Vancouver CoastalHealth
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Vancouver General Hospital
Renal Social Work
Evidence Based Outcomes

Renal Program
Vancouver General Hospital
899 West 12th Avenue
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VGH Renal Social Work Evidence-Based Outcomes

Introduction:
At Vancouver General Hospital's Renal Program, all persons with chronic kidney disease are assigned a social worker. Assignment of a social worker occurs at the first appointment with the Kidney Clinic team or during the hospital admission when kidney replacement therapy is initiated.

Framework:
This framework (VGH Renal Social Work Outcomes) for psychosocial assessment, intervention, and outcome measurements guides evidence-based social work practice in the program. To supplement the framework, suggested assessment tools, databases and resources are listed. Continuous quality improvement (CQI) efforts will be enhanced through the identification and measurement of psychosocial related indicators that can be generated from any category within the framework.

Ten broad social work themes have been identified. The themes address patient issues relevant in all treatment areas and acknowledge the cultural and language diversity of this population.

Definition of Terms

Headings – These themes are the primary areas for social work involvement with kidney patients and their families

Problem/Goal – Specific behaviors, moods, and problems that are brought to the social workers' attention. These can be by the patient, family, team member as well as issues social workers explore as part of their follow-up.

Intervention – The action that the social worker takes to address the problem/goal. The intervention can be directly with the patient/family as well as with other professionals or the team.

Tool/Resources – A list of possible tools such as pamphlets, questionnaires, and services from our own renal program as well as external resources. This list is not exhaustive.

Outcome – This suggests best outcomes generated from the work of the renal social workers. One or several of these outcomes may be achieved. Quality Indicators may also be chosen to measure from these outcomes.

1. Adherence to Treatment

Problem/Goal	Intervention	Outcome
Patient not taking medications/ following fluid restrictions Patient doesn't attend Kidney Clinic appointments, dialysis treatment on time, or doesn't stay for duration of dialysis treatment Difficulty engaging in lifestyle changes to enhance health such as an exercise program or stop-smoking program (See substance use category)	Explore patient's knowledge base about medical situation related to recommended treatment Explore patient's health beliefs and how they relate to prescribed treatment regimes Explore possible barriers for patient or in patient's family to following treatment Help patient and family set realistic goals to achieve recommended treatment Assist patient with development of action plan to achieve specific goals Discuss patient's cultural beliefs related to recommended medical treatment in a sensitive and respectful manner. Direct communication with the patient in his/her own language of choice should be facilitated when possible. Staff and interpreter services will be involved as necessary. **Tools/Resources:** Psychosocial Assessment *(VGH Nephrology Social Work Assessment, Kidney Clinic Initial Visit Assessment)* Perception of Adherence Burden Questionnaire – *NFK/Council of Nephrology Social Workers, An Outcomes Driven Practice Model, CNSW Annual Meeting, 2000* Behavior Plans/Contracts – "*Dealing With Challenging Dialysis Patient Situations- A Practical Handbook of Expert Guidance", Mary Rau-Foster, Foster Seminars and Communications Publishing, l999*	Patient verbalizes adequate understanding of expected behavior Patient demonstrates improved adherence to part or all of treatment plan Patient's measurable health indicators improve, eg. blood work, attendance at dialysis or appointments Patient attempts or makes lifestyle change

2. Depression/Anxiety/Decreased Coping

Problem/Goal	Intervention	Outcome
Patient or family describes that patient has depressed mood Patient's ongoing behaviours indicate problems with coping; crying, emotional distress, substance use, risk taking activities, poor sleep, anger Patient is anxious Patient's Kidney Disease Quality of Life questionnaire scores indicate depression	Explore possible causes of difficulty in personal or family situation Assess for types of symptoms including frequency, duration and severity Discuss history of depression including connection with community resources Assess for patient's understanding of and beliefs about depression and treatment including cultural influences and perspectives Discuss coping strategies that patient has tried/not tried Counsel patient/family using a variety of strategies, eg. brief intervention , goal setting Refer to other disciplines, eg. nephrologist, psychiatrist, mental health agencies **Tools/Resources:** Canadian Mental Health Questionnaire – *Vancouver-Burnaby Branch, 2004: Tel: 604-872-4902, http://modena.intergate.ca/cmha-vb* Beck Depression Inventory, Dr. Aaron T. Beck, l996 – *http://www.lifelineeap.com/The BeckDepressionInventory.htm* Kidney Disease Ouality of Life-Short Form 36, Version 1.3 (KDQOL –36) Rand, l995 – *http://gim.med.ucla.edu/kdqol/thankyou.html* "Coping Effectively" *National Kidney Foundation pamphlet, l997 – www.kidney.org* "Mental Health Services" pamphlet – *Vancouver Coastal, 2000*	Patient's mood improves Patient demonstrates improved behaviors Patient shows improvement on questionnaire scores. Patient demonstrates improved coping with problem Patient reports improvement with physical symptoms eg. crying, sleeping etc. Patient is seeing another mental health professional

3. Compromised Ability to Care for Self or Perform Activities of Daily Living

Problem/Goal	Intervention	Outcome
Compromised ability to care for self or perform activities of daily living Caregiver's stress level high (as identified by patient, caregiver, or team) Patient has little or insufficient information about available services Patient describes increased pain impacting activities of daily living	Assess patient and family's psychosocial circumstances related to management at home including caregiver stress Explain services to patient and family and assess for eligibility for services Explore how services may assist with non-medical support, eg. homemaking, meal replacement, transportation, financial assistance, nursing home placement, housing Refer to community resources including, Occupational Therapy, Health Unit services, Ministry of Employment & Income Assistance, Employment Insurance, exercise programs Discuss additional coping strategies with patient/family including setting boundaries, accessing support services, problem-solving Liaise/refer to activities for increased social involvement, eg. adult day care, community centre programs Liaise with other VGH complex pain service to follow-up on pain issues, eg nephrologist for assessment and/or referral to complex pain service, community pain clinic/ arthritis centre, etc. Recognize how cultural backgrounds and ethnicity influence one's ability to cope with problems, interact with others, and influence help-seeking behaviors Explore how cultural beliefs and expectations of family support may facilitate/jeopardize patient's activities of daily living, independence and safety at home **Tools/Resources:** Home Support Services through BC Health Services – *http://www.vch.ca/community/home_and_community_care.htm* Lifeline pamphlets – *www.lifelinecanada.com* Red Cross Medical Equipment Loans – *www.redcross.ca; Vancouver: 604-301-2566* Zarit Screener for Care Giver Burnout – *http://www.aafp.org*	Patient is able to function adequately at home with new services/ equipment Patient receiving adequate care in new facility Patient or family using community services Patient has declined service but has knowledge and eligibility criteria for services Patient acknowledges team's culturally sensitive approach and respect for patient's decisions Caregiver reports reduced stress

4. Pre-existing Psychiatric Disorder; Observation of Psychiatric Behavior or Cognitive Impairment

Problem/Goal	Intervention	Outcome
Pre-existing psychiatric disorder; behavior indicates possible psychiatric disorder or cognitive impairment Patient behaves in ways that are disruptive or harmful to other patients/staff Patient behaves in ways that are harmful to self/ family	Obtain collateral information about history of disorder or diagnosis Review previous treatment plans/ interventions with patient and current relevance Goal setting with patient/team, eg. understanding need for dialysis and acceptable behavior while on dialysis or at Kidney Clinic appointments Supportive counseling with patient and family Liaise and refer to relevant community agencies and hospital resources for assessment and/or treatment Provide education and support to team about particular problem and available resources **Tools/Resources:** Mental Health Services, *Vancouver General Hospital pamphlet, 2000* Community Mental Health Teams – *http://www.vch.ca/community/mental_health.htm*	Patient demonstrates improved or stable behavior Team observes more appropriate behaviour Patient/family connected to appropriate community resources Family demonstrates less stress, more knowledge of patient's condition and resources Patient/family report decreased level of stress at home Team observes less harmful and disruptive behavior Team and social worker observe fewer stress-related incidents by family in the unit.

5. Relationship/Social System Problems

Problem/Goal	Intervention	Outcome
Family problems Inadequate social supports Family stresses Abuse and neglect issues Conflictual relationship with health care team	Provide supportive counseling to patient and family Liaise with team Refer to community services, groups Plan patient/family team meetings Develop Care Plan Refer to protective services **Tools/Resources:** KDQOL survey Family Services of Greater Vancouver – *www.fsgv.ca* www.vcha.ca, *VGH Domestic Violence Program pamphlets* The Chronic Disease Self-Management Program – *www.coag.uvic.ca/cdsmp*	Patient/family verbalizes improvement Scores on KDQOL indicate improvement Team reports improvement Patient/family participates in community programs No evidence of abuse noted in dialysis unit Patient/family living in safe environment

6. Employment

Problem/Goal	Intervention	Outcome
Unemployed but employable. Employment fit/ suitability compromised. Patient reviewing employment goals. Patient has specific disadvantages to employment which can include age, functional ability, employment history and previous vocational training/ education	Checklist /assessment list for employment screening Assess patient and family's cultural beliefs about what it means to be ill. Discuss any possible stigma or negative connotations associated with an ill individual having to work Work Adjustment Program referral Refer to government or private employment/training programs **Tools/Resources:** VGH Work Adjustment Program pamphlets Employment Services – Theo BC – *www.theobc.org* Mayo Clinic Work Place Stress Questionnaire – Mayo Clinic, Dec. 2004 – *www.mayoclinic.com* "Working With Kidney Disease" – *Kidney Foundation pamphlet, www.kidney.org* Community Incentive Program – *www.gov.bc.ca/mhr*	Referral to Vocational Rehab Vocational Rehab plan Employment Community Incentive Program Work Adjustment Employment Volunteer Work

7. End of Life/Advance Care Planning

Problem/Goal	Intervention	Outcome
Different amounts of information given to all program patients about advance care planning Specific opportunities requiring immediate intervention: 1. CKD patients– GFR less than 15 and patient chooses no dialysis option 2. Dialysis patient– education/support if contemplating discontinuation of dialysis 3. Dialysis – decision to withdraw	A) Assessment/education – inquire about what documents the patient has or is planning to get, eg. wills, Power of Attorney, Advance Directive. Provide written and verbal information B) Decision-making – counselling about withdrawal from dialysis regarding patient/family beliefs/ wishes C) Explore cultural beliefs patient and family have that may impede end of life/advance care planning, eg. it is believed that in some cultures talking about something negative ensures that it will happen D) Liaise with and refer to community and palliative resources/programs/ grief counselling E) Follow up with grief counseling as appropriate **Tools/Resources** Representation Agreement Resource Centre – *www.rarc.ca* "Living Wills(Advance Directives)" – *www.vch.ca* Palliative Performance Scale (PPS) – *www.healthservices.gov.bc.ca* Vancouver Home Hospice Program – *Vancouver 604-709-3575* Public Trustee – *www.trustee.bc.ca* "Choosing to Stop Dialysis" – *The Kidney Foundation of Canada pamphlet, www.kidney.bc.ca* The People's Law School – *www. publiclegaled.bc.ca*	All program patients receive general information about Advance Directives If Advance Directive done, it is placed on the patient's chart Patient/family's questions/ concerns are answered and appropriate referrals made Patient/family express satisfaction with how staff responds to end of life issues Patient/family verbalize understanding about resources available but choose not to access them

8. Treatment Decision

Problem/Goal	Intervention	Outcome
Chronic Kidney Disease patients choosing dialysis modality with a GFR less than 20 Dialysis patient contemplating change in treatment modality Potential transplant candidate Patient/family conflicted about treatment option Barriers to starting treatment, eg. transportation	Educate patient/family about psychosocial impact of dialysis options, including lifestyle issues, time commitments, transportation Assess lifestyle issues and family dynamics influencing treatment decision and patient's ability to choose particular options Individual and/or group counseling about implications of specific treatments Explore and discuss cultural values and beliefs about being a burden to loved ones and how this may impact treatment decision Provide information/address concerns about barriers mentioned by patients **Tools/Resources** HandyDart Registration – *www. translink.bc.ca* Dialysis Unit Tours "Peer Support Program" – *Kidney Foundation of Canada pamphlets*	Patient has spoken with Peer Support Volunteer Patient has had a tour of the dialysis unit Patient makes decision having worked through psychosocial factors Patient/family report less stress about treatment decision Plans established for treatment start

9. Sexuality

Problem/Goal	Intervention	Outcome
Patient expresses concern about changes in sexuality	Assess situation and concerns eg. other relationship issues Initiate discussion in a culturally respectful way keeping in mind possible issues of privacy Educate about resources available to obtain more information Refer to appropriate health professional, eg. G.P., nephrologists, sexual health counselor Liaise with team regarding physical causes/treatments for sexual problems **Tools/Resources** "Sexuality and Chronic Kidney Disease" – *NKF pamphlet* Industry Based pamphlets – *eg. Pfizer* Sexuality and Kidney Disease, *The Ottawa Hospital pamphlet*	Patient/family indicates they received adequate information Patient indicates they have less concern about sexual functioning/health Patient has sought further medical explanation or treatment about problem Patient's privacy and cultural beliefs are respected Patient knows that social worker is available to provide sexual health information in a manner that is discreet. Patient seeing a professional regarding his/her sexual health

10. Alcohol/Prescription/Illegal Drug Use

Problem/Goal	Intervention	Outcome
Patient or family member's use of alcohol identified as a problem by patient, family or team Patient's use of prescription drugs identified as a problem by patient, family or team member Patient, family, team member describe patient's illegal drug use as a problem Patient smokes	Discuss recommended amount of alcohol intake with patient's nephrologist, team and patient Explore patient's beliefs about connection between level of pain and prescription drug use Refer to alcohol or drug counseling (CDRT), detox or treatment centre. Liaise with team members for discussion of referral to VGH Complex Pain Service or St. Paul's Outpatient Pain Clinic Refer to related community resources Assess understanding of risks of smoking – history of quitting smoking attempts and motivation to quit. Give patient "Quit Smoking" information Give family support if patient does not wish to address substance use Give patient support if family member has the problem which impacts patient **Tools/Resources** John Hopkins Screening Tool, *John Hopkins University Hospital, Baltimore, MD.* CKD Health AssessmentQuestionnaire, *VGH, Kidney Clinic Form* CAGE Alcohol Screening Instruments, VCH, *Van. Community Addictions Services*	Patient verbalizes knowledge of acceptable limit of alcohol intake for them Participation in hospital or community counseling or group program, eg. A.A. Patient verbalizes that illegal drug use has impact on lifestyle, finances, living situation and relationships Patient is able to set related goals. Patient reduces amount of cigarettes smoked/tries to quit Patient quits smoking

Acknowledgements

Handbook of Continuous Quality Improvement for Nephrology Social Work Practice: Measuring and Improving Psychosocial Interventions and Outcomes Through CQI. National Kidney Foundation, United States, Council of Nephrology Social Workers (CNSW), 1998.

Handbook of "Outcomes-Driven Practice Model" Stephanie Johnstone, LCSW & Mary Beth Callahan, ACSW/LCSW , Chicago 2004 National Kidney Foundation Conference.

Kidney Foundation of Canada Print Materials

National Kidney Foundation Education Materials

Vancouver Coastal Health Authority – Education Print Materials

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