Establishing Evidence-Based Renal Social Work Practice Guidelines

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The purpose of the Renal Management Clinic (RMC) is to manage the initiation of treatment for people with end stage renal disease in a timely manner. For social work, this means completing a compensative psychosocial assessment and developing a plan to assist the patients with adjusting to requirement of renal replacement therapy before they are admitted to the hospital for dialysis or transplantation. Practically, this means each patient who came through the RMC would have been assessed by the RMC social worker.

The system implemented and practiced by the RMC social worker to ensure that all RMC patients were assessed before they initiated treatment was well thought out; however, there was no evidence, beyond the anecdotal kind, that it was working.

Consequently, this research study was conducted in order to review the current renal social work practice guidelines target, which states that every renal management clinic patient will receive a social work assessment. This study found convincing evidence that the system implemented to achieve this goal is effective and should be maintained. Additionally this study demonstrates how a systemic review of practice procedures can provide solid evidence to back up practice. Basically it has reaffirmed what was already suspected, with the only difference being that there is now quantitative data to back it up. This gives social work the confidence to say what works without having to rely on saying, "trust me."

Background

TGH Renal Social Work Context

At the time of this study the Nephrology program at Toronto General Hospital (TGH) of the University Health Network consisted of two in-center hemodialysis units each with approximately 150 stations, a home peritoneal dialysis unit with approximately 130 patients, a home hemodialysis and self/community care dialysis program with approximately 65 patients, an in-patient nephrology unit with 28 patients and the a renal management clinic with approximately 100 patients.
The nephrology social work compliment was three full time masters' level social workers. The first social worker covered the in-patient unit, the second covered the home peritoneal dialysis unit and one of the two in-center hemodialysis units, while the third covered the home and self-care/satellite hemodialysis unit, one in-center unit and the renal management clinic (RMC), formerly know as the Pre-Dialysis Clinic

The RMC social worker has an approximate caseload of 150 in-center hemodialysis patients, 100 RMC and 65 home hemodialysis and satellite hemodialysis patients for a total caseload of approximately 314. A benchmarking workload study at the Toronto General Hospital showed that renal social work at the hospital was understaffed. These finding are further supported by the NKF guidelines for patient to social workers ratio, which is 75 patients to every 1 master's-level social worker. To address this, the Renal Social Work team, which consists of three social workers and one practice leader, decided to develop and implement a rationalization strategy for renal social work services. This strategy was presented to and accepted by both the Allied Health Department and Nephrology Department. In developing the rationalization strategy, the renal social work team decided to maintain a smooth transition to dialysis for patients by continuing to provide comprehensive psychosocial assessments for all new patients. However, the rest of the team would not provide comprehensive initial assessments on patients, but instead follow the Renal Social Work Rationalization Strategy (Aug 2001), which directs social work interventions to focus on specific identified issues.

Renal Management Clinic Philosophy and Staff Make Up

The RMC is a multi-disciplinary clinic whose goal is to manage patients' pre-dialysis renal health within the context of a multi-disciplinary health care model. Practically, this means managing or delaying the onset of chronic renal failure, and/or preparing patients for initiation of treatment if/when required. At the time of this study the TGH RMC team consists of four nephrologists, two coordinators/nurses, one administrator, one pharmacist, one dietitian and one social worker. All staff members have duties that fall outside of the clinic.

TGH Renal Management Clinic Operating Structure

Each of the four doctors has their own caseload and has a clinic one day a month. The rest of the team's caseload is comprised of all four of the doctor's caseloads (approximately 100 patients). On Tuesday afternoons the team interviews patients. On Fridays, after the clinic day, the team and the doctor review the outcomes from the clinic earlier that week. After that meeting ends, the rest of the team plans for the next week's clinic, with each team member deciding on which patient they need to see. The doctor will usually see about 10 to 15 patients while the rest of the team will usually see up to around 5 each.

The social worker's first priority is to interview all new patients for initial comprehensive assessments and establish what their psychosocial risk/priority status is, as this will aid in determining how soon they will be interviewed by social work again. The social worker's second priority is to interview high-risk follow up cases.

Usually there are not more than two new patients a week, and occasionally there are no new referrals at all. Every new patient is mailed out in advance a questionnaire that is used to assist in the initial social work assessment. Most patients fill it out and bring it on their first visit to the clinic and it is placed on the chart. The social worker then refers to this at the initial interview.

Research Questions

1) To define the number of Renal Management Clinic patients admitted to the in-patient nephrology ward (IPNW) for dialysis initiation that had an initial RMC social work assessment during a seven-month time period.

2) To determine the number of RMC patients admitted to the in-patient nephrology ward for initiation of dialysis that did not have a RMC initial social work assessment during the stated seven-month time period.

3) To review the social work patient transfer process from the RMC to the IPNW and make recommendations based on the evidence established during this study

Method

The data was collected by asking the renal coordinators to review their files. They provided information on the number of all patients who were admitted for peritoneal dialysis (PD) and hemodialysis (HD) initiation on the IPNW during a 7-month period from March 2002 to September 2002, inclusive. From this total number, the actual number of those who were also RMC patients was determined. Separate analyses were performed on HD and PD patients on the IPNW from the RMC. The numbers from PD and HD initiations were then compiled and a secondary integrated analysis was performed. Finally, once the patients who did not receive a RMC assessment were identified, both a chart review and interview with a renal coordinator and the administrative assistant were undertaken to determine the reason they were not assessed. With the reasons established, several cases were removed from the original analysis and a final adjusted analysis was provided along with the unadjusted analysis.

Table 1

Number of all HD patient starts on IPNW for 7-month period

Month	Total # of initiations	RMC Pts	Without Assessments
March:	9	2	0
April:	22	5	1
May:	7	3	1
June:	13	1	1
July:	6	2	0
August:	7	1	0
September:	4	0	0
Total:	68	14	4

Analysis: Table 1

Percentage of RMC HD starts on the IPNW

- 79.4 % (54/68) of all HD starts are not RMC pts
- 20.5% (14/68) of all HD starts were RMC pts

Percentage of RMC HD starts on IPNW with RMC Assessments

- 71.4% (10/14) of all RMC HD starts have RMC SW assessment
- 28.5% (4/14) of all RMC HD starts did not have RMC SW assessments

Table 2

Number of all PD patient starts on IPNW for 7-month period			
Month	Total IPNW Pt's	RMC Pt's	Without Assessments
March:	4	0	0
April:	11	6	0
May:	8	1	0
June:	2	0	0
July:	1	1	0
August:	4	2	0
September:	3	1	1
Total:	33	11	1

Analysis Data Set B

Percentage of RMC PD starts on IPNW

- 33.3% (11/33) of all PD starts are RMC patients.
- 66.6% (22/33) of all PD starts are not RMC patients.

Percentage of RMC PD starts on IPNW with RMC Assessments

- 90.9% (10/11) of all RMC PD starts have a RMC SW assessment.
- 9.0 % (1/11) of all RMC PD starts did not have RMC SW assessment.

Integrated Analysis of Data Sets A and B

Combined Total: (68[HD] + 33[PD]) = 101 dialysis patient starts on IPNW
Combined Total: (14[HD] + 11 [PD]) = 25 patients are RMC patients

- 75.3% (76/101) of all HD and PD starts on IPNW were not RMC patients
- 24.7% (25/101) of all HD and PD starts on IPNW were RMC patients

Renal Management Clinic

- 80.0 % (20/25) of all RMC HD and RMC PD starts on IPNW were assessed by RMC social work
- 20.0 % (5/25) of all RMC patients on IPNW were not assess by RMC social work.

Results

Ratio of patients with RMC assessment admitted to IPNW

During the seven-month period a total of 101 patients were admitted to the IPNW for initiation of dialysis. Of those 101 patients, 68 were HD initiations and 33 were PD initiations. Interestingly a substantial number, 76 of the 101 (75.2%) of all dialysis initiations on IPNW were not patients from the RMC. RMC patients accounted for only 24.4% of dialysis initiation on IPNW. Out of this 24.4% of patients, a substantial 80.0% of them were RMC patients who had received an assessment from the RMC social worker. Alternately, this means 5 out of 25, or 20% of the RMC patients did not have an RMC social worker assessment.

Out of the five patients not assessed by RMC social workers, one was not seen because there was no non-emergency social work holiday coverage. Two were not assessed because of non-compliance. Two were not seen due to late referral to the RMC. Four out of five had on their chart a completed RMC social work mail-out self-assessment questionnaire.

Thus 40% of the patients with no RMC assessment can be attributed to non-compliance, 40% are related to late referral and 20% are related to lack of social work coverage resources. Interestingly 80% of this group with no RMC social worker assessment had on their chart the completed RMC social work mail out self-questionnaire, which forms a significant part of the social work initial assessment process. This information is something that other renal social workers would have access to despite no formal assessment by RMC social workers.

It is possible to remove at least two of the five non-assessed patients by saying that their not being assessed was due to forces beyond the clinic's control. One patient missed by RMC social work due to lack of holiday coverage, and another who never made it to RMC, though he was an RMC "patient on paper." While it is arguable that the three non-compliant patients could have been seen if RMC social work had had an appointment with them and they stayed around for it, it could still be said that they may not have waited around for a social work interview. This information is unknown. Thus the conservative analysis is that with the removal of two of the five non-assessed patients, that the number of RMC assessments on IPNW patients rises from 80% to 88%.

Discussion/Conclusion

The results of the integrated analysis for all RMC patients admitted to IPNW for initiation without RMC social work assessments are conservatively estimated at 12%. These findings suggest that there are no substantial problems with patient flow through the Renal Management Clinic to IPNW for initiation. On the contrary, the RMC social work assessment rate is 88%. This large ratio suggests that the RMC current referral structure and priority system is overall working very well.

Yet despite this positive conclusion of an effective RMC referral structure, it is still possible to aim for improvement. One area for improvement would be to have early referrals from nephrologists to the RMC. Besides being generally cost effective (Mclaughlin, Manns, Culleton, Donaldson & Taub; 2001) early referrals to multidisciplinary clinic also would give the clinic more time to plan for the care of the patient, which would includes a complete social work assessment. This would require a concerted effort on education to referral sources.

However, the problem may be located beyond just physician and referral source education. An unknown number of the nephrologists at Toronto General Hospital do not refer their patients to the RMC. Even some of the nephrologists who participate in the clinic may not refer all their patients to the RMC. Why is this? One suggestion is that the philosophy of multidisciplinary care is still not held by all nephrologists, or they may not understand the potential benefits it may yield. Another speculation is that there may be incentives for private practice nephrologists to not transfer their patient's care to the RMC. On the other hand, the RMC does not have the capacity to handle increased referrals. This lack of capacity may be in fact a budgetary item as there is "no money" to expand the clinic at the time. Why there is no money is open to speculation. Essentially no money means "not a priority." Why not a priority? It could be that either the RMC has failed to demonstrate its relevance, or there is just simply not political will power at the corporate level. Further speculation on this topic is beyond the scope of this paper.
The discussion with the renal coordinator ruled out the idea of assessing the patients "outside of clinic" hours and before dialysis initiation as a way to target patients who were not assessed by social work at the RMC, as it was thought this would undermine the multidisciplinary care philosophy of the clinic. Additionally, it may not address the issue of non-compliant and late referrals, and will definitely not address the lack of holiday coverage. Moreover, this study suggests that there is no need to adjust the structure of the RMC social referral framework.

Another area for possible improvement would be to have RMC social work assess the patient on the first visit to the clinic. This would provide an assessment for non-compliant patients who refuse to come to the second clinic interview, but may have no effect on those who leave early from the clinic and never return. It also has no effect on those that are "referred," but never come due to late referrals. Also not addressed by this change would be the issue of holiday coverage for social work at the RMC. It may also increase non-compliance by having long clinic appointments.

In discussing the matter with the renal coordinator it was acknowledged that the policy of not having the patient see the dietitian and social worker on the same day could be revisited. However it would have to weigh against the interest of the patient to not have a long afternoon at the RMC, which can be a problem for patients.

One possible solution is as follows. If a patient saw the dietitian on the first visit, but the doctor had not requested to see the patient next month, then the patient would be brought in for a social work assessment despite not being recalled by the doctor. This method would guarantee that the patient would have a social work assessment at least one month after the first clinic appointment. It would also maintain the concept of multidisciplinary care provided by the clinic; by having the patients cared for and reviewed by the whole team during their own doctor's clinic. Possibly this may allow for other team members to see the patient if required. During this visit, which would not include a doctor visit, there may be time for a quick consult with the doctor if it was required. A limitation of this idea may be that patients will expect to see their doctor despite not having an appointment, or that they will not come to the clinic unless they have a doctor's appointment.

The findings of an unbalanced ratio of HD (67.3%) to PD (32.6%) initiations seems to indicate shift away from UHN Clinical Activity Targets. These targets set the corporate strategic goals for the hospitals which are part of the network, and identify which programs will expand, be maintained, scaled back or eliminated. With regards to Nephrology the corporate goal is to expand the home dialysis PD program while controlling the growth of in-center hemodialysis by keeping the in-center patient volume static. However, renal coordinators report anecdotally that many patients have or are being sent to other hospitals to have PD catheters inserted due to system delays here at TGH. This may be one reason for the imbalance in HD to PD initiation rates. Another possible explanation may be that some of the hemodialysis starts are home hemodialysis starts. However, more data would have to be gathered before any conclusions could be reached.

Implications for Practice

It is recommended that to maintain the current RMC referral framework with minor adjustments. Overall RMC referral framework is working well in the renal social work context, but some minor adjustments may help to increase the number of assessments completed by RMC social work.

Minor adjustments to the framework that are recommended include introducing a new RMC practice of trying to have patient seen on first clinic visit by both the dietitian and social worker, if conveniently possible for the patient. Additionally if the patient is not seen by social work on first visit then have them brought in next month for that doctor's next clinic. This will maintain multidisciplinary clinic focus.

The practice of mailing out a social work questionnaire is good practice. First, it sped up the initial assessment, and second, there is a good chance that if the patient initiates dialysis before seeing RMC social workers that other renal social workers will have access to it as it may be placed on the chart even if the patient is not seen by RMC social workers.

Implications for Research

This study has been a useful exercise and could be incorporated into the Continuous Quality Improvement review for the RMC as a social indicator. That is, the percentage of completed assessment could be seen as a social indicator for CQI. Repeating this study in the future may be of use to determine if the recommended changes made to RMC social work referral process for initial assessments have had any impact on reducing the rate of RMC patients who are not assessed by RMC social work.

The issue of why there are not more early referrals to the clinic, and how the clinic might expand are intertwined in a multi-systemic matrix of micro and macro levels of care. Further investigation into this matter may reveal possible interventions, which could be of benefit to all involved.

Reference

McLaughlin, K, Manns, B., Culleton, B., Donaldson, C., & K. Taub. (2001). An *economic evaluation of early versus late referral of patients with progressive renal insufficiency. American Journal of Kidney Disease Nov; 38 (5): 1122-8* JNSW