

## **DOPPS: Making the Case for Using Functioning and Well-Being Surveys to Assess Risk and Improve Outcomes**

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*The prevention of frailty and dependence optimizes dialysis patients' quality of life and has the potential to reduce the overall costs associated with their care.*

*—Christopher Blagg, MD, Nephrologist  
(Life Options Rehabilitation Advisory Council, 1994)*

*Multiple studies of people with chronic kidney disease and kidney failure included measurement of functioning and well-being using the SF-36 or the Kidney Disease Quality of Life™ survey. Those on dialysis have scored consistently lower than norms. The Dialysis Outcomes and Practice Patterns Study found that in patients on hemodialysis low physical component summary and mental component summary scores were significantly associated with higher risks of hospitalization, death, and dialysis withdrawal. Higher scores on the “down in the dumps” and “downhearted and blue” questions were significantly associated with higher risk of hospitalization, death, and dialysis withdrawal. Preliminary research has found that rehabilitation interventions can improve functioning and well-being and that scores can help direct team care planning. More research is needed to determine which clinical social work interventions are associated with improved scores and outcomes. Answering this question could greatly improve the lives of those with kidney disease, save taxpayers' money, and help dialysis centers stay financially viable.*

### **INTRODUCTION**

Research has shown that even if new patients on dialysis never ask these questions out loud, most want to know “How long will I live?” and “How well will I live?” (Juhnke & Curtin, 2000). The question “How well will I live?” reflects the patient’s deeply personal concern about quality of life with chronic kidney disease (CKD) and its treatment.

One of the eight “articles of faith” of good medical care states “Good medical care treats the person as a whole” (Lee & Jones, 1933). In 1948, the World Health Organization (WHO) defined health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). Functioning is so important that the WHO added a classification scheme for functioning and health called the International Classification of Functioning, Disability and Health (ICF). However, it took Congress nearly 40 years to reiterate the importance of improving end-stage renal disease (ESRD) quality of care by improving clinical outcomes and patient functioning and satisfaction.

Since 1976, the Conditions for Coverage for Suppliers of ESRD Services have mandated that “the patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates the ESRD and other care required as well

as the individualized modifications in approach necessary to achieve the long-term and short-term goals.” To accomplish this, the regulations also require that all dialysis clinics have a qualified social worker who has a master of social work degree with clinical specialization from a graduate school accredited by the Council on Social Work Education and a license (if required by the state). These regulations mandate that:

[S]ocial services are provided to patients and their families and are directed at supporting and maximizing the social functioning and adjustment of the patient. Social services are furnished by a qualified social worker (§ 405.2102) who has an employment or contractual relationship with the facility. The qualified social worker is responsible for conducting psychosocial evaluations, participating in team review of patient progress and recommending changes in treatment based on the patient’s current psychosocial needs, providing casework and groupwork services to patients and their families in dealing with the special problems associated with ESRD, and identifying community social agencies and other resources and assisting patients and families to utilize them (42 CFR 405 Subpart U).

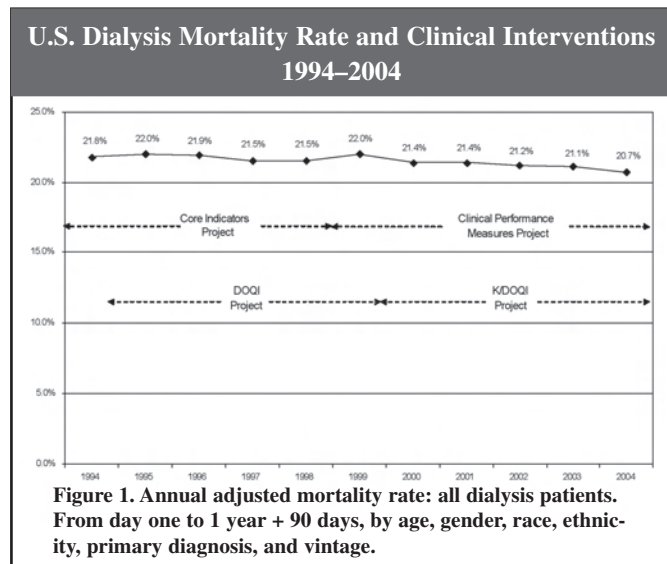
Since the late 1980s, the federal government and renal community have invested much in an attempt to address quality of care. The Omnibus Budget Reconciliation Act of 1987 mandated that the Institute of Medicine (IOM) examine patient quality of care measured by three variables: clinical indicators, functional status, and satisfaction (Rettig & Levinsky, 1991). Key initiatives included:

- A series of IOM conferences and reports on health status outcomes and quality of care for patients with kidney failure (Lohr, 1989, 1992; IOM, 1990; Rettig & Levinsky, 1991; Rettig & Lohr, 1994; Schrier et al., 1994).
- Collaboration between the Health Care Financing Administration (now Centers for Medicare and Medicaid Services [CMS]) and the ESRD Networks to develop the Core Indicators Project (McClellan et al., 1999).
- Development of guidelines by panels of experts to identify, classify, stratify, and treat patients with kidney failure at all stages of kidney disease through the National Kidney Foundation (NKF) Dialysis Outcomes Quality Initiative (DOQI; Eknoyan et al., 2000) and Kidney Disease Outcomes Quality Initiative (K/DOQI; National Kidney Foundation, 2002).
- Congress even mandated that CMS “implement...a method to measure and report quality of renal dialysis services under the Medicare program” leading CMS to choose 16 clinical performance measures to track based on the DOQI guidelines (Public Law 105-33, 1997).

The CMS, ESRD Networks, and NKF guideline initiatives have focused entirely on improving clinical indicators—treatment of anemia, dialysis adequacy and vascular access, nutrition, and the medical conditions that contribute to or result from kidney damage. As Figure 1 shows, over the 10-year period from 1994 to 2004, while the Core Indicators Project, DOQI, Clinical Performance Measures and K/DOQI initiatives were progressing, the U.S. annual adjusted mortality rate declined by a mere 1.1% (U.S. Renal Data System, 2006). One has to wonder: What are we missing? One explanation that should be considered is that the renal community’s focus on “clinical indicators” has largely ignored the importance of functioning and well-being (FWB) and facilities’ assignments of non-clinical tasks to social workers has denied patients access to social workers’ clinical interventions.

Focusing on disease of the kidney or other organs and tissues of the body ignores the person who is *experiencing* the disease and its limitations. By ignoring the patient’s physical and mental functioning, the renal community has failed to adequately answer the question that patients want to know: “How well will I live?” This article focuses on the research basis for why it is

**Figure 1**



important for social workers to assess and treat deficits in FWB in a person with kidney disease. By providing clinical interventions to address these deficits, social workers can help the renal community improve how long and how well patients live.

## BACKGROUND

In 1993, the IOM sponsored a conference entitled Measuring, Managing, and Improving Quality in the End-Stage Renal Disease Treatment Setting (Schrier et al., 1994). In addition to many presentations on clinical outcomes, two addressed FWB. One reported a study of 112 patients who completed the Medical Outcomes Study SF-36 quarterly for an average of 14 months. The SF-36 measures domains including physical functioning, pain, energy/fatigue, role limitations caused by physical health, role limitations caused by emotional health problems, social functioning, emotional well-being, and general health perceptions. Scoring of the various measures yields two summary scores: the physical component summary score (PCS) and the mental component summary score (MCS). The study revealed that staff’s assessments of patient functioning were quite different from patients’ self-reports and were “very naive,” and “neither systematic nor consistent.” However, patients told interviewers the survey helped them describe their health more fully than they routinely did with staff. Dialysis patients had lower FWB scores than the general U.S. population on all scales except social functioning. Dialysis staff used survey scores to determine who needed referral to physical therapy and treatment for depression. The author concluded that

completing the surveys empowered patients to participate more in their own care (Meyer et al, 1994).

The second report discussed a number of surveys available and described the benefits of generic instruments (e.g., the SF-36) that allow comparisons to the general population, and the benefits of disease- or treatment-specific surveys like the Kidney Disease Quality of Life™ (KDQOL), that allow assessment of the effects of a disease or treatment on scores. The author encouraged staff to use these surveys in clinical practice to identify necessary care and treatment and to track changes in functioning based on that treatment (Kutner, 1994).

In 1994, the IOM convened another workshop to evaluate and recommend multiple FWB survey instruments. Members of the Health Status Outcomes Group reviewed survey instruments for reliability, validity, ease of use, patient friendliness, and cost, and recommended four: the Dartmouth COOP Charts, the DUKE Health Profiles, the KDQOL, and the SF-36. It was also recommended that FWB be one-third of patient assessment along with physical findings and lab tests. The rationale given was that the inclusion of FWB assessment costs little and is appreciated by patients who receive feedback and interpretation of results (Rettig et al., 1997).

Early studies questioned whether a link would be established between FWB and clinical data and between care processes and outcomes. A historical prospective study of 1,000 patients on hemodialysis at three facilities established the link between FWB scores and outcomes, such as hospitalizations, death, missed treatments, and depression (DeOreo, 1997). In the study, patients who scored below the facility's median on the SF-36 were found to be twice as likely to die and one and a half times as likely to be hospitalized compared with those who scored above the median. The probability of survival increased 10% with each 5-point increase in the PCS score on the SF-36 and a 5-point increase in the PCS reduced hospitalization days nearly 6%. Those who missed two treatments at least twice a month ("skippers") were more likely to have higher PCS scores and lower MCS scores. The MCS and/or mental health score identified that 25% of patients at these facilities were depressed.

Development of the KDQOL-SFTM (short form) instrument and correlations of scores with patient outcome measures was discussed in a 1994 paper. The KDQOL-SF includes the SF-36 and kidney disease-specific questions measuring domains including symptoms/problems, effects of kidney disease, burden of kidney disease,

work status, cognitive function, quality of social interaction, sexual function, sleep, social support, dialysis staff encouragement, and patient satisfaction. The 80-question instrument takes about 16 minutes to complete and has been translated into multiple languages. It was administered to 165 patients at 9 dialysis clinics. Findings included hospital days in the prior 6 months were significantly correlated with 14 of the 19 kidney scales, and the emotional well-being scale correlated the most with hospital days. Number of medications the patient took correlated with 9 of the 14 kidney scales and physical functioning correlated most with number of medications. The authors recommended the KDQOL-SFTM as a valid and reliable measure of treatment effectiveness (Hays et al., 1994).

The NKF-K/DOQI work groups reviewed FWB research in the development of CKD guidelines. As a result, the guidelines recommend that clinicians (usually social workers) assess functional status early and regularly, especially as health setbacks or changes in therapy occur, and research studies be conducted to determine what clinical and rehabilitation interventions improve patients' functioning and reduce hospitalizations and death (NKF, 2002).

In 1996, a study of nearly 14,000 Fresenius Medicare Care patients examined clinical parameters, patient characteristics, hospitalizations, and deaths. The SF-36 was administered by social workers and completed by 13,952 patients. In this study, PCS scores below 43 and MCS scores below 51 were associated with higher risk of death. With each 1-point increase in PCS, the relative risk of death or hospitalization dropped by 2%. Each additional point in the MCS reduced the relative risk of death by 2% and hospitalization by 1%. The authors concluded that PCS and MCS measure something unique not accounted for by lab values or case mix. They encouraged the use of FWB surveys to prevent further decline in functioning by targeting interventions designed to address functional deficits (Lowrie et al., 2003). Today, many social workers regularly assess patients using FWB surveys; their scores help to direct social work clinical practice.

#### **THE DIALYSIS OUTCOMES AND PRACTICE PATTERNS STUDY**

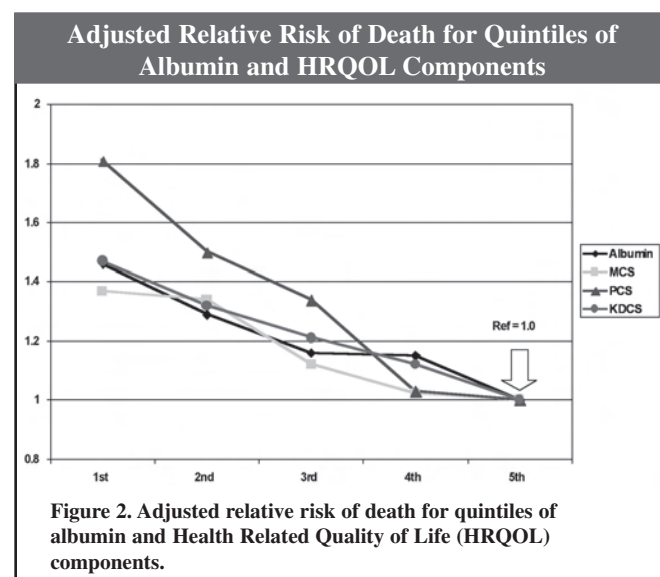
The Dialysis Outcomes and Practice Patterns Study (DOPPS) is an observational prospective study in nationally representative hemodialysis facilities. It began in 1996 and continues into the present. Phase I included 17,236 hemodialysis patients (full health-related quality of life data available on 10,030) in

148 nationally representative facilities in the United States, 101 facilities in five European countries (France, Germany, Italy, Spain, and the United Kingdom), and 65 facilities in Japan (Mapes et al., 2004). DOPPS II expanded to include 9,382 patients from Australia, Belgium, Canada, Italy, Japan, New Zealand, Spain, Sweden, the United Kingdom, and the United States (Lopes et al., 2004). The study examines relationships between patient sociodemographic and comorbidity variables and dialysis facility practice patterns with four primary outcomes—mortality, hospitalization, vascular access, and quality of life. In addition to comprehensive data collected on patient demographics, lab values, comorbidities, and treatment, more than 10,000 patients completed the KDQOL survey in participating facilities. Along with PCS and MCS scores from the SF-36, a kidney disease component summary (KDCS) score from disease-specific questions was obtained. Researchers wanted to learn whether PCS, MCS, and KDCS scores were associated with mortality and hospitalization rates. Because the survey includes two specific questions on depression, researchers were also interested in investigating the prevalence of patient depression and possible associations with the same study outcomes.

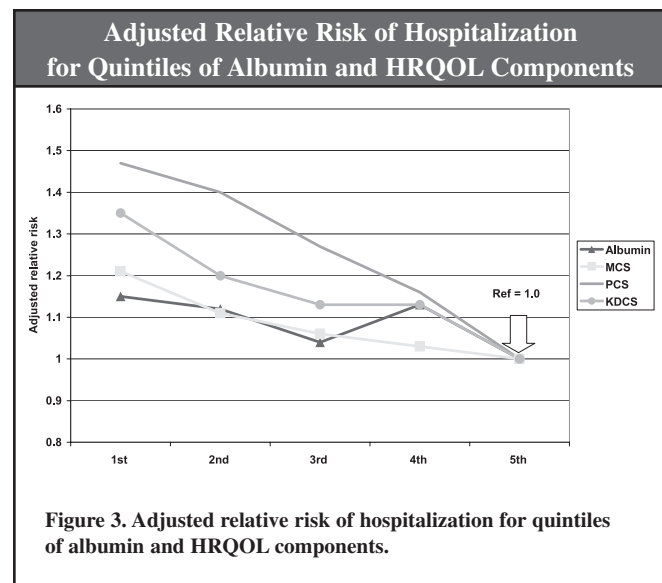
#### Low FWB Scores and Risks of Hospitalizations and Death in DOPPS Overall

DOPPS researchers found that low PCS, MCS, and KDCS scores across all countries were predictive of an increased risk of death and hospitalization, independent of demographic factors and comorbidities. As PCS, MCS, and KDCS scores decreased, statistically significant risks of death and hospitalization increased (see Figures 2 and 3; Mapes et al., 2003).

**Figure 2**



**Figure 3**



In Figures 2 and 3, the relative risks for death and hospitalization were statistically significant at  $P < 0.001$ , except for hospitalization and albumin, which were significant at  $P < 0.05$  (Mapes et al., 2003).

Patients who scored 10 points less on PCS had a 25% higher death risk and a 15% higher risk of first hospitalization. Those scoring 10 points lower on the MCS had a 13% higher death risk and a 6% higher risk of first hospitalization. Those with 10-point lower KDCS scores had an 11% higher death risk and a 7% higher risk of first hospitalization. Although MCS and KDCS were not as strongly associated with risk of hospitalization and death as PCS, they were still statistically significant. Patients with PCS scores in the lowest quintile had a 56% higher risk of hospitalization and a 93% higher risk of death compared with those in the highest quintile.

Albumin has long been considered the strongest independent predictor of poor outcomes in patients on dialysis. This study found that low PCS, MCS, and KDCS scores were at least as powerful in independently predicting hospitalization and death as albumin death risk (Mapes et al., 2003). The logical conclusion is that it is just as important to collect and respond to patient self-report FWB scores as it is to collect and respond to laboratory data.

DOPPS researchers also examined differences among patients in the United States, Europe, and Japan. Patients in the United States had the most comorbidities and patients in Japan had the least. People on dialysis in all countries scored lower on the SF-36 questions in

the KDQOL than the general population within each country. U.S. patients scored lower on PCS and higher on MCS than patients in Europe or Japan. Japanese patients scored higher on PCS and reported a greater burden of kidney disease than patients in the United States or Europe. Rates of employment were lower (16.8%) and disability rates were higher (36.0%) in the United States compared with Europe (26.8% and 20.0%, respectively) and Japan (53.3% and 4.0%). The authors recommended further research to find ways to improve physical functioning and reduce the burden of illness (Fukuhara et al., 2003).

Another question of interest in DOPPS was whether ethnicity was associated with FWB scores and hospitalization or death. Results indicated African American patients had higher PCS, MCS, and KDCS scores than white patients. Asian and Hispanic patients had higher PCS scores but did not score higher on MCS or KDCS compared with white patients. Compared with white patients, Native American patients scored lower on MCS and mental health. African American, Asian, and Hispanic patients all scored lower on patient satisfaction, but only in African American patients was this score significantly associated with increased death risk (Lopes et al., 2003). The authors suggested additional studies to further understand possible ethnic influences in FWB scores and to determine what interventions in low-scoring patients reduce hospital and death risks (Lopes et al., 2003).

### ***Depression and Risk of Hospitalization and Death***

There is substantial evidence that depression is a central component of health-related quality of life and is too often undiagnosed and untreated in people with kidney failure. Research has shown an association between depression and poor outcomes, including missed treatments, hospitalization, death, and suicide (DeOreo, 1997; Kimmel et al., 2000). The DOPPS researchers investigated the association between physician-diagnosed depression in the medical record and/or patient self-reported depression on the KDQOL and hospitalizations, death, and withdrawal (Lopes et al., 2003). The analyses included differences in outcomes if a patient record showed antidepressants had been prescribed. In U.S. and European patients on hemodialysis, depression was independently associated with mortality and hospitalization, even when adjusted for comorbidities, years on dialysis, sociodemographic variables, and country. In fact, DOPPS data showed that 19% of U.S. patients were diagnosed as depressed by physicians compared with 16.2% of European patients. Those who were older,

not white, and employed were less likely to be diagnosed as depressed by a physician. Because so many patients are not diagnosed as depressed, these patients may be depressed but do not express depression in the way doctors expect.

In the United States, 36.6% of physician-diagnosed patients were prescribed antidepressants, compared with 12.1% of those in Europe. Excluding patients prescribed antidepressants and adjusting for sociodemographic factors, comorbidities, years on dialysis, and country, patients diagnosed as depressed by a physician were 25% more likely to die, 11% more likely to be hospitalized, and were more likely to withdraw from dialysis. Those diagnosed with depression by physicians were more likely to die from cardiac disease, infections, and vascular causes.

Researchers classified patients as depressed by self-report if they responded to either of two SF-36 questions—"Have you felt so down in the dumps that nothing could cheer you up?" and "Have you felt downhearted and blue?"—with a 4 (a good bit of the time), 5 (most of the time), or 6 (all of the time). Self-reports of depression were higher among U.S. patients. Those who self-reported depression on the "down in the dumps" question were more likely to be younger, high school graduates, unemployed, have diabetes, lung disease, or gastrointestinal bleeding. Patients who self-reported depression on "so down in the dumps," "downhearted and blue," or both had a statistically significant higher risk of dying, being hospitalized or withdrawing from treatment compared with those who did not self-report depression. In those who were not physician-diagnosed, the "so down in the dumps" question was more strongly associated with mortality risk than the "downhearted and blue" question. A patient who self-reported depression on either or both of the two questions was more likely to be hospitalized. Interestingly, whether a patient was prescribed antidepressant medications did not significantly alter the risks of death or hospitalization. It is unknown whether adding counseling would have altered these risks. The authors recommended asking the "so down in the dumps" question to identify and target at-risk patients and implement medical and psychosocial interventions designed to reduce risks of hospitalization and death (Lopes et al., 2002). Social workers could easily add these two questions to their initial psychosocial assessment to perform an initial screening for depression.

In the second phase of the DOPPS, researchers administered the Center for Epidemiologic Studies Depression (CES-D) screening index to people on hemodialysis

(Lopes et al., 2004). Scores of 10 or higher on the 10-question CES-D short form indicate likely depression. Only 13.9% of patients had been diagnosed with depression by their physician, whereas the CES-D identified 43% of patients as depressed. Patients were more likely to be diagnosed as depressed by their physician and to have been identified by the CES-D as depressed if they were female, unemployed, had a low serum albumin level, and debilitating comorbidities.

DOPPS also examined the relationship between clinical outcomes, those identified as depressed on the CES-D, and those diagnosed by physicians as depressed. Researchers found that those scoring at or higher than 10 on the CES-D were more likely to die, be hospitalized, or withdraw from treatment. Patients who were physician-diagnosed as depressed were more likely to die or withdraw from dialysis, but were not more likely to be hospitalized.

Of patients who were diagnosed as depressed by their physician, only 38.9% of U.S. patients were prescribed antidepressants. Whether or not a patient with self-reported depression had been prescribed antidepressant medications was not significantly associated with mortality.

The DOPPS researchers found agreement between the SF-36 “downhearted and blue” question and scores of 10 or higher on the CES-D. They were unable to test the “so down in the dumps” question because it was not in the second phase of the DOPPS, but they believed it would have as strong an agreement with the CES-D as with the “downhearted and blue” question. The 10-question CES-D and the two SF-36 questions were all predictive of hospitalization and death. Depression is too often undiagnosed and untreated. Therefore, the authors suggested that clinicians screen patients to identify and treat those at risk to reduce hospitalizations and death (Lopes et al., 2004).

### **THE LINK BETWEEN INTERVENTIONS, FWB SCORES, AND OUTCOMES**

Some believe that research has not yet established what interventions will improve FWB scores and outcomes in dialysis patients. Although more work needs to be done to assess interventions, we know that some interventions have improved these scores and/or outcomes.

Research has shown that patients who are not physically active will become more debilitated over time—what Dr. Patricia Painter has called the “cycle of deconditioning” (Painter, 1994). A 2-month home exercise intervention followed by a 2-month, in-center intervention improved PCS scores. In fact, in patients with PCS scores less

than 34, exercise improved these scores by an average of 7 points (Painter et al., 2000). Because the intervention was brief, it was impossible to determine the intervention’s effect on mortality. However, if one accepts multiple studies that document a significant association between low PCS scores and morbidity and mortality, one can see that improving PCS scores through exercise could reduce hospitalization and death rates.

The Medical Education Institute, Inc. conducted a study in the ESRD Network of Texas for the Life Options Rehabilitation Program. A total of 169 Fresenius dialysis clinics reported clinical, demographic, and facility characteristics; mean PCS and MCS scores for facilities; and used the Life Options Unit Self-Assessment Tool (USAT) to report rehabilitation activities. USAT rehabilitation activities are separated into five categories: encouragement, education, exercise, employment, and evaluation. The mean USAT score for participating Texas facilities was 36.67 out of a possible 100 points. The lowest mean score was for exercise with a mean score of 3.71 out of 20. The only significant association with facility-level MCS scores was a higher facility USAT score, indicating that the clinic offered more rehabilitation activities.

Fresenius social workers studied in-center hemodialysis patients to determine if rehabilitation goal setting could be enhanced by following a four-step process using the SF-36 and interdisciplinary team planning. Five clinics served as a control group, receiving usual care. In five other demographically comparable clinics, surveys were administered and interventions undertaken. The social worker explained and administered the SF-36, reviewed the results with patients, and asked patients to identify functioning or well-being goals to work on over the next four months. The social worker explained the SF-36 and shared patients’ results and goals with the interdisciplinary team. All team members were asked to help design interventions—social, vocational, emotional, physical, and functional—to help the patients achieve their rehabilitation goals. After four months, the SF-36 was administered again and patients were asked “How close are you to the goal we set four months ago?” The two role disability scales—role physical and role emotional—improved significantly. Patients had set goals such as feeling stronger, being able to make their own beds, doing household chores, gardening and fishing again, feeling less lonely and anxious, taking care of grandchildren again, and being less dependent on family. Forty-two percent of patients met their goals, 46% made progress, and only 12% reported no progress toward goals (Callahan et al., 1999).

## IMPLICATIONS FOR CLINIC SOCIAL WORK PRACTICE

As can be seen from these studies, FWB surveys help identify people on hemodialysis who are at risk of hospitalization, death, and withdrawal. Two simple questions from the SF-36 identify depressed patients; depression is associated with increased risk of hospitalization and death. Social workers may want to add the “so down in the dumps” and/or “downhearted and blue” questions to their routine assessments to screen for depression without having to administer a longer depression survey. Once social workers identify patients who are at risk because of depression or low PCS or MCS scores, it would be important to alert the team that the patient is unstable and needs monthly team care planning and to report the scores to the patient to seek verification and feedback. If the patient attends the team care planning meeting, the social worker can review the scores with the team and encourage the patient to relate the factors that may have contributed to his or her low scores. Sharing this information in this way would allow the patient and the team to partner together to design clinical and psychosocial intervention plans and timelines with the goal of improving FWB scores and ultimately reducing the patient’s risk of hospitalization and death.

Social workers who understand the research basis for FWB measurement may want to share these connections with renal staff, administrators, and the dialysis corporation leadership.

1. Patients on dialysis have multiple comorbidities, become more debilitated over time, and more than 21% die each year, despite clinical guidelines, monitoring laboratory and other clinical measures, and clinical interventions designed to improve clinical outcomes.
2. DOPPS and other studies have shown that low PCS, MCS, and KDCS scores are significantly associated with key outcomes, including hospitalizations, deaths, and missed treatments.
3. Social workers regularly interview patients to identify their individual psychosocial needs, maximize their FWB, and participate in care planning. A social worker can complete an FWB survey during a routine patient contact and collect data about how the patient experiences kidney disease and dialysis.
4. Social workers can easily learn how to administer, score, interpret, and report to patients the results of surveys. Free online tools are available for this purpose for the KDQOL at [www.gim.med.ucla.edu/kdqol/](http://www.gim.med.ucla.edu/kdqol/).

5. Social workers may believe that patients will resist completing FWB surveys. However, social workers have reported that patients do not oppose completing these surveys when they know the purpose, receive feedback and offer input regarding their scores, and are allowed to partner with the team to achieve their goals.
6. When the team understands the surveys, knows the patients’ goals, and designs interventions to encourage patients to meet their goals, scores can improve and most patients will make progress or reach their goals. As a result, the team can gain better understanding of their patients’ attitudes and feelings.
7. Reducing the number of missed treatments and hospitalizations and increasing patient survival assures maximum utilization of dialysis equipment, keeps patients in clinics instead of in the hospital, and improves clinic revenues. Providing social workers time and administrative support to survey and treat at-risk patients could increase clinic profitability.

## CONCLUSION: A CALL TO ACTION

DOPPS data demonstrates that measuring FWB is key to identifying patients at risk for poor outcomes. FWB surveys supplement information professionals can glean from clinical data and patient interviews. Without data from such surveys, staff frequently misjudge patients’ quality of life and may make care planning decisions based on their misjudgments.

Social workers need to have the time and administrative support to learn how to administer, score, and interpret FWB surveys. These surveys are an important component to a social worker’s clinical resources. Using survey results to direct practice may improve how long and how well patients live and could dispel misperceptions of social workers. One such misperception is revealed in the following comment to the proposed Conditions for Coverage, in which CMS is asked to protect patients by deleting the requirement that social workers provide counseling:

We believe the proposed requirement to provide counseling services and long-term behavioral and adaptive therapy is fraught with potential patient danger and is not reflective of the realities of the functional role of the social worker in dialysis facilities....and the expansion of their activities into this role provides a potential minefield of potential unwanted clinical results...Social

workers spend a great percent of their time providing for the ‘social’ requirements of patients. This can be focused on food, clothing, shelter, transportation, and financial resources (including Medicare and insurance coverage). These are major factors contributing to the well-being of patients (McAllister et al., 2005).

Helping patients meet the day-to-day financial burdens of kidney disease is one aspect of a nephrology social worker’s role. However, there are many other roles that social workers can and should fulfill. These include:

- assessing patients’ current status, needs, strengths, and resources
- educating patients and their loved ones about managing kidney disease and feeling more hopeful about the future
- promoting improvement in physical functioning
- advocating for services patients need within the clinic and in the community
- helping patients keep their jobs or find new ones, go to school, and participate in as many age-appropriate activities as possible

A social worker who fulfills these roles will help patients live longer and better, assume more control over their health and their lives, and achieve maximum rehabilitation, while also improving the clinic’s payer mix. Instead of waiting for someone to give patients fish that will feed them for a day, social workers can and do help patients learn to fish so they can feed themselves and their families for a lifetime.

FWB surveys are essential in assessing patients and giving them a chance to tell the renal team what help they need. A mortality rate of nearly 21% is too high when validated surveys are available and the federal regulation requires clinically trained social workers to provide psychosocial services in every dialysis clinic. Using FWB surveys to identify at-risk patients and developing individualized interdisciplinary care plans that include clinical and psychosocial interventions designed to meet patients’ needs and goals may reduce morbidity, mortality, and the burden of kidney disease on the patient, payers, and society. To continue to ignore patients’ FWB and not use social workers’ clinical training and skills shortchanges patients, the social work profession, the renal community, and society.

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