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## One Social Work Group's Process of Conducting an Outcomes-Driven Project

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*Renal social workers across the country are being encouraged by the Council of Nephrology Social Workers to incorporate the outcomes-driven model of nephrology social work into their social work practice with dialysis patients. Initially this model of practice may seem overwhelming, not very useful, or too complicated to some renal social workers who are not used to quantifying their interventions. In spite of initial suspicion and cautious hopes, a small group of social workers at Saint Alphonsus Nephrology Center in Idaho decided to catch the outcomes-driven practice wave. This paper describes the process this group went through in their experience with an outcomes-driven practice model project.*

**Key Words:** *outcome-driven model; nephrology social work; fluid education; kidney disease*

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The Outcomes-Driven practice model of nephrology social work is being written about and discussed increasingly in nephrology social work circles. There have been several training programs that tout the efficacy of this model of nephrology social work. According to the Nephrology Social Work: An Outcomes-Driven Practice Model training manual (Johnstone et al, 2003) "an outcomes-driven practice model for nephrology social work will change the practice of nephrology social workers, expand the role of the nephrology social worker, and is necessary due to the changing health care delivery system and the changing CKD population." With regard to nephrology social work projects and interventions, the method "launch it, measure it, report it" (Johnstone, 2003) will put one on the right path to outcomes-driven nephrology social work.

A small group of five social workers at Saint Alphonsus Nephrology Center in Idaho decided to accept the challenge of conducting a project implementing the outcomes-driven practice model of social work. This report will discuss our efforts and our challenges in conducting such a project as well as what we learned from the experience. Because fluid management has been one of the most difficult challenges for our patients with end

stage renal disease, we decided to focus our project on that subject. Specifically, we wanted to carry out an experiment to see if our psychosocial interventions would impact the interdialytic weight gain (IDWG) of a group of our patients who struggled with managing their IDWG. We knew starting out that many patients find fluid restriction to be the hardest part of living with hemodialysis (Christenson, 1995). The experiment was the first time this particular group of social workers worked together on a project of this nature and the idea initially seemed overwhelming to some. While some were enthusiastic about trying out the new model of nephrology social work, others were skeptical. After several meetings, however, the group was able to come to a consensus on what exactly the project would entail. Because the thought of doing a "research project" seemed like more than we had the time or resources to tackle, we decided to simply do an evaluation of our social work intervention. Our goal was to compare a group of patients who received social work intervention with a group of patients who did not receive it. We agreed that, at the very least, an evaluation of our interventions would provide useful information for our practice.

### METHODS

#### *Participants*

The participants were all hemodialysis patients with diagnoses of end stage renal disease from a variety of causes. They were recruited from four of the six Saint Alphonsus

Nephrology Center facilities in southwest Idaho and eastern Oregon. In order to ensure the project would be manageable we used a small sample of 50 subjects.

We utilized a purposive sampling method of obtaining subjects. The RNs in the four facilities identified 50 patients who had difficulty with their IDWG. Patients eligible for the study were those who met the following criteria: 1) each had been on dialysis for at least six months, 2) each had not been hospitalized for more than three consecutive days in the past six months, 3) each had a cognitive status allowing them to give informed consent, and 4) each had a history of consistently coming to dialysis fluid-overloaded (four or more kilos over their estimated dry weight). The cognitive status of the patients was evaluated by the social worker who had the most familiarity with the patient through various interviews and their overall assessment of the particular patient. The total number of participants was divided in half. Half of the participants received the social work intervention, comprising the intervention group, and half did not, comprising the control group. The intervention group received weekly psychoeducational interventions by the social worker in addition to the standard education provided by the renal team. The control group received only the standard education provided by the renal team. Patients were assigned to either the intervention group or control group based on their verbal consent to receive the social work intervention that was obtained by the social workers after the RNs identified them as possible subjects. Confidentiality was maintained by assigning coded letters to each subject that were used when compiling data.

### Measure

We designed a simple pre-test/post-test study design to evaluate our intervention. Fluid levels served as the dependent variable and the social work intervention as the independent variable. We obtained an average IDWG for each patient for the three months (12 weeks) prior to the intervention. The average was obtained by adding up the IDWG between treatments for each patient and dividing that number by the number of dialysis treatments they had. At the end of the eight-week intervention we again measured the average IDWG for each patient using the same formula, enabling us to compare their average IDWG before intervention to their average IDWG during the eight-week intervention. We measured again two months later, to give us an idea of whether or not patients were able to maintain any improvement made.

**Table 1. Fluid Management Project**

		Participant Demographics ( <i>n</i> =40)	
		Intervention Group	Control Group
Gender	M	55%	60%
	F	45%	40%
Age	19-40 yrs	20%	10%
	41-64 yrs	60%	60%
	65+ yrs	20%	30%
Race Ethnicity	White	75%	75%
	Black	5%	0%
	Hispanic	20%	20%
	Native American	0%	5%
	Other	0%	0%
Marital Status	Married or cohabitating	50%	45%
	Single, divorced, widowed, or separated	50%	55%
Diabetic Status	Diabetic	70%	70%
	Nondiabetic	30%	30%

### Procedure and Intervention

Each social worker met individually once per week (for the eight weeks of the intervention phase) with each of the five patients in the intervention group assigned to them. The meetings took place chairside during the patients' dialysis treatments and lasted approximately 20 minutes each.

The interventions used were psychoeducational and behavioral in nature and had two components. The first was to provide education around the idea that a high level of fluid intake is a modifiable cardiovascular disease risk factor. The second component of the intervention focused on addressing psychosocial factors that contribute to nonadherence to prescribed fluid intake levels (such as stress or control issues) and on providing behavioral training to individually shape lifestyle and fluid-adherence behaviors. In order to establish some degree of uniformity in the intervention, each social worker followed a predetermined schedule of handouts and topics of discussion to start out the visits. These included focus areas such as the role of sodium in fluid control, tips for dry mouth relief, risks of high fluid gains, and a discussion of various psychosocial factors that could influence fluid weight gain (stress, lack of social support, anger, control, boredom, etc). Of course, each social worker and each patient have unique personalities and therefore the visits were quite varied in their content after the first several minutes.

At the end of the eight weeks, patients were given the opportunity to complete a questionnaire related to their experience of participating in the project.

## RESULTS

In terms of the evaluation of the social work intervention provided, we found the identified patient demographics of both the intervention group and the control group to be nearly identical. This is helpful when comparing the two groups. At the end of eight weeks of intervention, 80 percent of the patients in the intervention group showed a positive change compared to 60 percent of the patients in the control group. Eight weeks later, measurements taken again showed that in both groups, 58 percent of the patients had improvement in their IDWG compared to before the intervention (Table 1). These results echo information available in the literature, which documents that though this type of intervention yields initial success, maintenance interventions may be required to continue to secure positive outcomes (Lenart, 1998).

Positive Change in Intervention Group V Control Group				
	Intervention Group		Control Group	
	8 wks	16 wks	8 wks	16 wks
<i>Percent of patients who made positive change</i>	80%	58%	60%	58%

Additionally, we determined that meeting eight consecutive weeks with the patients to address this issue might be excessive. During the last few weeks of the intervention, the patients seemed to engage less in the process. We thought perhaps meeting for four consecutive weeks and then every other week might prove more effective and help patients maintain an interest in the subject matter. We would recommend fewer, less frequent visits with the patients, a sentiment reflected in the patients' comments on the questionnaire they completed at the end of the study.

Description of Change in Intervention Group		
Intervention Group (n=20)		
	8 weeks	16 weeks
Range of changes made	1%-37% less IDWG	1%-54% less IDWG
Average change made	11% less IDWG or .52 kilos	12% less IDWG or .60 kilos

In regard to our utilization of the outcomes-driven practice model, as opposed to other types of practice models, we support the claims made by its proponents. We

feel it is important and valuable for social workers to be able to quantify our work and this model gives us the framework to do so. In a fast-paced medical environment physicians and directors want numbers. Nephrology social workers, and professional social workers in general, typically do not measure the impact of our practice. Therefore, we often times do not have an effective and simple way to communicate the impact of our practice to our administrators and other health care professionals with whom we work. This puts us at somewhat of a disadvantage as we try to advocate for our patients and for ourselves as professionals. It also hinders us in our efforts to expand the role of nephrology social worker to include more clinical activities that impact our patients and facilities in areas such as adherence, fluid control, depression, quality of life, number of hospitalizations, etc. In other words, we feel that if social workers engaged more often in measuring our outcomes, we would be able to more easily and clearly demonstrate the impact of our practice that would enable us to expand our role into the areas in which we feel we can make positive impacts on patient outcomes.

Furthermore, the outcomes-driven practice model more visibly demonstrates the value of social work in a nephrology setting. With our fluid project, one can easily see the difference between the control group and the intervention group at the end of the first eight weeks of intervention. There was initial success, but when the social work intervention ended, the patients in the intervention group returned to their normal patterns of fluid intake. Thus we may be able to conclude that periodic, focused social work contact and intervention may have been beneficial to the patients as they attempted to make healthy changes and that without it, they struggled to maintain their initial achievements.

In addition, our group learned several important things while engaging in this project. First, we learned a lot about outcomes-driven practice. As social workers we don't typically engage in this type of practice model. In fact, prior to this project, we collectively had minimal experience with outcomes-driven practice. We now have more skills and knowledge related to this practice model, giving us a wider range of tools to use in our practice. Also, we found that our interventions were more focused than they might otherwise have been. During the fluid project, we had a specific, identified issue and we knew the data would be measured. Therefore, we were less likely to have conversations with patients that skimmed the surface of a variety of issues, but rather, we tended to stay on a topic and go in depth with it as much as a

patient would allow. Our willingness to try a new-to-us practice model demonstrated our sense of innovation, creativity, and desire to improve our practice. We showed ourselves and our administrators that we are ready and eager to look at new ways to expand and develop our practice to meet patient and facility needs.

As noted, the patients in the intervention group completed questionnaires related to their experience as participants of this project. For the most part, the patients responded that the interventions were helpful to them in their efforts to control their fluid intake.

## DISCUSSION

As social workers new to the outcomes-driven concept, we found working on such a project both rewarding and challenging. Of the three phases of the outcomes-driven model, we found the first phase, “launch it,” to be, perhaps, the smoothest. Our physicians and executive director were supportive of our idea and desire to initiate the project. It was by no means without its setbacks and struggles, however, as the five of us tried to get a collective vision of what it was we wanted to do and how we wanted to do it. We met several times to smooth out the details so that each social worker could feel comfortable with the project and also to gain as much uniformity in the interventions as possible. Though precautions were taken, at the end of the study period we noted that five of the patients in the intervention group received intervention different from the rest of the patients in the intervention group. Specifically, those five patients did not receive the same educational materials and frequency of social work intervention the other participants received. Because the differences were quite significant, we decided not to use the data from those patients.

The next phase of the outcomes-driven model, “measure it,” proved to be the most frustrating of the three. The actual procedure for measuring the data was fairly easy to do and not too time-consuming. Social workers who love crunching numbers and don’t get enough of it during a typical day of providing social work will really enjoy this part. Our biggest limitation with regard to measuring the outcomes is that we are not sure to what extent the data obtained correctly represented what we wanted to measure. We used our facility’s computer data system to generate the desired data (IDWG). In more than one instance we found numbers that simply did not make sense. For example, we occasionally found numbers such as “87” where the IDWG

would go. The problem there, of course, was data entry. And since we had no control over that aspect of the project, we found it somewhat frustrating.

Another technical limitation to the validity of our design was the assignment of subjects into either the control or intervention group. As this was not a random assignment, it is difficult to truly compare the two groups. Though the demographics of the two groups were nearly identical, we felt that the criteria “willingness to participate,” which was used in creating the intervention group, is a big distinction and could account for some of the difference in results.

The third phase of the outcomes-driven practice model, “report it,” is still under way. Basic math skills were used to obtain the results. We have compiled the data and will present it both in writing and verbally to the physicians and administrators at the next quarterly meeting.

One important lesson learned from this project is that applying the outcomes-driven practice model is achievable. Our project was small, but even small projects can yield valuable results. Another lesson learned from using the outcomes-driven practice model is that it is important to have a high level of social worker buy-in in order to carry out a project of this type. In our enthusiasm to initiate this fluid project, certain group members may have felt pressured to participate. Any type of group project requires organization and commitment on the part of each social worker involved. Without this, the interventions are at risk of being nonuniform, weakening the overall design of the study. In our case, we ended up not being able to use a significant portion of the results due to lack of uniformity of the interventions. Therefore, we recommend making sure each social worker involved truly does want to participate and is willing to do the necessary work involved in an outcomes-driven project.

It is more time consuming to use this practice model and is therefore important to be realistic in planning this type of project. We recommend starting with a small project. We also recommend there is at least one social worker involved who enjoys numbers and managing data. This is not an area of interest for many social workers but is extremely important with outcomes-driven projects. In our experiment, we were fortunate to have one social worker who wanted to take on the task of collecting all the data and compiling it into charts.

Finally, we suggest having patience with regard to the notion that the outcomes-driven practice model will change the practice of nephrology social work. While we do believe this to be a possibility, we also believe that it won't happen overnight or even after implementing one outcomes-driven project. The benefits are evident, however, and we concur with other practitioners of outcomes-driven social work, that it is worth the time and effort necessary for its implementation.

### REFERENCES

Christenson A. (1995). Coping with treatment related stress: Effects of patient adherence in hemodialysis. *Journal of Consultation in Clinical Psychology*, 63(3), 454-459.

Johnstone, S. (2003). Nephrology Social Work: An Outcomes-Driven Practice Model. (Presentation at the National Kidney Foundation Spring Clinical Meeting, April, Dallas, Texas).

Johnstone, S., Callahan, M., Funk Schrag, W. (2003). *Nephrology Social Work: An Outcomes-Driven Practice Model* (training manual without page numbers).

Lenart, A. (1998). The effects of patient and staff psychological orientation on patient adherence to fluid intake recommendations: A program evaluation. *Journal of Nephrology Social Work*, 18, 81-102. **JNSW**