff already trained in this area, learning while doing is not a good idea.

7. Spiritual Interventions

Referring to great figures in the Bible or other spiritual leaders can be a very effective way of helping patients become compliant. A good example is a man by the name of Hezekiah in the Bible who was about to die but was granted a few extra years of life. Dialysis can be seen as being granted a few extra years of life rather than as a burden of dietary restrictions and disrupted schedules. Assistance may be offered in accessing a spiritual support system. Encouragement can be given to the patient to interact with church groups or friends.

8. Reasons to Live

The dialysis patient could be reminded that dialysis can be seen as a gift that allows us a little more time to live. Doing something with our lives is a worthy goal for all of us, but for the dialysis patient it is especially meaningful. Patients can be told, "You have been kept alive to do *something*. Perhaps it involves your family…" The book "Reasons to Live" by Amy Hempel is a delightful collection of stories about people who faced death and chose to live instead.

9. Mobilizing Your Social Support System

A very effective way of influencing people to discontinue an undesirable behavior is to get their family and friends to help them. Patients can be taught ways that family and friends can be a resource to them in changing their behavior.

10. Shall we Talk Funerals?

This technique is listed last for a reason. This is a "last-ditch effort" which has been found helpful in extreme cases. This technique consists of telling the patient something like "Okay, I see that you are not going to do this compliance thing. It is your right to die with dignity. We will do what we can to make you comfortable. The doctor will prescribe pain medicine for you if you need it. It is better if you try to make funeral arrangements now so you will not leave a financial burden on your family. Shall we try to make some plans now?" This can be seen as cruel by some patients (and even staff) so it must be used only as a final resort and then only very carefully!

APPENDIX F

Stages of Readiness Theory

1. **Pre-contemplative**: not aware or not considering a change

2. **Contemplative**: thinking about a change, but not taking action

3. **Action**: has made behavior change and is practicing it

4. **Maintenance**: retaining the behavior via reinforcement or learning

5. **Termination**: the end of the intervention; the behavior is a part of life and is no longer seen as a change that needs attention or reinforcement

Source: Schilling McCann, "Patient Teaching Resource Manual."

APPENDIX G

RESOURCES AND REFERENCES

American Association of Kidney Patients Renalife. A patient magazine available from AAKP.

American Association of Kidney Patients "Patient Plan – Phases 1 through 4"

For Patients Only. A patient magazine available from Dialysis Incorporated Publishing.

Kidney School, Life Options www:kidneyschool.org

Funnell, M.M., "Helping Patients Take Charge of Their Chronic Illnesses," Family Practice Management, March, 2000.

Holmes, T. & Rahe, R. "Holmes-Rahe Social Readjustment Rating Scale," Journal of Psychosomatic Research. Volume II, 1967.

Lancaster, L. E.(editor), ANNA Core Curriculum for Nephrology Nursing, 3rd Edition, American Nephrology Nurses' Association, 1995.

Renal Physicians Association & American Society of Nephrology, Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis. Washington, D.C., February, 2000.

Schilling McCann, J.A. (publisher), Patient Teaching Reference Manual. Springhouse, PA.: Springhouse Publishers, 2002.

C. Doak, L. Doak & J. Root, Teaching Patients With Low Literacy Skills, 2nd edition. J.B. Lippincott Company, Philadelphia,1996.

D. deSouza, Handbook of Creative Approaches to Patient Compliance; A Guide To Assist Renal Dietitians Working with Dialysis Patients. Professional Nutrition Services, Pembroke Pines, FL, 2001.

The ESRD Network of Texas, Inc. has provided to each unit and available for purchase at a nominal price two patient education videos on Dialysis Adequacy and Vascular Access.