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Council of Nephrology Social Workers

The Journal of Nephrology Social Work

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- Relaxation Therapy and Mindfulness Meditation
One-Day Workshop—Part Two
- Increasing Physical Activity in CKD
- Nephrology Social Workers' Caseloads
and Hourly Wages: 2010/2014
- SCM15 Social Work Abstracts



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The Journal of Nephrology Social Work

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THE JOURNAL OF NEPHROLOGY SOCIAL WORK

The Council of Nephrology Social Workers (CNSW) of the National Kidney Foundation (NKF) is a professional membership organization of social workers dedicated to improving the quality of psychosocial services delivered to ESRD patients, as well as supporting the profession of nephrology social work.

The Council of Nephrology Social Workers of the National Kidney Foundation

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The Journal of Nephrology Social Work Editorial Board is comprised of nephrology social work experts who engage in research, policy analysis, and clinical practice. The board members include university faculty members and social work clinicians who are leaders and innovators in the field.

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If you are interested in submitting your resume for consideration to become a member of the Editorial Board, please contact Teri Browne, PHD, MSW, NSW-C by email (browne@sc.edu) or phone (803.777.6258)

CALL FOR MANUSCRIPTS

The Editorial Board of *The Journal of Nephrology Social Work* encourages the submission of original manuscripts. The *JNSW* contains articles addressing contemporary issues/topics relevant to nephrology social work. Authors may wish to address any of the following topics, which are listed as guidelines:

- | | | |
|------------------------|-----------------------------------|----------------------|
| ■ Social Work Outcomes | ■ Sexual Functioning | ■ Professional Roles |
| ■ Kidney Transplant | ■ Aging and Gerontological Issues | ■ Rehabilitation |
| ■ Pediatric Issues | ■ Disaster Preparedness | ■ HIV/AIDS |
| ■ End-of-Life Concerns | ■ Comorbid Illnesses | ■ Quality of Life |
| ■ Sleep Disorders | ■ Home Dialysis Modalities | ■ Ethics |

Please email manuscripts to: jnsw@kidney.org. Questions? Contact Editor Teri Browne, PHD, MSW, NSW-C by email (browne@sc.edu) or phone (803.777.6258).

INSTRUCTIONS FOR AUTHORS

The Journal of Nephrology Social Work (JNSW) is the official publication of the Council of Nephrology Social Workers of the National Kidney Foundation, Inc. Its purpose is to stimulate research and interest in psychosocial issues pertaining to kidney and urologic diseases, hypertension, and transplantation, as well as to publish information concerning renal social work practices and policies. The goal of *JNSW* is to publish original quantitative and qualitative research and communications that maintain high standards for the profession and that contribute significantly to the overall advancement of the field. The *Journal* is a valuable resource for practicing social work clinicians in the field, researchers, allied health professionals on interdisciplinary teams, policy makers, educators, and students.

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Conflict of Interest. The *JNSW* fully abides by the National Association of Social Workers' (NASW) Code of Ethics, [<http://www.socialworkers.org/pubs/code/code.asp>]; see clause 5.02 (a)-(p) focused on research). This portion of the code pertains to conflicts of interest, research with human participants, and informed consent. Per the code, "Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary." Authors who submit manuscripts to *JNSW* must disclose potential conflicts of interest which may include, but are not limited to, grants, remuneration in payment or in kind, and relationships with employers or outside vendors. When in doubt, authors are expected to err on the side of full disclosure. Additional information about conflicts of interest may be obtained via the International Committee of Medical Journal Editors' Uniform Requirement for Manuscripts Submitted to Biomedical Journals (URMSBJ): Ethical Considerations in the Conduct and Reporting of Research [http://www.icmje.org/ethical_4conflicts.html].

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PEER REVIEW PROCESS

Manuscripts submitted to *JNSW* are peer-reviewed, with the byline removed, by at least two Editorial Board members. The review process generally takes two to three months. *JNSW* reserves the right to edit all manuscripts for clarity or length. Minor changes in style and clarity are made at the discretion of the reviewers and editorial staff. Substantial changes will only be made with the primary author's approval.

Exclusive Publication. Manuscripts are accepted for review with the understanding that the material has not been previously published, except in abstract form, and is not concurrently under review for publication elsewhere. Authors should secure all necessary clearances and approvals prior to submission. Authors submitting a manuscript do so with the understanding that, if it is accepted for publication, the copyright for the article, including the right to reproduce the article in all forms and media, shall be assigned exclusively to the National Kidney Foundation. The publisher will not refuse any reasonable request by the author for permission to reproduce any of his or her contributions to the *Journal*.

A submitted manuscript should be accompanied by a **letter** that contains the following language and is signed by each author: "In compliance with the Copyright Revision Act of 1976, effective January 1, 1978, the undersigned author(s) transfers all copyright ownership of the manuscript entitled _____ to *The Journal of Nephrology Social Work* in the event this material is published."

To qualify as an original manuscript, the article or a version of the article must not have been published elsewhere. The author(s) must inform the editor if the manuscript is being reviewed for publication by any other journals. Once accepted for publication by the editor, the author(s) cannot make revisions to the manuscript.

TYPES OF MANUSCRIPTS BEING SOUGHT

Research and Review. The *JNSW* welcomes reports of original research on any topic related to renal social work. The editors will also consider manuscripts that document the development of new concepts or that review and update topics in the social sciences that are relevant to professionals working in the field of renal social work.

Reports and Commentary. The *JNSW* welcomes manuscripts that describe innovative and evaluated renal social work education programs, that report on viewpoints pertaining to current issues and controversies in the field, or that provide historical perspectives on renal social work. Commentaries are published with the following disclaimer: "The statements, comments, or opinions expressed in this article are those of the author, who is solely responsible for them, and do not necessarily represent the views of the Council of Nephrology Social Workers or the National Kidney Foundation."

Reviews. Review articles, in traditional or meta-analysis style, are usually invited contributions; however, letters of interest are welcome.

Original Research. Full manuscript format should include: introduction, method, results, and discussion of original research. The method section needs either a declaration of IRB approval or exemption. Length should usually not exceed 15 double-spaced pages, including references.

Clinical/Research Briefs. Abbreviated manuscript format presents clinical practice experience, preliminary research findings (basic or clinical), or professional observations in a shortened report form. Length should usually not exceed six double-spaced pages.

Practical Aspects Section. Contributions to this section are detailed protocols, forms, or other such materials that are successfully utilized for delivery of outcomes-based clinical social work services.

Case Studies. These detailed scenarios should illustrate a patient care situation that benefited from clinical social work intervention. Typically, they should consist of a brief clinical and psychosocial history, and a detailed intervention plan with discussion of recommendations focused toward practical application.

Letters to the Editor. Letters should be restricted to scientific commentary about materials published in the *JNSW* or to topics of general interest to professionals working in the field of renal social work.

MANUSCRIPT SUBMISSION PROCESS

Important Update: *JNSW* now has an optional MS Word template available for preparing your article. Using it will enhance the production process. To obtain this template, send an email with "Template Needed" in the subject line to jnsw@kidney.org.

Note: A sixth edition of the APA style guide has been published. However, there were errors in the first printing which were corrected in subsequent printings. For now, *JNSW* will adhere to the fifth edition.

Manuscript Format. Manuscripts should be formatted according to the rules laid out by the *Publication Manual of the American Psychological Association, Fifth Edition*. What follows is a brief synopsis of the broader style points used by the APA.

Manuscripts should conform to the following guidelines: Text should be double-spaced, set in 12-point type (preferably Times New Roman) and have 1-inch margins along all sides of every page. Starting with the title page, pages should be numbered in the upper, right-hand corner and should have a running head in the upper left-hand corner. The running head should be a shortened version of the manuscript's title and should be set in all uppercase letters. The first line of every paragraph in the manuscript should be indented, as should the first line of every footnote.

Order of the Manuscript Sections

- | | |
|---------------|---------------------|
| 1) Title page | 6) Author note |
| 2) Abstract | 7) Footnotes |
| 3) Text | 8) Tables |
| 4) References | 9) Figures |
| 5) Appendices | 10) Figure captions |

Title Page. The manuscript's title page should contain the title of the manuscript and the name, degree, and current affiliation of each author. Authors are generally listed in order of their contribution to the manuscript (consult the APA style guide for exceptions). The title page should also contain the complete address of the institution at which the work was conducted and the contact information for the primary author. A running head (a shortened version of the manuscript's title) should be set in the upper left-hand corner of the page, in all uppercase letters. Page numbering should begin in the upper right-hand corner of this page. With the exception of the page numbers and running heads, all text on the title page should be centered.

Abstract. The manuscript's abstract should be set on its own page, with the word "Abstract" centered at the top of the page. The abstract itself should be a single paragraph with no indentation and should not exceed 120 words. All numbers—except for those that begin a sentence—should be typed as numerals. Running heads and page numbers should continue from the title page.

Text. The text (or body) of the manuscript should begin on a new page, after the abstract. The title of the manuscript should be set at the top of the first page, centered and double spaced. Running heads and page numbers should continue from the abstract.

References. The reference list should begin on a new page, with the word “References” centered at the top of the page. Entries should be listed alphabetically, according to the primary author's last name, and should conform to APA style (see sample references provided). Running heads and page numbers should continue from the text. Do not use software functions that automatically format your references. This can cause the references or formatting to be lost when the manuscript is typeset.

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It should begin on a new page with the words “Author Note” centered at the top of the page. Each paragraph should be indented. Running heads and page numbers should continue from the last appendix. Consult the APA style guide for further details on the structure of an author note.

Authors must include a two-sentence disclosure. The author note should include this disclosure (source of funding, affiliation, credentials) and contact information: “address correspondence to” primary author.

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Figure 1. Exemplary formatting for all figure captions.

All figure captions should be listed on a separate page, according to the order in which they appear in the manuscript. Multi-line captions should be double-spaced.

Reference Examples

Journal Article, Two Authors

Wassner, S. J., & Holliday, M. A. (1989). Protein metabolism in chronic renal failure. *Seminars in Nephrology*, 9, 19–23.

Journal Article, Three to Six Authors

Gartner, J., Larson, D. B., & Allen, G. D. (1991). Religion commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology*, 19, 6–25.

Journal Article, More Than Six Authors

Larson, D. B., Sherrill, K. A., Lyons, J. S., Craigie, E. C., Thielman, S. B., Greenwold, M. A., et al. (1992). Associations between dimensions of religious commitment and mental health reported in the *American Journal of Psychiatry* and *Archives of General Psychiatry*: 1978–1989. *American Journal of Psychiatry*, 149, 557–559.

Journal Article in Press

Odaka, M. (in press). Mortality in chronic dialysis patients in Japan. *American Journal of Kidney Diseases*.

Complete Book, Edited

Levine, D. Z. (Ed.). (1983). *Care of the renal patient*. Philadelphia: Saunders.

Chapter of an Edited Book

Nixon, H. H. (1966). Intestinal obstruction in the newborn. In C. Rob & R. Smith (Eds.), *Clinical surgery* (pp. 168–172). London: Butterworth.

Article from a Journal Supplement

Paganini, E. P., Latham, D., & Abdulhadi, M. (1989). Practical considerations of recombinant human erythropoietin therapy. *American Journal of Kidney Diseases*, 14(Suppl. 1), 19–25.

Abstract

Bello, V.A. O., & Gitelman, H. J. (1990). High fluoride exposure in hemodialysis patients [Abstract]. *American Journal of Kidney Diseases*, 15, 320.

Editorial

Piantadosi, S. (1990). Hazards of small clinical trials [Editorial]. *Journal of Clinical Oncology*, 8, 1–3.

ACCEPTANCE PROCESS

If a manuscript is accepted for publication, the author will be required to send the following to the editorial office:

- An electronic copy of the final version of the manuscript. All components of the manuscript must appear within a single word processing file, in the order listed previously. Any features that track or highlight edits should be turned off; do not forget to hit the “accept all changes” function first. Do not use automatic numbering functions, as these features will be lost during the file conversion process. Formatting such as Greek characters, italics, bold face, superscript, and subscript, may be used; however, the use of such elements must conform to the rules set forth in the APA style guide and should be applied consistently throughout the manuscript.
- Art, tables, figures, and images should be high-resolution TIFF or EPS file formats only. Most other file formats (PowerPoint, JPG, GIF, etc.) are not of sufficient resolution to be used in print. The resolution for all art must be at least 300 d.p.i. A hard copy of each figure should accompany the files. These images should be black and white (grayscale) only.
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Relaxation Therapy and Mindfulness Meditation One-Day Workshop for Nephrology Social Workers: Exploring the Impact of This Training on Professional Practice

PART TWO – METHODOLOGY AND RESULTS

Gary Petingola MSW, RSW, Diabetes Care Service, Health Sciences North / Horizon Santé-Nord, Sudbury, Ontario, Canada

Relaxation therapy techniques and mindfulness meditation are clinical intervention tools that have demonstrated benefits associated with the reduction of negative psychological states and the enhancement of positive states of mind critical to the alleviation of physical and emotional distress (Jain et al., 2007). Many mind-body therapeutic training workshops are offered in a one-day format; however, there is a gap in the literature examining the direct impact of learning relaxation therapy and mindfulness meditation specific to nephrology social work practitioners, and how, if at all, learning these techniques might assist a practitioner in his/her work. A study was undertaken to examine the influence of a one-day educational workshop on relaxation therapy and mindfulness meditation on nephrology social workers' professional practice. Eight members of the Canadian Association of Nephrology Social Workers with limited previous exposure to mind-body therapeutic approaches participated in this project. Telephone and Skype participant interviews occurred following the workshop on three separate occasions over a period of four months. The key findings from this study suggest that (1) the workshop had an impact on professional practice, (2) the workshop had an impact on self-care, and (3) amid obstacles to implementation, nephrology social workers expressed their desire to expand their current scope of practice to include relaxation therapy and mindfulness meditation with their clients.

INTRODUCTION

The term “kidney disease” encompasses a variety of diseases and disorders that affect the kidneys, usually starting slowly and progressing over a number of years. Chronic kidney disease (CKD) is defined by the Kidney Foundation of Canada as “the presence of kidney damage, or a decreased level of kidney function, for a period of three months or more” and often requires psychosocial intervention in addition to medical care (2013). The effects of kidney failure and dialysis treatment are experienced amongst patients, family members, caregivers, and nephrology staff. Dialysis treatment is unique, because patients and families spend countless hours together with staff over several times a week for many years. It is easy to understand how the frequency of treatments, dependence on staff, and the close nature of the treatment impact the entire circle of care.

End-stage renal disease (ESRD) requires ongoing dialysis treatment or kidney transplant in order to sustain life. Hemodialysis, one treatment option, typically occurs thrice-weekly in an outpatient dialysis clinic setting or hospital and is designed to remove excess fluid and filter the blood of toxins because the patients' kidneys can no longer perform these functions. Dialysis patients require this treatment for the duration of their lives, unless they are candidates for kidney transplant. All members of the circle of care struggle with the manifestations, conflicts, and suffering that this illness evokes.

Working with ESRD patients can be difficult. Nephrology social workers are frequently exposed to patients who are frightened, suffering, and dying, and are therefore vulnerable to cumulative distress. “This accumulation of work related distress facilitates a quest for healthcare workers to

examine a deeper meaning of pain and suffering in their lives as well as in others, and repeated traumatization makes us vulnerable to burnout and vicarious trauma” (Schure, Christopher, & Christopher, 2008, p. 47). This unrelenting stress has negative ramifications for healthcare professionals, often illustrated with increased incidence of depression, decreased job satisfaction, disrupted personal relationships, psychological distress, and self-harm (Shapiro, Astin, Bishop, & Cordova, 2005). Stress negatively affects the healthcare professional's ability to concentrate. Stress also hampers sound decision making and deters healthy professional collegial relationships. Unmanaged stress disrupts patient/staff therapeutic relationships because healthcare professionals may become devoid of empathy, awareness, objectivity, and compassion (Shapiro et al., 2005). Segal et al. (2010) suggested that this constant influx of stress on healthcare professionals often contributes to burnout, exhibited by decreased attention, reduced concentration, compromised decision-making skills, and suboptimal relationships with patients.

This study examines how, if at all, learning mindfulness and relaxation therapy techniques in a one-day workshop format might assist the nephrology social worker both professionally and personally. This article is the second of a two-part series. Part One provided an overview of the literature in reference to mindfulness meditation, its use in social work practice, and the differences between mindfulness meditation and other mind-body interventions, such as relaxation therapies. Part Two will describe the methodology used in this study and provide a detailed summary of the study results.

BACKGROUND

I was invited by the Canadian Association of Nephrology Social Workers (CANSW) to provide a one-day workshop to introduce relaxation therapy and mindfulness meditation skills to a group of 23 Canadian nephrology social workers at their annual clinical meeting on October 1, 2011, in Halifax, Nova Scotia. The conference theme was “Staying Afloat in a Rising Tide: Navigating the Nephrology Journey.” My workshop, entitled *A Citadel in Turbulent Times: Relaxation Methods that Foster Resilience in Nephrology Social Work Practice*, examined relaxation interventions used in psychosocial nephrology practice.

WORKSHOP DESCRIPTION

The day-long workshop examined mind-body interventions that could be utilized in psychosocial nephrology practice. Presentation content built on the evidence supporting Relaxation Therapy (RT) and mindfulness meditation practice, and expanded on the use of additional therapeutic interventions such as the use of “walking the labyrinth,” music, and art. The approach was participatory, interactive and experiential. Body Scan, Progressive Muscle Relaxation, Safe Place Visualization, Autogenic Training, and Guided Imagery tools, as well as sitting meditation, walking meditation, and mindful eating were all taught, demonstrated, and then practiced. There was opportunity for participants to build upon their current skill set while learning new tools for practice. Together, we explored the application of various mind-body therapeutic modalities viable in busy conventional medical settings. The workshop was intended to be useful in assisting the nephrology social worker by increasing awareness of relaxation therapy and mindfulness meditation methods to strengthen and promote resilience for patients, families, and healthcare workers. This session was intended to address the provision of care for all members in the circle of care.

Explicit goals of the workshop, as stated in the participant packages, were to:

- examine Relaxation Therapy and mindfulness meditation methods to further understand their purpose, function, and application based on research;
- experience a variety of relaxation techniques and mindfulness meditation practices to increase awareness and understanding for optimal application;
- network with other clinicians to exchange ideas while building confidence to include relaxation therapy and mindfulness meditation as a regular part of clinical practice; and
- understand the power of Relaxation Therapy and mindfulness meditation application as a mechanism for self-care, resilience, and joy in the practice of nephrology social work, amidst the myriad demands and expectations of healthcare systems.

METHODOLOGY

Qualitative Research

A qualitative research design was used to understand the experiences of nephrology social workers who participated in this workshop, and to explore if this intervention influenced their professional practices. Jeanfreau and Jack (2010, p.612) described qualitative research as follows:

There is no universal definition of qualitative research, as it is an umbrella term that covers several approaches. However, Burns and Grove (2007) describe qualitative research as focusing on the human experience through systematic and interactive approaches.

This qualitative research study sought to understand a phenomenon specifically of concern to nephrology social workers; it is a matter that has not been previously explored in any depth (Miller, 2010).

Research Question

The research question for this study was “What influence, if any, has this one-day workshop on Relaxation Therapy and mindfulness meditation had on the nephrology social workers’ professional practices?” Other areas of inquiry focused on participant motivation for attending the workshop; changes in practice as a result of the workshop; changes in confidence in using skills derived from the workshop; challenges and obstacles in implementing relaxation therapy and mindfulness meditation in professional practice; and any secondary benefits derived from attending the workshop.

Participants and Sampling

Recruitment of participants was accomplished by issuing an invitation on the official CANSW LISTSERV® and website directing interested participants to contact me directly. There was no financial compensation provided to participants. As the CANSW administrator for both the website and the LISTSERV, I was prudent in obtaining CANSW executive committee approval to post any information regarding the study and did not take any liberties in doing so, given my position.

Cresswell (2007) suggested that “purposeful sampling specific to qualitative research means that the inquirer selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (p. 125). The purposive criteria for inclusion were that participants were members of CANSW, had participated in the full-day workshop, and were willing to commit to participating in a series of three interviews following the workshop.

Initially, 9 conference delegates indicated an interest in participating in this study; however, one nephrology social worker withdrew prior to the consent forms being completed and the study commencing. Eight participants were

successfully recruited for this study: seven female and one male, all CANSW members, ranging in age from 28 to 59 years old. Seven participants were nephrology social workers, and one was an associate CANSW member working with the Kidney Foundation of Canada. All except one of the nephrology social workers provided services to both in-patient and out-patient populations. Six of the 8 participants were employed full-time, while two participants worked part-time. Areas of expertise for nephrology study participants varied, with some having worked in all treatment modalities (i.e., pre-dialysis, hemodialysis, peritoneal dialysis, home hemodialysis, nocturnal dialysis, conventional home hemodialysis, transplant, and post-transplant), while some participants focused on only a few of nephrology treatment modality concentrations.

Caseload demands varied; however, most participants were responsible for 100 to 300 patients. All study participants except for one were Masters-level social workers. Geographically, 4 study participants serviced the eastern provinces, one serviced Southern Alberta, two provided service to the Toronto catchment area, and one participant provided service nationally. One participant reported a relationship status of single, and seven participants reported being in a partnered relationship.

All participants had previous exposure to mind-body therapy through limited education or participation in yoga, mindfulness meditation, Progressive Muscle Relaxation, hypnosis, Reiki massage, or reflexology. Only one participant reported utilizing meditation and Relaxation Therapy techniques previously as part of clinical practice with a patient.

Each participant who volunteered to take part in this study signed a Letter of Consent and completed a Demographic Questionnaire.

Data Collection

Data was collected by means of a Demographic Questionnaire and three individual semi-structured 30-to-60 minute interviews, using a Semi-Structured Interview Guide, conducted with each of eight participants in late October 2011, November 2011, December 2011 and early January 2012. The primary source of data collection was oral interviews, conducted with each participant individually, to address the question: "What influence (if any) has this one-day workshop on Relaxation Therapy and mindfulness meditation had on your professional practice?" The first set of interviews was semi-structured with clearly designed open-ended questions to explore the participants' experiences and perspectives. Subsequent sets of interviews were even less structured and more conversational, allowing for less rigidity and a more natural dialogue to occur, according to the participants' viewpoints.

Participants were invited to utilize Skype video calling technology or telephone contact for interviews. One participant elected to use Skype technology, and all others chose the telephone. Those interviewed by telephone preferred that

interviews occurred during daytime working hours and at their places of employment, which did not have web cam or Skype availability. Each interview was audio-recorded with two electronic recording devices to ensure accuracy, and as a precaution in the event that one recording device failed. Ten interviews were transcribed verbatim for analysis by a research assistant, and I personally transcribed 14 of the interviews as a means of furthering my familiarity with the data.

Additionally, I used a journal during the interviews to note observations made, certain revelations and questions that came to me, non-identifying information about each participant, and, lastly, my feelings about the interviews. I referred to these notes during the data analysis.

Researcher's Role

As a nephrology social worker, I bring my own understanding of the emotional and practical demands of nephrology social work practice. I also understand both clinician and patient vulnerability, because I witness this on a daily basis in my frontline practice. This understanding assisted me in engaging research participants with dignity and respect. I also sensed that research participants felt a kinship with me, because they frequently suggested that I, being a nephrology social worker, must understand what they were trying to convey. My familiarity with this work facilitated a sense of non-judgement and compassion for their working situations, limitations, and intentions. As a social worker in nephrology practice for 13 years I am familiar with institutional chaos, frightened patients living with multiple co-morbidities experiencing grief and loss, and anxious colleagues all trying to stay afloat amongst workload demands and public scrutiny.

In my professional practice I guide patients, staff and caregivers through mindfulness meditation, as well as employ an array of relaxation techniques. I acknowledge my bias as a result of seeing participant reactions and affirming feedback on how these complementary therapies help them cope and, in many instances, change their lives. Along with my bias, I bring a passion to seek change in the way nephrology social workers practice by heightening awareness of the benefits of relaxation and mindfulness practice, which fosters best professional practice and enhances self-care. Rock (2006) suggested that, through the committed practice of mindfulness meditation, a person develops the ability to recognize thoughts and emotion as they arise, and this skill enables greater insight, less reactive responses, and less rigidity.

Savin-Baden (2004) suggested:

Reflexivity for me is about situating myself in the research and the processes of research in ways that acknowledge and do justice to my personal stance and to the personal stances of those involved in the research. Reflexivity is about disclosing my value-base to those who participate in research. It is about working with people, doing research that is collaborative and sharing perspectives in the process of doing research. (p.366)

It should be noted that I kept a journal during the entire research study in which I recorded my thoughts, dilemmas, realignment of themes, and numerous attempts to reframe the research question, constantly reflecting and rethinking. Barry and O'Callaghan (2008) illustrated that reflexive journal writing can be useful in generating and demonstrating new understandings vital to extend practice. Additionally, I employed critical reflection, a process that conjures the identification of deep-seated assumptions with the key purpose being to identify and implement changes to practice (Fook & Askeland, 2007). As a researcher, I had to be aware of how my personal bias and experience may have influenced the project. As a nephrology social worker interviewing participants who were nephrology social workers, I had to make sure that I challenged participants' answers, regardless of the unsaid collegial bond that we shared. Additionally, I had to eradicate the notion that Relaxation Therapy and mindfulness meditation were unquestionably favorable, simply because I had found them helpful in my professional practice and personal self-care. I had to be open to whatever the participant wanted to share with me, even if it was contradictory to my own way of thinking.

It is my hope that this research study prompted reflective practice and promoted an opportunity for professional growth for all involved. Since 1999 when I first became a member of CANSW, my path has crossed with some of the study participants. Over the years, I have been a member of the CANSW executive committee, assisted in conference and educational planning for nephrology social work, presented at conferences, and am currently the web administrator for the official website and LISTSERV. My presence in the CANSW community may have invoked trust by potential study participants. However, this relationship may also have been a limitation to the study, because potential participants could have had a preconceived notion of me, possibly hampering or encouraging their participation in the study. As a nephrology social worker, I have my own understanding of the nephrology social work culture. I had to be aware that my work culture was unique to me and that each of the participants' work cultures was equally distinct. Hence, I could not form generalized viewpoints based on my personal exposure nor make assumptions that relaxation therapy and mindfulness meditation would be readily accepted into their work settings just because my work setting had embraced the implementation. As part of the research process, I facilitated open dialogue which required my attention to my verbal and non-verbal responses to ensure neutrality and non-judgement. As a truly receptive listener, I was successful in engaging prospective study participants from the announcement of the study onward, allowing for rich data to emerge.

RESULTS

A total of 24 interviews were analyzed after being transcribed verbatim. Rather than examine the data as one unit, careful attention was directed towards analysis of each of the three distinct subsets of interviews that spanned 4 months

(October 2011 – January 2012). This was done purposefully to respect the integrity and unique qualities of each set of interviews and to identify where participants were positioned along the influence trajectory over time. By analyzing the interviews in three groupings, attention could be paid to changes over time regarding the influence, or not, of the workshop.

The Initial Interviews

The first set of interviews occurred between October 31 and November 8, 2011, approximately one month following the workshop. Participants described this period as a time to reflect on the workshop and examine how Relaxation Therapy and mindfulness meditation might or might not be included in their professional practices. Participants said that this period also provided an opportunity for them to process the knowledge that they had acquired from the workshop for gradual, guarded implementation. Initially, 32 important ideas emerged in the first level coding of the analysis, but as the analysis progressed, the data was grouped into 7 categories, based on similarities and differences. Following this process, second level coding was completed and from that 5 main themes emerged.

In the first set of interviews, the 5 main themes were: 1) the workshop was an opportunity for skill development; 2) the workshop influenced professional practices; 3) the workshop influenced self-care; 4) nephrology social workers believed that their scope of practice should be expanded to include both therapeutic modalities; and 5) there were obstacles to implementation.

1. The Workshop was an Opportunity for Skill Development

All of the participants reported that they believed the workshop was an opportunity to build skills for enhanced professional practice and self-care. In describing the workshop, one participant shared, "It just really resonated and I thought everything seemed like it was so very practical and focused on the actual work that we do." All 8 participants had some previous exposure to mind-body therapeutic interventions in some capacity, but none had previously participated in a full-day comprehensive workshop specific to Relaxation Therapy and mindfulness meditation and its application to nephrology social work practice. Seven out of 8 participants reported that they attended the workshop to "gain more experience" and "knowledge" in this area. One participant found it "intriguing to go into more depth." Similarly, another participant stated:

It has been something that I've been interested [in] for a while... I have done some meditation myself... and I've done some relaxation with clients, and just wanted more information about it and was looking forward to the fact that it was a colleague who is doing this.

As participants implemented newly-acquired skills from the workshop, they acknowledged that they were still beginners simply trying out new techniques in an effort to gain more

skill and confidence. Participants were afraid that failure to implement new skills learned at the workshop would jeopardize their ability to retain the information, hence they sought to integrate these therapeutic modalities into their practices promptly to prevent them from “falling by the wayside.” Participants were hopeful that their skills would be further developed and refined through practice so they would feel more natural in their application. One participant stated:

I've been very open about the fact that for me this will be a chance to really practice this and [the patient is] willing to be my “guinea pig.” What I'm hoping is that it's going to give me an opportunity to get a sense of which of the techniques I'm most comfortable with so that... it just becomes a little more sort of internalized.

Although participants viewed their level of comfort with implementation as being “low” during the initial month following the workshop, all participants persevered putting skills into practice even if they felt “out of their comfort zone” during initial usage. One participant eloquently summarized this concept by stating, “My comfort level is low. I don't feel one hundred percent; I don't feel right now [that] it comes naturally for me. So I think it's also a confidence obstacle.” Another participant utilized Relaxation Therapy techniques with knowingly-receptive patients in order to build expertise. When not reacting to crisis situations, participants chose patients and family members whom they suspected or believed would be open to “take the bait,” or try relaxation techniques. Some participants indicated that they did not want to overwhelm the nephrology circle of care in the process of introducing new psychosocial interventions. One participant summarized, “I wanted to make sure that this was fitting into my practice and that this was not [becoming] my whole practice.”

One participant spoke of the need to implement Relaxation Therapy and mindfulness meditation personally in order to be able to offer it confidently to patients and families. Given that nephrology social workers practice from a “do no harm” standpoint, it is not surprising that this participant would have adopted this criterion for safe implementation:

I always find it's helpful to run things through on a personal level, even before you bring it to someone else, right? You know they often say if you're going to engage in counseling you should do some of your own. So I think it's a piece of it. An easy way to hone [a] skill is to look at it in terms of “how I can apply this in my own particular area?”

Overall, during this set of interviews, most participants expressed that they were eager to implement newly acquired relaxation therapy skills in their professional practices.

2. The Workshop Influenced Professional Practice

In total, 7 participants stated that the workshop had a positive influence on their professional practice. One participant

of the 7 used the adjective “powerful” to describe how the workshop had influenced professional practice. Another participant stated that, having attended the workshop, “I felt inspired to want to try” to implement new skills into practice. A further participant spoke of a desire to implement relaxation therapy and mindfulness meditation into practice and liked the idea of being able to offer “a holistic service” to patients who might be less receptive to pharmacological treatment. Chiu et al. (2009) estimated that the average hemodialysis patient takes 19 pills per day, so it is easy to understand the appeal of mind-body interventions to both patient and provider.

All 8 participants welcomed these new skills as a divergence from the usual instrumental task-oriented interventions, with one highlighting that there are “some real perks to being able to have something practical and tangible.” Four participants expressed that the workshop had been influential, because it provided them with “concrete tools” to use with patients and families, which they felt empowered them as nephrology social workers. One participant commented, “It's at least something tangible and in that moment that I can help, something that I can offer; it's been a good tool to have.”

Participants reported that the workshop influenced their practices whereby they had successfully incorporated relaxation therapy techniques to assist patients who were fearful of needles and anticipating or undergoing hemodialysis. Hemodialysis requires the insertion of large needles into a fistula or graft on the patient's arm and can be challenging to patients and nursing staff if the access site is difficult to cannulate. Intervention was achieved individually and participants implemented deep breathing, Safe Place Visualization, and Autogenic techniques to calm anxious patients. Intervention was frequently crisis driven and therefore, in many instances, unplanned and at the chair side. The benefit was that it thrust participants into utilizing relaxation techniques and these positive experiences helped participants to feel empowered and pleased to be able to intervene in this capacity. This led to feelings of satisfaction and achievement in their work, even if implementation felt awkward for some participants. Participants credited the workshop as having influenced this change in practice:

It was not like a planned intervention... it was kind of a crisis spur of the moment and I used the Safe Place Visualization. It was effective. Well, it was kind of happenstance. I was working in the unit one night and...there was a family member in absolute tears and I just happened to be there and so to be able to use that in that context as opposed to a planned counseling session was really helpful to me as the person providing the service...providing the intervention and certainly beneficial to the patient's wife.

Having attended the workshop, one participant altered clinical practice to now always include a question about the patient's “safe place” during initial assessments. This participant used this technique to learn more about the patient and

as an opportunity to make new patients aware of the availability of mind-body complementary approaches to care:

The one technique when you talked about, the “safe place”... that is something that I’ve started to do for a number of clients that I see on a regular basis for counseling and it’s a fairly easy, effective tool to get clients to see that’s how to do it. It’s also very telling.

Participants tended to use more Relaxation Therapy techniques during this time, because these were perceived as easier to implement than mindfulness meditation. This makes sense, because mindfulness meditation as a holistic philosophy is more broad and complicated to learn and incorporate into one’s life and work, compared to a variety of relaxation techniques and exercises. Additionally, it was crucial that participants had successful, achievable results at this tenuous stage of implementation if they were to continue to delve into using new techniques with confidence.

Overall, the participants spoke of being pleased during this time frame as implementation with patients was received positively and helped them to feel more confident. One participant elaborated:

I sort of took the plunge and approached a patient yesterday and asked if they would like to join me in going through one of the visualization exercises... I found that really, really positive, and this patient and I just decided that we will continue this on a regular scheduled basis.

One participant stated that confidence had “gone up 70 to 80 percent.” Participants suggested that they had more confidence in implementing mind-body interventions because their practices were validated by the literature shared at the workshop. Also, participants identified an increased confidence in using Relaxation Therapy techniques with their patients, having had the opportunities to build their skill set through “doing the actual techniques” at the workshop. Furthermore, the fact that the presenter was a social worker gave some participants the confidence that they, too, could successfully attain comfort with implementation of these therapeutic modalities in their practices. One participant commented:

Yes [the workshop] has altered my confidence. I see that you are using it so successfully and that you are a social worker and you as a social worker have taken this on and as a social worker can do well and that it makes a difference to the people and [it] doesn’t cost a cent, except a little bit of your time. And I’m thinking you can’t argue with any of that. I mean, I have the same training and background. I have the same basic clientele. There are lots of different niches that people fill here in the hospital, and clearly we have an opportunity. We have private offices. We do see people who benefit from some of these skills. We have an opportunity to put these things into practice.

One outlying yet significant theme emerged during the ini-

tial set of interviews by one participant and was later echoed in subsequent participant interviews throughout the study. It was reported that anticipated calls by the author served as a catalyst towards promoting follow-through and implementing skills derived from the workshop:

I do think that the fact you are doing this study is helpful. I can’t speak for others but for me, knowing that [this call] was scheduled, that I committed to this, was what gave me the extra push to make that point of trying it out yesterday.

3. The Workshop Influenced Self-care.

Another important theme that emerged during the first set of interviews was that participants were searching for tools that might help them “heal” as a mechanism for enhanced self-care. Interestingly, the workshop seemed to fulfill this need because it equipped participants with the tangible skills of Relaxation Therapy and mindfulness meditation that they could utilize for wellness. Given that participants were not directly asked about self-care in the interviews, it was interesting to see this theme converge with professional practice as an unexpected but welcomed guest. However, given that the issue of self-care was part of the workshop, this is not surprising.

Participants attributed the workshop as being influential in helping them to be more cognizant of, and subscribed to, enhanced self-care. Five participants referred to the workshop as a reminder about the importance of self-care, and one participant shared that the workshop was “very helpful in terms of centering oneself.” Another participant hypothesized that one could not “care and give to others” unless one practiced self-care. The notion of taking care of oneself in order to give to others is not a new one, but the workshop seemed to illuminate this concept for the participants, as it can be easily overlooked amidst workplace demands and excessive caseloads. In essence, the workshop may have been perceived as a “wake up call” for some participants at a crossroads. One participant described the workshop as being the impetus for “treating myself more kindly than I would normally have.” This same participant admitted to feeling quite vulnerable at the time of the workshop and acknowledged that it was timely in helping to promote positive change, stating, “I would honestly say that and it was just happenstance that when I was at the workshop, I was at a little bit of a personal crisis point, [feeling] burnout, and this has helped me walk my way back.”

Six participants were at the height of practicing many skills and concepts derived from the workshop without delay to improve self-care during this time. While participants were quick to grasp relaxation techniques to use with patients, they were more prone to use a mix of mindfulness meditation and relaxation techniques to improve self-care. One participant acknowledged, “I do have a very heavy workload and very stressful projects on the go right now and I have been really been relying on these techniques a lot to get myself through the day.” One participant positively illustrated how skills derived from the workshop “helped me to

feel less reactive and more in control”:

Yes, it's been a very positive thing. I don't get so strung up or at least not so quickly, and when I get to that place, I call it, you know, “spinney brain.” I just literally sit down and breathe and then I will give myself a time out and go and sit and give myself one of the 15-minute mindfulness meditations, and then I can go back to it calmer and feeling a bit more energized and a bit more hopeful.

Four participants shared that acquiring Relaxation Therapy and mindfulness meditation skills had impacted their productivity, allowing them to step back and prioritize tasks. One participant felt “better able to provide for the clients” and “better able to manage workload and stress.” One participant highlighted:

We can be pulled in a dozen different directions, you know, and be needed in five different places at once, and so that it's a way of taking even five minutes to shut the door to bring myself back to a place to be able to sort out [what] is the priority.

Six participants highlighted that they had specifically implemented mindfulness meditation to acquire more awareness of “the breath” and “the moment,” and in doing so, this helped to settle them and help them to “feel grounded.” Mindfulness was employed by participants formally through sitting meditation to quiet the mind and tame instinctual reactions. Body scan, which is associated with mindfulness meditation practice, was used by one participant to assist with sleep inducement:

I've been doing [Body Scan] every night before I go to bed, trying to do 10 to 15 minutes, but if I find myself lying in bed, doing either the breathing and visualizing...it's going to my feet and through my body. Or I do the tense my muscles and relax and work my way through that way, and so I've been getting much better sleep—certainly able to fall asleep much better.

Another participant shared that mindfulness meditation techniques assisted with non-judgement awareness and acceptance of thoughts and emotions as they arise to “fully experience life—the good, the bad, the ugly.” Mindfulness promotes the concept of facing fear and difficult emotions as they arise so that we can work with fear with more clarity and typical scripted reactivity (Santorelli, 1999).

Additionally, one participant used progressive muscle relaxation for sleep, and two participants used safe place visualization to calm and reduce anxiety from the work day. The first set of interviews revealed that self-care was a hidden gem that emerged as a secondary benefit to attending the workshop.

4. Participants Believed That Their Scope of Practice Should be Expanded to Include Both Therapeutic Modalities.

Six participants reflected on how they might “expand a little” and “take a few more risks” in implementing Relaxation Therapy and mindfulness meditation into their professional practices. One participant hoped to “challenge self” to include these new skills into professional practice, rather than forfeiting them as simply unutilized “professional development hours.” One participant summarized that skills acquired from the workshop were “perfectly suited to the work that we do in nephrology social work practice.”

Five participants believed that incorporating relaxation therapy and mindfulness meditation into their professional practices would enhance their discipline's reputation and justify their credibility as being able to offer specialized, outcomes-driven service within their organizations. They hoped that successful integration of these skills in professional practice would demonstrate their ability to do more therapeutic interventions, rather than solely hands-on, task-oriented, resource counseling. Some participants used words like “showcase,” “speciality,” and “niche” to illustrate the benefits of integrating these techniques derived from the workshop into their practices. The introduction of mindfulness meditation and Relaxation Therapy was viewed by 3 participants as a “golden opportunity” to enhance the “professional identity” of nephrology social work, “showcasing” that they offered specialized therapeutic services that made them valuable. One social nephrology worker stated that acquirement of these new skills would “help to expand people's understanding of our role.” Another participant declared that this was “something that I could do” and “wanted to try to do, given the current climate in healthcare,” and the constant “need to demonstrate and articulate skills.”

One participant had utilized several complementary therapies for self-care, but had not considered them clinical interventions with nephrology patients until attending the workshop. This participant typically outsourced for therapeutic services, and was pleased to be able to offer relaxation therapy and mindfulness meditation to patients under the social work umbrella of service. As the participant explained:

I generally outsource [or] put in a referral for this. “How can I help you get in touch with that?” But to give me a tool that I could do with our clients right then and there. And it never occurred to me and it was just something practical that our chronic disease patients would absolutely benefit from. It was exciting!

When the participants spoke about expanding their current scope of practice to include these mind-body modalities, they also spoke of the need to acquire support from their supervisors and team as a necessary prerequisite for the successful launch of these techniques into their practices. One participant shared:

After a little bit of research, we discovered that, in fact, there is a [physical] space [available], and now the next step is to how to best approach the managers to make use of that. And so as I talked with my unit manager, just to explore this with him. He was very interested when I talked about how this could be utilized to address needle phobia.

Another participant stated:

After I came back from our conference I was really excited, and I emailed my supervisor and asked if I could buy a CD, and if we could get our hands on a CD player with speakers that I could have with me... my supervisor said that was great. She immediately said "yes."

It became clear that participants felt that skills derived from the workshop should be expanded into their professional scope of practice to benefit both patients and nephrology social workers.

5. There Were Obstacles to Implementation.

During the first set of interviews, the participants indicated that the major obstacles to implementing Relaxation Therapy and mindfulness meditation into their practice were: a) lack of privacy; b) a lack of time due to heavy workload; c) poor proximity to patients; d) a lack of proper seating for patients; and e) a lack of quiet space. Most of the study participants had offices that were shared and located away from the dialysis units, sometimes "not physically located even in the same building as the bulk of the area[s] where we work." A participant described the work environment in the following manner:

I think if it was something that we did in the unit... but that would be very difficult because everybody's in one room and they're very close together and noisy and there's people walking around. In the actual unit [it] would be difficult because of the distractions and because of everyone wandering around, and no separate room in these two units. The other unit is even more squashed... people are facing other people, and so that's the difficulty. I share an office, and the space of this office is something that is an issue [because] it's a tiny office. So there are usually two of us in [t]here. It can be really difficult.

These problems with space made it more difficult to encourage clients to access the nephrology social worker(s). One participant stated:

There's nowhere I can take patients. It's a problem not just with this type of work, but with... all work. The problem is finding a proper space... They're working on it... getting a new unit. I think it's going to take years before it actually [comes] to fruition.

One participant elaborated, "It's a very, very busy service,

and you are often running from one thing to the next" and that "actually having one-on-one time in which I feel that I can slow down enough to try to slow somebody else down is probably a challenge." Another participant complained, "It's hard to find the time and fit it all in," even though there was an interest. One participant elaborated "I often feel like I am just running and putting out fires all the time. I'm having a hard time finding time in my day to move beyond really crisis intervention and [move] more towards therapeutic interventions."

Even though identified obstacles hindered full-fledged participant implementation of Relaxation Therapy and mindfulness meditation into professional practice, all 8 participants hoped for the eventual seamless integration that they believed would heighten their profile within their settings. They sought to implement these therapeutic modalities strategically and purposefully. Additionally, two participants anticipated that nephrology unit renovations might alleviate space and privacy issues in order to facilitate more successful incorporation of these modalities into their practice. In summary, even with obstacles, there was optimism that improvements in physical layout and workload would allow for the implementation of skills derived from the workshop. Managerial support was reported as favorable and at no time an obstacle.

The Second Interviews

The second set of interviews occurred between November 28 and December 5, 2011, approximately two months after the workshop. Initially, 24 important ideas emerged in the first level coding of the analysis, but as the analysis progressed, the data was grouped into 7 categories based on similarities and differences and subsequently named. Following this, second-level coding was completed, and from that, three themes emerged: 1) confidence was perceived to have increased regarding the implementation of newly-learned techniques; 2) self-care continued to be important; and 3) there continued to be obstacles to implementation. Noteworthy changes from the first set of interviews included more confidence with implementation of therapeutic practices with patients, but reduced prioritization for self-care by participants.

1. Confidence Was Perceived to Have Increased Regarding the Implementation of Newly-Learned Techniques

With the passing of two months since the workshop, participants said that they demonstrated greater use, more confidence, and more risk-taking in implementing relaxation therapy techniques with patients. Seven participants suggested that the workshop was influential in their professional practice, and 4 participants felt that the impact of the workshop had "made a huge difference" that would be long-lasting throughout their careers. Of these 4, one participant summarized, "I think it was a fantastic workshop and I think it will always be in my practice... I will always think of it and try to integrate it [into] my practice now."

Additionally, participants indicated that the workshop had “absolutely made an impression” influencing them to use these therapeutic approaches with patients. Participants said that they were optimistic about gaining proficiency with new skills, and they attributed this confidence directly to the caliber of the workshop and the learning methods utilized.

Although 3 participants had not progressed in terms of implementation of the new skills in their clinical settings, they acknowledged that the workshop and then the study had given them the impetus to continue to strive to incorporate Relaxation Therapy and mindfulness meditation into their future professional practices. This feeling of being “on the bottom rung” with implementation was attributed to heavy workload and inability to recruit interested patients. One participant stated that the workshop “really demystified [Relaxation Therapy and mindfulness meditation],” making it more achievable and less intimidating for use with patients. Another participant suggested that the workshop had made a difference to clinical intervention with heightened confidence in eliciting a safe place anchoring for all nephrology patients.

Heightened confidence through implementation of Relaxation Therapy and mindfulness meditation increased momentum to broaden the nephrology social work scope of practice to include these therapeutic modalities. One participant spoke of satisfaction with increased skill in offering Relaxation Therapy and mindfulness meditation service to patients that “previously involved a psychologist.” Participants continued to feel empowered by having tangible therapeutic techniques that they felt gave them heightened job satisfaction, credibility and respect within their organizations. One participant reflected:

I think it's a great idea that you do it, and I see it as something that social workers can do, and I like the fact that it doesn't cost any extra money, and it doesn't cost the system [because] the system here is strapped... So anything that can enhance is definitely worth being considered.

Three study participants were relatively new to their role in nephrology (less than 1.5 years), essentially carving out the domains of their positions, yet they were still confident to incorporate both of these treatment modalities into their professional role. One participant remained very confident while scouting out patients who might be receptive to utilizing newly-acquired skills from the workshop. New to the job of nephrology social work, this participant was still trying to validate the role on the team and within the renal community. Driven by the belief that these treatment modalities could make a difference, this participant challenged traditional, conservative, small town ideology with perseverance in implementation. This participant carried this theme of obstacles over from the first set of interviews and retrospectively gave it more attention during the second set of interviews.

It was important for 4 participants to feel that they had the support of their managers to implement new therapeutic

skills. One participant stated:

I have sent out an email to the nursing supervisor of all of our four dialysis units, just kind of reminding them that I do offer this service... and made the staff aware that is something I am available to do with patients.

One participant felt confident looking to the future, and had hopes of eventually being able to share skills from the workshop with staff to promote enhanced self-care. None of the participants felt confident enough yet to offer services directly to team members in this capacity. Participants may have felt that the team might be critical, possibly undermining their confidence and progress.

Five participants said they continued to be eager to implement Relaxation Therapy and mindfulness meditation into their professional practices and continued to feel that the skills derived from the workshop were “valuable” and “worthwhile.” A participant expounded, “I think it's not just a frill; it's something that we should be able to incorporate in our practice that will definitely benefit us as well as some of our patients or family members.”

This set of participant interviews suggested that participants were more confident in using many Relaxation Therapy techniques with patients and the feedback from patients was positive (no one reported “negative” experiences). Specific techniques implemented by nephrology social workers included Progressive Muscle Relaxation, diaphragmatic breathing, and Safe Place Visualization. One participant reported:

I've incorporated Safe Place Visualization into almost all of my assessments... it's just part of the assessment as opposed to coming to see someone because they're in crisis or seeing someone for counselling.... when they come back and perhaps they are having more difficulty we can talk [in terms of] “Remember we talked about, and this is what you told me. Let's see if we can work with that.” And so it's already something, it's like planting that seed.

When working with patients and families, participants utilized relaxation techniques as a preferred treatment modality. One participant shared, “I used the relaxation methods more so than the mindfulness because I felt that it was easier to talk the person through it, whereas I wasn't so confident about the mindfulness and how to actually do that.” This theme prevailed throughout the entire study.

Two study participants hoped to utilize a group format in the future, but made it clear that they had no urgency in doing this. Participants continued to acknowledge a certain awkwardness in terms of application. Six participants recognized that the skills would only be refined with regular use. They saw themselves as novices possessing a “general level of comfort and ease” in implementing Relaxation Therapy and mindfulness meditation and reiterated that “practice, practice, practice” was necessary for continued skill development

and improved confidence.

One participant stated:

So I see this as a great tool. It's inexpensive. I have the CD [from the workshop] sitting on my desk, I have your stuff in my filing cabinet... all of your print outs [from the workshop]. So it's a service that I can provide. Myself, I am feeling perhaps a little more nervous as time goes by. I haven't practiced it because I think it's still getting over that initial time or two, to kind of get into... to feel more comfortable in myself with it.

Two study participants were very successful in implementing Relaxation Therapy techniques specifically for needle phobia, or dialysis access problems and access shunt revision, and this bolstered their confidence. One reported:

It so happened that this young fellow had shared with me he felt very anxious about an upcoming line change. And so I had a session with him and we kind of explored a number of different things together, and in addition to that I offered him the opportunity to meet together the day before for a relaxation session. And he accepted that, and we met together on Monday—he had his line changed on Tuesday.

Two study participants felt confident enough to pursue more appropriate seating to accommodate patients for Relaxation Therapy sessions in their offices. Although this is not a direct application of Relaxation Therapy or mindfulness meditation, it does suggest that the workshop motivated these participants to make logistical changes that they perceived would allow them to practice techniques in a more conducive environment:

I actually have a recliner in my office now. It just so happened that the unit got all new chairs and so they were disposing of the old recliners. And so I just happened to be going by in the hallway when they were getting rid of them and asked if indeed I could have one. And I actually got one too... it's kind of great to think that I now have more of a better set up.

Two participant “camps” seemed to emerge in the discussions. One group of participants felt good with forging ahead, while the other group seemed to be much more tentative and cautious. The latter represented those participants who were struggling more with role ambiguity and unmanageable caseloads. These latter factors may have influenced their confidence in integrating mind-body techniques into their practices.

Four participants described the interviews as an opportunity for encouragement and “accountability” and this subsequently increased their confidence. Study participants said they began to anticipate “check ins” from the researcher and prepared for the upcoming calls. If they had not practiced a technique and knew that an interview call was upcoming, this seemed to motivate them to apply techniques in an

effort to be prepared to talk about therapeutic implementation. This was self-imposed by the participant. One participant summarized:

I really feel like if it wasn't for the workshop I wouldn't have done this... it's possible that if I wasn't part of this study I wouldn't have done it, to tell you the truth. As much as I truly did feel inspired to do it from the workshop, being part of this study has been a helpful means of being accountable to that.

In general, confidence increased for most of the participants and, even if implementation was limited, all of the participants planned to continue to strive for integration of the techniques into their practices. Confidence continued to be directly tied to interdisciplinary team involvement, team buy-in, and support.

2. Self-care Continued to be Important.

Seven participants indicated an increased use of Relaxation Therapy and mindfulness meditation practices for their own self-care during this second round of interviews, directly attributed to the workshop. They indicated the use of primarily relaxation techniques to assist with “unwinding, de-stressing, sleeping and simply being kinder to self.” One participant stated that the techniques derived from the workshop helped to “forget about what's happened for the day and take time for self.” Another participant stated “I used it more often for self than with clients... to bring my anxiety level down.” One participant spoke about being less reactive following the workshop, which is consistent with the literature (Bell, 2009). This participant declared: “So we're all stressing out and I could hear myself, telling myself as I'm talking to this person ‘OK just calm, breathe, you know this is doable – we can manage together.’” One participant “used it more often for self-care than with clients,” due to heightened “anxiety” associated with recent increased job responsibility and workload.

Four participants used breathing techniques for self-care to assist with sleep inducement and to help to “slow down.” One participant spoke about employing Relaxation Therapy and mindfulness meditation as a means of managing stress and for recuperation:

I am still using all of the different techniques that we went over in October. Actually, I just downloaded a few guided meditations on my iPod and was actually listening to one last night because I was having difficulty shutting my brain off... it's been a fairly intense few months for me... things have been really, really busy and stressful at work, so I find I am going to [meditation] as a way of managing my stress level, but then also kind of one step beyond that to try and relax and rest so that I can recuperate. So I am finding it very effective and I have found it's influenced my daily practice because it's influencing my well-being and my ability to manage my stress and to get things done.

Another participant shared that deep breathing was the most salient technique used to help calm down amidst many demanding roles personally and professionally:

The stomach breathing probably stuck with me the most.... I have a young child, I work, and I'm also in my Master's program. Coming home to find time to quickly get on the computer so I can quickly do a paper. So it's a juggling act as well, and so that's just something I think, just being cognizant to slow down and it's something that I'm aware of and to make a bit more of a conscious effort. I know I have been lying in bed a few times saying, "you do this, and you do this, and you do that," and just not being able to kind of shut off my own brain sometimes. But just being able to focus on my breathing and really, purposefully breath from my stomach and not my upper chest has probably been what has stuck with me the most, because it's practical, it's simple, it slows you down.

There was a shift in the second series of interviews whereas participants said that they had implemented Relaxation Therapy and mindfulness meditation more frequently in the first month immediately following the workshop for self-care, but were unable to always find the time to continue using these techniques with the passage of time. One participant stated that it was "probably something that I needed to do again." One participant admitted:

I haven't done that for weeks because it has just been crazy here. It's nuts. So, no, I haven't really been able to, and, of course, I go home and I have the house to manage and people to feed and other things to do in my life. So I can honestly say that since I spoke to you last, I haven't had a whole lot of relaxation time here or there.

Individually, four participants echoed the theme that they must prioritize "taking the time, finding the time, making the time, and guarding the time" to implement relaxation therapy and mindfulness meditation for their own self-care. Another participant spoke of it feeling like a "luxury" to take time for self, and described just how difficult this could be:

I have tried a couple of times, and I really like the effect when I do it—to sit with my eyes partially closed, and just sit for 15 minutes and try the mindfulness meditation. But that's not my first go-to thing, because it still feels like too much of a luxury actually [and] because I can talk myself out of it before I even sit down.

Participants gravitated toward mindfulness meditation practices appreciative of the "not judging" ideology that is important for optimal self-care. Participants practiced mindfulness meditation informally (walking the dogs, walking to work, eating, etc.), rather than formally by sitting meditation. Once again, this makes sense, given the busy schedules of participants and their need to be creative to incorporate skills into their daily lives. One participant described mindful eating:

Last night when I was eating supper, I made a chicken dinner, and I made potatoes and broccoli, and made the special sauce and was wolfing it down, and I was like 'okay,' and I just tried to slow it down and enjoy and be more cognizant and enjoy.

Another participant spoke of the challenge of attempting to do mindfulness meditation formally and the eventual transition to informal practice.

After the first month, I was kind of pushing myself that I wanted to be more consistent or rigorous with doing this every day, and in my mind that was sitting down for the 15 minutes—you know, "I am meditating now." And I think over the past month I've become much more aware of how I draw on this throughout the day, but it doesn't necessarily have to be that set-aside, deliberate time that I can use this throughout.

Self-care continued to be paramount to most participants.

3. There Continued to be Obstacles to Implementation

Three participants cited heavy workload, 3 participants spoke to poor or inadequate space, and 3 participants attributed lack of privacy as obstacles that prohibited optimal implementation of Relaxation Therapy and mindfulness meditation into their professional practice—the obstacles were still focused on physical barriers and workload matters. In addition to nephrology social work practice, some participants shared that they were expected to provide social work coverage to other parts of their hospitals, compromising implementation and self-care. The following excerpt from the second set of interviews illustrates the reality of nephrology social workers being stretched to the limit:

I would say slowly I am doing more [self-care] than I was doing. But you know that can depend on which week. This week's a bit of a mad week for me, because I'm covering. I'm doing coverage on a rehab ward. So I'm in dialysis, then upstairs doing rehab and discharge planning. So, it's not a good week this week, but when I'm just doing my renal work, it's much easier to incorporate. I'm only part time in renal, so I pick up different shifts from people who are on holidays. It's all inpatient work while the dialysis unit is outpatient.

Some participants also spoke of the reality of having assumed additional job responsibilities that negated their opportunities to implement skills acquired from the one-day workshop. One participant summarized:

I think [Relaxation Therapy and mindfulness meditation] has made a difference, because I do know that it works and I do aspire to use it more in my life and to use it with patients and family members. I'm thinking that when we get over the learning curve and dealing with the extra patients we have, and when things settle down a little bit, if hopefully they do, then I'll be able to kind of focus

on other ways of doing things a little bit more. It's just, as it is now, things have been a little too crazy lately.

Two participants conveyed cautious optimism that anticipated new nephrology spaces might provide more opportunities to put into practice many skills derived from the one-day workshop. They spoke about this providing them opportunities for more privacy, quiet space, and presence, right in the units.

Obstacles were summarized by one participant, who stated, "My office looked like some sort of tornado went through" and the office was not "conducive to even thinking about relaxing." Even given this typical scenario, this participant stated "I have every intention of getting there" having been directly influenced by the workshop that these therapeutic modalities were worthwhile.

The Third Interviews

The third set of interviews occurred between December 29, 2011, and January 13, 2012, approximately three months after the workshop. This last set of interviews was conducted over a larger span of time, due to the Christmas holiday season and several participants taking vacation time and not being easily available. Once again, only one participant chose to conduct this interview utilizing Skype technology while the remaining participants choose telephone as the method of interview. Initially, 17 categories emerged in the first level coding of the analysis, but as the analysis progressed, the data was grouped into 7 categories, based on similarities and differences and subsequently named. Following this, second-level coding was completed, and from that three themes emerged: 1) participants felt that the one-day workshop had significantly influenced practice and planned to continue to use these therapeutic modalities in future practice; 2) the practice of self-care continued to be important but had decreased; and 3) there continued to be obstacles, hindering implementation. While the second set of interviews illustrated growth with implementation of the techniques, this levelled off in this third set of interviews.

1. Participants Felt That the One-Day Workshop had Significantly Influenced Practice and Planned to Continue to Use These Therapeutic Modalities in Future Practice

In general, participants expressed much gratefulness for the workshop experience as a whole. They spoke about it as being "beneficial and meaningful," and appreciated it as being both "personally helpful and professionally helpful." One participant shared, "It will always be influencing me." Another participant reported:

I found it very helpful in the moment when you were doing the workshop, you know, in terms of experiencing the different types of relaxation. That was beneficial, and now being able to apply it in very concrete ways when people are experiencing high levels of anxiety.

Three participants articulated a recurring theme: they found calls from the researcher to be influential as far as prompting them to "keep on track," and offering them "guidance and encouragement." One of these 3 participants suggested that the calls had an "added effect [on] the whole process" and were viewed as being favorable for learning. In this context, calls from the researcher offered a vital link between the artificial learning environment of the conference setting and the real world thereafter, helping to put theory into practice.

At this point of the study, 5 participants were eager to share stories about successful interventions with patients. Participants employed Relaxation Therapy techniques to assist patients with heightened anxiety, needle phobia, depression, crisis situations, and life stressors. One participant stated, "It's amazing... how easy it is to say 'Ok, well, let's take some time; let's do some deep breathing' with people who are anxious and upset' in dialysis settings." This is further highlighted in the following participant interview excerpt:

So we went over a little bit about breathing from the belly... using it at night when his mind is spinning and he's worried about going to dialysis.... It's the needles— it's the 16 gage needles—I can't blame him—I'd be anxious—so, we talked a little bit about that and, you know and a few minutes of deep breathing and being conscious of where the breath is coming from and using that to slow the heart rate down and slow the mind down. That was good and so we talked about focusing on one body part, clenching, then relaxing, and to use that as a tool to be able to go to sleep for relaxation.... It was positive.

We started off with the deep breathing exercises, and then did the progressive muscle relaxation, and then we moved on to visualization, and he really found all of that very helpful.

All participants in this set of interviews suggested that the workshop was "useful across the board" in working with the nephrology population. One participant was clear to suggest that the workshop "will probably be something that I will think of when working with people throughout my entire career as a social worker."

Another participant described the workshop as being "influential" on a personal level:

I was really in a bad place and I've been slowly crawling my way out of it. It's because I'm using these techniques to manage my anxiety, to manage those physical manifestations of all the junk going on in my brain, and really trying to listen to my body. I can do that best when I'm using some of these techniques.

Another participant stated "[I] felt a little more competent" and that acquiring skills in Relaxation Therapy and mindfulness meditation gave the participant "something to offer" to patients, rather than the daily instrumental tasks viewed as

important, but stagnant and professionally unfulfilling. One participant shared that the workshop had influenced “[my] sense of confidence” in doing “therapy” that previously would have been shied away from due to feelings of inadequacy and low confidence. This same participant stated:

I would have previously had the tendency to sort of look to other disciplines... maybe psychology. Not that I didn't think social workers as [part of their] profession could offer Relaxation Therapy, but I might have been less inclined to think that I personally could.

One participant articulated that both the patient and nephrology social worker simultaneously benefited when Relaxation Therapy and mindfulness meditation was implemented into professional practice. Although this theme was only discussed by one study participant, it carries significance, because it addresses enhanced therapeutic presence and illustrates the depth that these modalities can bring to the therapeutic relationship. Once again, it reflects what the literature suggests. The following participant interview excerpt begins to examine the intimacy of such therapeutic encounters:

Even while you're doing the exercise—the visualization for example—it's reinforcing that's necessary for all of us, not just for this person and it's meditative in its own right, you know. It's like you're going on the journey.

Five participants felt that the one-day workshop had significantly influenced practice, and planned to continue to use these therapeutic modalities, reiterating that they hoped for “totally unconscious” incorporation of Relaxation Therapy and mindfulness meditation approaches into their practices and personal care. They expressed a desire to seamlessly employ these skills from the workshop without purposefully feeling that they were making “a conscious effort.” They realized that this necessitated practice, both personally and professionally. Additionally, several participants hoped for team engagement so that Relaxation Therapy and mindfulness meditation would become integrated into the patient plan of care, and they would feel supported with its implementation and this expanded scope of practice.

2. The Practice of Self-Care Continued to be Important but Had Decreased

Once again, this third set of interviews demonstrated that participants continued to recognize the value of the workshop, that it “definitely expanded knowledge about Relaxation Therapy and mindfulness meditation, and how to incorporate it not only in practice but in self-care.” All 8 participants confirmed during this period that they were still using many of the tools derived from the workshop for self-care. Three participants indicated that they were using techniques less frequently. One participant equated less usage to having been off on holiday for two weeks and not being highly stressed at work. The other two participants cited not taking the time as interfering in this process. One participant depicted this as follows:

Well, all along for me it has been most helpful with managing my own stress and workload, as it applies to my personal well-being and practice. I must admit that in December I was spiralling a little bit and not using the practices as much as I know would be helpful to me. I got into... one of those scenarios where I felt like I was too busy to take the time, even though I knew that taking the time would help me feel much better.

All participants continued to reiterate a clearer understanding of the importance of self-care following the workshop; one participant described the workshop as “a reminder to getting back to “self-care” and as an opportunity “to try some new techniques.”

Four participants suggested that Relaxation Therapy and mindfulness meditation were effective tools that had the potential to be restorative help for nephrology social workers:

Since I have been really busy at work and I leave feeling completely stressed out, I have been thinking more of how I can relax when I get home. So I've been doing breathing techniques to help relax, and doing visualization for my self-care. I think [the workshop] has impacted that, and has helped that resilience in the fact that I have come home and laid down for five minutes and then feel that I can go on and I can keep going, and I can actually go to work the next day and not feel stressed.

One participant emphatically stated “it's something to calm you down, something to calm your mind and your heart down when you've had a long, busy day, and we like to leave work at work.” Another participant shared, “When I find myself getting into my manic mode, that's when I start to spin. I say ‘okay, it's time to take some time out and do the things you need to do to look after yourself.’” All of these examples bring to light a fresh recognition by participants of the importance of self-care. Perhaps the workshop planted the seed for this metamorphosis.

One participant described how Guided Imagery was helpful for personal well-being:

I was using the white visualization a lot yesterday, one of the things that felt like it was helping my headaches. I was really picturing soothing the pain and breathing in the light and breathing out the pain, and that seemed to help quite a bit.

One participant felt that the workshop had been an impetus for establishing a more balanced life and committed to practicing these new skills in the future:

A year from now, I would hope that I give myself at least 15 minutes a day to do this for myself and to use whichever technique it is, but 15 minutes out of the day is not a lot and if I could be doing that consistently. I haven't figured out yet what the best time for me is. I've tried first thing in

the morning before everybody else is up, and I've tried before bed and I haven't figured out which seems to work best for me, but I would like to be doing that for myself, thinking that that's really going to help my overall practice in terms of well-being and balance and managing stress.

It is interesting to note that 4 participants indicated an interest in further pursuing mindfulness meditation for enhanced self-care. Mindfulness meditation allows one to be present with oneself. It is easy to understand then, how it might be intriguing for participants to wish to continue with this unfolding of self through mindfulness meditation to assist with self-care.

3. There Continued to be Obstacles, Hindering Implementation

Given the short time frame of this project, it is not surprising that the participants experienced little change in the obstacles that were impeding their use of relaxation techniques and mindfulness-based methods. Three participants continued to discuss obstacles, and once again made reference to limited time, inadequate space, and workload demands as major hindrances. One participant shared:

December has been a horrible month.... I haven't really over the last month actually had any situations where I actually practiced the relaxation or whatever with the patient. It's been a crazy month; I just unfortunately haven't had the time, which I know is a bad excuse.

This was echoed by another participant who articulated that at "different times of the year there are different pressures" and this contributes to "putting Relaxation Therapy and mindfulness meditation on hold because...you have to quickly address the problem that is happening."

Another participant shared:

It's been hectic around here, coming over Christmas. Were back at work now, all of us, and things are starting to ramp up again. Beds are being filled that had been emptied prior to Christmas, and prior to Christmas we were short-handed, so I'm not doing any of the extra stuff that I would like to do.

Obstacles continued to be apparent but all participants sought to expand their practice and self-care to include mind-body interventions in some capacity.

In summary, although this final set of participant interviews substantiated the influence of the workshop on professional practice and self-care, this was tempered by the reality of busy, high-paced, demanding environments in which nephrology social workers are immersed.

SUMMARY AND CONCLUSION

This study used a qualitative method to explore the value of a one-day educational workshop on Relaxation Therapy and mindfulness meditation for Canadian nephrology social

workers. The study set out to determine if the workshop had any influence on future professional practice and, if so, in which ways. The workshop was designed to examine mind-body interventions, and to understand the purpose, function, and application in the nephrology psychosocial context. The clinical modalities, Relaxation Therapy and mindfulness meditation, are researched therapeutic interventions that provide evidence of effectiveness in a variety of patient populations. This workshop provided a venue for nephrology social workers to experience a variety of Relaxation Therapy and mindfulness meditation exercises, essential for increased awareness and understanding, for optimal application.

It was hoped that this workshop would have provided attendees with an opportunity to network, exchange ideas, and build confidence to include these therapeutic modalities as a regular part of their clinical forte. Furthermore, it was hoped that the workshop would help nephrology social workers understand the influence of Relaxation Therapy and mindfulness meditation as a mechanism for self-care, resilience, and joy in the practice of nephrology social work.

To assess the long-term influence of the workshop on nephrology social workers, I developed a semi-structured interview schedule and interviewed 8 members of the Canadian Association of Nephrology Social Workers who had completed the full-day workshop. Three interviews with each participant were conducted over the span of three months following the conference workshop.

If the data were considered as a whole, the key findings from this study suggest that 1) the workshop did have an impact on professional practice; 2) the workshop had an impact on self-care; and 3) amid obstacles to implementation, nephrology social workers wanted to expand their current scope of practice to include Relaxation Therapy and mindfulness meditation.

The findings from this study suggest that the skills and knowledge acquired from participation in the workshop had a direct impact on professional practice of the nephrology social workers in several ways. First, all participants who enrolled in the study successfully implemented Relaxation Therapy techniques and some mindfulness meditation practices into their work with nephrology patients (such as Body Scan), and the feedback from patients was consistently positive. Throughout the course of the study, all participants viewed the workshop as being valuable, even when obstacles negated desired implementation. Relaxation Therapy techniques with patients seemed to be preferred by the majority of participants over mindfulness meditation practice, because participants, as novice practitioners eager to implement newly-acquired skills, perceived Relaxation Therapy as being easier to understand and to maneuver. Participants seemed to favor the use of deep breathing techniques, Autogenics, Progressive Muscle Relaxation and Safe Place Visualization, targeted mainly to patients with high anxiety who were anticipating or receiving hemodialysis treatment. Additionally, participants found these therapeutic modalities to be very helpful for patients who suffered an aversion

to needles, a condition that is frequent, undesirable, and deters from enhanced quality of life for persons requiring this life-sustaining treatment. Some participants did incorporate the mindfulness meditation fundamentals of Body Scan and breathing meditation into their work with patients, but most participants gravitated to employing relaxation techniques due to ease, comfort, and perhaps an unspoken need to feel that their intervention was successful. It must be considered that mindfulness meditation is a more nebulous concept to grasp for participants who were just beginning to increase confidence with provision of skills from the workshop. Many proponents of mindfulness meditation suggest that, in order to understand and teach mindfulness meditation, one must immerse oneself in it through daily practice and lived experience (Baer, 2006; Kabat-Zinn, 1990; Palmer, 1998; Woods, 2009). In keeping with this thought, it might have been unreasonable to expect participants to feel comfortable enough to teach key concepts of mindfulness practice with passion and confidence when they were still novices themselves, and trying to acquire a basic understanding of it. Additionally, mindfulness meditation necessitates attitudinal prerequisites that include a non-judging mind, patience to simply observe and “be,” a beginner’s mind that is open and willing to see everything for the first time, a trust in one’s intuition, non-striving, acceptance of things as they actually are, and letting go, also known as “nonattachment” (Carlson & Speca, 2010).

Participants agreed to be part of this study that had a specific goal of examining the influence of the workshop on professional practice. Many study participants may have also had personal self-imposed goals. In essence, one might argue that since this study was goal driven and participants were expected to implement new techniques into their practice for measurable outcomes, it is incongruous to the pedagogy of mindfulness meditation (Wong, 2004). Furthermore, it is easy to understand how mindfulness meditation could be more daunting for participants trying to feel good about their progress through perceived successful implementation. It makes sense then that, within the domain of their personal life, study participants gravitated to informal mindfulness meditation practice rather than formal sitting practice. Generally, participants shared that the workshop helped them to revisit the importance of the notion that in order to take care of others, one must be kind to oneself. Participants purchased books and discs on mindfulness meditation and indicated an eagerness to enhance their understanding of this modality. Participants integrated the practice of awareness to the breath, mindfulness eating, mindfulness walking, and appreciation of the moment into their self-care.

Secondly, the participants who did engage in either Relaxation Therapy or mindfulness meditation for self-care suggested that this practice was helpful in reminding them to slow down, which resulted in them being less reactive, more in control, and less vulnerable to the demands of daily social work practice. This outcome is consistent with the literature regarding the benefits of mindfulness meditation (Brown & Ryan, 2003; May & O’Donovan, 2007; McCollum & Gehart,

2010; O’Driscoll, 2009; Schure, Christopher, & Christopher, 2008; Shapiro, Brown, & Biegel, 2007). One study participant was at a crossroads and experiencing a personal crisis at the time of the workshop, having had a history of anxiety and depression, and credited the workshop with helping heal. Christopher et al. (2011) has also concluded that mindfulness training can have a long-term positive influence on helping professionals’ personal and professional lives.

Initially following the workshop, nephrology social workers implemented Relaxation Therapy and mindfulness practices as part of self-care, with enthusiasm, but as time passed, the ritual of taking care of one’s self faded as seasonal caseload demands escalated. However, the workshop did give credence to the importance of self-care and was instrumental in motivating nephrology social workers to reflect and commit to future self-care prioritization and planned change. Two participants made resolutions to combat workplace demands by taking better care of themselves. One participant committed to setting aside 15 minutes a day for self-care. Additionally, several participants practiced Relaxation Therapy and mindfulness meditation in their personal lives with friends and family members. This seemed to provide them with a fertile ground for practice, confidence, and skill building.

Nephrology social workers employ a systems approach to patient care. The application of a systems approach to self-care for the nephrology social worker makes sense to include loved ones and will likely have a positive spin off benefit for the nephrology social worker. Pruitt and McCollum (2010) suggest that mindfulness meditation has a profound effect on the mediators and that has positive benefits for those close to the mediators.

Thirdly, participants recognized that acquiring Relaxation Therapy and mindfulness meditation skills was an opportunity for enhanced job fulfillment, justification of service, and a heightened nephrology social work profile within their organizations. Finger and Arnold (2002) suggest that for future marketability and survival, social workers in healthcare must move from beyond their traditional role and expand their scope of practice to include mind-body interventions. Merighi (2004) supported this study’s findings that many nephrology social workers are not being used to their full potential and are searching for greater fulfillment in their role. Participants shared that they felt empowered by the implementation of skills derived from the workshop into their practice. For many, this workshop solidified their stance that they could do more than simply instrumental tasks with patients and families. Many participants viewed Relaxation Therapy and mindfulness meditation as being “tools” that are well-suited to social work, and they welcomed the opportunity to implement both into practice. Gallant, Holosko, and Gallant (2005) suggest that incorporation of relaxation and breathing exercises into practice can be beneficial to clients and relevant tools for social workers. Participants suggested that acquiring and implementing these skills validated their credibility and unique contribu-

tion to the nephrology circle of care. Participants also welcomed the opportunity to implement Relaxation Therapy and mindfulness meditation into their practices because, in their view, acquiring these skills reinforced their ability to do something they perceived as therapeutic, and this was both empowering and satisfying.

All participants viewed Relaxation Therapy and mindfulness meditation as worthwhile and important enough techniques to warrant gradual immersion into their daily work with patients and families. In order to achieve this goal, participants acknowledged that they needed to practice these skills frequently, be patient with themselves during the interim, and dedicate time to using these mind-body interventions for self-care and reflection. Some participants recognized that they were their own biggest hindrance to implementation in this regard. Finger and Arnold (2002) supported the notion that social workers have the capability of incorporating relaxation techniques into their frontline practice through additional training as well as a commitment to use relaxation techniques for personal care.

Fourthly, in nephrology social work, there were significant barriers to implementation of skills derived from the one-day workshop. These included insufficient quiet and private space conducive for optimal implementation; lack of dedicated time due to unmanageable workload demands; and lack of physical comfort due to inadequate seating and less-than-ideal environmental conditions that often included poor proximity to patients. Participants suggested that in order for progress to be made in offering these therapeutic modalities, obstacles needed to be articulated, addressed, and alleviated. Many participants were physically situated at a distance from their patients and this made it difficult to implement workshop skills into practice.

Implementation was further challenged by a population of patients who must frequent dialysis thrice weekly for the remainder of their lives (or until kidney transplant), and are eager to receive treatment and leave the hospital setting quickly. It is the author's experience that many patients simply want to make the dialysis treatment regimen as simple as possible, which often means "getting treatment and getting home." Nephrology social workers frequently struggle in trying to institute successful group work in their practices, due to this pattern.

Many participants shared office space and this was suboptimal. Several participants spoke of having inherited more job responsibilities that prohibited them from having adequate time to do Relaxation Therapy and mindfulness meditation. This study took place prior to and during the Christmas holiday season, which usually means increased patient crises and workload demands. It is easy to understand how this factor may have influenced implementation and possibly study results.

Lastly, the most unexpected outcome of this study was the positive impact that this researcher's calls seemed to have on study participants. It became apparent that the monthly calls

were not only helpful in encouraging participants to meet personal expectations of applying workshop knowledge and skills into practice, but these calls actually provided an opportunity for consultation, encouragement, and validation. None of the participants missed calls during the entire study, and all concluded that the study was both enjoyable and appreciated. This appears to indicate that regularly scheduled follow-up may assist workshop participants with integrating these methods into their professional and personal lives.

The experiences described by participants are consistent with the limited literature that generically examines the influence of Relaxation Therapy and mindfulness meditation on professional practice and self-care domains.

STUDY STRENGTHS

This study had several strengths that made it meaningful. It represents a valuable contribution to the literature, as there is nothing previously published (that the author is aware of) that specifically examines the influence of a one-day workshop on Relaxation Therapy and mindfulness meditation for nephrology social workers. This study typifies the importance of using Relaxation Therapy and mindfulness meditation for optimal patient and nephrology social work functioning. Furthermore, it suggests the value of a one-day workshop with systematic follow-up with participants as a valid mechanism for learning. This study exemplifies the significance of self-care for nephrology social workers and suggests the need for further scientific inquiry to examine why self-care is so essential for this profession in the first place. Hopefully, this study will provide nephrology social workers with continuing evidence required to substantiate arguments for further study of this topic, and garner support from colleagues and superiors for implementation and continued funding. In the future, it would be interesting to study if training in these methods helps nephrology social workers to deal with workplace stresses.

This study has provided an opportunity for nephrology social workers to reflect on their current personal and professional practices while strategizing new ways to bring Relaxation Therapy and mindfulness meditation to both domains. This study supports the idea of nephrology social workers filling a void in existing nephrology programs that is frequently supplied by therapeutic sources and services outside of the team. Given the present funding cuts to healthcare, this study might also assist nephrology social workers in gaining fiscal support from their programs for continuing education in this area by simply diverting funds that otherwise may have been slated for purchase of outside service. Lastly, it is hoped that this study will lay the foundation for future networking, consultation, and collaboration between nephrology social workers who wish to refine their skills in mind-body interventions and expand scope of practice.

STUDY LIMITATIONS

This study had several limitations that should be considered when planning future research. First, the study used participants who independently decided to participate in the workshop; therefore, a limitation of the study could be self-selection bias. Participants in the study were predominantly female, Caucasian, Masters-prepared nephrology social workers; therefore there are limits to the generalizability of the findings for individuals from other racial/ethnic/academic backgrounds or across genders. The study participants consisted of a cross-sample of nephrology social workers from Eastern, Central and Western Canada; however, 3 participants were from the same geographical area and also members of the conference planning committee. A deficiency might exist because they expressed many of the same experiences and ideas, possibly skewing study results. It should be noted that the CANSW conference planning committee members actually sought out and invited me to present on this topic, so it may be argued that they had preconceived expectations of what the workshop would deliver, expecting that it would be successful in order to justify costs to the membership to whom they are accountable. This also indicates their specific interest in the topic which may not be shared by the broader membership.

I was both a presenter and researcher, so it may be argued that my bias and power influenced interpretation of results. Workshop participants might have felt inclined to speak positively about the workshop and the influence of Relaxation Therapy and mindfulness meditation skills on their practices in order to please or for fear of being criticized. Furthermore, I was known to some of the study participants, so professional reputation and familiarity might have subjectively influenced the study results. Additionally, the workshop title, *A Citadel in Turbulent Times: Relaxation Methods that Foster Resilience in Nephrology Social Work Practice*, might have been suggestive to study participants, because it promised a workshop that was expected to yield resilience and positive results. It would be interesting to have this study replicated by an independent researcher who is not a nephrology social worker, or a member of CANSW, and who has no vested interest in the workshop. Given all of these limitations of the study, I made stringent attempts not to influence or use my power to alter the direction of the study or cause any harm to participants. One last flaw of the study is that the construction of the workshop may have been too overzealous, attempting to teach such a breadth of knowledge about both Relaxation Therapy and mindfulness meditation in only one day. In hindsight, I believe that, although it was my intention to teach as many of these interventions as possible, it would be more preferable to perhaps tackle Relaxation Therapy and mindfulness meditation separately, and to allow for mindfulness meditation to be taught over a 5-to-7 day span, in order to allow for key concepts to be more fully understood and experienced.

IMPLICATIONS FOR FUTURE RESEARCH

The themes identified in this study suggest implications for future research endeavors in the area of psychosocial nephrology. This study suggests that a one-day workshop on Relaxation Therapy and mindfulness meditation for nephrology social workers had a positive influence on professional practice. Perhaps most salient was the theme that many nephrology social workers who participated in the study attended the workshop not only looking for modalities that would assist them as practitioners, but also in search of methods that would enhance self-care. Continued qualitative inquiry might examine why nephrology social workers are under such stress and why they have this need for knowledge about enhanced self-care. This type of research could promote nephrology social work wellness through prevention. We know that nephrology social workers are under much stress due to unmanageable workloads, the rigors of dealing with patients and families who are shackled by the devastation of CKD, and the dissatisfaction with professional role identification. We know that nephrology social workers are not utilized to their full capacity and are frequently called upon to complete excessive paperwork, manage instrumental tasks, and rectify endless conflicts in dialysis units. A closer examination of nephrology social work self-worth and confidence through personal reflections would be a poignant area of future study which might be helpful to the profession. Also, the findings of this study seem to indicate that incorporating Relaxation Therapy skills may help nephrology social workers to stake out a more solid professional identity within the hospital context.

Additionally, this study demonstrated that nephrology social workers had a keen interest in acquiring more knowledge and practice of mindfulness meditation for self-care. It would be very interesting to have nephrology social workers complete an 8-week Mindfulness Based Stress Reduction (MBSR) program and then examine the impact of the program on their professional and personal domains. Likewise, future qualitative research examining the influence of an 8-week MBSR program directed to patients with CKD would be a potentially rich data source, considering that, to date, there is no published literature in this area.

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A Rationale for Increasing Physical Activity in Chronic Kidney Disease: Quality Insights Renal Network 3's Learning and Action Network's Campaign

Joan Wickizer, MSW, LSW, NSW-C, Quality Insights Renal Network 3, Cranbury, NJ

Danielle Kirkman, PhD, Department of Kinesiology and Applied Physiology, University of Delaware, DE

Individuals diagnosed with chronic kidney disease (CKD) are often reluctant to engage in physical activity. Research has demonstrated myriad physical and psychological health benefits of regular exercise in this population. The challenge for many renal care providers has been translating these benefits for patients in a manner that engages them in the process. Quality Insights Renal Network 3 (QIRN3) worked with in-center hemodialysis providers to promote increased physical activity with patients within the network. These patients were provided with education about the benefits of increasing physical activity and were asked to sign pledge cards indicating their goals in this regard. The final results of this campaign showed 42.3% of patients in the targeted facilities signed pledge cards indicating their plans to increase their physical activity and well-being.

It is well established that physical inactivity is a leading cause of non-communicable disease and mortality in the present-day society (Mokdad, Marks, Stroup, & Gerberding, 2004). Physical inactivity is prevalent among chronic kidney disease (CKD) patients, who report activity levels that are 25% of age-matched sedentary healthy individuals (Johansen et al., 2000). Reductions in cardiorespiratory fitness and physical function become evident around Stage 3 CKD (Johansen & Painter, 2012; Padilla et al., 2008) and continue to decline as kidney function worsens (Odden et al., 2006). When patients reach end-stage renal failure, high levels of exercise intolerance are reported, with patients having to work at up to 75 percent of their maximum capacity just to carry out activities of daily living (Ip et al., 2006; Koufaki, Naish, & Mercer, 2001). It is therefore unsurprising that one third of these patients are unable to carry out activities of daily living unassisted (Ifudu et al., 1994). Furthermore, the incidence of frailty (defined as the presence of three or more of the following conditions: unintentional weight loss, weakness, exhaustion, slow gait, and inactivity) among middle aged and younger CKD patients is double that of aged healthy individuals (Roshanravan et al., 2012). This decline in physical activity and physical capacity and the increased prevalence of frailty is noteworthy, because these factors independently predict hospitalization, comorbidity, quality of life, and mortality in this patient population (Howden et al., 2014; Johansen, Chertow, Jin, & Kutner, 2007; Pagels, Soderkvist, Medin, Hylander, & Heiwe, 2012; Painter & Roshanravan, 2013).

Increasing physical activity levels is therefore a pertinent aspect of a healthy lifestyle in CKD patients. The National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI™) Clinical Practice Guidelines recommend that hemodialysis patients be counseled and encouraged to increase their physical activity levels (National Kidney Foundation, 2005). Yet, despite these guidelines, regular physical activity and exercise rehabilitation remains to be established as part of routine care in this patient cohort. Previous research has reported myriad

health benefits resulting from regular exercise in hemodialysis patients. Significant increases in cardiorespiratory fitness and muscular strength have been reported following both aerobic and strength exercise training carried out inter- and intra-dialytically (Heiwe & Jacobson, 2011; Konstantinidou, Koukouvou, Kouidi, Deligiannis, & Tourkantonis, 2002). In addition, regular exercise has shown benefits pertaining to blood pressure control (Miller, Cress, Johnson, Nichols, & Schnitzler, 2002), inflammation (Cheema et al., 2007; Viana et al., 2014), muscle wasting (Kirkman et al., 2014), cardiac function (Howden et al., 2013), dialytic phosphate removal (Kirkman et al., 2013), and quality of life (Jhamb & Weiner, 2014) in CKD patients.

Importantly, improvements in cardiac function and endothelial function have been observed following low-volume, voluntary physical activity. Furthermore, physical function, cardiovascular, and anti-inflammatory improvements have been reported following daily walking programs in this patient population (Kosmadakis et al., 2012; Viana et al., 2014). In this respect, simply increasing daily habitual physical activity levels or taking part in lower intensity activity can be a beneficial and pragmatic starting point for patients who perceive structured exercise to be daunting, unrealistic or unobtainable.

Despite published clinical guidelines in favor of exercise, physical activity counseling behavior of health care providers has not increased (Delgado & Johansen, 2010). Recent surveys suggest that the majority of patients state an interest in physical activity, yet this is not translated into true increases in physical activity (Delgado & Johansen, 2012). Thus, the barriers to implementing physical activity into routine care, faced by both patients and healthcare providers, need to be addressed. Previously, it has been suggested that tools, training and encouragement need to be made available to both healthcare providers and patients in order to increase physical activity assessment, counseling, and recommendation (Delgado & Johansen, 2012).

Corresponding Author: Joan Wickizer, MSW, LSW, NSW-C, Patient Services Director, Quality Insights Renal Network 3, 109 S. Main Street, Suite 21, Cranbury, NJ 08512; jwickizer@nw3.esrd.net; 609.490.0310 Ext. 2430.

Based on these recommendations, in the Spring of 2014, Quality Insights Renal Network 3 (QIRN3) created a Patient Learning and Action Network (LAN) educational campaign, aimed to educate patients about the importance of increasing physical activity and well-being. This campaign was established by patients of the LAN, for patients in the Network 3 community. A campaign plan outlining the number of facilities that would be incorporated into the project was created and presented to the Centers for Medicare and Medicaid Services (CMS) for approval. Once approved, QIRN3 staff members, in conjunction with LAN Subject Matter Experts (SMEs), developed educational materials for use by staff members at the selected facilities during their educational interventions with patients. The goal of the campaign was to get at least 10 percent of patients, in the targeted facilities, to sign pledge cards indicating their goals for increasing their physical activity and well-being.

FACILITY SELECTION

QIRN3 is the renal network with a territory that includes New Jersey, Puerto Rico, and the U.S. Virgin Islands. Its patient population in February 2014 was 18,060. The campaign incorporated 20 percent of hemodialysis patients in the Network, or 3,612 patients. The facilities were randomly chosen throughout QIRN3; the only exclusions were facilities that had participated in a QIRN3 LAN campaign in 2013. Ultimately, 37 hemodialysis facilities were chosen to participate in the educational campaign. Hospital-based facilities, large dialysis organizations (LDOs), small dialysis organizations (SDOs) and independents made up the selected facilities. The facilities were located in all 3 of the geographic areas covered by QIRN3: 27 in New Jersey, 9 in Puerto Rico and 1 in the U.S. Virgin Islands.

QIRN3 determined the campaign would be best managed by the social workers at the facilities. Social workers were selected because they typically have an understanding of each patient's lifestyle and needs, enabling them to assist and encourage patients to make appropriate pledges. The social workers and facility administrators for the selected facilities were notified by the Network of their selection in April 2014. These facilities were randomly selected by the Network, and there was no opportunity for facilities to volunteer for this campaign. On April 29, 2014, a webinar was conducted by QIRN3 staff for participating social workers and facility administrators. The project plan was reviewed with the facility staff and their roles and responsibilities were presented. Timelines for data submission were also provided to the staff members. Strategies and ideas for gaining patient participation in the campaign were addressed. QIRN3 recognized that buy-in from the selected facility staff was paramount to the campaign's success. This webinar was utilized as a tool to create excitement and develop a mutually beneficial relationship between QIRN3 staff and the facility staff.

CAMPAIGN IMPLEMENTATION

The campaign materials included a booklet outlining the benefits of increased physical activity. This booklet was made available in both English and Spanish to ensure patients in

Puerto Rico would benefit from the material. A PowerPoint slideshow of the booklet, with voice-overs in English and Spanish, was created for illiterate patients. Pledge cards were included with the booklets. The educational material was discussed with patients in relation to their current activity levels, after which they were given the option to sign a pledge card indicating the changes they planned to implement to increase their activity level. Renal healthcare providers play a pivotal role in the education and encouragement of adopting physical activity as part of a healthy lifestyle. Therefore, direct contact between dialysis facility staff and patients was integral to distributing the Network-developed educational materials to patients. In order to avoid bias, healthcare providers encouraged patients to take part in the campaign without coercing them; signing pledge cards was optional and not a requirement.

The social workers were asked to meet with all patients at their facilities during the implementation months of July, August, September, and October. For measurement purposes, it was suggested they divide their patient census by four and meet with one quarter of the patients each month. The meetings could be conducted individually or in groups. "Lobby Days" were suggested as a means of reaching a group of patients at one time. This strategy was utilized by numerous facilities and proved very successful in generating interest in the campaign.

The Renal Center of Juncos, Puerto Rico, created a poster with a soccer field drawn on it to display the pledge cards. The entire interdisciplinary team worked to educate patients about the program. They culminated their interventions with a patient and family outing to a local park with food and activities for all. Atlantis Mayaguez, Puerto Rico, had an exercise day in their lobby, and trainers came to the facility to work with patients. Fresenius Medical Care (FMC) Yauco, Puerto Rico, brought an exercise bike in to the lobby, which was utilized by patients waiting to enter the treatment area. In New Jersey, FMC Philipsburg conducted a lobby day set up with a summer beach theme to promote activity. The staff utilized a Nintendo Wii game console as a tool to encourage physical activity with patients in the lobby area.

QIRN3 staff participated in several lobby days at dialysis facilities in New Jersey. Exercise physiologist support was provided from the Vascular Physiology Lab at the University of Delaware. Patients were provided with education about the overall benefits of increasing physical activity in a way that was specifically related to their renal disease and cardiovascular functioning.

CAMPAIGN OUTCOMES

The number of patients who signed pledge cards in July, the first measurement month, was 383, exceeding our 10 percent goal for the project. In August, there were an additional 564, followed by 445 in September, and 136 in October. The cumulative total was 1,528, equaling 42.3 percent of patients in the targeted facilities.

As a result of this success, QIRN3 determined this campaign should be replicated in additional facilities, beginning in April 2015. Plans are in place to educate facilities about the successful strategies used by participating facilities in 2014. The goal will be to achieve greater than 42 percent of the newly-selected patients signing pledge cards, indicating their plans to increase their physical activity and improve their well-being.

QIRN3's goal was to initiate a campaign that would stimulate patients to increase their physical activity level. Initiating and maintaining physical activity is a complex behavior change that involves many stages. Behavioral interventions to adopt or maintain physical activity may differ depending on an individual's motivation and readiness for change. This pragmatic campaign allowed staff to interact individually with patients, providing education and setting specific goals that were relevant to each patient's current stage of behavior change. The campaign sought to initiate the first step in implementing physical activity as part of routine care in the CKD population through awareness, providing educational materials and resources regarding the benefits of physical activity in this patient cohort. Future research is required to further investigate the efficacy of such an intervention on translational adherence to increasing physical activity and the subsequent hypothesized benefits relating to hard outcome measures, such as quality of life, mortality, and morbidity.

Patient and Healthcare Provider Resources for Physical Activity Used in this Research:

- QIRN3 "Increasing Patient's Physical Activity and Well-Being" English brochure: http://qirn3.org/Files/Patients-and-Families/Patient-Focused-LAN/IncreasingActivity_Booklet.aspx
- QIRN3 "Increasing Patient's Physical Activity and Well-Being" Spanish brochure: http://qirn3.org/Files/Patients-and-Families/Patient-Focused-LAN/IncreasingActivity_Booklet_Spanish.aspx
- The Importance of Exercise for Chronic Kidney Disease Patients (Kirkman, Lennon-Edwards, & Edwards, 2014) PDF article: <http://www.jrnjournal.org/article/S1051-2276%2814%2900144-7/pdf>
- National Kidney Foundation "Staying Fit with Kidney Disease" web page: <http://www.kidney.org/atoz/content/stayfit.cfm>
- British Renal Society TIME package PDFs: <http://www.britishtrenal.org/AboutUs/Time/Exercise.aspx>
- Medical Education Institute "Exercise: A Guide for People on Dialysis": <http://lifeoptions.org/catalog/pdfs/booklets/exercise.pdf>

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Nephrology Social Workers' Caseloads and Hourly Wages in 2010 and 2014: Findings from the National Kidney Foundation Council of Nephrology Social Work Professional Practice Survey

Joseph R. Merighi, PhD, MSW, LISW, University of Minnesota, Saint Paul, MN

Teri Browne, PhD, MSW, NSW-C, University of South Carolina, Columbia, SC

In 2010 and 2014, the National Kidney Foundation Council of Nephrology Social Workers (NKF-CNSW) conducted online surveys of nephrology social workers to assess caseload and salary trends at the state, national, and End-Stage Renal Disease Network level. Between 2010 and 2014, outpatient dialysis social workers experienced decreases in mean caseload size from 79 to 75 (down 5.1%) for those employed 20–31 hrs/wk, 121 to 113 (down 6.6%) for those employed 32–40 hrs/wk, and 126 to 116 (down 7.9%) for those employed 40 hrs/wk. Increases in mean hourly wage between 2010 and 2014 were also reported across all three employment status groups: \$28.16 to \$29.45 per hour (up 4.6%) for those working 20–31 hrs/wk, \$27.18 to \$28.23 per hour (up 3.9%) for those working 32–40 hrs/wk, and \$26.93 to \$28.21 per hour (up 4.8%) for social workers employed 40 hrs/wk. Pre-transplant evaluations of potential donors decreased between 2010 and 2014 for social workers who were employed full time (32–40 hrs/wk) and those who worked 40 hrs/wk. Specifically, the mean number of potential donor evaluations declined from 40.5 to 22.1 (down 45.4%) for those employed 32–40 hrs/wk and 44.7 to 23.0 (down 48.5%) for those employed 40 hrs/wk. However, pre-transplant evaluations of potential recipients decreased for those employed full-time (522.5 to 283.7, down 45.7%) and increased for those employed 40 hrs/wk (232.6 to 315.6, up 35.7%). Mean hourly wage data showed a slight increase for transplant social workers employed full time (\$29.56 to \$30.74, up 4%) and a slight decrease for those employed 40 hrs/wk (\$29.79 to \$28.74, down 3.5%). In general, decreases in social work caseload and increases in hourly wages were found on a national level; however, variability across states requires further attention.

INTRODUCTION

The National Kidney Foundation Council of Nephrology Social Workers (NKF-CNSW) conducted three national online salary and caseload surveys of nephrology social workers in 2007, 2010, and 2014. The overarching goal of these surveys was to create a database that archives quantifiable data on caseloads and salaries over time. Through the online surveys, NKF-CNSW has successfully scanned the nephrology social work landscape and collected a rich source of empirical data.

In accordance with a Federal Centers for Medicare and Medicaid Services (CMS) mandate, a Master's-level social worker is required in every U.S. dialysis center and kidney transplant center (CMS, 2007, 2008) because of the many psychosocial barriers to optimal dialysis and transplant outcomes (Browne, 2012; Cukor, Cohen, Peterson, & Kimmel, 2007). Nephrology social workers assist patients with issues such as coping, sexuality, body image concerns, pain management, end-of-life concerns, social role adjustment, and vocational rehabilitation (Browne, 2012). In dialysis units, social workers must assess and provide interventions related to patient quality of life and counseling needs in order to help patients and their families cope with their kidney failure and treatment regimens (CMS, 2008). In kidney transplant centers, social workers assist all transplant patients, in addition to living donors and patients' families (CMS, 2007).

Research suggests that nephrology social work interventions are helpful in improving patient depression (Beder,

2000), adjustment (Beder, 2000), self-management (Beder, Mason, Johnstone, Callahan, & LeSage, 2003), physical activity (Johnstone, 2005), fluid management (Johnstone, 2005; Johnstone & Halshaw, 2003), quality of life (Johnstone, 2005), insomnia (Johnstone, 2005), depression (Johnstone, 2005; McCool et al., 2011; Sledge et al., 2011), pursuit of living kidney donation (Boulware et al., 2013) and missed dialysis treatments (Medical Education Institute, 2004). Encouragingly, kidney disease patients also value and desire nephrology social work interventions (Holley, Barrington, Kohn, & Hayes, 1991; Rubin et al., 1997; Siegal, Witten, & Lundin, 1994), and find them helpful (DePasquale et al., 2012).

Recognizing the important role of nephrology social work interventions, the CMS Conditions for Coverage for all dialysis units in the United States mandate that nephrology social workers have caseloads that allow them to fulfill their duties (CMS, 2008). Specifically, Condition §494.180 declares that "an adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs" (p. 20483). Accordingly, NKF-CNSW recommends an acuity-based social worker-to-patient ratio that takes into consideration the psychosocial risks of patients and recommends a maximum of 75 patients per full-time dialysis social worker (NKF-CNSW, 1998, 2014). The state of Texas

mandates a caseload of 75 to 100 patients per full-time social worker. However, previous research has demonstrated that nephrology social workers across the country have caseloads that far exceed these recommendations (Browne, Merighi, & Herold, 2008; Merighi & Browne, 2010, 2012; Merighi, Browne, & Bruder, 2010; Merighi & Ehlebracht, 2002, 2004).

Large nephrology social work caseloads have been linked to decreased patient satisfaction and less successful patient rehabilitation outcomes (Callahan, Moncrief, Wittman, & Maceda, 1998). Social workers report that high caseloads prevent them from providing adequate nephrology clinical services, most notably counseling (Merighi & Ehlebracht, 2002, 2004). Nephrology social workers have also reported that large caseloads hindered their ability to provide clinical interventions (Bogatz, Colasanto, & Sweeney, 2005).

Given the critical importance of nephrology social workers in dialysis and kidney transplant centers, the National Kidney Foundation Council of Nephrology Social Workers (NKF-CNSW) has conducted national social work caseload and salary surveys in 2007 and 2010 (Merighi et al., 2010). The findings presented in this article summarize nephrology social workers patient caseload and hourly wage trends for 2010 and 2014, with a particular emphasis on social workers employed in outpatient dialysis facilities across the United States.

METHOD

Study Design

A cross-sectional research design was used to conduct an online survey of nephrology social workers in the United States.

Respondents

Dialysis Social Workers – Part Time. 109 part-time (i.e., 20–31 hours per week) dialysis social workers responded to this study. The sample was 93.5% White, 3.2% Native American, 2.2% African American, and 1.1% Asian/Pacific Islander. Respondents who identified as Hispanic or Latino/a comprised 5.4% of the sample. The majority of the respondents were women (95.7%), and had a social work license in their state of employment (95.4%). The social workers' mean age was 36.1 years (SD = 8.3), and they reported an average of 9.9 (SD = 8.3) years of nephrology social work practice experience.

Dialysis Social Workers – Full Time. 685 full-time (i.e., 32–40 hours per week) dialysis social workers responded to this study. The sample was 87.0% White, 7.7% African American, 3.7% Asian/Pacific Islander, and 1.6% Native American. Respondents who identified as Hispanic or Latino/a comprised 5.6% of the sample. The majority of the respondents were women (92.6%), and had a social work license in their state of employment (89.2%). The social workers' mean age was 34.7 years (SD = 9.1), and they reported an average of 10.1 (SD = 7.7) years of nephrology social work practice experience.

Transplant Social Workers – Full Time. 25 full-time (i.e., 32–40 hours per week) transplant social workers responded to this study. The sample was 83.3% White, 11.1% Asian/Pacific Islander, and 5.6% African American. Respondents who identified as Hispanic or Latino/a comprised 11.8% of the sample. The majority of the respondents were women (82.4%), and every one had a social work license in their state of employment (100%). The social workers' mean age was 32.3 years (SD = 9.5), and they reported an average of 11.8 (SD = 8.6) years of nephrology social work practice experience.

Measure

A 70-item Caseload, Salary, and Professional Practice Survey was used in 2014 to assess nephrology social work practice in dialysis and transplant settings at both the state and national level, and across all 18 End Stage Renal Disease (ESRD) Networks. In particular, the survey measured social workers' level of responsibility for a variety of professional tasks (e.g., patient education, counseling, advance care planning), frequency of collaborations with healthcare professionals and family members, caseload size, hourly pay rate, and employer characteristics. To assess the survey's face validity, four social workers with expertise in dialysis or kidney transplant social work were asked to review each survey item and provide detailed feedback regarding word choice, relevance to the specific domain of practice (dialysis vs. transplant), and alignment with real-world practice.

Data Collection Procedure

The National Kidney Foundation (NKF) distributed email announcements about the survey to its Council of Nephrology Social Workers membership, in addition to non-member social workers in the NKF database (approximate N = 2,100 email addresses) from January 2014 to March 2014. These announcements, which were sent on four occasions during the data collection period, included information about the study aims, instructions on how to access the surveys using a SurveyMonkey® hyperlink, and a request to distribute the announcement to other nephrology social workers. Prospective respondents were informed of the confidential and voluntary nature of the survey, and that it would take 25 minutes to complete. No incentives were offered for participation. The survey data were initially sent to NKF and housed on their secure server prior to being released for statistical analysis. Once the data were de-identified by NKF staff (i.e., by removing e-mail addresses and other information that could potentially reveal the identity of an individual respondent), one of the authors (JRM) received the data in Statistical Package for the Social Sciences (SPSS) format, which facilitated data management and analysis. All the data were stored on a secure network at the University of Minnesota. Please see Merighi, Browne, and Bruder (2010) for a summary of the study procedures used for the 2010 findings presented in this article. This study was approved by the University of Minnesota Institutional Review Board.

RESULTS

The survey data are summarized according to employment status groups, based on the number of hours worked per week (hrs/wk): 20–31 hrs/wk, 32–40 hrs/wk, and exactly 40 hrs/wk. The “exactly 40 hours per week” category was created by selecting only the respondents who reported having a 40 hrs/wk position. Therefore, these respondents constitute a subset of the 32–40 hrs/wk category. Individual sample sizes are provided for all employment status groups in Tables 1–6.

Descriptive findings (i.e., mean, median, and range) for caseload and salary data collected in 2010 and 2014 are presented in Tables 1–6. National summaries for social workers in outpatient dialysis and transplant social workers are provided in Tables 1 and 2. In order to preserve the confidentiality of the sole part-time transplant social worker who provided usable caseload and salary information, no summary information is reported in Table 2. Breakdowns by ESRD Network (see Figure 1 for map) for outpatient dialysis social workers are provided in Tables 3 and 4, and state-level findings are presented in Tables 5 and 6.

Between 2010 and 2014, outpatient dialysis social workers experienced decreases in mean caseload size from 79 to 75 (down 5.1%) for those employed 20–31 hrs/wk, 121 to 113 (down 6.6%) for those employed 32–40 hrs/wk, and 126 to 116 (down 7.9%) for those employed 40 hrs/wk. Increases in mean hourly wage between 2010 and 2014 were also reported across all three employment status groups: \$28.16 to \$29.45 per hour (up 4.6%) for 20–31 hrs/wk, \$27.18 to \$28.23 per hour (up 3.9%) for 32–40 hrs/wk, and \$26.93 to \$28.21 per hour (up 4.8%) for social workers employed 40 hrs/wk.

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In general, caseload and hourly wage data by ESRD Network (Tables 3–4) and state (Tables 5–6) showed similar trends to the overall/aggregate trends reported above for social workers employed in outpatient dialysis settings.

DISCUSSION

The summary tables presented in this article provide important snapshots regarding nephrology social worker remuneration and caseload demands across a spectrum of work contexts and geographic regions. Encouragingly, at

the national level, social work caseload and hourly wage were found to improve between 2010 and 2014. However, social workers in some states reported increased caseloads and decreased salaries, which is not commensurate with national trends.

When making comparisons between the 2010 and 2014 findings, it is important to note that the number of respondents in 2014 is markedly lower in some states and employment status groups, as compared to 2010. For this reason, the findings must be interpreted with caution due to the threat of sampling bias. Future research is also needed to better link social work caseloads and salaries to patient and professional outcomes.

Despite the aforementioned limitations, these findings reflect a large national sample size and may be helpful for nephrology social workers to advocate for lower caseloads in order to adequately meet the Conditions for Coverage (CMS, 2008) and provide quality patient care. For example, since the release of the 2008 Conditions for Coverage, applicable to all dialysis units in the United States, this and the 2010 NKF-CNSW nephrology social work survey (Merighi, Browne, & Bruder, 2010) suggest that overall caseloads for dialysis social workers have increased, when compared to national caseloads prior to 2008. This jeopardizes a dialysis unit's ability to meet Condition \$494.180:

Adequate number of qualified and trained staff. The governing body or designated person responsible must ensure that—(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs. (Federal Register, 2008, p. 20483)

Indeed, in 2010, 70.4% of part-time and 76.6% of full-time dialysis social workers reported that they had insufficient time to provide psychosocial services to patients (Merighi et al., 2010). This is supported by the fact that dialysis survey citations for V552 (“The interdisciplinary team must provide the necessary monitoring and social work interventions...”) have risen in the list of the top 25 citations among all U.S. dialysis facilities; specifically, from 21st place in fiscal year 2010 to 11th place in fiscal year 2011 (Witten, 2011).

High caseloads prevent nephrology social workers from delivering clinical interventions that can ameliorate psychosocial barriers to improved kidney disease outcomes (Bogatz, Colasanto, & Sweeney, 2005; Merighi, & Ehlebracht, 2002, 2004). High caseloads and low compensation may also contribute to lower employment satisfaction and higher compassion fatigue. These may lead to greater levels of social work burnout that could contribute to social workers leaving their practice settings (Hamama, 2012; Lloyd, King, & Chenoweth, 2002; Thomas, Kohli, & Choi, 2014).

NKF-CNSW hopes that social workers will find this information helpful in their self-advocacy efforts with employers. Specifically, nephrology social workers can use these data to assess their salaries and caseloads in comparison to state and national trends. If social workers determine that they have a higher caseload and/or lower salary, they can present these findings to their employers. They can also share with their employers the importance of lower caseloads so that patient outcomes may improve, that the clinic remain in compliance with the Federal Conditions for Coverage (and avoid a survey citation), and that social workers may be more likely to avoid burnout and leave their employment setting. NKF-CNSW has also created many different resources for social workers to help in this effort (notably, the Advocacy Webinar Series and the Standards of Practice for Nephrology Social Work, 6th Edition (NKF-CNSW, 2014). Together, this information may be helpful for social workers to improve their caseloads and compensation and, ultimately, improve patient care.

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Figure 1. Map of ESRD Networks

| FIGURE 1 ESRD Network Areas | |
|--|---|
| Network | Geographic Area |
| 1 | CT, MA, ME, NH, RI, VT |
| 2 | NY |
| 3 | NJ, PR, VI |
| 4 | DE, PA |
| 5 | DC, MD, VA, WV |
| 6 | GA, NC, SC |
| 7 | FL |
| 8 | AL, MS, TN |
| 9 | IN, KY, OH |
| 10 | IL |
| 11 | MI, MN, ND, SD, WI |
| 12 | IA, KS, MO, NE |
| 13 | AR, LA, OK |
| 14 | TX |
| 15 | AZ, CO, NM, NV, UT, WY |
| 16 | AK, ID, MT, OR, WA |
| 17 | American Samoa, Guam, HI, Northern CA, Northern Mariana Islands |
| 18 | Southern CA |

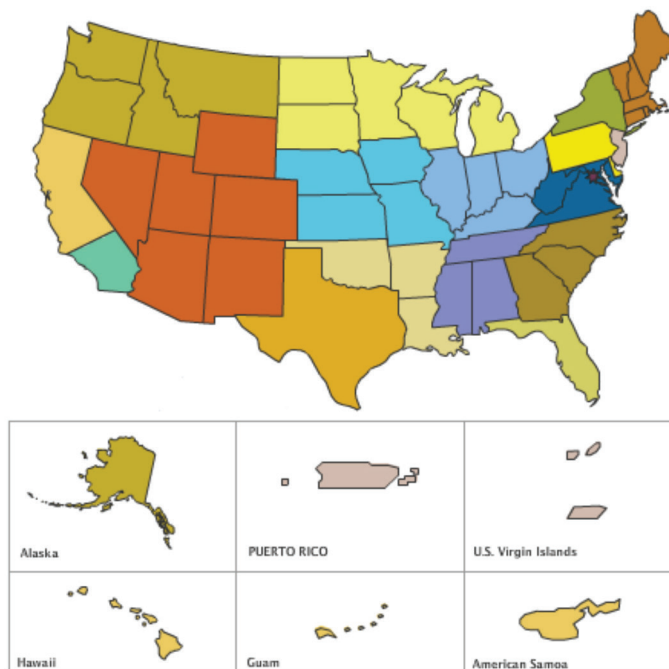


TABLE 1.
Social Workers in Outpatient Dialysis Settings

| | 2010 | | | 2014 | | |
|----------------------|----------|-----------------|---------------|----------|-----------------|----------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Caseload | | | | | | |
| 20–31 hrs/wk | 214 | 78.79 / 77.50 | 15–210 | 70 | 75.34 / 72.00 | 16–205 |
| 32–40 hrs/wk | 1037 | 120.80 / 120.00 | 1–711 | 352 | 113.22 / 110.00 | 1–1,500 |
| 40 hrs/wk | 815 | 126.17 / 125.00 | 1–711 | 272 | 116.14 / 117.00 | 1–1,500 |
| Hourly Wage | | | | | | |
| 20–31 hrs/wk | 224 | 28.16 / 27.48 | 16.00–45.00 | 92 | 29.45 / 27.87 | 19.98–53.23 |
| 32–40 hrs/wk | 1056 | 27.18 / 26.52 | 14.42–50.00 | 553 | 28.23 / 28.00 | 17.00–50.42 |
| 40 hrs/wk | 833 | 26.93 / 26.36 | 14.42–47.00 | 430 | 28.21 / 27.95 | 17.00–50.42 |
| Annual Salary | | | | | | |
| 32–40 hrs/wk | 1056 | 54,635 / 53,531 | 29,994–97,760 | 553 | 58,721 / 58,240 | 35,360–104,873 |
| 40 hrs/wk | 833 | 56,019 / 54,829 | 29,994–97,760 | 430 | 58,647 / 58,136 | 35,360–104,873 |

TABLE 2.
Social Workers in Transplant Settings

| | 2010 | | | 2014 | | |
|---|----------|-----------------|---------------|----------|-----------------|---------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Caseload (Potential Donors) 32–40 hrs/wk 40 hrs/wk | 29 | 40.48 / 17.00 | 0–500 | 16 | 22.13 / 11.00 | 1–101 |
| | 23 | 44.74 / 20.00 | 0–500 | 9 | 23.00 / 11.00 | 1–76 |
| Caseload (Potential Recipients) 32–40 hrs/wk 40 hrs/wk | 33 | 522.53 / 190.00 | 0–750 | 16 | 283.69 / 221.00 | 11–1,001 |
| | 26 | 232.62 / 200.00 | 0–750 | 9 | 315.56 / 241.00 | 11–1,001 |
| Hourly Wage 32–40 hrs/wk 40 hrs/wk | 37 | 29.56 / 28.85 | 21.47–40.80 | 17 | 30.74 / 30.00 | 22.00–45.00 |
| | 30 | 29.79 / 29.33 | 21.47–40.80 | 10 | 28.74 / 27.40 | 22.00–38.95 |
| Annual Salary 32–40 hrs/wk 40 hrs/wk | 37 | 60,079 / 60,008 | 42,765–84,864 | 17 | 63,934 / 62,400 | 45,760–93,600 |
| | 30 | 61,956 / 61,006 | 44,658–84,864 | 10 | 59,772 / 56,992 | 45,760–81,016 |

TABLE 3.
Caseload of Social Workers in Outpatient Dialysis Settings by
End-Stage Renal Disease (ESRD) Network
(See Figure 1. Map of ESRD Networks)

| ESRD Network | 2010 | | | 2014 | | |
|------------------|----------|-----------------|--------|----------|-----------------|--------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Network 1 | | | | | | |
| 20–31 hrs/wk | 12 | 72.67 / 75.00 | 40–90 | 4 | 84.25 / 98.50 | 40–100 |
| 32–40 hrs/wk | 40 | 111.38 / 115.00 | 53–150 | 11 | 90.90 / 92.01 | 1–161 |
| 40 hrs/wk | 25 | 121.44 / 120.00 | 70–150 | 10 | 92.00 / 110.00 | 1–161 |
| Network 2 | | | | | | |
| 20–31 hrs/wk | 8 | 83.50 / 83.50 | 64–117 | 3 | 114.00 / 72.00 | 65–205 |
| 32–40 hrs/wk | 32 | 114.69 / 110.00 | 64–188 | 16 | 98.50 / 109.50 | 32–135 |
| 40 hrs/wk | 25 | 117.04 / 110.00 | 64–188 | 12 | 95.67/101.00 | 32–135 |
| Network 3 | | | | | | |
| 20–31 hrs/wk | 14 | 97.71 / 95.00 | 43–167 | 2 | 75.00 / 75.00 | 24–126 |
| 32–40 hrs/wk | 36 | 123.58 / 120.00 | 75–200 | 10 | 115.10 / 112.50 | 65–187 |
| 40 hrs/wk | 24 | 127.37 / 120.00 | 80–200 | 6 | 118.33 / 116.00 | 65–187 |
| Network 4 | | | | | | |
| 20–31 hrs/wk | 12 | 68.83 / 69.50 | 30–100 | 6 | 66.67 / 67.50 | 39–92 |
| 32–40 hrs/wk | 55 | 125.02 / 120.00 | 25–262 | 8 | 99.63 / 107.50 | 17–140 |
| 40 hrs/wk | 43 | 133.63 / 125.00 | 70–262 | 4 | 88.00 / 97.50 | 17–140 |
| Network 5 | | | | | | |
| 20–31 hrs/wk | 21 | 76.38 / 79.00 | 26–140 | 2 | 37.00 / 37.00 | 20–54 |
| 32–40 hrs/wk | 75 | 119.51 / 120.00 | 68–200 | 12 | 111.92 / 105.00 | 72–155 |
| 40 hrs/wk | 52 | 126.23 / 127.50 | 80–200 | 11 | 115.55 / 105.00 | 88–155 |
| Network 6 | | | | | | |
| 20–31 hrs/wk | 16 | 83.81 / 78.50 | 50–140 | 2 | 77.00 / 77.00 | 54–100 |
| 32–40 hrs/wk | 110 | 126.58 / 130.00 | 60–240 | 24 | 117.88 / 116.00 | 26–180 |
| 40 hrs/wk | 89 | 133.98 / 132.00 | 69–240 | 15 | 121.73 / 130.00 | 26–180 |
| Network 7 | | | | | | |
| 20–31 hrs/wk | 4 | 97.50 / 102.50 | 60–125 | 1 | 150.00 | — |
| 32–40 hrs/wk | 54 | 127.44 / 129.50 | 66–175 | 18 | 108.61 / 121.00 | 8–180 |
| 40 hrs/wk | 46 | 130.24 / 135.00 | 66–175 | 13 | 111.92 / 125.00 | 8–180 |

TABLE 3.
Caseload of Social Workers in Outpatient Dialysis Settings by
End-Stage Renal Disease (ESRD) Network
(See Figure 1. Map of ESRD Networks)

| ESRD Network | 2010 | | | 2014 | | |
|-------------------|----------|-----------------|--------|----------|-----------------|--------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Network 8 | | | | | | |
| 20–31 hrs/wk | 4 | 85.00 / 92.00 | 54–102 | 4 | 101.00 / 92.50 | 79–140 |
| 32–40 hrs/wk | 42 | 135.31 / 135.00 | 70–225 | 25 | 127.88 / 135.00 | 1–240 |
| 40 hrs/wk | 41 | 134.22 / 135.00 | 70–225 | 22 | 135.95 / 139.00 | 75–240 |
| Network 9 | | | | | | |
| 20–31 hrs/wk | 14 | 66.00 / 70.00 | 30–90 | 12 | 85.33 / 83.00 | 49–125 |
| 32–40 hrs/wk | 89 | 121.25 / 125.00 | 1–190 | 38 | 114.58 / 117.50 | 5–223 |
| 40 hrs/wk | 74 | 124.15 / 129.00 | 1–190 | 30 | 112.27 / 120.50 | 5–170 |
| Network 10 | | | | | | |
| 20–31 hrs/wk | 8 | 78.50 / 83.00 | 40–105 | 0 | — | — |
| 32–40 hrs/wk | 30 | 119.90 / 120.00 | 50–166 | 22 | 96.36 / 106.00 | 5–140 |
| 40 hrs/wk | 23 | 129.65 / 125.00 | 70–166 | 20 | 95.75 / 106.00 | 5–140 |
| Network 11 | | | | | | |
| 20–31 hrs/wk | 20 | 74.55 / 78.50 | 43–120 | 3 | 52.67 / 54.00 | 45–59 |
| 32–40 hrs/wk | 73 | 106.15 / 105.00 | 17–173 | 45 | 100.22 / 97.00 | 1–186 |
| 40 hrs/wk | 47 | 108.89 / 110.00 | 17–173 | 34 | 100.76 / 96.50 | 20–186 |
| Network 12 | | | | | | |
| 20–31 hrs/wk | 27 | 75.78 / 75.00 | 37–120 | 6 | 79.00 / 73.00 | 40–125 |
| 32–40 hrs/wk | 69 | 109.64 / 110.00 | 50–232 | 28 | 102.25 / 96.00 | 40–300 |
| 40 hrs/wk | 51 | 115.96 / 110.00 | 60–232 | 20 | 96.60 / 97.50 | 40–150 |
| Network 13 | | | | | | |
| 20–31 hrs/wk | 4 | 76.50 / 62.00 | 47–135 | 4 | 49.75 / 47.00 | 30–75 |
| 32–40 hrs/wk | 33 | 137.36 / 135.00 | 66–300 | 10 | 113.60 / 121.00 | 72–140 |
| 40 hrs/wk | 31 | 139.61 / 135.00 | 66–300 | 10 | 113.60 / 121.00 | 72–140 |
| Network 14 | | | | | | |
| 20–31 hrs/wk | 14 | 86.29 / 80.00 | 47–210 | 0 | — | — |
| 32–40 hrs/wk | 88 | 122.82 / 110.00 | 65–711 | 14 | 106.93 / 112.00 | 57–155 |
| 40 hrs/wk | 81 | 124.72 / 110.00 | 65–711 | 12 | 114.17 / 115.00 | 72–155 |

TABLE 3.
Caseload of Social Workers in Outpatient Dialysis Settings by
End-Stage Renal Disease (ESRD) Network
(See Figure 1. Map of ESRD Networks)

| ESRD Network | 2010 | | | 2014 | | |
|-------------------|----------|-----------------|--------|----------|-----------------|----------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Network 15 | | | | | | |
| 20–31 hrs/wk | 11 | 55.45 / 65.00 | 15–75 | 0 | — | — |
| 32–40 hrs/wk | 68 | 110.47 / 113.50 | 14–200 | 7 | 98.14 / 100.00 | 65–122 |
| 40 hrs/wk | 54 | 115.52 / 122.50 | 14–200 | 5 | 99.40 / 100.00 | 65–122 |
| Network 16 | | | | | | |
| 20–31 hrs/wk | 7 | 83.14 / 80.00 | 60–110 | 7 | 55.86 / 60.00 | 16–81 |
| 32–40 hrs/wk | 37 | 108.68 / 110.00 | 9–180 | 27 | 171.04 / 118.00 | 60–1,500 |
| 40 hrs/wk | 25 | 112.52 / 120.00 | 9–180 | 21 | 193.81 / 127.00 | 97–1,500 |
| Network 17 | | | | | | |
| 20–31 hrs/wk | 8 | 79.50 / 81.50 | 53–100 | 2 | 73.00 / 73.00 | 72–74 |
| 32–40 hrs/wk | 33 | 117.18 / 121.00 | 50–151 | 12 | 87.50 / 87.50 | 29–153 |
| 40 hrs/wk | 27 | 121.89 / 125.00 | 60–151 | 7 | 103.57 / 105.00 | 29–153 |
| Network 18 | | | | | | |
| 20–31 hrs/wk | 10 | 102.00 / 100.50 | 60–180 | 9 | 80.11 / 75.00 | 63–108 |
| 32–40 hrs/wk | 68 | 136.62 / 127.50 | 61–500 | 25 | 126.84 / 132.00 | 1–254 |
| 40 hrs/wk | 54 | 141.09 / 130.00 | 72–500 | 20 | 123.95 / 131.00 | 1–254 |

TABLE 4.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by
End-Stage Renal Disease (ESRD) Network
(See Figure 1. Map of ESRD Networks)

| ESRD Network | 2010 | | | 2014 | | |
|------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Network 1 | | | | | | |
| 20–31 hrs/wk | 13 | 27.53 / 28.05 | 21.43–34.59 | 4 | 26.68 / 27.15 | 23.00–29.40 |
| 32–40 hrs/wk | 41 | 29.29 / 30.00 | 19.77–40.14 | 12 | 30.72 / 30.38 | 20.43–41.25 |
| 40 hrs/wk | 26 | 29.46 / 28.68 | 21.90–40.14 | 12 | 30.72 / 30.38 | 20.43–41.25 |
| Network 2 | | | | | | |
| 20–31 hrs/wk | 8 | 31.52 / 31.25 | 24.11–41.00 | 7 | 30.51 / 28.00 | 24.65–38.50 |
| 32–40 hrs/wk | 31 | 29.79 / 30.56 | 22.50–39.90 | 24 | 31.22 / 30.48 | 22.86–41.25 |
| 40 hrs/wk | 25 | 28.92 / 28.50 | 22.50–39.90 | 18 | 30.64 / 29.67 | 22.86–41.25 |
| Network 3 | | | | | | |
| 20–31 hrs/wk | 15 | 30.86 / 31.00 | 26.26–36.00 | 3 | 32.05 / 35.00 | 26.00–35.16 |
| 32–40 hrs/wk | 38 | 30.49 / 29.76 | 24.30–40.00 | 16 | 28.94 / 27.69 | 22.70–39.00 |
| 40 hrs/wk | 25 | 30.80 / 29.71 | 24.68–40.00 | 10 | 28.41 / 26.01 | 22.90–39.00 |
| Network 4 | | | | | | |
| 20–31 hrs/wk | 12 | 26.60 / 27.38 | 20.75–31.20 | 8 | 26.82 / 26.08 | 23.00–31.00 |
| 32–40 hrs/wk | 56 | 26.25 / 26.00 | 18.26–34.60 | 20 | 27.58 / 28.31 | 21.26–32.50 |
| 40 hrs/wk | 44 | 26.27 / 25.80 | 18.26–34.60 | 13 | 27.46 / 28.61 | 21.26–32.50 |
| Network 5 | | | | | | |
| 20–31 hrs/wk | 20 | 30.35 / 31.06 | 22.00–38.48 | 2 | 32.34 / 32.34 | 29.00–35.67 |
| 32–40 hrs/wk | 76 | 27.98 / 29.03 | 17.08–34.00 | 20 | 27.91 / 29.22 | 19.68–33.65 |
| 40 hrs/wk | 52 | 27.30 / 28.91 | 17.08–33.00 | 17 | 27.50 / 28.85 | 19.68–32.00 |
| Network 6 | | | | | | |
| 20–31 hrs/wk | 18 | 26.20 / 25.70 | 18.28–33.00 | 2 | 32.50 / 32.50 | 24.50–40.50 |
| 32–40 hrs/wk | 107 | 24.98 / 24.77 | 16.38–35.00 | 45 | 26.90 / 27.00 | 18.39–33.52 |
| 40 hrs/wk | 88 | 24.61 / 24.50 | 16.38–35.00 | 37 | 26.52 / 26.92 | 18.39–33.52 |
| Network 7 | | | | | | |
| 20–31 hrs/wk | 6 | 26.66 / 25.76 | 23.50–31.45 | 1 | 30.00 | — |
| 32–40 hrs/wk | 57 | 26.72 / 26.50 | 17.09–38.00 | 29 | 27.88 / 27.15 | 24.04–34.53 |
| 40 hrs/wk | 48 | 26.74 / 26.50 | 17.09–38.00 | 22 | 28.23 / 27.89 | 24.04–34.53 |

TABLE 4.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by
End-Stage Renal Disease (ESRD) Network
(See Figure 1. Map of ESRD Networks)

| ESRD Network | 2010 | | | 2014 | | |
|-------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Network 8 | | | | | | |
| 20–31 hrs/wk | 4 | 24.70 / 25.38 | 21.20–26.84 | 6 | 23.39 / 21.19 | 19.98–30.13 |
| 32–40 hrs/wk | 44 | 24.29 / 22.63 | 14.42–37.00 | 38 | 24.79 / 24.50 | 17.00–36.00 |
| 40 hrs/wk | 43 | 24.34 / 22.73 | 14.42–37.00 | 33 | 24.79 / 23.62 | 17.00–36.00 |
| Network 9 | | | | | | |
| 20–31 hrs/wk | 16 | 24.45 / 24.05 | 20.40–30.25 | 13 | 27.17 / 26.25 | 22.80–33.65 |
| 32–40 hrs/wk | 89 | 24.82 / 25.00 | 18.50–34.50 | 63 | 26.20 / 26.44 | 19.78–34.31 |
| 40 hrs/wk | 73 | 24.83 / 24.60 | 18.50–34.50 | 48 | 24.99 / 25.93 | 20.00–34.31 |
| Network 10 | | | | | | |
| 20–31 hrs/wk | 10 | 26.85 / 26.98 | 20.00–35.00 | 2 | 22.80 / 22.80 | 20.19–25.40 |
| 32–40 hrs/wk | 28 | 25.76 / 26.00 | 20.06–31.52 | 32 | 26.68 / 26.39 | 20.90–34.98 |
| 40 hrs/wk | 23 | 26.18 / 26.00 | 20.63–31.52 | 28 | 26.19 / 26.04 | 20.90–31.60 |
| Network 11 | | | | | | |
| 20–31 hrs/wk | 18 | 27.49 / 26.25 | 20.00–35.00 | 9 | 27.15 / 26.91 | 24.43–31.76 |
| 32–40 hrs/wk | 77 | 26.25 / 26.39 | 19.00–40.00 | 60 | 27.64 / 24.47 | 19.14–35.91 |
| 40 hrs/wk | 49 | 26.11 / 26.12 | 19.00–40.00 | 39 | 27.35 / 26.75 | 19.14–34.00 |
| Network 12 | | | | | | |
| 20–31 hrs/wk | 27 | 26.51 / 26.00 | 20.30–42.00 | 10 | 26.43 / 26.00 | 21.95–31.92 |
| 32–40 hrs/wk | 70 | 26.63 / 24.70 | 17.30–39.07 | 37 | 26.75 / 26.00 | 19.01–38.00 |
| 40 hrs/wk | 52 | 25.38 / 24.47 | 17.30–39.07 | 26 | 27.28 / 26.69 | 19.01–38.00 |
| Network 13 | | | | | | |
| 20–31 hrs/wk | 4 | 25.07 / 27.71 | 16.00–28.85 | 2 | 36.00 / 36.00 | 29.50–42.50 |
| 32–40 hrs/wk | 33 | 24.27 / 24.03 | 18.27–32.20 | 15 | 27.99 / 28.00 | 22.39–36.53 |
| 40 hrs/wk | 31 | 24.51 / 24.43 | 18.27–32.20 | 15 | 27.99 / 28.00 | 22.39–36.53 |
| Network 14 | | | | | | |
| 20–31 hrs/wk | 14 | 26.61 / 26.75 | 23.60–29.50 | 0 | — | — |
| 32–40 hrs/wk | 88 | 25.83 / 25.88 | 18.99–36.30 | 31 | 27.61 / 28.00 | 20.80–35.00 |
| 40 hrs/wk | 81 | 25.80 / 25.95 | 18.99–36.30 | 22 | 27.88 / 27.82 | 22.24–35.00 |

TABLE 4.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by
End-Stage Renal Disease (ESRD) Network
(See Figure 1. Map of ESRD Networks)

| ESRD Network | 2010 | | | 2014 | | |
|-------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Network 15 | | | | | | |
| 20–31 hrs/wk | 11 | 26.54 / 25.20 | 21.00–35.00 | 4 | 29.49 / 29.25 | 25.78–33.66 |
| 32–40 hrs/wk | 70 | 26.70 / 26.05 | 19.00–35.70 | 21 | 28.06 / 28.85 | 21.68–32.50 |
| 40 hrs/wk | 57 | 26.59 / 26.00 | 19.00–35.70 | 17 | 28.49 / 29.18 | 21.68–32.50 |
| Network 16 | | | | | | |
| 20–31 hrs/wk | 7 | 28.52 / 27.03 | 24.00–36.50 | 6 | 29.01 / 28.98 | 21.70–35.50 |
| 32–40 hrs/wk | 38 | 28.00 / 27.80 | 19.12–38.00 | 33 | 29.90 / 29.00 | 22.38–39.40 |
| 40 hrs/wk | 26 | 27.91 / 27.56 | 19.12–38.00 | 26 | 30.39 / 30.00 | 25.00–39.26 |
| Network 17 | | | | | | |
| 20–31 hrs/wk | 8 | 38.39 / 39.13 | 30.50–45.00 | 2 | 45.46 / 45.46 | 37.69–53.23 |
| 32–40 hrs/wk | 36 | 33.76 / 32.30 | 25.00–50.00 | 17 | 34.16 / 34.06 | 25.65–44.00 |
| 40 hrs/wk | 29 | 33.13 / 31.98 | 25.00–47.00 | 14 | 34.01 / 34.08 | 25.65–44.00 |
| Network 18 | | | | | | |
| 20–31 hrs/wk | 12 | 33.91 / 34.75 | 28.60–38.63 | 10 | 38.71 / 39.74 | 29.52–49.49 |
| 32–40 hrs/wk | 71 | 33.64 / 33.69 | 25.00–43.00 | 38 | 34.63 / 33.45 | 26.00–50.42 |
| 40 hrs/wk | 57 | 33.55 / 33.28 | 25.00–43.00 | 31 | 34.87 / 33.40 | 26.00–50.42 |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|-----------------------------|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Alabama | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 79.00 | — |
| 32–40 hrs/wk | 8 | 141.63 / 135.00 | 105–225 | 10 | 129.90 / 141.50 | 1–240 |
| 40 hrs/wk | 8 | 141.63 / 135.00 | 105–225 | 9 | 144.22 / 145.00 | 100–240 |
| Alaska & Montana | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 60.00 | — |
| 32–40 hrs/wk | 3 | 63.67 / 59.00 | 32–100 | 0 | — / — | — |
| 40 hrs/wk | 3 | 63.67 / 59.00 | 32–100 | 0 | — / — | — |
| Arizona | | | | | | |
| 20–31 hrs/wk | 5 | 56.60 / 65.00 | 15–75 | 0 | — / — | — |
| 32–40 hrs/wk | 27 | 121.56 / 127.00 | 67–173 | 1 | 65.00 | — |
| 40 hrs/wk | 25 | 123.40 / 130.00 | 67–173 | 1 | 65.00 | — |
| Arkansas | | | | | | |
| 20–31 hrs/wk | 1 | 47.00 | — | 2 | 52.50 / 52.50 | 30–75 |
| 32–40 hrs/wk | 5 | 157.00 / 135.00 | 102–300 | 0 | — / — | — |
| 40 hrs/wk | 3 | 193.33 / 145.00 | 135–300 | 1 | 28.00 | — |
| California | | | | | | |
| 20–31 hrs/wk | 18 | 92.00 / 85.00 | 53–180 | 11 | 78.81 / 74.00 | 63–108 |
| 32–40 hrs/wk | 92 | 132.01 / 123.00 | 50–500 | 36 | 115.72 / 130.00 | 1–254 |
| 40 hrs/wk | 72 | 137.39 / 127.50 | 72–500 | 26 | 121.12 / 131.00 | 1–254 |
| Colorado | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 55.00 | — |
| 32–40 hrs/wk | 7 | 83.57 / 70.00 | 14–160 | 0 | — / — | — |
| 40 hrs/wk | 5 | 94.20 / 125.00 | 14–160 | 0 | — / — | — |
| Connecticut | | | | | | |
| 20–31 hrs/wk | 2 | 73.50 / 73.50 | 67–80 | 0 | — / — | — |
| 32–40 hrs/wk | 12 | 116.67 / 120.00 | 80–150 | 4 | 117.75 / 115.00 | 80–161 |
| 40 hrs/wk | 9 | 128.89 / 125.00 | 110–150 | 3 | 130.33 / 120.00 | 110–161 |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|----------------------------|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| DC | | | | | | |
| 20–31 hrs/wk | 2 | 102.50 / 102.50 | 65–140 | 0 | — / — | — |
| 32–40 hrs/wk | 6 | 129.50 / 131.00 | 100–150 | 1 | 105.00 | — |
| 40 hrs/wk | 5 | 135.40 / 136.00 | 120–150 | 1 | 105.00 | — |
| Delaware | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 10 | 130.00 / 126.00 | 95–170 | 0 | — / — | — |
| 40 hrs/wk | 8 | 138.12 / 131.00 | 110–170 | 0 | — / — | — |
| Florida | | | | | | |
| 20–31 hrs/wk | 4 | 97.50 / 102.50 | 60–125 | 1 | 150.00 | — |
| 32–40 hrs/wk | 54 | 127.44 / 129.50 | 66–175 | 16 | 111.75 / 123.50 | 8–180 |
| 40 hrs/wk | 46 | 130.24 / 135.00 | 66–175 | 13 | 111.92 / 125.00 | 8–180 |
| Georgia | | | | | | |
| 20–31 hrs/wk | 8 | 89.00 / 81.00 | 50–140 | 1 | 39.00 | — |
| 32–40 hrs/wk | 43 | 109.98 / 104.00 | 60–193 | 8 | 118.13 / 121.00 | 91–145 |
| 40 hrs/wk | 27 | 120.89 / 124.00 | 69–193 | 4 | 124.75 / 131.50 | 91–145 |
| Hawaii | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 13 | 123.69 / 130.00 | 60–150 | 0 | — / — | — |
| 40 hrs/wk | 12 | 125.33 / 130.00 | 60–150 | 0 | — / — | — |
| Idaho & Wyoming | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 7 | 91.14 / 100.00 | 58–115 | 2 | 114.5 / 114.5 | 104–125 |
| 40 hrs/wk | 4 | 79.50 / 75.00 | 58–110 | 1 | 125.00 | — |
| Illinois | | | | | | |
| 20–31 hrs/wk | 8 | 78.50 / 83.00 | 40–105 | 1 | 65.00 | — |
| 32–40 hrs/wk | 30 | 119.90 / 120.00 | 50–166 | 21 | 103.95 / 102.00 | 65–165 |
| 40 hrs/wk | 23 | 129.65 / 125.00 | 70–166 | 17 | 106.18 / 102.00 | 68–165 |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|------------------|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Indiana | | | | | | |
| 20–31 hrs/wk | 6 | 66.67 / 70.00 | 30–90 | 1 | 80.00 | 80–80 |
| 32–40 hrs/wk | 38 | 118.92 / 125.00 | 1–175 | 12 | 102.00 / 120.00 | 10–133 |
| 40 hrs/wk | 32 | 122.53 / 130.00 | 1–175 | 11 | 102.73 / 120.00 | 10–133 |
| Iowa | | | | | | |
| 20–31 hrs/wk | 4 | 62.25 / 56.00 | 37–100 | 0 | — / — | — |
| 32–40 hrs/wk | 11 | 104.64 / 106.00 | 56–145 | 13 | 98.23 / 100.00 | 53–140 |
| 40 hrs/wk | 6 | 115.50 / 116.50 | 80–145 | 9 | 101.00 / 100.00 | 53–140 |
| Kansas | | | | | | |
| 20–31 hrs/wk | 4 | 95.00 / 90.00 | 80–120 | 2 | 64.50 / 64.50 | 63–66 |
| 32–40 hrs/wk | 7 | 103.14 / 100.00 | 85–125 | 2 | 89.00 / 89.00 | 85–93 |
| 40 hrs/wk | 4 | 110.50 / 115.00 | 87–125 | 0 | — / — | — |
| Kentucky | | | | | | |
| 20–31 hrs/wk | 1 | 42.00 | — | 0 | — / — | — |
| 32–40 hrs/wk | 14 | 133.00 / 137.50 | 84–190 | 11 | 120.55 / 120.00 | 70–170 |
| 40 hrs/wk | 14 | 133.00 / 137.50 | 84–190 | 8 | 134.25 / 135.00 | 70–170 |
| Louisiana | | | | | | |
| 20–31 hrs/wk | 3 | 86.33 / 74.00 | 50–135 | 1 | 40.00 | — |
| 32–40 hrs/wk | 16 | 130.56 / 135.00 | 80–160 | 4 | 104.25 / 99.50 | 78–140 |
| 40 hrs/wk | 16 | 130.56 / 135.00 | 80–160 | 4 | 104.25 / 99.50 | 78–140 |
| Maine | | | | | | |
| 20–31 hrs/wk | 1 | 40.00 | — | 1 | 100.00 | — |
| 32–40 hrs/wk | 6 | 99.67 / 100.00 | 53–130 | 1 | 86.00 | — |
| 40 hrs/wk | 2 | 120.00 / 120.00 | 110–130 | 1 | 86.00 | — |
| Maryland | | | | | | |
| 20–31 hrs/wk | 5 | 72.20 / 79.00 | 39–98 | 1 | 54.00 | — |
| 32–40 hrs/wk | 34 | 114.26 / 119.00 | 68–160 | 3 | 121.67 / 120.00 | 105–140 |
| 40 hrs/wk | 19 | 122.58 / 125.00 | 80–150 | 3 | 121.67 / 120.00 | 105–140 |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|----------------------|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Massachusetts | | | | | | |
| 20–31 hrs/wk | 6 | 72.33 / 74.00 | 60–90 | 2 | 98.50 / 98.50 | 97–100 |
| 32–40 hrs/wk | 19 | 112.74 / 110.00 | 70–150 | 2 | 59.00 / 59.00 | 1–117 |
| 40 hrs/wk | 12 | 117.17 / 120.50 | 70–145 | 2 | 59.00 / 59.00 | 1–117 |
| Michigan | | | | | | |
| 20–31 hrs/wk | 13 | 80.77 / 82.00 | 43–120 | 1 | 45.00 | — |
| 32–40 hrs/wk | 32 | 116.03 / 116.00 | 87–173 | 16 | 104.63 / 108.00 | 1–145 |
| 40 hrs/wk | 23 | 118.43 / 120.00 | 87–173 | 11 | 110.82 / 106.00 | 85–145 |
| Minnesota | | | | | | |
| 20–31 hrs/wk | 2 | 75.00 / 75.00 | 58–92 | 1 | 59.00 | — |
| 32–40 hrs/wk | 13 | 121.85 / 130.00 | 92–145 | 9 | 114.33 / 125.00 | 67–160 |
| 40 hrs/wk | 8 | 129.00 / 132.50 | 92–145 | 7 | 124.57 / 125.00 | 97–160 |
| Mississippi | | | | | | |
| 20–31 hrs/wk | 1 | 102.00 | — | 0 | — / — | — |
| 32–40 hrs/wk | 15 | 159.33 / 154.00 | 110–205 | 7 | 139.71 / 150.00 | 70–180 |
| 40 hrs/wk | 14 | 157.86 / 154.00 | 110–205 | 6 | 151.33 / 152.50 | 128–180 |
| Missouri | | | | | | |
| 20–31 hrs/wk | 15 | 74.87 / 75.00 | 48–115 | 3 | 101.67 / 100.00 | 80–125 |
| 32–40 hrs/wk | 41 | 107.76 / 110.00 | 50–150 | 12 | 94.83 / 88.50 | 40–150 |
| 40 hrs/wk | 32 | 112.31 / 110.00 | 60–150 | 11 | 95.72 / 92.00 | 40–150 |
| Nebraska | | | | | | |
| 20–31 hrs/wk | 4 | 73.50 / 69.00 | 65–91 | 1 | 40.00 | — |
| 32–40 hrs/wk | 10 | 127.40 / 114.00 | 89–232 | 2 | 205.00 / 205.00 | 110–130 |
| 40 hrs/wk | 9 | 131.67 / 118.00 | 100–232 | 1 | 110.00 | — |
| Nevada | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 55.00 | — |
| 32–40 hrs/wk | 13 | 110.54 / 125.00 | 50–150 | 0 | — / — | — |
| 40 hrs/wk | 7 | 125.29 / 132.00 | 50–150 | 0 | — / — | — |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|--|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| New Hampshire & Vermont | | | | | | |
| 20–31 hrs/wk | 3 | 83.67 / 84.00 | 80–87 | 0 | — / — | — |
| 32–40 hrs/wk | 2 | 97.50 / 97.50 | 85–110 | 3 | 96.67 / 110.00 | 60–120 |
| 40 hrs/wk | 1 | 110.00 | — | 3 | 96.67 / 110.00 | 60–120 |
| New Jersey | | | | | | |
| 20–31 hrs/wk | 14 | 97.71 / 95.00 | 43–167 | 2 | 75.00 | 24–126 |
| 32–40 hrs/wk | 36 | 123.58 / 120.00 | 75–200 | 8 | 123.25 / 128.50 | 85–187 |
| 40 hrs/wk | 24 | 127.37 / 120.00 | 80–200 | 4 | 136.25 / 133.50 | 91–187 |
| New Mexico | | | | | | |
| 20–31 hrs/wk | 4 | 66.75 / 67.50 | 60–72 | 0 | — / — | — |
| 32–40 hrs/wk | 10 | 113.10 / 112.50 | 90–135 | 2 | 111.00 / 111.00 | 100–122 |
| 40 hrs/wk | 7 | 118.29 / 115.00 | 108–135 | 2 | 111.00 / 111.00 | 100–122 |
| New York | | | | | | |
| 20–31 hrs/wk | 8 | 83.50 / 83.50 | 64–117 | 3 | 114.00 / 72.00 | 65–205 |
| 32–40 hrs/wk | 32 | 114.69 / 110.00 | 64–188 | 16 | 97.500 / 105.00 | 32–135 |
| 40 hrs/wk | 25 | 117.04 / 110.00 | 64–188 | 12 | 86.00 / 95.50 | 4–135 |
| North Carolina | | | | | | |
| 20–31 hrs/wk | 3 | 70.33 / 75.00 | 57–79 | 0 | — / — | — |
| 32–40 hrs/wk | 28 | 128.14 / 130.00 | 95–165 | 2 | 111.00 / 111.00 | 110–112 |
| 40 hrs/wk | 26 | 129.04 / 130.00 | 95–165 | 2 | 111.00 / 111.00 | 110–112 |
| North Dakota & South Dakota | | | | | | |
| 20–31 hrs/wk | 1 | 54.00 | — | 0 | — / — | — |
| 32–40 hrs/wk | 8 | 73.88 / 76.00 | 17–113 | 6 | 70.25 / 76.50 | 20–100 |
| 40 hrs/wk | 5 | 77.00 / 82.00 | 17–113 | 6 | 70.25 / 76.50 | 20–100 |
| Ohio | | | | | | |
| 20–31 hrs/wk | 7 | 68.86 / 75.00 | 40–87 | 9 | 88.78 / 91.00 | 49–125 |
| 32–40 hrs/wk | 37 | 119.19 / 120.00 | 70–180 | 21 | 108.19 / 120.00 | 5–233 |
| 40 hrs/wk | 28 | 121.57 / 125.00 | 70–180 | 19 | 102.21 / 115.00 | 5–155 |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|-----------------------|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Oklahoma | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 54.00 | — |
| 32–40 hrs/wk | 12 | 138.25 / 142.50 | 66–170 | 4 | 114.25 / 122.50 | 72–140 |
| 40 hrs/wk | 12 | 138.25 / 142.50 | 66–170 | 4 | 114.25 / 122.50 | 72–140 |
| Oregon | | | | | | |
| 20–31 hrs/wk | 2 | 80.00 / 80.00 | 60–100 | 3 | 64.33 / 70.00 | 42–81 |
| 32–40 hrs/wk | 10 | 109.50 / 121.50 | 9–165 | 8 | 133.38 / 139.50 | 80–160 |
| 40 hrs/wk | 7 | 113.00 / 125.00 | 9–165 | 7 | 141.00 / 144.00 | 127–160 |
| Pennsylvania | | | | | | |
| 20–31 hrs/wk | 12 | 68.83 / 69.50 | 30–100 | 5 | 72.20 / 75.00 | 50–92 |
| 32–40 hrs/wk | 45 | 123.91 / 120.00 | 25–262 | 8 | 99.63 / 107.50 | 17–140 |
| 40 hrs/wk | 35 | 132.60 / 121.00 | 70–262 | 4 | 88.00 / 97.50 | 17–140 |
| Rhode Island | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 40.00 | — |
| 32–40 hrs/wk | 1 | 120.00 | — | 2 | 78.50 / 78.50 | 35–122 |
| 40 hrs/wk | 1 | 120.00 | — | 2 | 78.50 / 78.50 | 35–122 |
| South Carolina | | | | | | |
| 20–31 hrs/wk | 5 | 83.60 / 80.00 | 65–112 | 2 | 77.00 / 77.00 | 54–100 |
| 32–40 hrs/wk | 39 | 143.77 / 140.00 | 98–240 | 14 | 118.71 / 120.00 | 26–180 |
| 40 hrs/wk | 36 | 147.36 / 145.50 | 105–240 | 9 | 122.78 / 139.00 | 26–180 |
| Tennessee | | | | | | |
| 20–31 hrs/wk | 3 | 79.33 / 90.00 | 54–94 | 3 | 108.33 / 95.00 | 90–140 |
| 32–40 hrs/wk | 19 | 113.68 / 119.00 | 70–170 | 8 | 115.00 / 122.50 | 75–142 |
| 40 hrs/wk | 19 | 113.68 / 119.00 | 70–170 | 7 | 112.14 / 110.00 | 75–142 |
| Texas | | | | | | |
| 20–31 hrs/wk | 14 | 86.29 / 80.00 | 47–210 | 0 | — / — | — |
| 32–40 hrs/wk | 88 | 122.82 / 110.00 | 65–711 | 14 | 106.93 / 112.00 | 57–155 |
| 40 hrs/wk | 81 | 124.72 / 110.00 | 65–711 | 12 | 114.17 / 115.00 | 72–155 |

TABLE 5.
Caseload of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|-----------------------|----------|-----------------|---------|----------|-----------------|---------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| U.S. Territory | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 0 | — / — | — | 2 | 67.50 / 67.50 | 65–70 |
| 40 hrs/wk | 0 | — / — | — | 2 | 67.50 / 67.50 | 65–70 |
| Utah | | | | | | |
| 20–31 hrs/wk | 2 | 30.00 / 30.00 | 25–35 | 0 | — / — | — |
| 32–40 hrs/wk | 11 | 97.91 / 95.00 | 52–200 | 4 | 100.00 / 105.00 | 80–110 |
| 40 hrs/wk | 10 | 97.70 / 92.50 | 52–200 | 2 | 105.00 / 105.00 | 100–110 |
| Virginia | | | | | | |
| 20–31 hrs/wk | 12 | 71.08 / 65.00 | 26–100 | 2 | 30.00 / 30.00 | 20–40 |
| 32–40 hrs/wk | 32 | 120.34 / 120.00 | 72–157 | 4 | 110.25 / 112.00 | 72–145 |
| 40 hrs/wk | 25 | 124.32 / 128.00 | 88–157 | 3 | 123.00 / 124.00 | 100–145 |
| Washington | | | | | | |
| 20–31 hrs/wk | 5 | 84.40 / 80.00 | 65–110 | 3 | 46.00 / 60.00 | 16–62 |
| 32–40 hrs/wk | 17 | 123.35 / 112.00 | 85–180 | 17 | 194.53 / 112.00 | 60–1500 |
| 40 hrs/wk | 11 | 137.55 / 140.00 | 110–180 | 13 | 226.38 / 115.00 | 97–1500 |
| West Virginia | | | | | | |
| 20–31 hrs/wk | 2 | 92.50 / 92.50 | 80–105 | 0 | — / — | — |
| 32–40 hrs/wk | 3 | 150.00 / 150.00 | 100–200 | 3 | 92.33 / 89.00 | 88–100 |
| 40 hrs/wk | 3 | 150.00 / 150.00 | 100–200 | 3 | 92.33 / 89.00 | 88–100 |
| Wisconsin | | | | | | |
| 20–31 hrs/wk | 4 | 59.25 / 56.00 | 48–77 | 1 | 54 | — |
| 32–40 hrs/wk | 20 | 93.05 / 90.00 | 30–170 | 13 | 100.15 / 87.00 | 71–186 |
| 40 hrs/wk | 11 | 88.82 / 90.00 | 30–135 | 10 | 92.30 / 83.50 | 71–186 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|-----------------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Alabama | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 2 | 21.13 / 21.25 | 20.36–21.89 |
| 32–40 hrs/wk | 9 | 23.31 / 22.00 | 20.00–27.88 | 17 | 24.99 / 24.50 | 17.00–36.00 |
| 40 hrs/wk | 9 | 23.31 / 22.00 | 20.00–27.88 | 15 | 24.79 / 23.62 | 17.00–36.00 |
| Alaska & Montana | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 26.71 | — |
| 32–40 hrs/wk | 3 | 26.21 / 27.00 | 19.12–32.50 | 3 | 29.67 / 29.67 | 27.59–35.00 |
| 40 hrs/wk | 3 | 26.21 / 27.00 | 19.12–32.50 | 3 | 29.67 / 29.67 | 27.59–35.00 |
| Arizona | | | | | | |
| 20–31 hrs/wk | 5 | 27.99 / 27.00 | 24.00–35.00 | 1 | 25.78 | — |
| 32–40 hrs/wk | 29 | 25.95 / 26.00 | 19.75–33.10 | 7 | 28.37 / 28.50 | 23.40–31.67 |
| 40 hrs/wk | 27 | 25.78 / 25.90 | 19.75–33.10 | 7 | 28.37 / 28.50 | 23.40–31.67 |
| Arkansas | | | | | | |
| 20–31 hrs/wk | 1 | 27.61 | — | 1 | 42.50 | — |
| 32–40 hrs/wk | 5 | 21.62 / 21.00 | 18.27–26.85 | 1 | 23.04 | — |
| 40 hrs/wk | 3 | 22.37 / 22.00 | 18.27–26.85 | 2 | 22.52 / 22.52 | 22.00–23.04 |
| California | | | | | | |
| 20–31 hrs/wk | 21 | 35.41 / 35.50 | 28.60–45.00 | 12 | 39.83 / 39.75 | 29.52–53.23 |
| 32–40 hrs/wk | 97 | 34.27 / 34.00 | 25.00–50.00 | 52 | 34.60 / 33.98 | 25.00–50.42 |
| 40 hrs/wk | 76 | 34.05 / 34.00 | 25.00–47.00 | 45 | 34.76 / 33.95 | 25.00–50.42 |
| Colorado | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 2 | 30.58 / 30.58 | 27.50–33.66 |
| 32–40 hrs/wk | 7 | 27.99 / 29.50 | 20.80–35.70 | 1 | 31.73 | — |
| 40 hrs/wk | 5 | 28.82 / 29.50 | 22.85–35.70 | 1 | 31.73 | — |
| Connecticut | | | | | | |
| 20–31 hrs/wk | 2 | 32.10 / 32.10 | 29.60–34.59 | 0 | — / — | — |
| 32–40 hrs/wk | 12 | 33.48 / 33.49 | 27.00–40.14 | 5 | 33.50 / 35.35 | 30.00–41.25 |
| 40 hrs/wk | 9 | 33.58 / 34.00 | 27.00–40.14 | 5 | 33.50 / 35.35 | 30.00–41.25 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|----------------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| DC | | | | | | |
| 20–31 hrs/wk | 2 | 31.75 / 31.75 | 30.50–33.00 | 0 | — / — | — |
| 32–40 hrs/wk | 6 | 29.84 / 30.18 | 26.57–31.63 | 2 | 26.71 / 26.71 | 25.60–27.81 |
| 40 hrs/wk | 5 | 29.81 / 30.35 | 26.57–31.63 | 2 | 26.71 / 26.71 | 25.60–27.81 |
| Delaware | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 9 | 24.77 / 24.35 | 18.50–29.50 | 2 | 28.20 / 28.20 | 27.69–28.70 |
| 40 hrs/wk | 7 | 24.99 / 24.35 | 22.95–26.85 | 0 | — / — | — |
| Florida | | | | | | |
| 20–31 hrs/wk | 6 | 26.66 / 25.76 | 23.50–31.45 | 1 | 30.00 | — |
| 32–40 hrs/wk | 57 | 26.72 / 26.50 | 17.09–38.00 | 25 | 27.89 / 27.50 | 24.04–34.53 |
| 40 hrs/wk | 48 | 26.74 / 26.50 | 17.09–38.00 | 21 | 28.30 / 27.90 | 24.04–34.53 |
| Georgia | | | | | | |
| 20–31 hrs/wk | 8 | 27.93 / 26.75 | 22.40–33.00 | 1 | 23.00 | — |
| 32–40 hrs/wk | 42 | 25.81 / 25.32 | 16.38–35.00 | 15 | 26.74 / 27.00 | 18.39–33.52 |
| 40 hrs/wk | 28 | 25.07 / 24.53 | 16.38–35.00 | 12 | 25.89 / 26.42 | 18.39–33.52 |
| Hawaii | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 15 | 29.32 / 29.47 | 25.00–31.98 | 3 | 31.65 / 30.75 | 30.15–34.06 |
| 40 hrs/wk | 14 | 29.41 / 29.60 | 25.00–31.98 | 3 | 31.65 / 30.75 | 30.15–34.06 |
| Idaho & Wyoming | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 7 | 25.23 / 24.50 | 22.00–31.59 | 2 | 26.87 / 26.87 | 23.75–30.00 |
| 40 hrs/wk | 4 | 24.25 / 24.25 | 23.50–25.00 | 1 | 30.00 | — |
| Illinois | | | | | | |
| 20–31 hrs/wk | 10 | 26.85 / 26.98 | 20.00–35.00 | 4 | 29.96 / 30.40 | 25.40–33.65 |
| 32–40 hrs/wk | 28 | 25.76 / 26.00 | 20.06–31.52 | 34 | 27.11 / 27.20 | 20.19–34.00 |
| 40 hrs/wk | 23 | 26.18 / 26.00 | 20.63–31.52 | 27 | 26.86 / 27.00 | 20.19–34.00 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Indiana | | | | | | |
| 20–31 hrs/wk | 6 | 25.31 / 24.80 | 21.00–30.25 | 2 | 23.90 / 23.90 | 22.80–25.00 |
| 32–40 hrs/wk | 38 | 24.61 / 24.80 | 19.23–31.75 | 26 | 26.03 / 24.82 | 20.00–39.00 |
| 40 hrs/wk | 31 | 24.66 / 24.60 | 19.23–31.75 | 23 | 25.38 / 24.60 | 20.00–39.00 |
| Iowa | | | | | | |
| 20–31 hrs/wk | 4 | 28.07 / 26.98 | 20.32–38.00 | 3 | 25.83 / 26.00 | 24.04–27.46 |
| 32–40 hrs/wk | 10 | 23.18 / 23.61 | 20.28–26.25 | 15 | 27.51 / 26.00 | 21.00–38.00 |
| 40 hrs/wk | 6 | 21.91 / 21.35 | 20.28–24.00 | 12 | 27.97 / 27.41 | 21.00–38.00 |
| Kansas | | | | | | |
| 20–31 hrs/wk | 3 | 30.96 / 28.87 | 22.00–42.00 | 3 | 26.29 / 25.00 | 21.95–31.92 |
| 32–40 hrs/wk | 8 | 26.18 / 25.26 | 20.00–33.00 | 3 | 25.62 / 24.64 | 24.50–27.70 |
| 40 hrs/wk | 5 | 27.20 / 25.88 | 20.00–33.00 | 2 | 26.10 / 26.10 | 24.50–27.70 |
| Kentucky | | | | | | |
| 20–31 hrs/wk | 2 | 22.63 / 22.63 | 22.25–23.00 | 0 | — / — | — |
| 32–40 hrs/wk | 14 | 24.98 / 24.47 | 18.94–34.50 | 13 | 24.69 / 25.50 | 19.78–28.00 |
| 40 hrs/wk | 14 | 24.98 / 24.47 | 18.94–34.50 | 9 | 24.69 / 25.00 | 21.50–27.00 |
| Louisiana | | | | | | |
| 20–31 hrs/wk | 3 | 24.22 / 27.80 | 16.00–28.85 | 0 | — / — | — |
| 32–40 hrs/wk | 16 | 23.77 / 23.55 | 19.25–32.20 | 6 | 25.98 / 25.35 | 22.39–30.45 |
| 40 hrs/wk | 16 | 23.77 / 23.55 | 19.25–32.20 | 8 | 26.74 / 25.35 | 22.39–35.00 |
| Maine | | | | | | |
| 20–31 hrs/wk | 1 | 28.00 | — | 1 | 23.00 | — |
| 32–40 hrs/wk | 6 | 25.52 / 27.13 | 19.77–31.11 | 1 | 20.43 | — |
| 40 hrs/wk | 2 | 27.38 / 27.38 | 27.26–27.50 | 1 | 20.43 | — |
| Maryland | | | | | | |
| 20–31 hrs/wk | 5 | 31.95 / 32.25 | 29.40–33.29 | 1 | 35.67 | — |
| 32–40 hrs/wk | 34 | 29.10 / 29.69 | 20.43–34.00 | 4 | 31.97 / 31.60 | 31.00–33.65 |
| 40 hrs/wk | 18 | 28.60 / 29.34 | 20.43–32.29 | 3 | 35.70 / 32.00 | 31.21–43.89 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|----------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Massachusetts | | | | | | |
| 20–31 hrs/wk | 6 | 28.40 / 28.53 | 27.00–29.30 | 2 | 29.35 / 29.35 | 29.30–29.40 |
| 32–40 hrs/wk | 19 | 27.63 / 28.01 | 21.90–33.00 | 2 | 32.47 / 32.47 | 27.95–37.00 |
| 40 hrs/wk | 12 | 26.50 / 25.30 | 21.90–33.00 | 2 | 32.47 / 32.47 | 27.95–37.00 |
| Michigan | | | | | | |
| 20–31 hrs/wk | 12 | 27.06 / 26.25 | 20.00–35.00 | 3 | 28.07 / 27.73 | 26.97–29.50 |
| 32–40 hrs/wk | 33 | 27.76 / 27.35 | 21.57–40.00 | 22 | 29.28 / 29.08 | 23.50–35.91 |
| 40 hrs/wk | 24 | 27.80 / 27.39 | 21.57–40.00 | 16 | 29.23 / 29.08 | 24.45–34.00 |
| Minnesota | | | | | | |
| 20–31 hrs/wk | 1 | 25.00 | — | 1 | 25.75 | — |
| 32–40 hrs/wk | 15 | 25.91 / 26.44 | 22.00–30.05 | 16 | 26.98 / 26.99 | 23.00–33.00 |
| 40 hrs/wk | 9 | 24.53 / 23.32 | 22.00–30.05 | 13 | 27.56 / 26.67 | 23.10–36.40 |
| Mississippi | | | | | | |
| 20–31 hrs/wk | 1 | 24.00 | — | 0 | — / — | — |
| 32–40 hrs/wk | 15 | 22.13 / 22.00 | 20.00–25.96 | 10 | 23.79 / 23.50 | 19.23–29.00 |
| 40 hrs/wk | 14 | 22.12 / 21.97 | 20.00–25.96 | 8 | 24.12 / 23.69 | 19.23–29.00 |
| Missouri | | | | | | |
| 20–31 hrs/wk | 15 | 25.65 / 26.30 | 20.30–30.00 | 3 | 28.00 / 28.00 | 26.00–30.00 |
| 32–40 hrs/wk | 42 | 25.01 / 24.56 | 17.30–35.00 | 18 | 26.69 / 26.70 | 19.01–34.88 |
| 40 hrs/wk | 32 | 24.35 / 24.04 | 17.30–35.00 | 13 | 26.98 / 27.04 | 19.01–34.88 |
| Nebraska | | | | | | |
| 20–31 hrs/wk | 5 | 25.16 / 25.00 | 21.50–30.77 | 1 | 24.00 | — |
| 32–40 hrs/wk | 10 | 30.19 / 28.51 | 23.08–39.07 | 3 | 29.70 / 26.20 | 25.77–37.14 |
| 40 hrs/wk | 9 | 30.35 / 28.22 | 23.08–39.07 | 2 | 31.45 / 31.45 | 25.77–37.14 |
| Nevada | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 31.00 | — |
| 32–40 hrs/wk | 13 | 29.16 / 28.48 | 25.00–35.00 | 3 | 28.25 / 29.50 | 25.00–30.25 |
| 40 hrs/wk | 8 | 29.54 / 28.49 | 27.00–35.00 | 2 | 27.25 / 27.25 | 25.00–29.50 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|--|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| New Hampshire & Vermont | | | | | | |
| 20–31 hrs/wk | 4 | 23.83 / 23.75 | 21.43–26.39 | 1 | 25.00 | — |
| 32–40 hrs/wk | 2 | 27.50 / 27.50 | 25.00–30.00 | 3 | 25.01 / 26.23 | 22.35–26.44 |
| 40 hrs/wk | 1 | 25.00 | — | 3 | 25.01 / 26.23 | 22.35–26.44 |
| New Jersey | | | | | | |
| 20–31 hrs/wk | 15 | 30.86 / 31.00 | 26.26–36.00 | 3 | 32.05 / 35.00 | 26.00–35.16 |
| 32–40 hrs/wk | 38 | 30.49 / 29.76 | 24.30–40.00 | 13 | 28.46 / 26.87 | 22.70–36.60 |
| 40 hrs/wk | 25 | 30.80 / 29.71 | 24.68–40.00 | 8 | 27.76 / 26.01 | 22.90–36.60 |
| New Mexico | | | | | | |
| 20–31 hrs/wk | 4 | 25.95 / 24.90 | 24.38–29.60 | 0 | — / — | — |
| 32–40 hrs/wk | 10 | 26.40 / 25.75 | 23.48–34.00 | 4 | 28.94 / 29.05 | 28.00–29.64 |
| 40 hrs/wk | 7 | 27.25 / 26.10 | 24.75–34.00 | 4 | 28.94 / 29.05 | 28.00–29.64 |
| New York | | | | | | |
| 20–31 hrs/wk | 8 | 31.52 / 31.25 | 24.11–41.00 | 7 | 30.51 / 28.00 | 24.65–38.50 |
| 32–40 hrs/wk | 31 | 29.79 / 30.56 | 22.50–39.90 | 26 | 31.33 / 30.88 | 22.86–41.25 |
| 40 hrs/wk | 25 | 28.92 / 28.50 | 22.50–39.90 | 21 | 30.39 / 29.80 | 22.86–41.25 |
| North Carolina | | | | | | |
| 20–31 hrs/wk | 3 | 24.92 / 25.00 | 24.00–25.75 | 0 | — / — | — |
| 32–40 hrs/wk | 28 | 24.56 / 24.95 | 18.50–29.70 | 9 | 27.39 / 26.49 | 24.41–31.25 |
| 40 hrs/wk | 26 | 24.44 / 24.82 | 18.50–29.70 | 10 | 26.82 / 26.49 | 21.63–31.25 |
| North Dakota & South Dakota | | | | | | |
| 20–31 hrs/wk | 1 | 25.00 | — | 1 | 25.12 | — |
| 32–40 hrs/wk | 8 | 23.64 / 23.06 | 19.36–29.35 | 5 | 26.33 / 24.97 | 19.14–33.74 |
| 40 hrs/wk | 5 | 23.23 / 22.85 | 19.36–29.35 | 5 | 26.33 / 24.97 | 19.14–33.74 |
| Ohio | | | | | | |
| 20–31 hrs/wk | 8 | 24.26 / 24.17 | 20.40–30.00 | 9 | 25.65 / 25.00 | 20.19–32.00 |
| 32–40 hrs/wk | 37 | 24.97 / 25.00 | 18.50–33.00 | 27 | 26.99 / 27.04 | 21.63–34.31 |
| 40 hrs/wk | 28 | 24.95 / 24.70 | 18.50–33.00 | 22 | 26.73 / 26.83 | 21.63–34.31 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|-----------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| Oklahoma | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 1 | 29.50 | — |
| 32–40 hrs/wk | 12 | 26.05 / 25.74 | 21.80–30.40 | 6 | 28.32 / 28.71 | 23.75–32.63 |
| 40 hrs/wk | 12 | 26.05 / 25.74 | 21.80–30.40 | 7 | 28.27 / 28.70 | 23.75–32.63 |
| Oregon | | | | | | |
| 20–31 hrs/wk | 2 | 27.02 / 27.02 | 27.00–27.03 | 2 | 32.08 / 31.25 | 31.25–32.90 |
| 32–40 hrs/wk | 9 | 29.96 / 28.93 | 25.98–33.57 | 9 | 28.99 / 30.00 | 22.38–34.16 |
| 40 hrs/wk | 7 | 30.48 / 31.31 | 25.98–33.57 | 8 | 29.82 / 30.24 | 25.27–34.16 |
| Pennsylvania | | | | | | |
| 20–31 hrs/wk | 12 | 26.60 / 27.38 | 20.75–31.20 | 7 | 27.37 / 27.15 | 23.00–31.00 |
| 32–40 hrs/wk | 47 | 26.53 / 26.00 | 18.26–34.60 | 18 | 27.51 / 28.31 | 21.26–32.50 |
| 40 hrs/wk | 37 | 26.52 / 26.00 | 18.26–34.60 | 13 | 27.46 / 28.61 | 21.26–32.50 |
| Rhode Island | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 2 | 33.00 / 33.00 | 30.00–36.00 | 1 | 36.53 | — |
| 40 hrs/wk | 2 | 33.00 / 33.00 | 30.00–36.00 | 1 | 36.53 | — |
| South Carolina | | | | | | |
| 20–31 hrs/wk | 7 | 24.79 / 25.60 | 18.28–32.00 | 2 | 32.50 / 32.50 | 24.50–40.50 |
| 32–40 hrs/wk | 37 | 24.35 / 24.00 | 18.31–33.60 | 22 | 26.72 / 27.46 | 21.00–31.25 |
| 40 hrs/wk | 34 | 24.36 / 23.95 | 18.31–33.60 | 18 | 26.31 / 26.94 | 21.00–31.25 |
| Tennessee | | | | | | |
| 20–31 hrs/wk | 3 | 24.93 / 26.75 | 21.20–26.84 | 4 | 24.52 / 24.00 | 19.98–30.15 |
| 32–40 hrs/wk | 20 | 26.36 / 26.65 | 14.42–37.00 | 11 | 25.38 / 25.07 | 21.89–29.65 |
| 40 hrs/wk | 20 | 26.36 / 26.65 | 14.42–37.00 | 10 | 25.32 / 24.04 | 21.89–29.65 |
| Texas | | | | | | |
| 20–31 hrs/wk | 14 | 26.61 / 26.75 | 23.60–29.50 | 0 | — / — | — |
| 32–40 hrs/wk | 88 | 25.83 / 25.88 | 18.99–36.30 | 31 | 27.61 / 28.00 | 20.80–35.00 |
| 40 hrs/wk | 81 | 25.80 / 25.95 | 18.99–36.30 | 23 | 27.83 / 27.63 | 22.24–35.00 |

TABLE 6.
Hourly Wage of Social Workers in Outpatient Dialysis Settings by State

| State | 2010 | | | 2014 | | |
|-----------------------|----------|---------------|-------------|----------|---------------|-------------|
| | <i>n</i> | Mean / Median | Range | <i>n</i> | Mean / Median | Range |
| U.S. Territory | | | | | | |
| 20–31 hrs/wk | 0 | — / — | — | 0 | — / — | — |
| 32–40 hrs/wk | 0 | — / — | — | 3 | 25.73 / 25.73 | 23.00–31.25 |
| 40 hrs/wk | 0 | — / — | — | 3 | 25.73 / 25.73 | 23.00–31.25 |
| Utah | | | | | | |
| 20–31 hrs/wk | 2 | 24.13 / 24.13 | 21.00–27.25 | 0 | — / — | — |
| 32–40 hrs/wk | 11 | 25.21 / 25.96 | 19.00–30.00 | 6 | 26.40 / 25.60 | 21.68–32.50 |
| 40 hrs/wk | 10 | 24.85 / 25.48 | 19.00–30.00 | 3 | 27.89 / 29.50 | 21.68–32.50 |
| Virginia | | | | | | |
| 20–31 hrs/wk | 11 | 30.15 / 29.35 | 24.00–38.48 | 2 | 29.00 / 29.00 | 29.00–29.00 |
| 32–40 hrs/wk | 33 | 26.83 / 28.00 | 17.08–33.00 | 9 | 29.09 / 29.81 | 24.40–32.00 |
| 40 hrs/wk | 26 | 26.27 / 26.12 | 17.08–33.00 | 7 | 29.27 / 29.81 | 24.40–31.14 |
| Washington | | | | | | |
| 20–31 hrs/wk | 5 | 29.12 / 29.00 | 24.00–36.50 | 3 | 27.73 / 26.00 | 21.70–35.50 |
| 32–40 hrs/wk | 19 | 28.37 / 27.62 | 20.99–38.00 | 18 | 30.68 / 30.00 | 25.00–39.40 |
| 40 hrs/wk | 12 | 28.05 / 27.56 | 22.20–38.00 | 14 | 31.49 / 31.38 | 25.75–39.26 |
| West Virginia | | | | | | |
| 20–31 hrs/wk | 2 | 26.02 / 26.02 | 22.00–30.03 | 0 | — / — | — |
| 32–40 hrs/wk | 3 | 24.26 / 24.13 | 18.30–30.35 | 3 | 21.59 / 22.45 | 19.68–22.65 |
| 40 hrs/wk | 3 | 24.26 / 24.13 | 18.30–30.35 | 3 | 21.59 / 22.45 | 19.68–22.65 |
| Wisconsin | | | | | | |
| 20–31 hrs/wk | 4 | 30.00 / 29.93 | 26.00–34.15 | 4 | 27.33 / 26.56 | 24.43–31.76 |
| 32–40 hrs/wk | 21 | 25.10 / 26.12 | 19.00–31.00 | 18 | 26.53 / 25.03 | 22.00–32.32 |
| 40 hrs/wk | 11 | 25.01 / 26.12 | 19.00–29.29 | 11 | 27.09 / 26.75 | 22.00–32.32 |

NATIONAL KIDNEY FOUNDATION 2015 SPRING CLINICAL MEETINGS ABSTRACTS MARCH 25–29, 2015

CKD-ESRD—Other

3. **“Talking Control” As a Method to Improve Patient Satisfaction with Staff Communication in the Dialysis Setting**
DeeDee Velasquez-Peralta, Anna Ramirez. Heartland Kidney Network, Kansas City, MO, USA

Other

1. **Symptom Targeted Intervention Decreased Missed Treatments in Hemodialysis Patients**
Shaun Boyd,¹ Duane Dunn,¹ Joseph Remington,¹ Melissa McCool,² Debbie Benner.¹ ¹DaVita HealthCare Partners, Inc, Denver, CO, USA; ²STI Innovations, Encinitas, CA, USA
2. **Peer-To-Peer Mentoring Programs in ESRD**
Jennifer St. Clair Russell. Mid-Atlantic Renal Coalition (ESRD Network 5), Richmond, VA, USA

1. SYMPTOM TARGETED INTERVENTION DECREASED MISSED TREATMENTS IN HEMODIALYSIS PATIENTS

Shaun Boyd,¹ Duane Dunn,¹ Joseph Remington,¹ Melissa McCool,² Debbie Benner.¹ ¹DaVita HealthCare Partners, Inc, Denver, CO, USA; ²STI Innovations, Encinitas, CA, USA

Previously, Symptom Targeted Interventions (STI) demonstrated that nephrology social workers could help improve quality of life scores and decrease depression scores with in-center hemodialysis patients. We report here implementation and outcomes of an expanded version of STI to decrease missed treatments within a large dialysis organization (LDO).

Within the LDO, social workers from select dialysis clinics were equipped through in-person training, resource materials, weekly training calls, and tracking tools to intervene with 1-4 dialysis patients at each selected clinic. Patients with the highest missed treatment rates were targeted for intervention.

For the 182 patients who graduated from the 90-day STI clinical program, approximately 3,300 intervention coaching sessions occurred, and the most frequently used interventions included coping thoughts (23.2%), behavior activation (19.7%), and deep breathing (10.7%). Three months post graduation from the STI program, the study cohort displayed a nearly 3.0% decrease in missed dialysis treatment rates (missed treatment rate: pre, 18.1%; post, 15.4%).

Results suggest that implementation of a social worker-based STI clinical program targeting improved quality of life for in-center hemodialysis patients, results in additional health improvements due to increased adherence to the prescribed dialysis treatment regimen assessed in the least compliant patients.

2. PEER-TO-PEER MENTORING PROGRAMS IN ESRD

Jennifer St. Clair Russell, Mid-Atlantic Renal Coalition (ESRD Network 5), Richmond, VA, USA

Self-management of ESRD is a challenge. Patients tend to have a number of comorbidities and high symptom burden, which can lead to hospitalization. Peer-to-peer (P2P) mentoring programs have been used in chronic disease to impact self-management and hospitalization.

Little has been published on ESRD-focused P2P programs. The Mid-Atlantic Renal Coalition conducted a national environmental scan in July 2014 to identify ESRD-focused P2P programs. Individuals, including patients and professionals, within the ESRD community were asked to submit information about P2P programs they knew about or with which they had experience.

Thirty-one formal peer-to-peer mentoring programs were isolated from 452 respondents. Staff/patients representing formal peer-to-peer mentoring programs submitted were contacted for interviews. Interviews were held with 23 individuals. The remaining 8 programs were not interviewed because of a lack of response. The interviews sought to elicit information about the program's structure, goals, audience, mentor training, and evaluation.

ESRD P2P programs vary in their format and goals. Few of the programs have conducted any formal evaluation to assess process or impact. An important component to program sustainability was the active involvement of patients or being patient-led. No particular theoretical foundation underpinning was reported by interviewees; however, program descriptions often focused on developing patients' self-efficacy or confidence managing self-management tasks.

It appears as though no one P2P format is best; the program must meet patients' needs, while working within the constraints of available resources and organizational policies.

As part of a CMS Special Innovation Project, Peer Support to Enhance Self-Management and Reduce Hospitalization Rates, these results have been used to inform the development of an ESRD P2P self-management program that will be implemented and evaluated in 2015.

3. "TALKING CONTROL" AS A METHOD TO IMPROVE PATIENT SATISFACTION WITH STAFF COMMUNICATION IN THE DIALYSIS SETTING.

DeeDee Velasquez-Peralta, Anna Ramirez. Heartland Kidney Network. Kansas City, MO, USA.

Heartland Kidney Network identified a grievance trend of poor staff communication throughout the Network and developed a Quality Improvement Activity (QIA) to address this trend. The QIA utilized the evidence based method of "talking control" to improve communication in the dialysis setting. The QIA was called "Take 5 to Tune In." 17 facilities encompassing approximately 1,500 patients were selected to participate in the project. Facility staff members conducted five minute face-to-face random encounters utilizing "talking control." Talking control can be defined as similar to "befriending" within a professional environment. Staff members "control the talk" and move the conversation to the patient sharing. Sessions are patient led with a focus on enthusiasm and interest toward the patient.

Facilities were provided training on the "talking control" method by "talking control" expert Dr. Judith Beto. Facility staff members then conducted 5 minute or more "talking control" sessions with patients monthly from July – September 2014. Facilities tracked the number of sessions held with patients.

"Take 5 to Tune In" project utilized the 2014 In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) data as a pre-intervention baseline measure on 5 questions related to patient satisfaction with staff interactions. The goal of the project was a 5% improvement in the total % positive responses ("Always" or "Yes") to the 5 questions. In October 2014, a post assessment was conducted. At baseline, 64% of patients responded "Always" or "Yes" to the 5 ICH-CAHPS questions. Post-intervention, 70% of patients responded "Always" or "Yes" to the 5 ICH-CAHPS questions. Interventions resulted in a 6% improvement in positive responses to the ICH-CAHPS questions surpassing the Network goal of 5% improvement. "Talking control" is an effective means to improve dialysis provider communication and patient satisfaction with their care.



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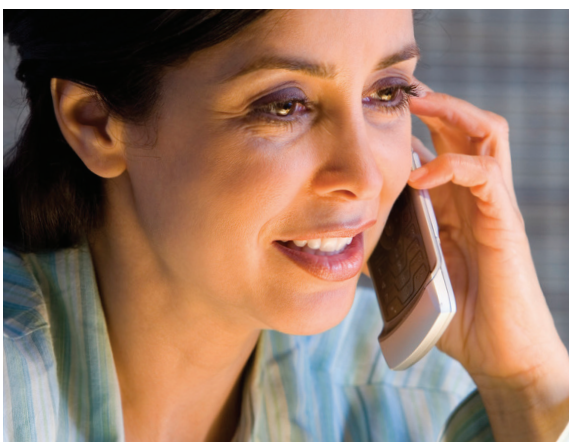
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