National Kidney Foundation 2023 Spring Clinical Meetings Social Work Abstracts

CKD/ESRD—Otherv

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1. IN A NATIONAL SURVEY—NEPHROLOGY SOCIAL WORKERS' OPINIONS ON THE USE OF ACCEPTABLE HUMOR IN CONVERSATIONS WITH ADVANCED ILLNESS PATIENTS:

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By using acceptable humor, defined as "a smile, a laugh or a joke," do social workers experience less burnout on their own lives? Do they believe that humor alleviates perceived pain or discomfort in advanced illness patients? Smiling, laughing, and a kind joke is a part of many social workers lives and no less important for those patients with advanced illness. Social workers frequently encounter patients with advanced illness in the end-stage renal disease (ESRD) setting. They assess for depression, anxiety, pain, and suicidality. Death is all too frequent in this population, and this contributes to burnout. In multiple studies on palliative care, the use of humor allows providers, patients, and caregivers to be connected, provide them hope, decrease their agitation, and improve their own unique perspectives.

This study was a cross-sectional, 33-item anonymous online survey. It was sent out by the Executive Directors from the 18 ESRD Networks. Permission to proceed from the Centers for Medicare & Medicaid Services (CMS). No identifiable information was collected, all questions were optional and the survey could only be taken once.

Over 6,100 surveys were e-mailed with a rate of return of 21% (1,018) over three weeks in May-June 2022, with a 100% completion rate.

The survey used a Likert scale. A majority of social workers (92%) strongly agreed or agreed that they engage in acceptable humor and (80%) use humor in their practice 26-100% of the time. These social workers experienced burnout (80%) and (67%) felt that humor decreased this burnout and enhanced their personal connection(s) (95%) with their patient. Most did not use humor until the patient initiated (83%). A majority (60%) felt that their cultural background influenced positively their ability to engage in humor. Humor was also useful in allowing for the patient to cope with grief (72%), emotional distress (84%) and their overall well-being (95%). There was no difference in the use of acceptable humor by gender, ethnicity or region of the country. However, the use of acceptable humor slightly increased as the provider's age and the number of years in practice increased in white respondents (*N*=753).

2. LOW UTILIZATION OF OUTPATIENT SOCIAL AND BEHAVIORAL SERVICES AMONG PATIENTS WITH DOCUMENTED PROBLEMS (ICD-10-CM Z-CODES):

Yun Han[1], Tiffany Veinot[1], Brenda Gillespie[1], Jennifer Bragg-Gresham[1], Yoshihisa Miyamoto[2], Meda Pavkov[2], Hal Morgenstern[1], Rajiv Saran[1]. [1]University of Michigan, Ann Arbor, MI, United States; [2]Centers for Disease Control and Prevention, Atlanta, GA, United States

ICD-10 Z-codes were launched in 2015 to record health-related social needs and behavioral health issues. Social and behavioral services may be important to improve care, especially for conditions like chronic kidney disease (CKD). We assessed whether patients received appropriate social and behavioral services following records of selected Z-code concerns.

Patients insured by Medicare Advantage (MA) or Commercial (COM) plans with 5 Z-code concerns were extracted separately: 1) dietary, 2) tobacco use, 3) primary support group, 4) social environment, and 5) upbringing problems (Optum data 2015-2020). Outpatient social and behavioral services—dietary counseling visits, smoking and tobacco use counseling visits, and social worker visits—were captured using CPT codes or provider ID. Patient demographics, CKD, and other conditions that predict social and behavioral services were assessed using logistic models.

More COM patients than MA patients received appropriate services when they had records of problems related to dietary (32.4% vs 5.7%), primary support group (18.8% vs 12.1%), and social environment (15.7% vs 6.6%), while less COM patients received such services when they had records of tobacco use (7.1% vs 11.4%) and upbringing problems (23.5% vs 35.8%). Younger age and male sex were associated with less use of social and behavioral services after adjusting for patient factors (Tab). CKD patients with COM plans and dietary problems were less likely to receive dietary counseling.

Use of social and behavioral services was low in patients with Z-code concerns. The inverse association between CKD and receiving dietary counseling suggests missed opportunities in health-care delivery tailored to nonmedical problems.

2. (*continued*) LOW UTILIZATION OF OUTPATIENT SOCIAL AND BEHAVIORAL SERVICES AMONG PATIENTS WITH DOCUMENTED PROBLEMS

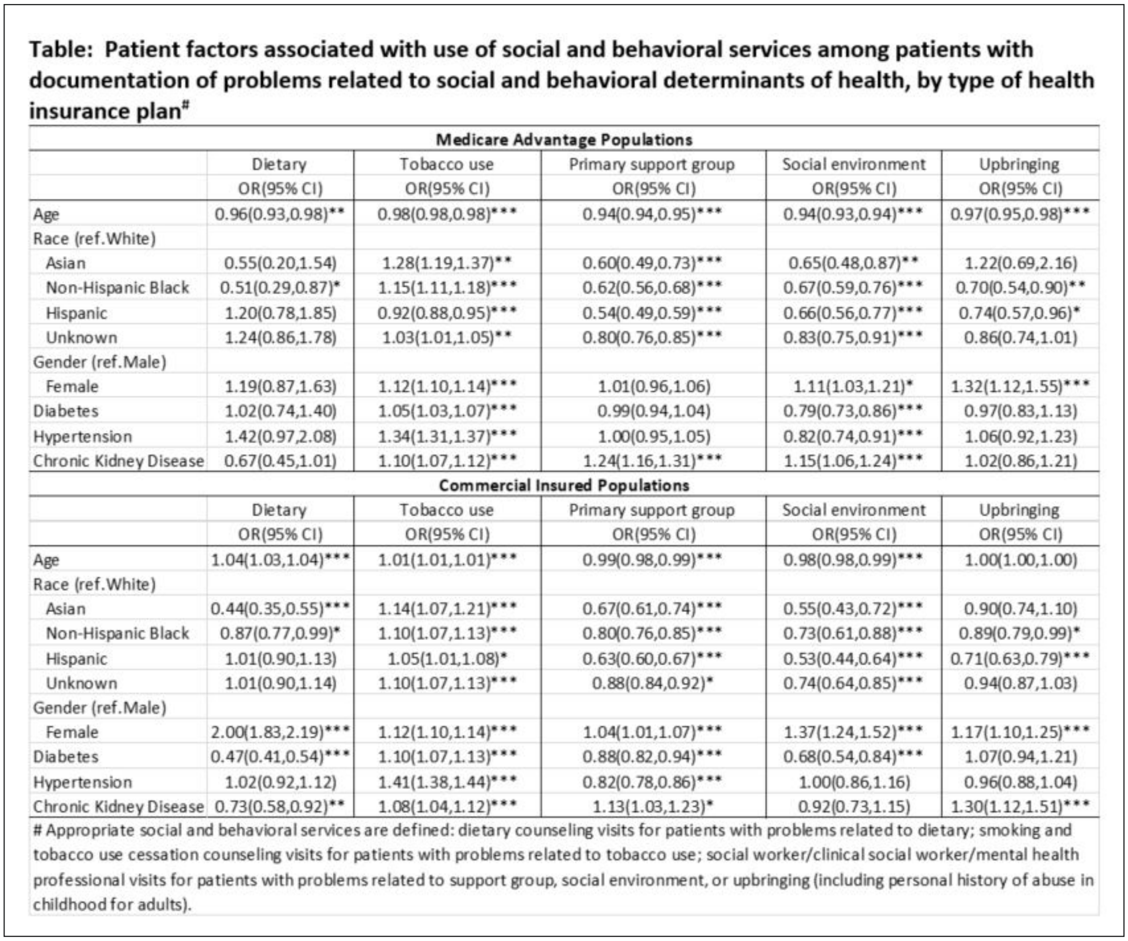


Table: Patient factors associated with use of social and behavioral services among patients with documentation of problems related to social and behavioral determinants of health, by type of health insurance plan#

Medicare Advantage Populations

	Dietary	Tobacco use	Primary support group	Social environment	Upbringing
	OR(95% CI)	OR(95% CI)	OR(95% CI)	OR(95% CI)	OR(95% CI)
Age	0.96(0.93,0.98)**	0.98(0.98,0.98)***	0.94(0.94,0.95)***	0.94(0.93,0.94)***	0.97(0.95,0.98)***
Race (ref.White)					
Asian	0.55(0.20,1.54)	1.28(1.19,1.37)**	0.60(0.49,0.73)***	0.65(0.48,0.87)**	1.22(0.69,2.16)
Non-Hispanic Black	0.51(0.29,0.87)*	1.15(1.11,1.18)***	0.62(0.56,0.68)***	0.67(0.59,0.76)***	0.70(0.54,0.90)**
Hispanic	1.20(0.78,1.85)	0.92(0.88,0.95)***	0.54(0.49,0.59)***	0.66(0.56,0.77)***	0.74(0.57,0.96)*
Unknown	1.24(0.86,1.78)	1.03(1.01,1.05)**	0.80(0.76,0.85)***	0.83(0.75,0.91)***	0.86(0.74,1.01)
Gender (ref.Male)					
Female	1.19(0.87,1.63)	1.12(1.10,1.14)***	1.01(0.96,1.06)	1.11(1.03,1.21)*	1.32(1.12,1.55)***
Diabetes	1.02(0.74,1.40)	1.05(1.03,1.07)***	0.99(0.94,1.04)	0.79(0.73,0.86)***	0.97(0.83,1.13)
Hypertension	1.42(0.97,2.08)	1.34(1.31,1.37)***	1.00(0.95,1.05)	0.82(0.74,0.91)***	1.06(0.92,1.23)
Chronic Kidney Disease	0.67(0.45,1.01)	1.10(1.07,1.12)***	1.24(1.16,1.31)***	1.15(1.06,1.24)***	1.02(0.86,1.21)

Commercial Insured Populations

	Dietary	Tobacco use	Primary support group	Social environment	Upbringing
	OR(95% CI)	OR(95% CI)	OR(95% CI)	OR(95% CI)	OR(95% CI)
Age	1.04(1.03,1.04)***	1.01(1.01,1.01)***	0.99(0.98,0.99)***	0.98(0.98,0.99)***	1.00(1.00,1.00)
Race (ref.White)					
Asian	0.44(0.35,0.55)***	1.14(1.07,1.21)***	0.67(0.61,0.74)***	0.55(0.43,0.72)***	0.90(0.74,1.10)
Non-Hispanic Black	0.87(0.77,0.99)*	1.10(1.07,1.13)***	0.80(0.76,0.85)***	0.73(0.61,0.88)***	0.89(0.79,0.99)*
Hispanic	1.01(0.90,1.13)	1.05(1.01,1.08)*	0.63(0.60,0.67)***	0.53(0.44,0.64)***	0.71(0.63,0.79)***
Unknown	1.01(0.90,1.14)	1.10(1.07,1.13)***	0.88(0.84,0.92)*	0.74(0.64,0.85)***	0.94(0.87,1.03)
Gender (ref.Male)					
Female	2.00(1.83,2.19)***	1.12(1.10,1.14)***	1.04(1.01,1.07)***	1.37(1.24,1.52)***	1.17(1.10,1.25)***
Diabetes	0.47(0.41,0.54)***	1.10(1.07,1.13)***	0.88(0.82,0.94)***	0.68(0.54,0.84)***	1.07(0.94,1.21)
Hypertension	1.02(0.92,1.12)	1.41(1.38,1.44)***	0.82(0.78,0.86)***	1.00(0.86,1.16)	0.96(0.88,1.04)
Chronic Kidney Disease	0.73(0.58,0.92)**	1.08(1.04,1.12)***	1.13(1.03,1.23)*	0.92(0.73,1.15)	1.30(1.12,1.51)***

Appropriate social and behavioral services are defined: dietary counseling visits for patients with problems related to dietary; smoking and tobacco use cessation counseling visits for patients with problems related to tobacco use; social worker/clinical social worker/mental health professional visits for patients with problems related to support group, social environment, or upbringing (including personal history of abuse in childhood for adults).

3. COVID-19 VACCINE PERSPECTIVES AND EXPERIENCES AMONG PATIENTS WITH KIDNEY FAILURE IN THE SOUTHEASTERN U.S.:

Megan Urbanski[1], Laura Plantinga[1], Emma Blythe[1], Monique Hennink[1], Stephen Pastan[1], Rachel Patzer[1]. [1]Emory University, Atlanta, GA, United States

Patients with kidney failure are at an increased risk for morbidity and mortality from COVID-19 infection making vaccination a priority for this population. However, patients' perspectives regarding the COVID-19 vaccine have not been fully explored.

A cross-sectional survey and semi-structured interviews were conducted in 2022 with hemodialysis patients in the Southeastern U.S. Surveys included Likert scale items [range 1 (strongly disagree) to 5 (strongly agree)] informed by the Health Belief Model that assessed participants' perceived susceptibility to and severity of COVID-19 infection, barriers to and benefits of the COVID-19 vaccine, and cues to action; interviews explored accessing dialysis during the pandemic and reasons for accepting or refusing the vaccine.

A total of 24 hemodialysis patients completed the survey [median age 57 years; 50% female; 87.5% Black]. Most (87.5%) respondents had received at least one vaccine dose. Domain scores for perceived susceptibility, severity, barriers, benefits, and cues to action [median (IQR)] were 2.3 (2.0-3.0), 4.5 (4.0-5.0), 1.9 (1.4-2.4), 4.0 (3.5-4.5), and 3.9 (3.3-4.5). The news/other media (61.3%), nephrologist (58.1%), and dialysis staff (58.1%) were the most reported vaccine information sources. The dialysis clinic (38.7%), community vaccine clinic (19.4%), and local pharmacy (13.0%) were the most reported locations for receiving the vaccine. Preliminary analysis of interviews (*n*=7) revealed a conflict between attending dialysis as life sustaining vs. life-threatening due to possible COVID-19 exposure, vaccination as an opportunity to take control over one's health, and desire for vaccine information from dialysis providers because of longstanding trusting relationships. Our findings suggest that the outpatient dialysis center may be an advantageous setting for the provision of COVID-19 vaccine-related resources and inform interven-tions in the dialysis setting aimed at improving vaccination rates for dialysis patients.

4. APPLYING THE KDQOL SURVEY IN ETHIOPIA:

Niya Ahmed[1], Wubshet Jote[1,2], Tigist Demisse[1], Biruh Workeneh[3]. [1]King Menelik II Hospital, Addis Ababa, Ethiopia; [2]St. Paul Millennium Medical College, Addis Ababa, Ethiopia; [3]University of Texas MD Anderson Cancer Center, Houston, TX, United States

Little is known about the disease burden of patients with ESRD in Ethiopia. The kidney disease quality of life (KDQOL) survey is essential to managing psychological health and safety in dialysis patients in the United States and beyond. However, it is challenging to apply in countries where very little English is spoken. Aided completion of KDQOL may affect the validity, particularly questions patients may find sensitive, which was the case after administering the survey to an initial cohort of 19 patients. Ethiopia's dialysis population is underserved, and there is an acute need for a validated tool in the local language to assess disease burden and target improvement.

YeAbe Dialysis at Menelik II Hospital is a comprehensive dialysis care center with a psychologist and social worker on the staff. Partnering with the RAND Corporation, which developed and managed the KDQOL-Complete, we sought to develop an Amharic version of the survey. Language experts formally translated the survey.

After several rounds of review, including the social worker, the tool was validated and is nearing completion. The KDQOL Amharic version will be available to administer using the online platform.

This experience demonstrates the difficulty of administering the currently available KDQOL and shows that adding a context-appropriate KDQOL is feasible and achievable in developing countries that have the appropriate conditions and resources to develop it.

5. BARRIERS IN ACCESS TO TRANSPLANTATION IN CENTRAL TEXAS IN THE SETTING OF A NEW TRANSPLANT PROGRAM:

Gloria Chen[1], Brindha Anantharam[2], Cindy Hu[2], Sofia Jimenez[2], Anderson Slack[2], Arnold Kuk[2], Brian Lee[2], Nicole Turgeon[2], Joel Adler[2]. [1]Dell Seton Medical Center at The University of Texas at Austin, Austin, TX, United States; [2]Dell Medical School at The University of Texas at Austin, Austin, TX, United States;

Barriers in accessing kidney transplantation remain poorly understood. The founding of a new transplant center provides an opportunity to identify local disparities and build solutions. We sought to better understand the barriers to accessing kidney transplantation among our first evaluated patients.

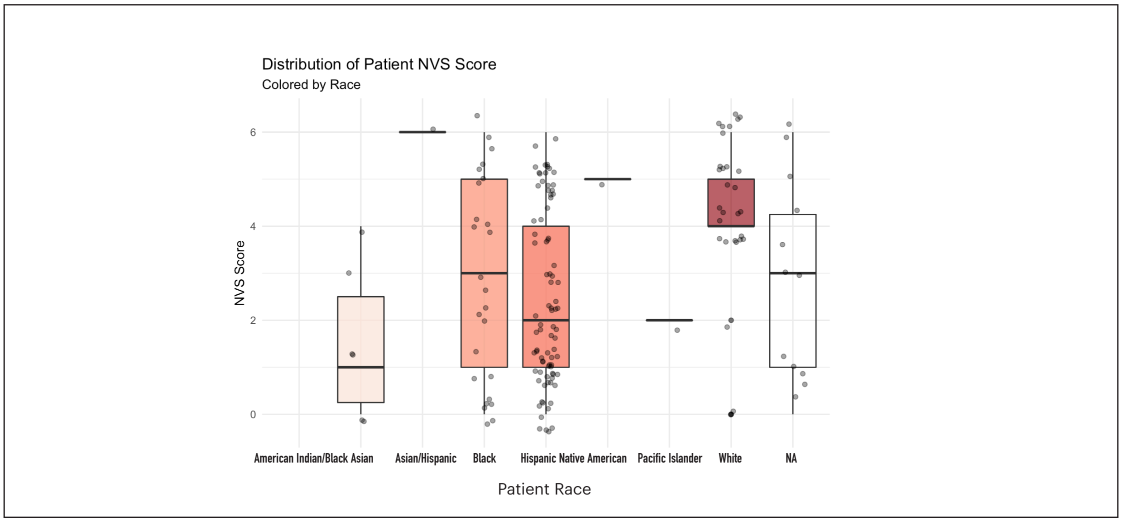
We employed a parallel mixed-methods design, inviting all patients undergoing evaluation to collect demographics and measure health literacy (Newest Vital Sign), mood (PHQ9 and GAD7), social needs (AAFP SDOH Screening Tool), and quality of life (KDQOL). Results were analyzed descriptively.

134/170 patients (78.8%) participated in the study. Median age was 53 years (IQR 43-63 years), and 54.6% male. 45.2% were Hispanic, while White and Black patients were equally represented (19.2%). 50.8% had Medicare and 22.3% had employer insurance. 67% held a high school diploma or higher. 45.9% had been previously evaluated at another center.

Identified barriers were an annual personal income of <$25,000 for 46.7% of patients. 55.1% had a Newest Vital Sign score of ≤3, indicating limited health literacy (figure). 31.5% had mild-moderate depression and 14.9% reported mild-moderate anxiety. Identified social needs were not having enough money to pay bills (35.1%), food insecurity (17.7%), housing and living environment (14%), and personal safety (3.1%). The median kidney symptom score was 67 (IQR 55.5-79.9), indicating a lower burden of disease.

We identified key barriers of lower income, limited health literacy, and multiple social determinants of health. These suggest potential barriers that can be targeted for future research.

5. (*continued*) BARRIERS IN ACCESS TO TRANSPLANTATION IN CENTRAL TEXAS IN THE SETTING OF A NEW TRANSPLANT PROGRAM



6. BARRIERS AND FACILITATORS OF TRANSPLANT LISTING FOR ESKD PATIENTS WITH LIMITED HEALTH LITERACY:

Colleen Satarino[1], Karen Crampton[1], Deb Manderachia[2], Silas Norman[1]. [1]University of Michigan Health, Ann Arbor, MI, United States; [2]Veterans Administration, Ann Arbor, MI, United States

Equal access to kidney transplantation for all patients with end-stage kidney disease (ESKD) is imperative as kidney transplant is the best treatment for ESKD. The literature has established that ESKD patients with limited health literacy (LHL) make up at least 30% of the ESKD population and are less likely to attend their transplant evaluation, less likely to complete their evaluation, and less likely to be placed on the waiting list. This phenomenological study focuses on a cohort of pre-kidney transplant patients with LHL to identify barriers and facilitators to achieving listing and transplantation.

Semi-structured phone interviews were conducted with 37 participants who were evaluated for kidney transplant between August 2018 and October 2019. Eligible participants had no previous transplants and scored 6 or lower on the Rapid Evaluation Assessment of Health Literacy – Short Form. Participants were asked to provide their own definition of 9 common kidney transplant terms. Other variables such as informal and formal support, self-efficacy and knowledge of their listing requirements were discussed.

Among the 37 interviewed, 19 participants were eligible for listing after their initial evaluation. 9 participants were listed at 6 months and an additional 2 participants at 12 months. Patient transplant status was reviewed after 2 years, and 11 participants received a transplant. Several transplant terms were misunderstood by the participants. Potential facilitators include support, knowledge of listing requirements and self-efficacy. Potential barriers include difficulty in reading their evaluation requirements by over 30% of the participants.

Knowledge of the barriers and facilitators of LHL ESKD patients to listing and transplant are critical when designing interventions to improve access. Assistance by family and friends, the dialysis and transplant communities, and beliefs about self-efficacy contribute to listing and transplantation. Identifying LHL remains crucial for dialysis clinics and transplant centers to provide the necessary support to achieve listing and transplantation.

7. DELIBERATE DELAY IN TRANSPLANT EDUCATION FOR “OVERWHELMED” DIALYSIS PATIENTS:

Jenny McDonnell[1], Megan Urbanski[1], Stephen Pastan[1], Janice Lea[1], Kimberly Jacob-Arriola[1], Cam Escoffery[1], Rachel Patzer[1], Adam Wilk[1]. [1]Emory University, Atlanta, GA, United States

Access to timely transplant education at a dialysis facility increases patient interest in transplant, likelihood of waitlisting, and transplant receipt. Evidence shows some dialysis patient groups are less likely to receive appropriate transplant education than others. It is unclear how dialysis providers’ transplant education practices may differ for patients who initiate dialysis unexpectedly (e.g., following hospitalization for ESRD).

We conducted 39 in-depth interviews during June-August 2022 with dialysis clinic providers in Georgia, North Carolina, and South Carolina about their processes leading up to referral or non-referral to a transplant center. We recruited dialysis social workers, nurse managers, nephrologists, and administrators using purposive sampling to capture diversity by participants’ role, years of experience, and county median household income. Semi-structured telephone interviews were recorded and transcribed. We managed textual data using MAXQDA software. We used thematic analysis to identify themes, with multiple coders developing the codebook and interpreting data.

Some dialysis providers described providing uniform transplant education to all patients, yet most providers described 3 types of transplant education practices for ESRD patients who initiate dialysis unexpectedly. In Type (1), these patients need time to stabilize and “settle into dialysis” *before* providers share any transplant education. In Type (2), patients who initiate dialysis unexpectedly receive transplant education best when it is limited and provided slowly over many weeks or months. In Type (3), these patients have greater transplant knowledge deficits compared to patients who had prior nephrology care; identifying and filling these patients’ knowledge gaps takes more time.

Despite recognition that ESRD patients who initiate dialysis unexpectedly often require more extensive transplant education than patients who had prior nephrology care, providers often delay or limit discussing transplant with these patients. Promoting equitable transplant education practices will require accommodating diverse patient needs as well as diverse provider perspectives on best practices in transplant education for all patient groups.

8. HOW DIALYSIS PROVIDERS ASSESS AND REFER PATIENTS FOR KIDNEY TRANSPLANT EVALUATION: A PROCESS MODEL:

Adam Wilk[1], Jenny McDonnell[1], Megan Urbanski[1], Stephen Pastan[1], Janice Lea[1], Kimberly Jacob-Arriola[1], Cam Escoffery[1], Rachel Patzer[1]. [1]Emory University, Atlanta, GA, United States

For most patients with kidney failure, transplant is the preferred treatment modality, yet they receive dialysis first. Referral to a transplant center is a key early step toward receiving a transplant, but only 34% of patients are referred within 1 year of dialysis start. Efforts to mitigate any provider and clinic-level barriers to referral are hampered by the absence of a process model to characterize how dialysis clinics approach the decision of whether to refer patients for transplant.

We conducted 39 in-depth interviews during June-August 2022 with dialysis clinic providers in Georgia, North Carolina, and South Carolina about their processes leading up to referral or non-referral to a transplant center. We recruited dialysis social workers, nurse managers, nephrologists, and administrators using purposive sampling to capture diversity by participants’ role, years of experience, and county median household income. Semi-structured telephone interviews were recorded and transcribed. We managed and analyzed transcripts using MAXQDA software. We used a phenomenological approach to identify key constructs, including discrete steps and decisions, with multiple coders developing the codebook and interpreting data.

Most participants described a 4-step process preceding any transplant referral decision. (1) At patient intake, providers assess whether the patient has a non-modifiable contraindication to transplant, in which case referral does not proceed. (2) Providers engage in parallel dialogues with the patient (including transplant education) and within the care team about the patient’s likely eligibility, culminating in asking the patient “Are you inter-ested?” If the patient demurs, step 2 is repeated. (3) If the patient assents, a lead provider (e.g., nephrologist) or the care team collectively judges whether to make the referral then or to wait and intervene with the patient to improve their chances of waitlisting. (4) On the specified timetable, providers carry out the referral.

Qualitative interviews with dialysis providers revealed a 4-step process for approaching transplant referral decisions. This model can be used to inform interventions on dialysis clinics’ assessment and referral processes.