

## Kidney Transplant Patient Employment: Vocational Training and Intervention by Use of an Impairment Rather Than Disability Model—The Job Club

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*The present study is an attempt to test an intervention model that evaluates the impairment assessment model. N=342 kidney patients followed at a major Southwestern transplant program who had been transplanted from 2005–2009 were contacted. A total of N=27 unemployed kidney transplant recipients volunteered to participate in the Job Club Vocational Rehabilitation Program that was especially developed in a psychoeducational model in conjunction with local representatives of the state department of vocational rehabilitation services to address the needs of kidney transplant recipients. From pre- to post-Job Club there was significant ( $p<0.05$ ) improvement in their knowledge gain with minimal changes in their social support and self-esteem. Quality of life improved in all areas, but saw significant improvement in role-physical and general health. Patients were able to secure a significant number of jobs in a vocational program done in a psychoeducational group setting that had the ability to both get patients back to work and do so without major life disruptions to their self-esteem or increased anxiety. There has also been an ongoing interest among patients and staff about vocational rehabilitation services.*

### INTRODUCTION

Previous research has produced innumerable articles addressing whether or not patients return to work posttransplant. This has been true for patients with kidney as well as other organ transplants. As early as the 1970s, some of the first attention to “rehabilitation” (i.e., employment) of kidney recipients was seen (Shapiro & Schwabach, 1973; Chyatte, 1979; Naish, 1979). To this day, there has been continuing interest in employment of kidney patients and attempts to develop new evaluation paradigms and intervention methodologies (Callahan & Paris, 2009). However, regardless of the time frame, approach used, or the efforts of transplant teams, there has been consistent mention of less-than-ideal posttransplant employment rates (Cardinal et al. The Elderly Recipients Transplant Group, 2005; Callahan, 2005; Cooper & Paris, 1993; Evans, 1990; Flechner, Novick, Braun, Popowniak, & Steinmuller, 1983; Gross, Limwattananon, Matthees, Zehrer, & Savik, 2000; Griva et al., 2002; Hathaway et al., 1998; Mei et al., 2007; Niu & Li, 2005; Paris, 2006; Paris et al., 1998; Paris, Tebow, Dahr, & Cooper, 1997; Raiz & Monroe, 2007). Without fail, clinical research has reported higher numbers of patients *able* to return to work, than those who actually do. However, posttransplant employment remains an important measurement of surgical success.

The most obvious and important reasons given for this criterion for “success” are that employment is a significant indicator of functional benefit to the recipient and social benefit to the community (Callahan & Paris, 2009). Another reason has been cost-benefit analysis (Paris, 2006). The logic is that, given the high cost of the transplant procedure and drug maintenance regimen, do the benefits to society outweigh their costs? In this way, either the transplant recipient returns to work or the procedure merely prolongs the period of disability, coupled with increased costs to society. The reasoning

goes that, through work, the patient again becomes a productive, contributing member of society. In other words, the individual patient then becomes a value to society rather than an ongoing burden. Although a rather cynical viewpoint, and lacking viable numbers supporting the argument, some outside of transplant medicine, have attempted to apply this logic to question the justification of the ongoing expense required to maintain transplant patients (Paris, 2006).

Areas virtually ignored in the discussion about the importance of employment have been psychological or philosophical rationales, which suggest an even greater justification—the person’s mental health. For example, an authority no less than Sigmund Freud addressed employment: “No other technique for the conduct of life attached the individual so firmly to reality as laying emphasis on work; for his work at least gives him a secure place in a portion of reality, in the human community.” (Packham, 2010). Although somewhat different in his view, Oscar Wilde reported work as the “curse of the drinking classes” (Chandler, 2010). Albert Camus suggested that “without work all life goes rotten” (Chandler, 2010). Probably one of the strongest arguments in favor of employment from the transplant literature was from Callahan (2005), who indicated that it was an important component in the reestablishment of a transplant recipient’s identity and self-esteem. Whatever the logic, from the psychological to the humorous, it is universally agreed upon that work is important for the individual’s attachment to and being considered as part of the larger community.

Why then, given the importance of employment, has there been so little improvement in the overall posttransplant patient work rates? Recent research conducted by the authors suggests that this may be due, in part, to the continued use of “disability status” as the standard by which patient physical capacity is measured (Callahan & Paris, 2009). In a study

of 111 kidney recipients, it was found that employment decisions and perceptions may have been influenced by very subtle physical (including medication-induced) and emotional factors that were previously not quantifiable with standardized assessment criteria. This was first suggested by Paris (2006) in the study of heart and liver transplant recipients, where it was found that patients who did not meet Social Security disability criteria and had been determined by their physician as “not being disabled” were influenced in their employment and perception of employment by multiple mechanisms, which limited their ability in ways that had not been previously quantifiable, e.g., heat, sun exposure, medication reactions, etc.

When identified physical limitations were assessed using the American Medical Association’s *Guides to the Evaluation of Permanent Impairment (AMAGPI)* (4th ed.) (1993), the picture as to why some patients did and did not go back to work became more evident (Paris, 2006). Though most patients were not disabled in the classic sense, as defined by Social Security criteria, individual patients continued to suffer impairment which, at the very least, complicated their work options, and although not reaching “disability” status, still helped to better explain patient employment decisions. In other words, as the percentage of physical impairment increased, the individual patient’s perception of employability declined. This suggests that disability may be too narrowly defined by just organ function when the transplant patient’s physical ability is also impacted by multiple underlying medical problems [i.e., level of impairment].

Further complicating a patient’s employment options are the limitations imposed by disability status and its impact on the availability of Vocational Rehabilitation Services. Seldom will a patient be accepted for vocational training or education in the absence of documented disability. Given that most kidney patients have “impairments” which do not rise to full disability status, their potential for qualifying for job training is significantly lessened. In cases where patients may be motivated to work, their having been out of the workforce has resulted in the lessening of their employability because of decreasing job skills. Only through their involvement with vocational rehabilitation retraining and education can this problem be ameliorated.

Thus, the double-bind of disability as the primary measure of the kidney patient’s physical status is that on the one hand it may be necessary to document the overall benefit to the patient of no longer being disabled; but in doing so, this process may give the impression that they are absent limitations which may limit the availability of vocational retraining and educational services. Services which may be the key to the patients regaining the skills necessary to become competitive in the job market and for any real chance for employability may become harder to obtain as physical limitations to employment decrease.

The current work is an attempt to overcome these inherent difficulties. It was designed and conducted on the basis of the assumptions that impairment, not disability, is the best measure of employability, and that the providing of and participation in vocational rehabilitation services are key to improving post-kidney transplant employment rates.

## METHODOLOGY

The participants in this study were patients at Dallas Transplant Institute. Dallas Transplant Institute is a subsidiary of Dallas Nephrology Associates, employing over 60 nephrologists, and has a sufficient patient base to provide the number of participants required for statistical analysis. The proposed work is psychoeducational in nature and used a pretest/posttest design with nonequivalent groups following guidelines reported by Rubin and Babbie (2008). Due to the nature of the project, only a small segment of the patient base was appropriate for this study (those who remained unemployed post-tx (transplant)), thus, the proposed study would use a systematic sampling design.

After approval by the appropriate institutional review board (IRB), adult kidney transplant patients between the ages of 18 and 55 who met Texas Department of Assistive and Rehabilitative Services (TDARS) requirements for acceptance and who had been transplanted at least 3 months were invited to come to Job Club. After exclusion criteria were reviewed, information was sent to 342 people who had transplants from 2005 to March 2009. It was not known if these patients were currently employed. Additionally, as other patients saw the signs in the lobby of DTI or were referred by physicians or nurses in the clinic, they were invited to future Job Club sessions, if they met criteria.

The group size was kept to below 8 participants so that discussion was easily achievable. There were four Job Club sessions offered. Each session consisted of 4 sequential meetings that contained sequential content. The same group was asked to attend each 4-meeting session.

Prior to the beginning of the sessions, the Principal Investigator met with representatives from the TDARS counselors and an Area Work Incentives Coordinator to explain Job Club and the desired outcomes. All were very motivated and supportive.

It was hoped that a minimum of 20 recipients who met the selection criteria would agree to participate and complete the series of four training sessions. Given a response of 27 who agreed to participate, and given that there was a limit of less than 8 participants per group, this necessitated that each of the training sessions be conducted on four separate occasions. Each of the sessions included the same content per Job Club protocols and was led by the same individuals.

At the time of initial contact, letters of invitation and informed consent were given to candidates, which described the proposed study, its aims, and patients’ right of refusal to participate without jeopardizing their medical care at the

Dallas Transplant Institute (see *Addendum 1*). Those who agreed to participate were asked to complete the consent form and return it to the PI. Following this, the patient was contacted by the PI and randomly assigned to a group.

At the initial and final meetings, demographic information was gathered, including age, gender, marital status, education level, how long since tx, number of txs, pre- and post-tx employment status, type of pre- and post-tx employment, and their perception of employability. After completion, this was included with medical test results and physician or physician assistant assessment per the American Medical Association's *Guides to the Evaluation of Physical Impairment* (6th ed.) guidelines (2008). This allowed for comparison of the results with the existing literature to help determine the effectiveness of the Job Club intervention model. Additional standardized surveys were completed which measure quality of life, social support, and self-esteem (i.e., MOS SF-36, MOS Social Support Scale, and Self-Esteem Rating Scale, respectively).

Quality of life was measured by use of the MOS Short-Form Health Survey (SF-36), a measure of health perceptions and functioning (Ware & Sherbourne, 1992). It consists of 36 items measuring perceived physical and mental health with eight domains: physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health. Adequate convergent and discriminant construct validity and internal consistency was documented.

The MOS: Social Support Scale is a 19-item multidimensional scale which measures social support in patients with severe medical illnesses (Sherbourne & Stewart, 1991). It consists of four subscales: emotional/informational, tangible, affection, and social interaction. It is highly correlated with other measures of social support, mental distress, and use of health services. It also has excellent internal consistency and factorial validity.

The Self-Esteem Rating Scale (SERS) is a 40-item instrument that was developed to provide a clinical measure of self-esteem that can indicate not only problems in self-esteem but also positive or non-problematic levels (Nugent, 2004). It also has excellent internal consistency and factorial validity.

The Job Club consisted of four regularly scheduled meetings:

The goals of Meeting 1 were to: (a) take the Pre-Test and surveys; (b) create a safe place to share and learn; (c) establish common ground and make a connection with one another; and (d) prepare each participant to receive the information prepared for them in the coming sessions.

Meeting 2 was designed to reduce the patients' anxiety about returning to work by introducing and discussing the many work incentives that are offered by Social Security. This meeting included an Area Work Incentives Coordinator (AWIC) coming to speak with the group to discuss work incentives from Social Security. She explained work incentives for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). She clarified the difference in Social Security benefits, identified problems people had, and then explained various incentives appropriate for them individually.

Meeting 3 was designed to provide support to patients, and to help them understand that they do not have to search for employment or training on their own. Social workers at DTI have developed collaboration with specific TDARS counselors who understand transplant patients' needs. Two of these counselors attended Meeting 3 of each group. They discussed the services offered by TDARS and how the referral and intake process worked. The assessment process was discussed in detail and how this differed with each individual.

Meeting 4 included discussion of what was learned in Meetings 1 through 3. This meeting allowed participants an opportunity to make notes, ask for further information, discuss what they were most interested in from the meetings, and share their future plans. When possible, a previous user of TDARS services was present so that they could relate their experience using DARS. Each patient was asked to complete standardized posttests.

All data was formatted and analyzed using of the most recent version of SPSS statistical software. All tests of statistical significance had a margin of error of 5%. The limited number of bivariate significance tests further limited the risk of Type 1 error.

## RESULTS

The profile of those who chose to participate in the Job Club program could best be described as middle-aged, married, Caucasian males with a high school diploma (see Table 1).

**Table 1**

### *Job Club Participants' Demographic Profiles*

|                        |             |
|------------------------|-------------|
| Mean Age<br>(SD)       | 44.6<br>(9) |
| Mean Education<br>(SD) | 12.4<br>(3) |
| Gender                 |             |
| Male                   | 17 (63%)    |
| Female                 | 10 (37%)    |
| Ethnicity*             |             |
| Caucasian              | 14 (56%)    |
| African American       | 7 (28%)     |
| Hispanic               | 3 (12%)     |
| Native American        | 1 (4%)      |
| Marital status         |             |
| Married                | 19 (70%)    |
| Single                 | 7 (26%)     |
| Divorced               | 1 (4%)      |

\*(n=1 missing)

At the time of Job Club, none of the 27 participants were employed full time. However, 19% (5/27) had secured some form of temporary employment posttransplant prior to Job Club. The posttransplant medical status for those who attended Job Club was primarily disabled per Social Security guidelines (48%; 13/27), with most believing they were physically able to work prior to program attendance (63%; 17/27) (see Table 2).

**Table 4**

### *Pre- and Post-Job Club Knowledge Level*

|                  | Trial Work Period | Keeping Medicare | Return-to-Work Options | Rehabilitation Services Available | Anxiety | Work Incentives |
|------------------|-------------------|------------------|------------------------|-----------------------------------|---------|-----------------|
| Prescore (mean)  | 2.1*              | 1.6*             | 1.5*                   | 1.5*                              | 2.9     | 1.9*            |
| Postscore (mean) | 4.2               | 4.0              | 4.0                    | 4.1                               | 2.8     | 4.6             |

\*(sig <p 0.05)

**Table 2**

### *Posttransplant Employment Status by Employment Perception Prior to Job Club Attendance\**

|                     | Employed | Students/<br>Homemakers | Disabled |
|---------------------|----------|-------------------------|----------|
| Physically Able     | 4        | 3                       | 10       |
| Not Physically Able | 1        | 0                       | 3        |

\*(n=2 missing)

Of the 27 Job Club participants, at the time of their initial meeting: 20% (5/25) had 0–14% impairment; 12% (3/25) had 15–34% impairment; 28% (7/25) had 35–59% impairment; and 28% (7/25) had 60–95% impairment per physician assessment of AMAGPI guidelines (see Table 3).

**Table 3**

### *Posttransplant Patient Evaluation by Most Recent Physician Assessment of AMA Impairment Level Prior to Job Club Participation\**

|                    | Class 1<br>0–14%<br>Impairment | Class 2<br>15–34%<br>Impairment | Class 3<br>35–59%<br>Impairment | Class 4<br>60–95%<br>Impairment |
|--------------------|--------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Number of Patients | 5                              | 3                               | 7                               | 7                               |

\*(n=2 missing)

Those who attended all the Job Club sessions saw significant improvement in their knowledge levels of the rules and regulations regarding trial work period, keeping Medicare while employed, their return to work options, services available through the TDARS, and the work incentives available to them (see Table 4).

When considered on the basis of their perception of social support, those who attended the Job Club found improved or similar social support in most areas, but reported significant improvement in the area of emotional/informational support (see Table 5).

**Table 5**

*Pre- and Post-Job Club MOS Social Support Scale*

|                     | Emotional/<br>Informational | Tangible | Affection | Social<br>Interaction |
|---------------------|-----------------------------|----------|-----------|-----------------------|
| Prescore<br>(mean)  | 3.6 *                       | 4.2      | 4.6       | 4.1                   |
| Postscore<br>(mean) | 4.1                         | 4.2      | 4.5       | 4.3                   |

\*(sig p<0.05)

There were no significant differences found with regards to reported self-esteem pre- to post-Job Club attendance (see Table 6).

**Table 6**

*Pre- and Post-Job Club Self-Esteem Rating Scale*

|                  |      |
|------------------|------|
| Prescore (mean)  | 61.2 |
| Postscore (mean) | 61.9 |

When measuring their quality of life as it related to the period of time during Job Club, attendees reported improvement in all areas except physical functioning. There was, however, a significant improvement in their perception of their ability to fulfill their responsibilities associated with employment, and improved general health functioning (see Table 7).

**Table 7**

*Pre- and Post-Job Club MOS SF-36 Quality of Life Scores*

|                         | Prescore<br>Mean | Postscore<br>Mean |
|-------------------------|------------------|-------------------|
| Physical<br>Functioning | 64.6             | 62                |
| Role-Physical           | 32.5             | 41.3*             |
| Bodily Pain             | 56.7             | 65                |
| General Health          | 40.1             | 48.5*             |
| Vitality                | 67.7             | 73.4              |
| Social Functioning      | 60.9             | 66.5              |
| Role-Emotional          | 60.3             | 65.3              |
| Mental Health           | 40.3             | 44.6              |
| Overall                 | 198              | 207               |

\*(sig p<0.05)

For those who participated in Job Club, 4 used individual services of AWIC, and 11 were referred to TDARS. The employment results from the Job Club showed that, after collapsing Classes 1 through 3 there was significant improvement in employment, per Chi-Square statistical analysis (see Table 8).

**Table 8**

*Post-TX Patient Employment Post-Job Club Attendance by Most Recent Physician Assessment of AMA Impairment Level\**

|            | Class 1<br>0–14%<br>Impairment<br>n=6 | Class 2<br>15–34%<br>Impairment<br>n=4 | Class 3<br>35–59%<br>Impairment<br>n=8 | Class 4<br>60–95%<br>Impairment<br>n=7 |
|------------|---------------------------------------|--|--|--|
| Employed   | 1                                     | 2                                      | 2                                      | 0                                      |
| Unemployed | 5                                     | 2                                      | 6                                      | 7                                      |

\*(n=2 missing)

## DISCUSSION

The primary purpose of kidney transplantation is patient rehabilitation (Manninen, Evans, & Dugan, 1991). That was true in the early 1990s, and possibly more so today, given the dramatic medical improvements in the past 20+ years since that research was published. One aspect that has changed has been the criteria by which one measures “rehabilitation” success. No longer is it simply the removal or absence of medical disability.

In 2004, the AMA adopted a policy statement on patient employment which stated:

The AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients’ return to work.

In response, Talmage and Melhorn (2005) asked, somewhat rhetorically, that if the *Physicians Desk Reference* (PDR, 2004) had a warning that stated, “‘This drug is detrimental to your patients’ mental, physical, and social well-being,’ would physicians prescribe it?” They went on to ask an even more important question: “Is it really true that being out of work is hazardous to one’s health?” (p. 3). After a very exhaustive review of the scientific literature, Talmage and Melhorn (2005) concluded that there was overwhelming evidence to support the idea that unemployment was, in fact, hazardous to one’s health.

The transplant literature has documented that recipients who do not return to work will rate more poorly on almost every psychosocial measure for which they have been evaluated. As laudable as patient employment is, however, it remains an elusive goal.

The current work was an attempt to test an alternative approach to patient employment education and treatment, based on discrete and incremental limitations [i.e., impairment] they may be experiencing, rather than the more traditional categorical method of disabled/not disabled approach. Given the current findings, there is some support for the idea that there may be merit in the argument that when the patients’ vocational programs look at discrete and incremental limitations, they may be more successful in getting patients back to work.

With the current cohort, five participants were employed post-Job Club and 3 out of the 27 were in the process of job placement following referrals from Job Club. However, it is important to recognize, as Life Options has noted (1993), that creating an atmosphere of empowerment and encouragement promotes rehabilitation. Therefore, Job Club continues to promote rehabilitation at Dallas Transplant Institute.

Literature suggests that 30–50% of patients go back to work without assistance from vocational rehabilitation (Paris et al., 1992; Paris et al., 1993; Paris, Tebow, Dahr, & Cooper, 1997). This has been true with lung recipients as well, regardless of their nationality [i.e., American vs. Canadian] (Paris et al., 1998).

This research focused on concern about how other psychosocial areas would be impacted by such an intensive program. An equally important component was the potential psychosocial harm and/or benefit that could have occurred as measured by social support, education, self-esteem, and quality of life.

The reason why this was an important question is related to some suggestion from previous research which reported that an aggressive employment program could, and in fact, had resulted in patients feeling less supported by their families and suffering increased stress (Paris et al., 1997; Paris, 2006). Unlike previous research, there was not a reduction in perceived social support by the patients’ attendance at Job Club. One area, emotional/informational, saw a significant improvement. This may be potentially explained by the significant educational component as well as group attendance which supported a stronger positive emotional reaction. From a practical standpoint, the Job Club approach differs dramatically from other employment programs where the patient may simply be told to seek out vocational rehabilitation services, that the program would no longer support their disability claims, etc. The Job Club approach is based on an acknowledgment that the individual patient needs information provided in various formats, as well as significant support in working through the process of rehabilitation.

In that sense, education may have been one of the key components that contributed to the program’s success. It was found that when patients were asked, they found that their knowledge level had increased significantly in the areas of trial work period, keeping Medicare, return to work options, rehabilitation services available, and work incentives. This was accomplished with no significant increase in their anxiety level from pre- to post-Job Club attendance.

Somewhat surprisingly, Job Club saw only marginal improvement in patient self-esteem. Looking at individuals who found employment and those who did not, there was not any clear trend that could be identified as having any influence on self-esteem, either in a positive or negative direction. One factor could be that self-esteem would have improved if the scale had been given after the person found a job rather than after the classes. It was hoped that the peer support from the group would increase self-esteem. Although this was a very small cohort of patients, regrettably, there is no data to clearly explain this occurrence, and all the rationales are pure speculation at this point in time.

The quality of life responses were of particular interest. Overall, patients reported improved functioning in the areas of having less bodily pain, more vitality, better social functioning, improved emotional state, and better mental health. They reported significant improvement ( $p < 0.05$ ) in their perceived ability to work (i.e., role-physical), and general health. The only area that was reported as having declined was their physical functioning. Since creatinine clearance and AMAGPI impairment level were the only measures of physical ability, and those were assessed on only one

occasion, this limits any real explanation of these results beyond conjecture or speculation. It is certainly encouraging to have found a potential way to get patients involved in a fairly intensive educational program, given that so many of them made major changes by beginning work with vocational rehabilitation services and that some secured employment. The quality of life survey was given twice within a 4-week time span, at the beginning and end of the program. A more accurate measurement of quality of life improvement for those participants who became employed may have been to provide another survey at the time of employment. However, due to protocol, that was not possible. The current group of patients did see improvement in the quality of their lives, but it was limited in scope to two significant areas in the time frame given (perception of ability to fulfill responsibilities associated with employment, and improved general health functioning).

What, then, can be said about the importance of Job Club? As interesting and encouraging as these findings may be, they should be approached rather cautiously. First, this was a small cohort of patients from one transplant program. Second, the type of job, benefits secured, etc. were not tracked or reported. Third, there is no way to guarantee that this group of participants were demographically similar to their fellow patients, or whether they were a self-selected group who may have gone back to work anyway. Fourth, in the absence of replication, this program should still be considered as experimental.

### CONCLUSION

So what, then, can be taken away from this work? The most important finding here is not necessarily that patients were able to secure jobs, but rather that a vocational program done in a group setting, has the potential to both get patients back to work and do so without being associated with major life disruptions to their self-esteem, increased anxiety, or poorer quality of life. Patient reports also suggest the importance of psychoeducation. From a clinical perspective, this suggests that what we know as social workers is really true, that the key element in client treatment is psychoeducation. Having a group format with multiple meetings certainly provides the forum for the greatest opportunity to learn and gain social support from peers experiencing similar life situations.

Certainly the results are encouraging, but there are still many unanswered questions. The authors hope that the current work will help to provide some guidance on how to better prepare transplant recipients in their attempts to secure employment. This program needs further refinement and replication to clarify exactly what occurred; however, a new and easily achievable format in transplant rehabilitation seems possible.

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## ADDENDUM 1

## DTI

*Dallas Transplant Institute*

*3604 Live Oak, Dallas, Texas 75204 (214) 358-2300; Fax (214) 579-6976*

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*May 21, 2009*

In an effort to provide better *return to work services* for interested patients, we will be offering a “Job Club” at Dallas Transplant Institute during the months of July, August, September, and October. The **Job Club** will consist of 4 classes focused on returning to work. The classes will include information on

1. Support from DTI social workers and other **Job Club** participants
2. Work incentives from Social Security
3. Rehabilitation services from the Texas Division of Assistive and Rehabilitation Services
4. The opportunity to speak with other patients who have been through this experience.

Since this will be the first time **Job Club** will be offered at DTI, we are doing this as part of a project grant called: “Kidney Transplant Patient Employment: Vocational Training and Intervention by Use of an Impairment Rather than Disability Model.” As such, we will be asking those who join us to complete 3–5 surveys so that we can measure the usefulness of what we are doing and make needed changes to improve **Job Club**. The surveys you complete will be coded with a number so that your name will not be associated with the surveys. The surveys will then be kept within the social work department at DTI and will be under lock and key and password protected.

Once **Job Club** is completed, the coded information will be provided by me in a confidential manner to my co-Principal Investigator, Dr. Wayne Paris at Southern Illinois University at Carbondale, School of Social Work for data entry and analysis. Once analyzed, the data will be used by us for professional presentations, publications, and future grant proposals. This study will be funded in part by the National Kidney Foundation Council of Nephrology Social Workers and the Society of Transplant Social Workers.

Your participation is entirely voluntary and refusal to participate will not affect your ongoing care at DTI. If interested, please print your name, sign and return the form in the enclosed envelope and someone will be in contact with you within a month.

\_\_\_ Yes, I wish to participate. My name is

\_\_\_\_\_ (Print)

Date \_\_\_\_\_ Signature \_\_\_\_\_

**Thank you.**

**Mary Beth Callahan, ACSW/LCSW (214) 358-2300, ext. 6290**