Nephrology social work has come a long way since it was regulated into the Medicare Conditions for Coverage in 1976. These early regulations identified the important areas nephrology social work could focus on to improve the lives of the end-stage renal disease patient. CMS offered no strategy, however, for working with the types of psychosocial barriers that would surface in the chronic kidney disease patient population at the turn of the 21st century.

Now, after nearly three decades of seeking the best way to provide social work treatment to this diverse group of patients, nephrology social work has developed one of the most important movements in renal disease management: wellness programming.

**Tackling nonadherence**

The social work team at FMCNA–San Diego developed wellness programming in 2001 when nurses became frustrated with nonadherent hemodialysis patients at the clinic. The team’s efforts to increase education or apply pressure on these patients seemed to have little impact. Staff identified these patients on their care plans as “unmotivated” or “self-destructive” after the team had run out of intervention options, which only disempowered them further.

The social workers knew there was more to this problem, and that the barriers were not always a lack of education. When they took the time to look into the eyes and hearts of these patients, they didn’t see “I didn’t know” or “I don’t care.” Instead they saw, “I want to change, help me.”

The social workers reorganized their services, steering away from unskilled clerical tasks and focusing on the nonadherence issue. “Our [dialysis clinic] management team was very supportive,” said Carolyn King, MSW, a member of the San Diego SW team for more than 12 years. “They needed us in this area much more than they needed us faxing and copying travel forms. They felt pressure to reduce missed treatments and fluid gains. They needed to decrease the stress on the team in these areas. They trusted we could help, and they were right.”

**Researching the problem**

The social work team dug into the behavioral health literature to find more progressive ways of strengthening adherence skills. They designed a series of wellness programs to teach skills that helped motivate, empower, and celebrate a patients’ interest in their own health outcomes. “We hit a nerve,” said Cheryl Weller, LCSW, a member of the SW team for more than five years. “Patients that had previously never shown interest in this area began signing up for our wellness classes. The class bug spread and soon many of our classes were wait-listed.”

The physicians and other members of the renal team also grew excited with these social work interventions. They were able to refer the patients into the programs that needed the interventions the most. They enjoyed moving away from confrontive interactions with nonadherent patients and moving into a support role as the patients began setting wellness goals for themselves.

The team began to see results and added it to their care plans. It was clear patients attending these wellness programs were starting to take better care of themselves, and coaching other patients to do the same. The entire team, including the patients, saw these programs as a win-win. Together, they helped the social workers drive them forward. “Allowing our social workers to focus their time on this type of wellness programming has been a smart decision for our entire region. It’s very uplifting for all of us. And we know the programs work because we measure their success,” said Lynne Walrath, FMCNA area manager.

**Wellness programming and renal disease management**

Although all patient participants benefit from their involvement in the wellness classes, it is the patient at risk of poor outcomes that the FMCNA-San Diego social workers focus most on, which is perhaps why it is of interest to renal disease managers. The late John Dickmeyer, MD, who served as senior vice president of RMS Disease Management Inc., noted in his update on renal disease management at the World Congress of Nephrology in 2001 that “the original concepts of disease management held the premise that if you identify those 20% of the patients that are most responsible for 80% of the cost, and you developed focused management programs for those patients, that health care costs could be significantly controlled.” It is for this reason the industry has identified psychosocial issues as important determinants of successful renal disease management in these high-risk patients.

In ESRD, disease management models seek to improve health outcomes while reducing costs associated with health care delivery. Wellness programming hits both of these targets. Reducing fluid gains can help keep these patients out of the hospital. Reducing depression can mobilize patients to take their medications correctly, and help them cope with staying through the entire dialysis treatment. It also enhances the odds that patients will rehabilitate on many levels. Patients that sleep well the night before don’t miss as many treatments. Helping patients improve their lives in these areas keeps patients healthy and out of the hospital, where a lot of the ESRD dollar is spent.

**Advancing the idea of wellness programming**

When news of these social work programs spread into the literature and at national meetings, nephrology social workers across the nation started to get excited. The concept of wellness...
programming clipped onto the outcomes-driven nephrology social work modules that were just being released through the National Kidney Foundation’s Council of Nephrology Social Workers. “Nephrology social workers were ready for the idea of strategic interventions that could provide measurable outcomes important to the patients as well as industry,” said Mary Beth Callahan, ACSW, LCSW, past-chair of the CNSW and codesigner of the NKF/CNSW Outcomes Training Program.

“The beauty of this type of programming is that a social worker with a caseload of 80–100 patients can identify and treat the outcome barriers of many patients at once. It is ‘macro’ case management at its best.” These interventions can also be done chairside during the dialysis treatment for patients that cannot get to the classroom. Even one-on-one, these programs are time-manageable because they are designed to be delivered within a certain time period.

Wellness programming—a definition

So what exactly is a wellness program, and how does it really improve outcomes? There are three components to a successful wellness program (see Fig. 1).

John, a dialysis patient, describes these principles from the patient’s perspective:

John’s experience with wellness programming is a common one. Patients don’t naturally just walk into the disease with all the skills they need to be a successful patient. There are learning curves. Patients like John need more support. The challenges seem harder to him.

Wellness programming provides an accepting atmosphere where patients can learn and experiment with new ideas. The support built into the training removes all the sense of failure. It allows each patient to form new skills right where they need them.

Donna Halshaw, MSW, who enjoys examining the outcomes data on the programs, said: “When we measure the outcomes of our programs, we often see two mediators of change. You see improved perception of skill level and also a stronger sense of hope—a sense that it could be done—and done by them.”

Let’s continue to look at how wellness programming works by examining six different wellness programs.

Wellness Program #1

Live Longer, Live Better

The National Kidney Foundation Cardiovascular Disease Task Force included nephrology social work on its review team when it drafted a report on the epidemic of CVD in the ESRD population. Social workers immediately saw their role in working with the “modifiable health behaviors” that contributed to one of the leading causes of CVD in ESRD patients: hypertension. Patients often missed or shortened their dialysis treatments, had excessive interdialytic weight gain, and were nonadherent with prescribed antihypertensive medications and salt restriction. In addition, they did not take part in regular physical activity.

The review of the cardiovascular and renal literature submitted by the social workers to that task force, and the literature that followed, brought forth the importance of additional, psychosocial risk factors. The most prominent of these—stress, depression, and lack of social support—fell within the social worker’s ability to modify.

In the general population, these three factors can cluster together to equal a major risk factor in CVD, such as smoking. CNSW was pleased when the task force
WHAT’S NEW: LIVING LONGER/LIVING BETTER

Results obtained from the 2000–2001 NKF/CNSW research project have demonstrated a number of outcomes indicating the importance of the nephrology social worker with regard to impacting positive treatment outcomes in the renal setting. A cognitive-behavioral intervention, which included psycho-educational components, was found to significantly improve levels of physical activity, improve hypertension medication compliance, and make improvements in treatment attendance, all of which have been shown to impact cardiovascular disease outcomes. Patients participating in the one-hour social work intervention evidenced a statistically significant reduction in blood pressure compared to the control group.

Potential risk areas and create a personal wellness plan to reduce actual risk. The program used cognitive-behavioral and problem-solving social work interventions to help patients overcome the barriers they identified. “Living Longer, Living Better” significantly modified several health-risk behaviors. The news release (above) of the program shared the results.

“We hit on something very exciting,” said Lynne Walrath, MSW, MPH. “It was our social work team’s first attempt at a wellness class. The patient’s responses thrilled us. They were more ready to make change than we suspected. This new approach reached into that readiness.”

At right are comments from one of the participants in the program and the two-part class outline is shown below. The NKF is currently working on the release of the Living Longer/Living Better program through CNSW.

Wellness Program # 2

The Nephro-Gliders

One of the outcomes of the Living Longer/Living Better program was an increase in physical activity among participating patients. Many patients were interested in creating a weekly walking program in a local park. Each Tuesday, these patients began to meet on their own. They named themselves the Nephro-Glider’s Health Support Team. FMCNA sponsored them with blue T-shirts. “This is a program near and dear to our hearts at FMCNA-San Diego,” said Mary Brattich, RN, CNN, FMCNA area manager. “It is also an example of how the wellness programs dovetail into each other. It is very exciting to watch the wellness movement take hold in patients and see them joining together to improve their health. We get just as excited as the patients.”

The quality of life measurement outcomes of this program were very positive. As Table 1 demonstrates, 33% of patient participants improved their “role physical” score, 40% improved their physical function score, and 60% improved their overall physical composite scale score from the six-month pre- and six-month post-measurement interval.

All of these improvements, according to the literature, should improve their odds of survival.

“T | was a fairly new patient when my social worker offered me the Living Longer/Living Better class. I was surprised to learn that almost half of us kidney patients at the center were likely to die of heart disease, not kidney disease. That was an eye opener for me. There are a lot of things us patients don’t understand about all this. The class helped me. It taught things in a way I could really understand them. It also helped show me how to set up my life to support my health. I got some very good suggestions out of it. I still use them today; several years later.”

Unlike other wellness programs, the Nephro-Glider program has had to adapt to changes. Transportation became a big barrier to patient participation and it became necessary to roll the Nephro-Gliders program into a “walk on your own” program. The new program still provides T-shirts and will soon provide timers. Nephro-Gliders will now count their minutes each week. The goal is to slowly increase minutes. They will still be able to see their own success. Many of them choose to participate in a

CLASS OUTLINE: LIVING LONGER/LIVING BETTER

Part 1: Video

• Nephrologist introduces the risk of CVD and the role of high blood pressure. He then explains the nine things patients can do to keep their blood pressure under control and invites them into part 2 where the social worker can help them to create personal “wellness plan” to keep them “heart-healthy”

Part 2: Flip chart class

• Social worker examines possible psycho-social and behavioral barriers to wellness in each of the nine risk areas. Patients identify their own probably risk areas and create a personal wellness plan to respond to those barriers.
pre “sit-to-stand” test so they can personally see the change in strength as they keep walking and repeating that test.

“This time we are recruiting friends and family members into the program as ‘health support partners’ to keep the encouragement and support components of the program going,” says Cheryl Weller, who is heading up the revision of the program.

“Friends and family members are always asking the team how they can help. They are thirsty for direction in this area, but the patients often fear being a burden, so they don’t ask.”

To offset this barrier to the social support component of wellness, the FMC–San Diego social workers have developed a set of “health support partner” guidelines and a key ring reminder of their importance in their loved one’s wellness. They use these tools to encourage enrollment into the Nephro-Gliders program and to promote other types of helpful support in the home environment.

**Table 1: Percentage of Nephro-Glider Participants Perceiving Change in Three Areas of SF-36 Quality of Life Survey**

<table>
<thead>
<tr>
<th>SF-36 scale/domain</th>
<th>Percentage of Nephro-Glider participants reporting improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role physical</td>
<td>33%</td>
</tr>
<tr>
<td>Physical function</td>
<td>40%</td>
</tr>
<tr>
<td>Physical composite summary</td>
<td>60%</td>
</tr>
</tbody>
</table>

With the “walk on your own” program, Nephro-Gliders will expand to a much larger group of patients in all geographic areas, Cheryl said, “The physicians are very excited that we will be able to reach more patients with the walking program.”

With the help of more literature detailing the benefits of physical activity for the ESRD patient, and the Renal Physician Association guidelines for preparing patients for renal replacement therapy, physicians are recognizing more and more that physical activity is important in reducing mortality and stopping the cycle of de-conditioning that accompanies CKD. 16-20

Patients that need to lose weight for transplant as well as patients whose hearts need more conditioning are patients that the nephrologists and transplant surgeons will refer into the new “walk on your own” Nephro-Glider’s program. “Our medical directors are even hoping that regular walking can help modulate blood sugar in the diabetic ESRD patient and help our older patients prevent falls by maintaining strength and balance,” Cheryl said. “Overall, the doctors feel this program is good for a lot of our patients. And from a disease management perspective, this all means less days in the hospital which is a big savings for the ESRD program.”

**Wellness Program #3**

*Making Peace with Fluid*

Excess interdialytic weight gain has been a troublesome area of nonadherence for dialysis patients and the renal team. The problem plays a key role in the progression of cardiovascular disease and leads to unnecessary hospitalizations for congestive heart failure. 21-23 In addition, excess interdialytic weight gain increases patient-staff tension as the renal team struggles for time to address the additional needs of the fluid-overloaded patient during his/her normally scheduled time slot. This dynamic has led to a “shame-based” relationship between the patient and the renal team. Frequently, the patient accepts the role of the “hopeless, bad patient,” which perpetuates the problem.

The Making Peace with Fluid class, described in detail in the December 2003 issue of *Nephrology News and Issues*, uses a new approach to helping patients manage fluid intake. 24 It goes beyond where the dietitians and nurses have always been very effective in educating patients about the dangers of fluid gains, and offering strategies for fluid control. It explores the internal psychosocial relationship between the patient and fluid. For some patients this is right where the problem lies. “This class works beautifully to complement what the dietitian does with fluid management,” said Nancy Daigle, RD, FMCNA San Diego. “In fact, when the social worker in one of my clinics near the border of Mexico launched the Making Peace with Fluid class, I partnered with her on a joint continuous quality improvement project and launched a patient program right along side it on salt reduction. We put the materials into Spanish and had great outcomes.”

As the class outline illustrates, the Making Peace with Fluid class maintains a paradoxical approach with the patient. It does not focus on change itself, but rather on the patient’s understanding of their struggle. Once a patient stops feeling ashamed and avoiding the power that fluids have in their life, they can meet fluid as a neutral force, rather than an enemy. At the moment that occurs in the classroom, patients begin to feel motivated to change. The remainder of the class guides them, when they are ready, into experimenting with new approaches and techniques that can offer greater success. Many of these techniques, located in what the class calls the “craving control toolbox,” are new to the patient. They include instruction in relaxation, mindfulness, imagery, and challenging cognitive distortions.

“When we first launched the class, I remember that patients were so grateful to have a place to come that
would acknowledge how hard this struggle was for them,” said Donna Halshaw, MSW, who has been on the FMCNA-San Diego social work team for more than 14 years. “Some members of the team were skeptical we could create change, especially in the patients that had been coming to the clinic with eight kilos of fluid on for years. I think we were all surprised when we found that not only did almost all the patients in the class make change, but it was these patients that often made the most change.”

These results (see Table 2 below) confirmed what the social workers suspected would work differently with this type of approach. They hypothesized that the patients would release their power struggle with the illness and develop hope. This would then prompt patients to leave their fear of failure and to trust taking small steps toward change again. That is exactly what they did. Using a paradoxical interviewing process conducted within 48 hours of a missed treatment, the social workers got information from the patients that were new. Among the most surprising: 32% of patients that had missed a treatment over the past month had slept poorly the night before. The social work team decided that a wellness class, which included an intervention to improve sleep quality, could be effective in their mission to reduce missed dialysis treatments.

**Wellness Program #4**

*Getting a Good Night’s Sleep! A guide for patients on dialysis*

The renal literature supports the connection between sleep difficulties and missed treatments, especially on the morning dialysis shift. It also suggests that we know a great deal about the impact of poor sleep quality on mortality in hemodialysis patients, but outcome studies that demonstrate how to improve sleep quality are limited. After a period of consultation with sleep centers and a solid review of the outcomes literature, the social workers developed a three-phase sleep intervention program to tackle the problem. The patients met the program with open arms. Keirre da Luz, LCSW, headed up the pilot in her clinic near the Mexican border. “I didn’t have one patient in the first pilot that had graduated from high school. Still, the sleep class concept was a total hit. They were starving for help in this area.”

*Making Peace with Fluid*

When the social work team at FMCNA-San Diego looked at ways to reduce missed treatments, it was a quiet and serious time for the team. This was a very important area in renal disease management. They needed to examine the barriers in a different way. And

<table>
<thead>
<tr>
<th>Average pre-intervention weight gain</th>
<th>% of patients making positive change</th>
<th>Average change made 0–6 weeks post-intervention</th>
<th>Average change made 0–12 weeks post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4.0 kilos</td>
<td>25%</td>
<td>24% less IDWG</td>
<td>19% less IDWG</td>
</tr>
<tr>
<td>&lt; 4.0–4.9 kilos</td>
<td>25%</td>
<td>9% less IDWG</td>
<td>17% less IDWG</td>
</tr>
<tr>
<td>&lt; 5.0–5.9 kilos</td>
<td>44%</td>
<td>14% less IDWG</td>
<td>10% less IDWG</td>
</tr>
<tr>
<td>&lt; 6.0 kilos</td>
<td>100%</td>
<td>46% less IDWG</td>
<td>46% LESS IDWG</td>
</tr>
</tbody>
</table>

| TABLE 2: PERCENTAGE OF PATIENTS IN ENGLISH CLASS MAKING POSITIVE CHANGE AND QUALITY OF CHANGE OVER TIME BASED ON PATTERNS OF INTERDIALYTIC WEIGHT GAIN (IDWG) |

| TABLE 3: CHANGE IN PERCEIVED SELF-EFFICACY: “CAN I CHANGE? AM I ABLE TO?” |

<table>
<thead>
<tr>
<th>% yes</th>
<th>% no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-class response: 20%</td>
<td>80%</td>
</tr>
<tr>
<td>Post-class response: 80%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Table reprinted with permission from NN&I, December 2003, p. 46.
was important to assess the impact of the hygiene intervention on its own. It surprised the team to find that that a large number of patients (50%) could not be entered into this first pilot because they were using some form of medication to enhance sleep.

The outcomes of the pilot were positive and the results were presented at the National Kidney Foundation annual meeting last spring. The patients liked the chair-side flip chart-based class, which ran about 30 minutes. They could easily identify sleep hygiene areas that they could improve on. Almost all patients were very open to making some personal changes for a four-week period following the class to see if they could improve their sleep. And they did as demonstrated in Table 4. This class is now being offered across the entire FMCNA-San Diego region and across several other FMCNA regions where social workers have formed outcome-driven teams. In San Diego, the patients are wait-listed to attend. “There were lots of other outcomes that were exciting. We saw improvements on the MCS and PCS (mental and physical composite scores) of the SF-36 in over half the participants” Keirre said. “And this is with less than a one-hour intervention. We definitely hit the target with Phase I.”

Keirre and Villalobos are now moving into the Phase II class. Only 17% of the patients in Phase I reported their sleep problems to be completely resolved as a result of the sleep hygiene intervention. Phase II will move further in and focus on assessing how the patients are using their medications to improve their sleep and revising medication regimens. “Some frightening things were discovered when the social worker screened the patients for phase I,” said Kathy Laws, RN, FMCNA area manager. “We found that several patients were taking their blood pressure medications at the wrong time. They were so desperate for sleep they actually developed more health-risk behaviors. This is what wellness programming is all about here, to discover and work closely with these underlying barriers.”

### The Three-Phase Program: Getting a Good Night’s Sleep

**Phase I:** sleep hygiene (45 minute flipchart) and sleep wellness plan

**Phase II:** medication assessment and revision

**Phase III:** pending designs: to include formal sleep apnea evaluation/referral to a sleep clinic as needed

### Social Work

in the ESRD population have been sorely needed. Historically, ESRD patients have not pursued referrals to outpatient mental health providers for treatment of their depression. In 1998, The San Diego chapter of CNSW sought out to determine why.

The chapter conducted a survey of more than 100 randomly selected patients in the greater San Diego area. The survey identified that, among these patients, only 36% would consider seeking treatment for depression outside the renal team. The survey also showed, however, that 86% of patients would accept the depression treatment services of the nephrology social worker in their clinic to reduce depression. When questioned as to why, patients alluded to comfort with their renal social worker in this area, loss of privacy, fear of the stigma associated with depression, and transportation hardship. This was important information for the industry. Nephrology social workers confirmed what they always suspected: if treatment in this area were going to be delivered, they would be the likely providers. This should not be surprising. Onsite agency access is perhaps a key reason that social workers have always been the lead mental health providers across the nation.

The timing for that CNSW survey was good. Successful, brief models of depression treatment were launching out into primary care. The National Council of Nephrology Social Workers needed to design a brief treatment model that fit the dialysis clinic environment. When Susan Guzman, PhD, approached FMCNA-San Diego about conducting her research on predictors of depression in ESRD patients in our San Diego clinics, CNSW had no idea how important her work would become. With the help of FMCNA Medical Director Judy Adler, MD, the study was able to isolate the medical illness (disease severity) from the cognitive predictors of depression in dialysis patients. Guzman’s findings, (see page 69), were published in the Journal of Behavioral Medicine. These findings have also directed the development of three new depression management programs to be released by the NKF through CNSW. These new classes, developed by a team of nephrology social workers across the country in collaboration with Guzman, targeted treatment into the exact predictors that she isolated. One of these classes is called Living with Kidney Disease.

Contemporary treatment models for depression point to the

### Table 4: Pre- and Post-intervention Sleep Problems Identified by Pilot Participants

<table>
<thead>
<tr>
<th>Problem</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty Falling</td>
<td>66%</td>
<td>50%</td>
</tr>
<tr>
<td>Difficulty Staying</td>
<td>83%</td>
<td>50%</td>
</tr>
<tr>
<td>Interrupted Sleep</td>
<td>50%</td>
<td>66%*</td>
</tr>
<tr>
<td>Restless Legs</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Difficulty Awakening</td>
<td>33%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Note: this increase most likely related to the improvement in falling and staying asleep.

### Wellness Program #5

**Living with Kidney Disease**

A class designed to improve quality of life, reduce depression, and promote rehabilitation in the person with chronic kidney disease.

Research in disease management has identified the importance of depression in ESRD treatment outcomes, including mortality. Methods of depression screening and treatment

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success of psychotherapy as an initial form of group or individual treatment in mild to moderate depression and as an adjunct to pharmacotherapy in patients suffering from severe depression. All levels of depression are prevalent within the ESRD patient population. Among the models of available psychotherapy the literature supports the use of the interpersonal therapy model as one with reliable individual and group outcomes, and it has been used in the treatment of medically ill patients. This model of treatment, which focuses on losses, role disputes and transitions, social isolation, deficits in social skills, and other interpersonal factors, was incorporated into the Living with Kidney Disease depression management class. The class was designed to include 20 minutes of psychoeducation designed to reach patients on an emotional level and stimulate skill building in the areas identified by Guzman’s study to predict depression.

Following that initial presentation in each class was an hour of interpersonal sharing, strengthening, and support between class participants. Each class ended with a 10-minute reading that was empowering and positive.

The class was piloted and modified for more than two years by the FMCNA-San Diego social work team. For many social workers this was the most exciting moment of their wellness programming. They had previously tried support groups that had failed. The patients that attended this class suffered from mild to moderate depression. “It wasn’t like they were ‘acutely distressed,’ but their lives were going nowhere. Their quality of life scores were low. Life held no meaning for them. They had given up their identities and their futures. They were just patients now,” said Wendy Dan, MSW, one of the lead FMCNA social workers on this wellness program. “These women and men came alive in the depression management classes. They seemed to reconnect to a core part of them. They got to know once again the part of them that was separate from the illness. They set goals to help that person within them come alive again.”

What Wendy Dan and the other social workers have seen in the class shows up in the outcomes. When the patients are surveyed after the class, they report their moods have improved and their satisfaction with care has increased (see Table 5). The small pilot classes also demonstrated improved mood with the Beck Medical Fast Screener instrument. The changes in mood scores were often focused in the area of “perceived failure.” All of these outcomes are very important to successful renal disease management.

In this wellness program, patients were rehabilitating on an emotional level, laying the groundwork for other levels of continuing rehabilitation. As the class prescribes and schedules regular activities, these patients walk more, connect more into their social worlds, and consider returning to work and begin relationships. “It’s very exciting to see what six hours of strategic social work treatment can do. We hit the target here because Guzman’s study showed us exactly where the target was,” said Carolyn King, MSW. “I saw patients at my clinic make some major emotional breakthroughs in the class. They were all touched deeply on some level.”

**Guzman findings: “Some predictors of depression in ESRD patients”**

- Increased negative self-illness schema (the filters through which one views him/herself as the illness relates to them)
- Decreased positive self-illness schema
- Poor body image
- Perceived stigma associated with depression
- Decreased “belongingness” support (helps patients feel more a part of the world around them)
- Decreased “self-esteem” support (helps a patient to feel that he/she is special to others)

**Table 5: Outcomes of Living with Kidney Disease Class**

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was valuable to me</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>2. I would recommend to others</td>
<td>91%</td>
<td>85%</td>
</tr>
<tr>
<td>3. Provided me with support</td>
<td>73%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Increased my satisfaction w/clinic care</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>5. Made me increasingly emotionally able to cope</td>
<td>55%</td>
<td>85%</td>
</tr>
<tr>
<td>6. Increased my understanding of adjusting to CKD</td>
<td>73%</td>
<td>85%</td>
</tr>
<tr>
<td>7. Improved my mood</td>
<td>45%</td>
<td>85%</td>
</tr>
</tbody>
</table>

**Living with kidney disease for men**

- Class #1: The impact of kidney disease: Tips for men to deal with changes
- Class #2: Physical change: How it effects us as men
- Class #3: Men with kidney disease in relationships: The challenges
- Class #4: Scheduling life again: Slowly moving toward goals

**Living with kidney disease for women**

- Class #1: How chronic kidney disease has changed our lives
- Class #2: Women living with kidney disease in relationship to others
- Class #3: Body image: Staying connected to our attractiveness
- Class #4: Looking ahead and creating the life we want with kidney disease
The Living with Kidney Disease class is one of the most frequently scheduled classes in the San Diego region. Classes are often run separately for women and men, and sometimes combined. Both types of classes are valuable in terms of the issues and emotional barriers that get tabled. The class topics for the men’s and women’s classes are listed below. One can notice the Guzman study findings woven right into them. Watch for the NKF/CNSW release of these programs, which is still to come.

**Wellness Program #6**

**Feeling Better Again!**

*A depression management class designed for patients with kidney disease*

Treating patients suffering from severe depression was a very important target for the social worker team that collaborated with Dr. Guzman to design the Feeling Better Again! class. The literature suggests that patients with stronger depression scores suffer increased mortality and utilize more care.\(^{47,48,49}\) They can be more symptomatic, and co-existing anxiety can drive them to seek more urgent medical care.\(^{50,51}\)

Providing treatment to this group of depressed patients is very important to the future of renal disease management. Like in the primary care arena, however, it is the more severely depressed patient that is harder to recruit into treatment.

The literature supports the effectiveness of cognitive-behavioral therapy in the treatment of the more severely depressed patients. By challenging irrational beliefs and distorted attitudes toward self, the environment, and the future, which perpetuate depressive affects, cognitive behavioral therapy has been successful in many of its 80 controlled trials with major depressive disorder.\(^{42}\) The Feeling Better Again! class is based on the cognitive-behavioral treatment model. The six-session class outline is shown at right.\(^{52}\)

As the data comes in, it is obvious that this class has been successful in improving mood. In the San Diego pilots, 75% of participants made a 5%–10% improvement on mood scores in just six weeks, based on the Cognitive Depression Inventory instrument, a 15-item subset of the BDI without the somatic items.\(^{53,54}\) The pilots also demonstrated improved quality of life scores, especially in the areas of social functioning, mental health, and bodily pain. Preliminary data from a current NKF study, under the direction of Jessica Cabness, DSW, at the University of Florida, also look positive. Dr. Cabness said, “The FBA class definitely improved mood based on the Beck Medical Fast Screener. And the social workers in the study centers saw multiple changes in these participants’ lives. Overall, it was a wonderful experience for the social workers involved.” Cabness will present her data at the 2006 NKF meeting next spring and her study will be published in the *Journal of Nephrology Social Work*.

The FMCNA-San Diego social workers have gotten creative about recruitment for the Feeling Better Again! class. They are utilizing conference phones to allow patients that feel emotionally homebound to call into the classes. They are moving classes to later in the day or just before the patient’s dialysis treatment. They are individualizing a class for the patient who misses one. They are recruiting the nephrologists to refer the patient to the program. All these things are helpful.

**The potential for wellness programming**

Continuing to overcome barriers is part of wellness programming. The social work team is serving a very diverse and challenged group of patients with health risk behavior profiles. They must continually think outside the box. Eventually, they find ways to get the programs to the patient. And once they do, the patient always benefits, the facility benefits, the renal team benefits, and the social workers are perhaps the happiest of all.

“A lot of great things have come out of this reorganization of social work services. Social workers rarely leave this team,” said Mary Brattich, FMCNA-San Diego area administrator. “We have no retention or recruitment problems in that area. But, as an area manager, I see the advantages of the social work focus on wellness programming for the entire team. The nurses and techs really benefit also. They can rely on the social work team to provide interventions that they can refer to on their treatment plans. They understand so much more about nonadherent behavior that they don’t personalize it as often. As a region, we have less patient-staff conflict in this area. And our facility outcomes just continue to improve.”

Other members of the renal team have different perspectives about the value of wellness programming. Georgeanne Floyd, clinical manager of an FMCNA San Diego clinic just two miles from the Mexican border, looks forward to the future of more wellness programming: “We feel lucky to have the social workers running these programs here in San Diego. And we are beginning to deliver them in Spanish, which is so needed. We feel we are really serving the patients with this model.”

**CLASS OUTLINE: FEELING BETTER AGAIN**

Class #1: Understanding depression and how to feel better again

Class #2: Cognitive-behavioral training: How it works to decrease depression

Class #3: Balancing your thinking

Class #4: Practicing new skills

Class #5: Reducing worry

Class #6: Maintaining and moving forward

Martha Snyder, CHT, from one of the FMCNA-San Diego clinics, said: “It’s funny, we always thought that patients wouldn’t come to these types of things, especially on nondialysis days. But they do. I am amazed. I hear them talking about what they learn in the classes and how it has helped them. I think it is refreshing to us all to see the changes they are making.”
There are many more programs scheduled for development. The FMCNA-San Diego social work team meets for a full day each month to design interventions to support our company’s goals to improve targeted treatment outcomes. “Once you get started with this type of social work programming, you begin to see things in different ways,” said Cheryl Weller, LCSW, who is the editor of the FMCNA San Diego Region’s Patient Wellness Connection Newsletter. “Now, when we see nonadherence, we hear ‘there are several of us struggling in this area—we need help and more skills.’ When we hear this we come together as a social work team to design a class in that area.

“Our toolbox of nephrology social work interventions has become core to our daily work, both in the wellness classroom, and as we work on the dialysis clinic floor. They are always there when we need them, or any part of them. We feel we are providing active social work treatment on a regular basis. As social workers, that makes us happy.”

Looking back, those initial regulatory directives of 1972 seem to have come from a world of the past. Yet we aren’t so far from where we began. When Dr. Barry Straube, the chief medical officer of the Centers for Medicare & Medicaid Services, listened to a presentation a few years back about the wellness programming at FMCNA-San Diego, he commented that, “these types of services actually return us to the very essence of what the initial regulations called for: the rehabilitation of the ESRD patient.”

This focus on rehabilitation remains a core of the new proposed Medicare Conditions for Coverage for dialysis facilities. Whether you are looking into the future of patient outcomes, or the calling of renal referral management, it seems that nephrology social workers have carved out these interventions at a very opportune time for both the patient and the industry at large.

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