Dialysis Social Work, Professional Practice, and Social Work Education

Diane C. Holliman, PhD, LCSW; Christopher O. Downing Jr., PhD; Sarah P. Chambers, LMSW; Beth Hebert, LMSW; Paige Murphy, LMSW; MSW Program, Department of Human Services, Valdosta State University, Valdosta, GA

The purpose of this study is to identify tasks, setting characteristics, and practice barriers encountered by dialysis social workers in order to inform social work education. Through convenience sampling, 62 dialysis social workers from the United States completed a 31-item survey. Findings revealed that 45 of the 62 respondents (72.5%) indicated that they had minimal or no supervision, and only six (9.7%) had supervisors who were social workers. Respondents reported high caseloads, role confusion, and role ambiguity in this setting. Recommendations for social work education include: strengthening content on healthcare social work in all specializations, and emphasizing leadership and autonomy in practice, ethical decision making, professional advocacy, and policy practice.

Keywords: dialysis, education, nephrology, social work

INTRODUCTION

The purpose of this research is to identify the roles and tasks performed by social workers in dialysis clinics to inform and strengthen healthcare social work, education, supervision, and professional clinical practice.

Social workers are key members of the interdisciplinary team in dialysis and nephrology settings (Jackson, 2014), and since 1976, Medicare regulations have required that these specialty settings have qualified and licensed social workers on staff (National Archives and Records Administration, 1976). There are more than 7,500 dialysis clinics throughout the United States (Levin, Lingam, & Janiga, 2020), yet the number of social workers in dialysis settings is hard to determine. Although there is not an exact number of how many dialysis social workers there are in the United States, dialysis social work is a popular specialty and employment setting for social workers (Craig et al., 2016; Jackson, 2014; Spigner, 2017).

The Council of Nephrology Social Workers (CNSW) provides valuable resources and materials for dialysis social workers, such as standards of practice, professional networking, and webinars. In addition, two health social work textbooks (Dziegielewkski & Holliman, 2020; Gehlert & Browne, 2019) include sections on dialysis and nephrology social work. Other health social work texts (Allen & Spitzer, 2016; Cowles, 2003; Heyman & Congress, 2018; McCoyd & Kerson, 2016) do not explicitly cover dialysis social work, but these texts present examples and models that could be applied to social work in dialysis settings.

Because of the importance of dialysis social work, we were perplexed by the dearth of content and literature on the specialty in health social work textbooks and social work education. This led to our interest and further exploration of the specialty to learn more about the roles of social workers in dialysis settings.

METHODOLOGY

Survey

To assess the perceptions and work environment of dialysis social workers, a 31-item survey titled "Clinical Opportunities for Dialysis Social Workers" (CODSW) was developed. The CODSW consisted of closed-ended and open-ended questions that explored the work setting of dialysis centers (e.g., tasks completed in dialysis centers and social work supervision) and dialysis social work characteristics (e.g., the number of hours worked and the number of patients). The CODSW also assessed the demographics of the research participants. To access this online survey, the participants were informed of the purpose of the survey, the number and categories of survey items, and the amount of time it may have taken to complete the survey, and that their participation was strictly voluntary. In addition, the survey introduction explained that data from the survey would only be reported in aggregate form and that the survey was constructed using the ethical guidelines of the National Association of Social Workers (NASW) Code of Ethics (2021). The survey and study were approved as Exempt after full review by the Institutional Review Board of the authors' institution.

Sampling Strategy and Data Analysis

The survey was created using Qualtrics XM (2019) and disseminated to dialysis social workers. Dialysis social workers were identified through the personal and educational contacts of the investigators. The CODSW was sent to dialysis social workers through their personal emails to avoid work oversight and conflicts of interest. The survey was also advertised on Facebook groups for social workers, such as the Net-

Corresponding author: *Diane C. Holliman, PhD, LCSW, MSW Program, Department of Human Services, Valdosta State University, 1500 North Patterson Street, Valdosta, GA, 31698;* ***dhollim@valdosta.edu***

work of Professional Social Workers, Hospice Social Work Support Group, and our university's MSW alumni page. In addition, the CODSW was sent to the Listserv of the National Kidney Foundation Council of Nephrology Social Workers twice—initially in January 2020, and then two weeks later. Data was collected over a two-month period.

The data from the closed-ended questions were entered into IBM® SPSS (Statistical Package for Social Sciences)(2023) to calculate the means, standard deviation, frequencies, and percentages, while the data from the open-ended questions were transferred to a spreadsheet in Microsoft® Excel for analysis. A content analysis, as described by Cummings and Worley (2018), was used to analyze the open-ended questions for emerging themes. The content analysis method involved having three dialysis social workers (i.e., Georgia Licensed Master Social Workers with at least two years of work experience in dialysis settings) as subject matter experts to sort each statement into domains (i.e., themes) that they perceived to emerge throughout the sorting process. Inter-rater agreement of the three professionals was utilized to ensure accuracy of the sorting process. A statement was not sorted into a theme without consensus from all raters during the sorting session. If the three raters could not come to a consensus, a fourth rater (i.e., a social work professor with at least five years of clinical experience) would settle the dispute. However, there were no disputes among the three dialysis social workers. The thematic labels were created to allow for more meaningful interpretation of the data.

RESULTS

Participants

Sixty-two social workers (all of whom identified as female) responded to the survey. Of the 62 participants, 44 (71%) identified as White, 11 (17.7%) identified as African American/Black, three (4.8%) identified as Hispanic/Latino, two (3.2%) identified as more than one race, one (1.6%) identified as Asian, and one (1.6%) individual did not indicate their race or ethnicity. The survey participants were employed in 18 different U.S. states. Of the 62 participants, 16 worked in Georgia; seven from Texas; six from Illinois; five from California; three were working in each of these states: Florida, Pennsylvania, New York, Minnesota, and Michigan; two respondents worked in each of these states: Hawaii, Virginia, and Indiana; and one respondent worked in each of these states: Tennessee, Wisconsin, Arkansas, Connecticut, Oklahoma, and Louisiana. One respondent did not identify their location. This demographic and locational information is also found in **Table 1**.

Table 1. *Survey Respondents' Demographic and Locational Information*

Survey Respondents (*N* = 62)	**Number (*N*) and % of respondents**
Sex/Gender	
Female	62 (100%)
Male	0 (0%)
Race/Ethnic Identifiers	
African American/Black	11 (17.7%)
Asian	1 (1.6%)
Biracial/Multiracial	2 (3.2%)
Hispanic/Latino	3 (4.8%)
White	44 (71.0%)
Did not indicate race/ethnicity	1 (1.6%)
Location of Respondent	
Arkansas	1 (1.6%)
California	5 (8.1%)
Connecticut	1 (1.6%)
Florida	3 (4.8%)
Georgia	16 (25.8%)
Hawaii	2 (3.2%)
Illinois	6 (9.7%)
Indiana	2 (3.2%)
Louisiana	1 (1.6%)
Michigan	3 (4.8%)
Minnesota	3 (4.8%)
New York	3 (4.8%)
Oklahoma	1 (1.6%)
Pennsylvania	3 (4.8%)
Tennessee	1 (1.8%)
Texas	7 (11.3%)
Virginia	2 (3.2%)
Wisconsin	1 (1.6%)
Not reported	1 (1.6%)

All of the participants held an MSW degree. All but one social worker indicated that they were licensed in social work. The job positions held by the research participants included job titles such as social worker, dialysis social worker, renal social worker, and nephrology social worker.

As shown in **Table 2**, the participants' mean number of patients was 106.20 (*SD* = 32.28) and the range of patients served by a social worker was from 30 to 150. Participants worked an average of 38.4 hours per week (*SD* = 8.46), with a range of 8 to 50 hours per week. The social workers surveyed

worked in their current position for an average of 89.73 months (*SD* = 107.10), just over seven years. One social worker stated they had worked at their center for 1.5 months, and the one with the longest tenure had worked in dialysis settings for 34 years. The average number of centers covered by the social work respondents was 1.65 (*SD* = 0.83) or one to two centers. More than 80% of the participants stated they worked in private/for-profit dialysis centers, compared to 17.7% in private/non-profit and 1.6% in city or county.

Table 2. *Participant Work Setting Characteristics*

Characteristics of participants' work settings (*N* = 62)	**Mean (*SD*) or *n* (%) or range (lowest to highest)**
Number of patients	106.20 (*SD* 32.28)
Lowest to highest number of patients (range)	30–150
Hours worked	38.40 (*SD* 8.46)
Lowest to highest (range)	8–50
Months/years in current position	89.73 months (*SD* = 107.10), approx. 7.5 years
Lowest to highest (range)	1.5 months to 34 years
Number of centers covered by workers	1.65 (*SD* = 0.83)
Lowest to highest (range)	1–2
Dialysis center ownership	
Private/for-profit	50 (80.7%)
Private/non-profit	11 (17.7%)
City/county	1 (1.6%)

Job Skills

To gain an understanding of how often social workers use the skills they acquired during their social work education and field placements, survey participants were asked to rate on a 1 ("Never") to 5 ("Always") Likert scale the frequency at which they used their social work skills on their job. The average response was 3.23 (*SD* = 1.12), indicating most of the time they use their social work skills. See **Table 3** for frequencies and percentages. Examples of social work skills most often utilized were psychosocial assessment, depression and suicide risk screening, supportive counseling, and cognitive behavioral therapy (CBT).

Table 3. *Frequency of How Often Respondents Indicated They Used Professional Social Work in Dialysis Settings*

Survey question: How often are you able to use professional social work skills in dialysis social work? *N* = 62. (Likert Scale (1 Never, 2 Rarely, 3 Sometimes, 4 Very often, 5 Always))	**Number (percentage)**
Always	11 (17.7%)
Very often	14 (22.6%)
Sometimes	15 (24.2%)
Rarely	22 (35.5%)
Never	0 (0%)

Avg. 3.23% (*SD* = 1.12)

Regarding the tasks these social workers performed, most indicated they occasionally performed clerical tasks, such as greeting those who entered the center, answering the center phone, and copying/scanning/faxing documents along with other center personnel. Approving work hours/time off and scheduling patients was typically done by the charge nurse and/or administrators. When it came to addressing insurance concerns and education, 60 (97%) of social workers indicated they performed that task in their center. Forty-nine (79%) of social workers indicated they arranged transportation, and 61 (98%) of social workers indicated they linked patients and caregivers with community resources.

Stress and Supervision on the Job

To assess the stress levels experienced by social workers, a 1 ("not stressful") to 10 ("very stressful") Likert scale was used. The average response among the social workers was 6.28 (*SD* = 2.16), indicating they experienced moderate stress levels.

To examine factors that can cause stress for social workers, the type of supervision and the frequency of the interruptions experienced by social workers was explored. A 1 ("I really don't have supervision. I almost never see my supervisor.") to 5 ("I have extreme close supervision in which my supervisor checks my work all the time.") on The Likert scale was used to assess the social workers' supervision. The average response of the social workers was 1.10 (*SD* = 0.76). Forty of the 62 respondents (64.5%) indicated that they had minimal or no supervision at work. See **Table 4** for frequencies of types of supervision of dialysis social workers. When asked about the discipline and background of the respondents' supervisors, 45 of the 62 (72.5%) respondents stated that their supervisor had a nursing background, six (9.7%) stated their supervisor was a licensed social worker, two (3.2%) reported their supervisor had an MBA or a business background, and other responses included a dialysis technician, a registered dietitian, a physician assistant, and someone with a BS in Criminal Justice. Four respondents did not include the pro-

fessional or educational background of their supervisor. To assess how frequently social workers got interrupted when working with a patient, a 1 ("never") to 5 ("always") Likert scale was used. The results showed the average response was 3.19 (*SD* = 0.92), indicating that many of the social workers do get interrupted while interacting with patients.

Table 4. *Frequency of Supervision*

Describe the supervision you have in your present job? *N* = 62	**Number and percentage of respondents indicating this frequency of supervision**
I have extremely close supervision in which my supervisor checks my work all the time.	2 (3.2%)
I have moderate supervision in which my supervisor occasionally checks my work	15 (24.2%)
I have minimal supervision in which my supervisor rarely checks my work.	32 (51.6%)
I really don't have supervision. I almost never see my supervisor.	13 (20.9%)

The respondents were also asked an open-ended question to discuss what they believed were the barriers in their settings to using professional social work skills, such as doing psychosocial assessments and clinical and behavioral interventions with patients who are living on dialysis and with end-stage kidney disease and their caregivers. Fifty-eight of the 62 (93.5%) respondents wrote about these challenges in the survey; two stated that there were no barriers to providing these services, and two left this item blank. From the 58 written responses, a content analysis was performed with the barriers organized into the categories of: *client characteristics, social worker characteristics, setting/facility/organizational characteristics,* and *procedural and policy characteristics*.

Client Characteristics

Client characteristics are described as factors or qualities of patients and caregivers that may make it challenging for social workers to perform psychosocial assessments and interventions in dialysis settings. From our content analysis of the barriers, appointment fatigue (i.e., clients being exhausted due to multiple medical appointments and long treatments), clients not feeling well, stigma of receiving psychosocial services, and transportation schedules affected the client's willingness and ability to participate in psychosocial treatment from social workers.

Social Worker Characteristics

"Social worker characteristics" are defined as limitations that social workers identified in themselves or other social workers as barriers or weaknesses in conducting clinical assessments and performing social work interventions in dialysis settings. These limitations and barriers stem from their beliefs about their lack of clinical skills, language barriers between themselves and clients, or not seeing dialysis social work as clinical social work. **Table 5** lists responses from the survey respondents that implied that some social worker characteristics were limitations/barriers in providing clinical and therapeutic services to dialysis clients.

Table 5. *Limitations and Barriers of Social Workers to Provide Clinical Social Work*

Social worker characteristics identified by survey respondents as potential barriers to providing clinical mental health and therapy interventions:	
Response 1	"Because I've been doing case management so long, I am out of practice with my clinical skills."
Response 2	"New social workers need extended training and continuing education to provide clinical treatment. They don't often have this in dialysis social work."
Response 3	"There are language barriers between many of the patients and the dialysis staff, and it is not fair to ask the family members to interpret, and in therapy there may be things the patient doesn't want their family members to hear and interpret."
Response 4	"There is not enough consensus among social workers to do therapy with dialysis patients. Some social workers don't want to do therapy with patients."
Response 5	"This job doesn't pay enough for me to do therapy as well."
Response 6	"Providing clinical social work would be a conflict of interest for clinic social workers. We know their families and if they are compliant or not. It is a conflict because we are often the ones to tell them what they should be doing or what they can't do rather than being their therapists."
Response 7	"Dialysis social work is a task-oriented job, not a clinical job."

Setting/Facility/Organizational Characteristics

Work setting, facility, physical, and organizational characteristics are factors within the work environment that affect the delivery of services. In the survey results, these characteristics were most commonly listed as barriers to providing professional social work interventions. Twenty-one (33.9%) reported that physical work setting factors, such as lack of privacy and quiet (e.g., people talking and machines making beeping noises), in dialysis settings were barriers for social workers to engage in in-depth therapy with clients. **Table 6** provides responses from participants describing setting/facility and organizational barriers.

Table 6. *Setting/Facility and Organizational Barriers to Providing Clinical Social Work*

Setting/facility and organizational barriers to providing clinical social work in dialysis settings as identified by survey respondents	
Response 1	"Treatment floor is not quiet or private. There are lots of interruptions, including taking patient vitals, responding to the machines, and checking on how the treatment is going."
Response 2	"It is difficult to get into deeply personal information chairside."
Response 3	"Private office space is not available where I work."
Response 4	"Lack of space to have confidential discussion; lack of time when patient is present; physical issues that superseded dealing with psychosocial issues."

Procedural and Policy Barriers

Forty-eight respondents (77.4%) identified procedural and policy barriers, such as large caseloads, not having enough time to provide longer term interventions with patients/caregivers, lack of understanding of the competencies and professional skills of MSWs, and the corporatization of dialysis and healthcare. See **Table 7** for responses describing these barriers.

Table 7. *Procedural and Policy Barriers to Providing Clinical Social Work*

Procedural and policy barriers to providing clinical social work in dialysis settings as identified by survey respondents	
Response 1	"At my clinic it seems like they look at me when there is a problem or when pt's [sic] need help with transportation or insurance."
Response 2	"Micromanaging by telling SWs how to do every aspect of their job, totally misunderstanding what an MSW is trained for and capable of."
Response 3	"After 34-plus years in dialysis, I can tell you that the actual quality of time a social worker is able to spend with a patient has drastically deteriorated due to the clerical tasks placed on the social worker by the company they work for, the Network, the government, etc."
Response 4	"When dialysis became corporate, the paradigm changed. It became all about checking the box for annual transplant education, advanced care [sic] planning, screening for depression—redundant and rote—not much time to find out about family stressors or address what was going on or needed at home—too much focus on missed treatments—outcome[s] driven; forced, structured social work program—like the programs they want us to implement—to the point of harassment and almost threatening if you don't get the numbers—not about quality—no flexibility/freedom to do what would be helpful; also too much time spent on insurance issues; high caseload and unrealistic expectations for social workers."
Response 5	"...medical staff don't understand what social workers do."

CONCLUSION

The results of the Clinical Opportunities for Dialysis Social Workers (CODSW) survey yielded an array of data to describe characteristics of dialysis social workers, their work environments, and barriers to their work with patients. For this study, we examined the components of social work practice and barriers to providing professional services. For the dialysis social workers surveyed, setting, facility and orga-

nizational characteristics were reported to be the most burdensome for them as they engaged in social work practice with patients. In dialysis centers most of the social workers' time—approximately 25 to 30% per week—is allocated for administrative tasks, such as addressing insurance and financial concerns, implementing center initiatives and projects, documentation, setting up transportation, risk management, answering the phone, copying/faxing, and scheduling transportation (S. Chambers, B. Hebert, & P. Murphy, personal communication, November 3, 2021). Social workers also reported that, in dialysis settings, licensed social workers addressing insurance concerns and patient financial and transportation issues had been more common than in other medical settings where they have worked, such as hospice, inpatient care, or transplant services (B. Hebert, personal communication, November 3, 2021, & P. Murphy, personal communication, June 19, 2023).

The average caseload size for the social workers surveyed was 106.20 (*SD* = 32.28). Roughly this could mean that, in a 40-hour week, each social worker had three minutes to spend with each of their patients. However, this did not include time for documentation, addressing insurance and financial concerns, participating in center initiatives, setting up transportation, risk management, administrative meetings, and more. High caseloads and the amount of time spent doing indirect social work practice made it difficult, if not impossible, to provide individualized and in-depth services to patients and caregivers.

The results of this survey led to recommendations for direct and macro social work practice and education. Dialysis social workers face challenges similar to those faced by medical social workers, as well as social workers in settings where they may be considered "guests" in host settings. Dane and Simon (1991) describe how social workers have been "guests" in host settings, such as hospitals, medical clinics, schools, psychiatric settings, and juvenile courts since professional social work was first formalized in the early 20th century. Dane and Simon (1991) define "host settings" as organizations whose mission, structure and authority are defined by those who are not social workers.

Professional guests in host organizations, as social workers are in dialysis settings, are confronted with role ambiguity, role strain, professional tokenism, and isolation (being the only social worker in a setting), as well as discrepancies between their own social work values and ethics and institutional values and requirements (Dane & Simon, 1991).

Furthermore, practicing dialysis social workers become acutely aware of the social inequities faced by their patients and gaps in the healthcare system that interfere with providing quality patient care. Advocacy is an important tool for social workers. Joining organizations such as the National Association of Social Workers (NASW) and the National Kidney Foundation (NKF) as a social worker are ways to join with others to advocate for systemic and structural changes in policies, communities, and organizations to provide early, accessible, and high-quality services for people with kidney disease.

Other startling findings from this survey were that only six of the 62 social work respondents (9.7%) had social work supervisors, and that 45 of the 62 respondents (72.5%) stated that they had minimal or no work supervision. From these findings, it is recommended that all MSW specializations strengthen their content on health and healthcare social work and emphasize leadership and professional autonomy in social work practice, ethical decision making, advocacy, and policy practice. The NASW Code of Ethics (2021) and Peace's (2016) standards of practice provide a foundation for nephrology social workers for ethical practice and leadership.

Knowing when and how to seek supervision and consultation from social work colleagues, the interdisciplinary team, professional networks, and advocacy organizations is also critical. Furthermore, implications from this survey may include professional development and continuing education specific to dialysis centers, providing language interpreters in settings, and further qualitative studies of dialysis social workers to provide more detail about social work practice and barriers in dialysis centers.

As dialysis social work can be considered a subspecialty of health social work, content from health social work texts is clearly applicable to dialysis social work. This content includes human biology; medical diagnosis; treatment and terminology; social workers and role ambiguity and role confusion; working on multidisciplinary and interdisciplinary teams; documentation and technology in healthcare settings; and clashes between social work values and those of the host settings. In addition, topics from macro social work and policy—the development and structure of the U.S. healthcare system, Medicare, Medicaid, private and managed payor sources, and the corporatization of human services—are also pertinent to dialysis social work practice.

The limitations of this research are that the data for this survey was collected through convenience and network sampling, and this is not as robust as random sampling. Also, the data were collected in January and February 2020, before the COVID-19 pandemic and restrictions came to the United States. This may have affected the sample size. Additionally, starting March 2020, medical settings changed dramatically. Staff and patients were required to wear and use personal protective equipment and dialysis centers required that all have their temperature taken before entering the dialysis center. In some dialysis centers, the social worker was the professional required to do the additional tasks of tak-

ing temperatures and doing a short questionnaire to screen for COVID-19 risks and symptoms (S. Chambers, personal communication, March 30, 2020).

Despite the sample size and convenience and network sampling, the researchers were impressed with how quickly completed surveys were returned and how detailed some of the written responses were to the open-ended questions. We concluded that this showed interest and enthusiasm for dialysis social work. We see potential for dialysis social workers to become powerful advocates for those with kidney disease, and to work for changes in the healthcare system to promote more comprehensive psychosocial care for those with chronic illnesses.

Author Note: *The authors would like to thank all who completed the survey for this research. This research received no type of funding from any university or organization. This project was completed by Valdosta State University faculty and MSW alumni. Authors have no known financial or non-financial conflicts of interest to disclose.*

REFERENCES

Allen, K., & Spitzer, W. (2016). *Social work practice in healthcare: Advanced approaches and emerging trends.* Sage.

Cowles, L. A. F. (2003). *Social work in the health field: A care perspective* (2nd ed.). The Haworth Press, Inc.

Craig, S., Frankford, R., Allan, K., Williams, C., Schwartz, C., Yaworski, A., Janz, G., & Malek-Saniee, S. (2016). Self-reported patient psychosocial needs in integrated primary health care: A role for social work in interdisciplinary teams. *Social Work in Health Care, 55*(1), 41–60. doi: 10.1080/00981389.2015.1085483

Cummings, T. G., & Worley, C. G. (2018). *Organization development and change* (11th ed.). Cengage Publishing.

Dane, B. O., & Simon, B. L. (1991). Resident guests: Social workers in host settings. *Social Work, 36*(3), 208–213.

Dzielegielewski, S. F., & Holliman, D. C. (2020). *The changing face of health care social work* (4th ed.). Springer Publishing Company.

Gehlert, S. & Browne, T. (2019). *Handbook of health social work* (3rd ed.). Jossey-Bass: A Wiley Brand.

Heyman, J., & Congress, E. (Eds.). (2018). *Health and social work: Practice, policy, and research.* Springer Publishing Company.

IBM® SPSS (Statistical Package for Social Services) [Computer software.]. (2023). Retrieved from https://www.ibm.com/products/spss-statistics

Jackson, K. (2014, September/October). Nephrology social work: Caring for the emotional needs of dialysis patients. *Social Work Today, 14*(5), 20. https://www.socialworktoday.com/archive/091514p20.shtml

Levin, D., Lingam, T., & Janiga, N. (2020). 2020 Outlook: Dialysis clinics and ESRD. *FMVantage Point: HealthCare Appraisers' Industry Insight.* https://healthcareappraisers.com/2020-outlook-dialysis-clinics-and-esrd/

McCoyd, J., & Kerson, T. (2016). *Social work in health settings practice in context* (4th ed.). Routledge.

National Archives and Records Administration. (1976, June 3, Thursday). Federal Register: 41 Fed. Reg. 22329 (June 3, 1976). Retrieved from the Library of Congress, https://www.loc.gov/item/fr041108/

National Association of Social Workers (NASW). (2021). *NASW code of ethics.* https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Peace, L. (2016). CNSW special article: Standards of practice: Are you in the know? *National Kidney Foundation.* https://www.kidney.org/sites/default/files/CNSW%20SOP%206th%20Ed_FINAL_July2014.pdf

Qualtrics XM [Computer software.]. (2019). Retrieved from https://www.qualtrics.com/

Spigner, D. (2017). *Roles of social workers at dialysis center: An action research project* (Order No. 10682431) [Doctoral dissertation, Walden University]. Available from ProQuest Dissertations & Theses Global (1973776806). https://www.proquest.com/openview/c37945291a24333e29fee62b4ec41067/1?pq-origsite=gscholar&cbl=18750

APPENDIX

Clinical Opportunities for Dialysis Social Workers

1. Gender: _____
2. Ethnicity or race: _____
3. Location of employment (city/state): _____
4. Educational background (major/field of study & degree):

   _____
5. List all professional licenses or credentials you currently hold: _____

   _____

   _____

6. What type of dialysis patients do you work with? Check all that apply:

   ___ In-center/clinic

   ___ Home

   ___ Other: _____

7. On average, how many patients do you serve?_____

8. What is the title of your present job?

   _____

9. Auspice of dialysis center:

   ___ Private/for-profit

   ___ Private/non-profit

   ___ Federal (VA or military)

   ___ State

   ___ City or county

   ___ Other_____

10. How long have you worked in your current position?

    _____ Months _____ Years

11. In a typical week, approximately how many hours do you work at this job? ____

12. How many dialysis centers do you cover? ____

13. On a scale of 1 to 10, with 1 being not stressful at all and 10 being extremely stressful, how stressful is your workload? ____

14. At your center, who carries out the following? List the position title of the person who most often completes the following tasks:

    Greeting those who enter the center _____

    Answering the center telephone _____

    Copying/scanning/faxing _____

    Approving work hours and time off _____

    Scheduling patients _____

    Addressing insurance concerns _____

    Education on insurance _____

    Community resources for patients _____

    Arranging transportation _____

15. How would you describe the type of supervision you have in your present job?

    ___ I have extremely close supervision in which my supervisor checks my work all the time.

    ___ I have moderate supervision in which my supervisor occasionally checks my work.

    ___ I have minimal supervision in which my supervisor rarely checks my work.

    ___ I really don't have supervision. I almost never see my supervisor.

16. What is the professional background/discipline of your supervisor? _____

17. How do you assess for depression in your patients?

    ___ PHQ-2 (Patient Health Questionnaire 2)

    ___ PHQ-9 (Patient Health Questionnaire 9)

    ___ The Beck Depression Inventory

    ___ Other: _____

18. How often do you screen for depression in dialysis patients? _____

19. If a patient scores positive for depression, how often do you refer to or recommend outpatient mental health therapy?

    ___ Always

    ___ Very often

    ___ Sometimes

    ___ Rarely

    ___ Never

20. If a patient scores positive for depression, how often do you inform the medical doctor?

    ___ Always

    ___ Very often

    ___ Sometimes

    ___ Rarely

    ___ Never

21. If outpatient therapy is recommended for a patient, how often do they agree to participate in outpatient therapy?

    ___ Always

    ___ Very often

    ___ Sometimes

    ___ Rarely

    ___ Never

22. If you answered "Sometimes," "Rarely," or "Never" to Question 21, why do you think patients decide not to receive outpatient mental health therapy?

    _____

    _____

23. If antidepressants are recommended to the patient by the medical doctor, how often does the patient agree to take them?

    ___ Always

    ___ Very often

    ___ Sometimes

    ___ Rarely

    ___ Never

24. If you answered "Sometimes," "Rarely," or "Never" to Question 23, why do you think patients respond negatively to taking anti-depressant medications?

25. How do you treat or address depression in your dialysis center? (Check all that apply.)

    ___ Groups

    ___ Psychoeducation

    ___ Self-care (Discuss exercise, walking, yoga)

    ___ Family support (talk to family to address and get family involved)

    ___ Supportive counseling

    ___ Cognitive behavioral therapy

    ___ Other (Please describe.) _____

    _____

26. How often are you able to use professional social work skills in dialysis social work?

    ___ Always

    ___ Very often

    ___ Sometimes

    ___ Rarely

    ___ Never

27. Describe the professional social work skills that you use.

    _____

28. What are the barriers to using professional social work skills in dialysis social work?

    _____

29. How often do you get interrupted when trying to use social work skills with a patient?

    ___ Always

    ___ Very often

    ___ Sometimes

    ___ Rarely

    ___ Never

30. What do you see as some of the potential interventions that dialysis social workers could use in treating/addressing depression with patients?

    _____

31. After completing this survey, do you have additional comments or feedback about social work in dialysis settings?

    _____

    _____

    _____

    _____

    _____