

## Clinical Case Review: Returning to Dialysis after Transplant: A Nearly Silent Matter

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*While looking for resources for patients and healthcare providers to assist when a transplanted kidney has failed, I found a significant lack of literature. This article will review transplant survival statistics which underscore the scope of the subject and coping strategies identified in the literature. There is also a call to professionals for more attention to this matter.*

In 2009, the National Kidney Foundation staff requested resources for dialysis patients and staff who are dealing with a person with kidney transplant failure. As I understood it, this was in response to a request from a dialysis unit about a specific patient situation. An internet search yielded no results and a Medline search did not turn up much either. The references I found were about the timing of resuming treatment, whether to continue immunosuppressant medications, and when a transplant nephrectomy was warranted. To meet the immediate need for this and other possible requests, I wrote an article geared for patients which was published in the Summer 2009 issue of the *Transplant Chronicles*, "When a Transplant Fails," based on my experiences with the kidney transplant team at Rush University Medical Center, Chicago, IL.

I was intrigued at the apparent paucity of information about this common occurrence. After being asked to present on this topic at 2010 National Kidney Foundation Spring Clinical Meetings, I did more research on the matter through MEDLINE, PsychINFO, and Google.

### **Scope of the Subject**

The truth is, if a transplant recipient lives long enough, every transplanted kidney will fail and most recipients will return to dialysis sooner than they had hoped. According to the *USRDS 2009 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States*, the conditional half-life of a kidney transplant from a deceased donor is 13 years. The conditional half-life of a kidney transplant from a living donor is 23 years. However, Meier-Kreische, Schold, and Kaplan (2004) indicate that for transplants performed in 1995, the half-life was actually 8 years. Whether the kidney lasts 8 years or 13 years or 20 years, the transplant will probably not last as long as the patient would like.

### **Adjusted Graft Survival, Deceased Donor, Non-ECD Kidney Transplants Survival at 3 Months, 1 Year, 5 Years, and 10 Years**

	3 months	1 year	5 years	10 years
	Tx 2006–2007	Tx 2006–2007	Tx 2002–2007	Tx. 1997–2007
Total transplants (% grafts working)	20,298 (95.4%)	20,298 (91.2%)	55,513 (69.1%)	94,990 (41.8%)

Note: From U.S. Department of Health and Human Services, Health Resources and Services Administration, Healthcare Systems Bureau, Division of Transplantation (2009). *2009 Annual Report of the U.S. Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients: Transplant Data 1999–2008*. Rockville, MD: Author. From [http://www.ustransplant.org/annual\\_reports/current/default.htm](http://www.ustransplant.org/annual_reports/current/default.htm)

### **Adjusted Graft Survival, Living Donor Kidney Transplants Survival at 3 Months, 1 Year, 5 Years, and 10 Years**

	3 months	1 year	5 years	10 years
	Tx 2006–2007	Tx 2006–2007	Tx 2002–2007	Tx. 1997–2007
Total transplants (% grafts working)	12,462 (98.1%)	12,462 (96.4%)	38,350 (81.4%)	62,864 (58.9%)

Note: From U.S. Department of Health and Human Services, Health Resources and Services Administration, Healthcare Systems Bureau, Division of Transplantation (2009). *2009 Annual Report of the U.S. Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients: Transplant Data 1999–2008*. Rockville, MD: Author. From [http://www.ustransplant.org/annual\\_reports/current/default.htm](http://www.ustransplant.org/annual_reports/current/default.htm)

Tx = transplant

These are good odds. Transplant centers share their survival statistics (graft and patient) with patients and how those compare nationally but, in my opinion, most of the focus is on the successes. Based on these charts, there are nearly 2,000 transplanted kidneys which fail in the first year and by 10 years over 75,000 transplanted kidneys have failed.

That is a lot of people starting dialysis after a failed transplant.

### ***Patient-Focused Article***

A Google search found only one reference specifically for patients about starting dialysis after transplant. The article from *aakpRENALIFE* (Bodziak, March 2002), was entitled “I Have to Begin Dialysis Again after Several Years as a Transplant Patient. Are There Any Issues or Concerns I Should be Aware of Before I Start Dialysis?” The doctor responded to the question by discussing the timing of resuming therapy, lifestyle changes (diet and fluid adjustments), medication management (resumption of dialysis medications and discontinuation of immunosuppressants), and the possible need for transplant nephrectomy and getting listed for another transplant.

### ***Professional Literature Search***

Most of the articles I found on the MEDLINE database were related to medical management of a person starting dialysis after a failed transplant. There were some articles on PsychINFO that had a psychological or psychosocial focus, however many of them were quite dated.

The range of emotional responses noted in the articles included: shock, depression, guilt, grief, recognition that the organ wasn't going to last forever (not shocked), relief, gratitude, and desire for re-transplantation. These seem consistent with what I have seen in my patient population.

Also not surprising are the factors which impact the emotional response: length of time the transplant functioned, type of donor (deceased or living), complications after transplant, episodes of rejection, sense of “fault,” support system, and coping style.

### ***Challenges to the Renal Community***

In 2008, Messa, Ponticelli, and Bernardinelli said, “A great number of uncertainties are still present, including the handling of these patients. This is mainly due to the fact that during the transition from transplant to dialysis, the patient with a failed graft enters a no-man's land, where all and none of the physicians involved (transplant nephrologists, transplant surgeons, dialysis nephrologists) feel to have the primary clinical charge of the patient. For this reason, very scattered data and no trials at all have been produced on the topics...” He goes on to say that some of this is attributable to “...the reluctance of both patient and doctor to accept the irreversible failure of the graft.”

### ***Depression***

One area of primary concern among nephrology social workers is the factors which can make a person more susceptible to depression. Would starting dialysis after failed transplants increase the rates of depression?

Akman, Ozdemir, Sezer, Micozkadioglu, and Haberal (2004) focused on rates of depression before and after transplant, including a group of patients who had failed transplants. Of their 88 participants, 31 had failed transplants. Dialysis patients who had failed transplants had the highest rates of moderate or severe depression. Of particular note, the shorter the kidney worked, the higher the stage of depression. Their explanation was that people who had their kidney for a long time likely had more complications and had time to adjust to the idea of needing dialysis. They indicated that people who had early transplant failures had more depression due to the unexpected nature of the loss. This study also showed that having a strong support system seemed to decrease the rates of depression.

Gill and Lowes (2009) reported that depression associated with graft failure is usually temporary and generally improves as the physical health improves. The primary source of depression was the “loss of imagined future.”

### ***Factors Which May Impact the Transition to Dialysis***

- **Sense of Vulnerability:** A sense that the kidney may not work “forever” can come from early or serious episodes of rejection, multiple hospitalizations, frequent infections, etc. Nadel and Clark (1986) showed that “...living through one or more rejections may impart an undeniable experience of vulnerability.” These episodes of illness or rejection may serve to warn the person that the kidney may not have a long life expectancy. As above, Akman et al. (2004) connect a shorter period of kidney function with higher rates of depression because of the unexpected nature of the loss.
- **Type of Donor:** In two of the articles and in my experience as a transplant social worker, the type of donor may impact a person's transition to dialysis. Two of the articles offer case presentations of people who had difficult transitions to dialysis after transplant failure. In both cases, the donors were family members. One recipient reported that he did not feel comfortable around his family because his lifestyle led to the loss of the kidney. The other case was a woman who had gotten a kidney from her husband. She noted that it was difficult because her husband had always been her source of support. She stated that she did not want to burden him with her depressed feeling after the failed transplant. In these situations, the fact that the kidney came from a known living donor seemed to complicate the emotional response to the transplant failure.

- **Sense of Fault or Guilt:** While it is important to take accountability for one's actions, getting stuck in a place of self-blame may make it difficult to successfully transition back to dialysis or in moving forward in other parts of the person's life. Recently I met with a young man who had been transplanted as a child, receiving his brother's kidney. Per his report, as a teenager he began to miss medications and skip followup appointments. Eventually his kidney failed and he returned to dialysis. He has been back on dialysis for 6 years, but still talks about feeling guilty about losing his transplant and confirmed that he feels dialysis is a punishment for not taking care of the kidney.
- **Relief:** In my work, I have worked with people who described their reactions upon learning that they needed to start dialysis as "a relief." Anecdotally, this seems to be the reaction of people who have had multiple complications after transplant including: infections, rejections, hospitalizations, procedures, difficult side effects to the medicines. Some people had a better sense of well-being when they were on dialysis and were looking forward to regaining that.

### **Coping Strategies**

In the literature search, I found three articles that focused on coping strategies used by people whose kidney transplants have failed and had started dialysis.

#### *Grievers Versus Deniers*

Stretzler, Moe, Yanagidy, and Siemsen (1983) identified two coping strategies that patients used as they started dialysis after transplant.

- *Grievers* are those "...who described going through a grief reaction during the rejection process including such feelings as depression, guilt, irritability, anger, sadness, and a preoccupation with the loss of the kidney and its implications for their future lifestyle."
- *Deniers* are those "...who described no or minimal depression and the notable absence of anger, guilt, discouragement or concern about the impact on their lifestyle."

Stretzler et al. (1983) looked at 25 dialysis patients who had had a previous transplant. Of the group, 14 fell into the "griever" coping style and 11 were "deniers." They noted that 24 of the 25 had a "good psychological readjustment to chronic dialysis." The one who did not was a young man who didn't take care of himself and lost his brother's kidney (the case referenced earlier).

#### **Grievers:**

- Less frequently reported feeling well prepared for rejection.
- 36% reported feeling thankful for returning to dialysis, 43% felt resignation to the need, and 21% felt it was a step backward.

#### **Deniers:**

- Reported having a more positive reaction to returning to dialysis.
- 80% reported being thankful for returning to dialysis, 20% were resigned to the need, and none felt it was a step backward

Stretzler et al. state that it is important to understand which category a person falls into. Grievers should be allowed, perhaps encouraged, to express their grief. Deniers should be supported in their denial and "not forced to vent their feelings."

### **Cognitive Dissonance**

In this model of coping, patients seem to "rewrite history" to make it fit the current circumstances. Wagener and Taylor (1986) interviewed 29 people; 16 had started dialysis after transplant and 13 still had functioning kidney transplants. They were all transplanted in the early 1980s at a particular center. At the time of transplant, all recipients were told that there was an expected success rate of 60% for deceased donor kidney transplants. People with failed transplants recounted being told that the success rate was lower. They also agreed that they would have taken the kidney no matter what the odds. Those patients with working kidneys did not quote lower odds. The transplant failure group was less likely to state that they seriously considered staying on dialysis and more likely to say that dialysis wasn't working well for them.

"The results of this study suggest that failed renal transplant patients were more likely than successful transplant patients to see the transplant as their only course of action." No decision was actually made, because there was no choice. This suggests that cognitive dissonance can be protective from negative outcomes.

### **Meaning Making**

Ouellette, Achille, and Paquet (2009) interviewed 15 people with failed transplants. Their goal was to find out how people develop constructive meaning from the transplant loss and return to dialysis; essentially, what "story" did they tell themselves? She found that the stories fell into a few categories.

- Transplant failure was due to a medical problem, e.g. it was a marginal kidney to begin with.
- Recipient went back to work too soon and didn't allow the body to fully recover first.
- Perceived benefits of the graft failure, including new appreciation of life, family, and friends, or that this is an opportunity to take on new challenges.

"By shattering their assumptive world, kidney graft failure eroded participants' meaning of life." When a person gets a transplant, they develop stories about what he or she will be doing with their life now that they have a new kidney. When the kidney fails—now what? The implication is that it could be protective if people with failed transplants are able to develop a positive understanding of their need to start dialysis.

### Call to Professionals

Based on these articles, it may benefit transplant and dialysis professionals to be attentive to these items when assessing a person coming to dialysis after a failed transplant:

- Attentive to signs of depressed feelings.
- Patients with limited support systems may need more support from the dialysis team.
- People who were not following up regularly with a transplant team or nephrologist may not have had as much warning of the upcoming need for dialysis. Starting dialysis may be a bigger shock to them.
- Impact on quality of life: Bremer, McCauley, Wrona, and Johnson (1989) identified people with failed transplants as having "...the greatest losses in both objective and subjective quality of life."

### "Would you do it again?"

I have asked many people as their kidneys are failing if they would do it again, knowing what they know now. Most say they would. The literature points in the same direction.

Nadel and Clark (1986) noted that two-thirds of patients want another kidney transplant. So, having firsthand experience of transplant failure is not a deterrent to re-transplant for most people. Holley, McCauley, Doherty, Stackiewicz, and Johnson (1996) reported that people who had a failed transplant were not less likely to be on the transplant list than people who have never been transplanted.

### CONCLUSION

Below are some opportunities for the renal community to do further study, based on the search of the literature.

#### Professional Opportunities:

- Increased understanding of what patients experience when they lose a kidney transplant and need to start dialysis.
- For patients, how is the loss of a transplanted kidney similar/different from the loss of their native kidneys?
- When are social workers (dialysis or transplant) informed that patients are returning to dialysis?
- What kind of support from the various healthcare teams would be the most effective and when?
- Encouraging articles from patients about their experiences with losing a transplant.
- What preparation can be offered to help ease loss and transition?
- What can the transplant team do so the patient doesn't feel abandoned when the kidney fails?
- How can communication improve between the transplant centers and the dialysis units?

- With the gathering of KDQOL information, there may be opportunities to look at large groups of people who are starting dialysis after transplant.
- Do people have a different experience starting dialysis if they are re-listed before beginning treatment?

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**SOCIAL WORK ABSTRACTS FROM THE NATIONAL KIDNEY FOUNDATION  
2011 SPRING CLINICAL MEETINGS**

**Chronic Kidney Disease**

- 1 **Dialysis Clinic: A Valuable Field Experience to Teach MSW Interns Advanced Generalist Practice**  
Steve Bogatz, FMS-Central Connecticut Dialysis Center, Meriden, CT, USA
2. **Video Education Increases Patient Attainment of Target Phosphorus Levels**  
Shaun Boyd, T. Christopher Bond, Tonya Zimmerman, Kathy Parker, Karen Spach, Duane Dunn  
DaVita Inc., Denver, CO, USA

**Hemodialysis: Other**

- 3 **Has Anything Changed Since the Implementation of the 2008 Conditions for Coverage? 2010 Nephrology Social Work Caseloads, Salaries and Implications for CKD Care in the United States**  
Teri Browne<sup>1</sup>, Joseph Merighi<sup>2</sup>, Kathleen Bruder<sup>2</sup>  
<sup>1</sup>University of South Carolina, Columbia, SC, USA  
<sup>2</sup>Boston University, Boston, MA, USA

**Home Hemodialysis**

- 6 **Psychosocial Barriers to Home Dialysis: A Literature Review**  
Julie Regimbald, Cindy Gill  
The Ottawa Hospital, Ottawa, Ontario, Canada

**Other**

- 4 **Transition: Navigating the Journey from Pediatric to Adult Renal Care**  
Angela Degnan, Cherie Burroughs Scanlon, JoLynn Grimes, Diana Hurley, Linda Jones, Angie Knackstedt, J. Tyson Moore, Rachel Nadon, Amy Nau, Leah Oladitan, Cheryl Orr, Bradley Warady  
The Children's Mercy Hospital, Kansas City, MO, USA
- 5 **Perceptions of Hemodialysis Patients and Renal Providers Regarding Advanced Care Planning in a Single Nonprofit Dialysis Unit**  
Shiloh Erdley, Ion D. Bucaloiu, Evan R. Norfolk  
Danville, PA, USA

1. **DIALYSIS CLINIC: A VALUABLE FIELD EXPERIENCE TO TEACH MSW INTERNS ADVANCED GENERALIST PRACTICE.**  
Steve Bogatz, FMS- Central Connecticut Dialysis Center, Meriden, CT  
 In recent years, some graduate social work programs have embraced the tenets of advanced generalist practice: the ethical and cross-culturally competent application of interventions at the micro, mezzo, and macro levels. The dialysis clinic presents rich educational opportunities for MSW interns to learn and practice these skills.  
 On the micro level, the intern learns the fundamentals of psychosocial assessment and counseling to improve patient and familial adjustment. Useful practice theories include Hepworth and Larson's Five Stages of Empathy, Prochaska and colleagues' Stages of Change Model, and evidence based practice with the Kidney Disease and Quality of Life tool. Connecting the client with concrete resources usually enhances the therapeutic relationship. The result illustrates how concrete and clinical services together may be necessary for client's total well-being. Also, the student can hone communication skills working with varied interdisciplinary-team personalities. Since kidney disease affects all races, genders, classes, and sexual orientations, work with diversity is ever present.  
 On the mezzo level, dialysis clinics are heavily regulated with most employers worried about tight margins. The cost of supplies and services is strictly monitored along with patients' clinical indicators. This dynamic can help build a student's ethical reasoning and create advocacy opportunities. The intern can interact with insurance companies, drug manufacturers, transplant centers and the home agency to ensure patients receive access to care. One learns to navigate complex systems and formulate effective arguments based on data.  
 On the macro level, dialysis patients depend on federal institutions. Assisting patients with Medicaid and Medicare means contact with state and federal agencies. Organizations like the NKF and American Kidney Fund lobby for research dollars and social justice for their constituency. Interns can observe and/or participate in the political process that these national organizations employ to achieve their goals.  
 Over the course of 9 years, the author supervised 6 MSW interns using an advanced generalist philosophy. Four have gone on to have successful careers in medical social work.
  
2. **VIDEO EDUCATION INCREASES PATIENT ATTAINMENT OF TARGET PHOSPHORUS LEVELS**  
Shaun Boyd<sup>1</sup>, T. Christopher Bond<sup>1</sup>, Tonya Zimmerman<sup>1</sup>, Kathy Parker<sup>1</sup>, Karen Spach<sup>1</sup>, Duane Dunn<sup>1</sup>  
 (1) DaVita Inc., Denver, CO, USA  
 The value of video education in the dialysis setting has not been reported in the literature. We assessed the acceptance of a video education project and its effectiveness in improving the percent of patients with phosphorous (P) levels within the recommended range ( $\leq 5.5$  mg/dL).  
 Eleven of 13 dialysis centers in one region of a large dialysis organization (LDO) participated in the video education project. Center census ranged from 13 to 141 patients. A mixed linear model was employed to assess changes in percent of patients who had P levels within range ( $\leq 5.5$  mg/dL) before and after the program.  
 The percent of patients within P range is shown.
 

Center-level mean	Mean pts/center	Before program 08/09-01/10	After program 04/-06/10
Participating (11)	49	69.9	72.8

 Of the over 300 patients who completed a post-video questionnaire, 79% indicated videos increased their overall knowledge of dialysis and 80% want more video education in the future.  
 The 2.9% increase in the % of patients within range for P after a video education program was marginally significant ( $p=0.059$ ), indicating a larger controlled evaluation might provide useful information.
  
3. **HAS ANYTHING CHANGED SINCE THE IMPLEMENTATION OF THE 2008 CONDITIONS FOR COVERAGE? 2010 NEPHROLOGY SOCIAL WORK CASELOADS, SALARIES AND IMPLICATIONS FOR CKD CARE IN THE UNITED STATES**  
Teri Browne<sup>1</sup>, Joseph Merighi<sup>2</sup>, Kathleen Bruder<sup>2</sup>  
<sup>1</sup>University of South Carolina, Columbia, SC, U.S.  
<sup>2</sup>Boston University, Boston, MA, U.S.  
 In 2010, The Council of Nephrology Social Workers conducted a confidential online survey of United States social workers in all settings, i.e., chronic kidney disease (CKD), dialysis, transplantation and administration. The study findings explicate the current salaries, benefits, licensure status, education level, number of dialysis units covered, scope of social work services provided and caseloads of nephrology social workers, and provide important guidance to improve CKD patient care. The 2010 study outcomes are compared to the results of a similar 2007 survey to examine trends with regard to work roles and responsibilities. Each wave of the survey had more than 1,000 respondents. In 2010, annual full-time salaries ranged from \$29,994–97,760 (median \$54,829) for dialysis social workers and \$44,658–84,864 (median \$61,006) for transplant social workers. Caseloads for full-time dialysis social workers in 2010 were as high as 711 patients (median 125), which represents an 8% increase since 2007. We conclude that caseloads for social workers have increased since the implementation of the 2008 Conditions for Coverage for End-Stage Renal Disease Facilities. We posit that social workers who have high caseloads, cover more than one dialysis unit, and have to drive great distances to their workplaces are less able to provide adequate assistance to CKD patients and their families in ameliorating psychosocial barriers to optimal care and outcomes.
  
4. **TRANSITION: NAVIGATING THE JOURNEY FROM PEDIATRIC TO ADULT RENAL CARE**  
Angela Degan, Cherie BurroughsScanlon, JoLynn Grimes, Diana Hurley, Linda Jones, Angie Knackstedt, J. Tyson Moore, Rachel Nadon, Amy Nau, Leah Oladitan, Cheryl Orr and Bradley Warady  
 The Children's Mercy Hospital, Kansas City, Missouri, USA  
 Transition and transfer of care from pediatric to adult renal providers is not well researched and best practice methods are not well defined. This results in less than optimal outcomes for patients with chronic kidney disease (CKD) who reach this developmental milestone. To address this important issue, a multidisciplinary group of pediatric and adult renal care providers from multiple institutions came together to identify barriers and solutions to a more successful process. Objectives for the day were: (1) review the stages of young adult development, including the impact of chronic illness on development; (2) describe transition strategies based on published research (3) describe the components of a pediatric transition education program; (4) discuss needs and expectations for successful transition to adult care; and (5) identify barriers and solutions to effective transition of young adults to adult care. The day consisted of a morning education program including lectures titled: *Trials & Tribulations of Working with Teens with Chronic Illness*, *Empowering Young Adults with Chronic Kidney Failure and Barriers to Adherence*. Presentations were also made by recently transitioned young adults. In the afternoon, collaborative roundtable discussions were held to explore the barriers and solutions to the transition/transfer process. There was unanimous consensus that to improve the process, a city wide transition steering committee should be established. In addition, a need for subcommittees to address solutions to specific issues was identified. The issues consisted of the need to create/nurture independence among pediatric patients, to integrate adult care concepts into the pediatric setting, to provide adult provider information to pediatric patients prior to the transfer of care, and to procure funding to support these efforts. The plan going forward is to populate these groups with both pediatric and adult renal care providers and to actively pursue solutions during the next 12 months. The entire group will reconvene in 1 year's time to evaluate outcomes, monitor success and further modify and improve the transition process.

5. **PERCEPTIONS OF HEMODIALYSIS PATIENTS AND RENAL PROVIDERS REGARDING ADVANCED CARE PLANNING IN A SINGLE NONPROFIT DIALYSIS UNIT**

Shiloh Erdley, Ion D. Bucaloiu, Evan R. Norfolk, Danville PA, USA

The low prevalence of end of life and advanced care planning in end stage renal disease (ESRD) patients is surprising considering the high mortality rates in this population. We simultaneously explored patient and nephrologist attitudes towards advanced care planning and end of life issues in a rural, nonprofit dialysis unit affiliated with a tertiary care center.

Prevalent ESRD patients (68) and their nephrologist (10) were asked to complete separate questionnaires exploring generic knowledge and perceptions of physician–patient communication regarding advanced care planning. We then retrospectively explored the relationship between pre ESRD education and completed advanced directives among the patients in our cohort.

Results indicated that the vast majority (67%) of patients lacked a basic understanding of end of life planning including the meaning and purpose of advanced directives and code status. 58% of patients reported minimal to any communication with their renal provider about end of life planning. 81% of patients and 100% of the renal providers indicate a desire to have an open communication to discuss advanced care planning. The providers unanimously felt that this topic should be incorporated into a multidisciplinary process involving a social worker, dialysis nurse and dietitian. 37% (24 of 65) of patients in the cohort attended a pre-dialysis options dialysis education class. Advanced directives completion rate was higher in the group that attended the class compared with those who did not [9/24 (37.5%), vs. 5/24 (14%) respectively].

Our results suggest that the low rate of advanced directives completion is multifactorial. Pre-ESRD education on advanced care planning may have an important role in increasing advanced directives completion rates. Improving patient and physician education regarding advanced care planning in addition to creating reliable processes of communication between patients and their renal care team are important priorities in order to improve the quality of care delivered to ESRD patients.

6. **PSYCHOSOCIAL BARRIERS TO HOME DIALYSIS: A LITERATURE REVIEW**

Julie Regimbald, Cindy Gill

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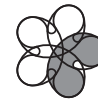
Home dialysis has been a viable treatment option for ESRD since the 1960's for hemodialysis and the mid-70's for peritoneal dialysis. The current rate of home dialysis is 12.9% in Canada, whereas worldwide rates reach as high as 40%. In Ontario, Canada, the goal is to increase the use of peritoneal dialysis to 30%. The psychosocial barriers facing home dialysis patients can easily be taken for granted. Social work has a key role to play in supporting the success of home dialysis programs.

This review explores the challenges and successes of home dialysis. The literature identified multiple psychosocial barriers: physical and cognitive ability, mental health, patient attitudes and personality, emotional impact on the patient and family, presence of helper for treatments, patient's adherence with procedures, cultural issues, suitability of patient's home, support from the medical team, time constraints, cost to patient, patient education on the benefits of home dialysis, staff support for expanding home dialysis, learned helplessness of in-centre dialysis patients, and loss of relationships with peers.

Assessment tools addressing potential barriers to home dialysis already exist (MATCH-D, JPat). However, the need for a more comprehensive tool assessing both practical and social issues is indicated. To this end, the authors have developed and are testing a new tool; the PATH-D (Psychosocial Assessment Tool for Home Dialysis).



# CNSW Research Grants Program



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Social Workers

## PURPOSE

In keeping with the overall goals of the National Kidney Foundation (NKF) and its Council of Nephrology Social Workers (CNSW), the purpose of the CNSW Research Grant Program is to further knowledge of psychosocial factors in kidney failure and to enhance clinical social work intervention with dialysis and transplant patients/families.

## AREAS OF INTEREST

- Research on psychosocial factors in kidney failure
- Clinical practice research projects focusing on social work assessment and treatment strategies with patient/families or staff
- Educational programs to enhance patient/family understanding of kidney failure treatment and its psychosocial implications
- Pilot or demonstration projects which have broad applicability to nephrology social work services and/or nephrology social workers

## ELIGIBILITY

Grant applications must meet the following eligibility requirements:

- Regular membership in CNSW
- Minimum of two years nephrology social work experience (CMS Guidelines)
- Approval of the department head or facility director of the organization within which the research is to be conducted
- Residence in the United States or its territories
- Applicant must meet the definition of a “qualified social worker” as stated in the Conditions for Coverage

Preference will be given to applicants who:

- Have ACSW accreditation or are licensed by their state

Awards typically announced in March. The Review Committee reserves the right to award grants or to decline funding without stating its reasons.

## GRANT REQUIREMENTS

Each grant recipient is responsible for:

- Conducting the project as set forth in the proposal and consistent with accepted, systematic research methods
- Obtaining appropriate human studies clearance within the dialysis/transplant facility and maintaining data in a confidential manner
- Completing the project within the specified time frame
- Providing financial reports as required by the National Kidney Foundation
- Acknowledging NKF-CNSW grant assistance on all publications arising out of the work done during the duration of the grant
- Submitting three interim progress reports and other requested reports, preparing a final report of the work accomplished within 60 days of the end of the grant year, and presenting a paper at the NKF Spring Clinical Meetings describing the research, results and implications for practice
- Submitting a manuscript based on the results to *The Journal of Nephrology Social Work* (and with the committee’s approval, another related journal).

## FUNDING

- CNSW annually requests grant monies from NKF.
- One or more grants may be awarded. Applicants submitting to more than one granting agency will be awarded the difference between the amount awarded by the other agency and the amount applied for from CNSW.
- CNSW grants assist in defraying the cost of research and projects. They are not intended to cover the entire cost of the research (i.e., office space, basic supplies, services, overhead, administration fees).
- Funds may not be used for the purchase of equipment.
- Budgets must allocate \$750.00 for airfare and one night’s accommodation to enable grantees to present their research at the NKF Spring Clinical Meetings. This amount will be withheld until the first draft of the manuscript is received by the *Journal of Nephrology Social Work* co-editors and the awardee has presented findings at the next NKF Spring Clinical Meetings.
- Funding for CNSW research grants typically runs from July 1 of the year of approval through June 30 of the following year.

## CNSW Research Grants Program *(cont'd)*

### HOW TO APPLY

If you are interested in preparing a proposal, please submit a letter of intent to the CNSW Research Grant Program, c/o the National Kidney Foundation. Your letter of intent is not part of your actual application, but rather a device to assist you and the grants coordinator in identifying your research objectives and goal. The letter of intent must include the following:

1. Name of the person and organization submitting the proposal
2. Address
3. Telephone number
4. Name of the principal investigator and his or her CNSW membership number
5. Short title of the project
6. Approximate cost
7. Brief abstract under 250 words, which includes:
  - a. A description of the project goal
  - b. How it relates to the purpose of CNSW research

Upon receipt and acceptance of your letter of intent, NKF-CNSW will send you a grant application packet. Due dates for letters of intent and grant proposals, in addition to the review schedule, will be posted on the CNSW website.

### CONSULTATION COMMITTEE

CNSW has volunteer consultants available to provide recommendations and prior review of your proposal. For more information, please contact your CNSW Region Representative or the CNSW Chair-Elect.

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The Council of Nephrology Social Workers (CNSW) is a professional organization established by nephrology social workers in 1973. CNSW is one of four Professional Councils of the National Kidney Foundation (NKF). The functional structure of CNSW includes an Executive Committee with regional representation, standing and ad hoc committees, and local chapters.

For more information contact:

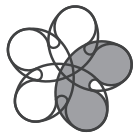
Stephanie Stewart, LICSW, CNSW Chair-Elect

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**[www.kidney.org/professionals/CNSW](http://www.kidney.org/professionals/CNSW)**

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website: **[www.kidney.org](http://www.kidney.org)**





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# WHAT CAN YOU DO?

## GET TESTED

If you have diabetes, high blood pressure, or a family history of these conditions or kidney disease, you are at risk. See your doctor and get screened. The National Kidney Foundation offers frequent free kidney health screenings across the country.

## VOLUNTEER

The Foundation welcomes volunteers of all ages and interests. Contact your local NKF office to sign up.

## JOIN NKF

Thousands of healthcare professionals, patients, donors, recipients and their families benefit from the educational information, guidance, support and advocacy opportunities provided by membership in the National Kidney Foundation and participation in the NKF "People Like Us" Take Action Network.

## SUPPORT NKF

You can help by making a direct or memorial gift, participating in a Kidney Walk or NKF Cadillac Golf Classic Tournament in your community, donating a vehicle to Kidney Cars, attending a fundraising event, or making the NKF a beneficiary of a planned gift.

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