The promise of symptom-targeted intervention to manage depression in dialysis patients

By Melissa McCool, LCSW, Stephanie Johnstone, LCSW, Renata Sledge, LCSW, Beth Witten, MSW, ACSW, LSCSW, Michelle Contillo, MSW, LCSW, Kathryn Aebel-Groesch, MSW, LCSW, and Jim Hafner, MSW, LSCSW, LCSW

Abstract
Research with tens of thousands of dialysis patients has established a link between depression, health-related quality of life scores, survival, and hospitalizations. In fact, physical and mental functioning scores are as predictive of death and hospitalization as Kt/V and albumin.

Some models for managing depression in the dialysis clinic have been developed. These models address barriers to accessing community mental health services. They also promote collaboration between the nephrology social worker and nephrologist to assure that patients receive counseling and/or antidepressant medications when they need them.

Part 1 of this article will introduce a promising new method designed for nephrology social workers to help patients manage depression. This method, known as Symptom-Targeted Intervention (STI), can be used in brief intervals with patients while they are receiving dialysis treatments to help reduce depressive symptoms and improve quality of life.

Psychosocial interventions in the new economic landscape of ESRD

In January, Medicare reimbursement for dialysis facilities moved from the fee-for-service reimbursement system that has been in effect since 1983 to a bundled prospective payment system. In 2012, Medicare will begin to pay facilities based on performance using quality-based measures. With these reimbursement changes, the disease management needs of the dialysis patient have taken on a new focus. In 2008, it cost 5.9% of the total Medicare budget to treat approximately 1% of the 45 million Medicare beneficiaries, namely, individuals with end-stage renal disease.

The focus of dialysis care has shifted to interventions that minimize hospitalizations and limit other costly expenditures. This change has led nephrology social workers to examine new psychosocial interventions to use with patients that help improve patient quality of care and quality of life while helping providers control costs.

Depression and dialysis
Studies suggest at least 25% of dialysis patients have clinical depression and at least 35% more have symptoms that put them at risk for depression. Depression increases the risk of infection and failure to follow treatment recommendations and is linked with an increase in risk of hospitalization and death. Depression adversely affects quality of life, is a predictor of withdrawal from dialysis, and is associated with shortening and skipping dialysis, all of which contribute to increased risk of hospitalizations and death. Low mental component summary (MCS) scores on the SF-36 and Kidney Disease Quality of Life survey identify depression in dialysis patients. A one point higher MCS score reduces the relative risk of death and hospitalization.

Regulatory requirements pertaining to mental functioning
Publication of these studies led to a requirement in the

The authors are collectively dedicated to the value of nephrology social work in CKD disease management. Any comments made or opinions expressed are of the authors and do not necessarily reflect those of, nor are they necessarily endorsed by, their employers. Ms. McCool was previously a nephrology social worker at Renal Advantage Inc., and is in private practice in San Diego. Ms. Johnstone, an NN&I Editorial Advisory Board member, has 27 years experience in nephrology social work and is with Fresenius Medical Care North America in San Diego, Calif. Ms. Sledge is a nephrology social worker for RAI Care Center-Lincoln in Fairview Heights, Ill. Ms. Witten has been in nephrology social work for 33 years and is with Witten and Associates, LLC in Overland Park, Kan. Ms. Contillo is a nephrology social worker for Fresenius Medical Services in Honolulu. Ms. Aebel-Groesch is a regional point social worker for DaVita Inc. in St. Louis, Mo. Mr. Hafner is a nephrology social worker for Davita Northland in Kansas City, Mo.
Table 1. The decreased risk of death and hospitalization with improved mental and physical component scores (SF-36)

<table>
<thead>
<tr>
<th>Each 1 point improvement in PCS score</th>
<th>Each 1 point improvement in MCS score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduces relative risk of death 2%</td>
<td>Reduces relative risk of death 2%</td>
</tr>
<tr>
<td>Reduces relative risk of hospitalization 2%</td>
<td>Reduces relative risk of hospitalization 1%</td>
</tr>
</tbody>
</table>

Conditions for Coverage, revised in 2008 and subsequently in the Interpretive Guidance (V552), that nephrology social workers and other interdisciplinary team members administer a standardized health-related quality of life survey to assess physical and mental functioning and use the results in planning care for dialysis patients. According to the Conditions, social workers, as part of the interdisciplinary team, are required to help patients “cope with kidney failure, follow the treatment plan, and achieve the patient’s goals for rehabilitation.”

The dialysis literature has called the prevalence of depression in dialysis patients an urgent priority in ESRD disease management. Nephrology social workers can provide needed intervention to accomplish these goals by redirecting their time and scope of services. Managing depression is within the scope of practice of a masters-prepared social worker. CMS’ Conditions for Coverage requires nephrology social workers to hold a masters degree from an accredited graduate school. The Interpretive Guidance (V681) states that the coursework of masters-prepared social workers prepares them to provide clinical services.

Promise of symptom-targeted intervention

Developed by nephrology social worker Melissa McCool, symptom-targeted intervention (STI) brings forward new methods to treat symptoms of depression in dialysis patients. With STI, the most salient or problematic symptom of the depression is identified and treated using cognitive, behavioral, and mindfulness techniques. Since the focus is very specific, interactions with the patient are brief and can be done chair-side at the dialysis clinic.

Dialysis patients are often overwhelmed by a myriad of psychosocial problems. Without a specific focus, interactions with the social worker can easily be derailed.

Dialysis patients are often overwhelmed by a myriad of psychosocial problems. Without a specific focus, interactions with the social worker can easily be derailed...

STI has been designed for and is well suited to the dialysis setting for a variety of reasons. First, in the dialysis environment, the nephrology social worker has an established, working relationship with the patient. Thus, some of the therapeutic relationship upon which good clinical work is done has been developed.

Second, patients prefer to receive mental health services from their nephrology social worker. The relationship between the patient and nephrology social worker is without the stigma often associated with mental health treatment. There are no transportation or financial barriers for the patient, who comes to dialysis on a regular schedule and has access to a social worker funded by the facility’s Medicare reimbursement for dialysis. This allows the social worker to provide more frequent, brief treatment interventions, to monitor outcomes, and to alter subsequent interventions accordingly until the patient’s symptoms improve. It also promotes a first line or adjunctive form of treatment for depression alongside the nephrologists’ consideration of antidepressant medication.

Third, there is no focus on clinical diagnosis of the depressed patient when using STI. Interventions address the symptom that is most problematic for the patient; it is irrelevant whether the symptom is caused by an adjustment disorder, dysthymia, a recurrent depressive episode, or another mood disorder. For this reason, STI is appropriate for almost all patients suffering from symptoms of depression.

How STI works

The intellectual premise for STI is based on systems theory, which is part of the core training of the masters-prepared social worker. Systems theory considers a system as a set of interacting and independent parts; when one part of the system is altered, the entire system changes. If depression is a system comprised of various symptoms, when one of the symptoms improves, the entire trajectory of the depressive episode is transformed.

With STI, once a depressive episode is identified, the social worker and patient, through a series of questions, identify the most urgent symptom of the depression. The social worker and the patient then contract to work together on resolving the symptom, recognizing that it often requires more than one session and may require...
Commentary
Should we treat depression in the dialysis clinic? The impact of STI

Research continues to call for the treatment of depression in dialysis patients to improve survival and quality of life outcomes.\(^1\) As an interdisciplinary team, we remain cautious about providing treatment for depression at the dialysis clinic. With the patient barriers to accessing community mental health treatment,\(^6\) however, where does that leave the team? As nurses, technicians, dietitians, and social workers, we feel helpless as we see the health of a depressed patient deteriorate. Our interdisciplinary plans of care struggle to set rehabilitation goals with these patients, who often have difficulty even getting out of bed in the morning and spend their non-dialysis days isolated from friends and family.

We continue to learn more about what mediates depression in ESRD. Positive and negative illness schemas and social support have been isolated as predictors of depression in dialysis patients.\(^7\) Cognitive behavioral therapy has been shown to improve mood in the dialysis patient.\(^8\)

Interpersonal and problem-solving therapy in the dialysis clinic have also demonstrated some positive outcomes with depression, though larger samples are needed for those studies.\(^9\) The field is hungry for a consistent approach to this dangerous and disabling condition.

Symptom Targeted Intervention may show promise in reaching the many depressed patients that are waiting for our help.\(^11\)

**Table 1. Should we treat depression in the dialysis clinic?**

<table>
<thead>
<tr>
<th>Arguments Against Onsite Treatment</th>
<th>Arguments For Onsite Treatment</th>
<th>The Influence of STI on the Argument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers don't have time to provide counseling.</td>
<td>Brief interventions work. Social work time can be redirected toward providing brief interventions to improve outcomes.</td>
<td>STI is brief. Each treatment session averages 20-30 minutes and can be delivered chair-side at the dialysis clinic.</td>
</tr>
<tr>
<td>Social workers aren't trained to provide counseling.</td>
<td>CMS states an MSW has sufficient clinical training. CMS requires dialysis clinics to provide an MSW whose degree, license, or certification allows him/her to counsel patients.(^1) The master's-level curriculum in social work provides an additional 800 hours of specialized clinical training. MSWs are trained in conducting empirical evaluations of their own practice interventions and to autonomously provide diagnostic, preventive, and treatment services for individuals, families, and groups in the context of their respective life situations.(^4,11)</td>
<td>The majority of social workers in the pilot felt prepared to provide clinical intervention.(^1) All social workers delivered STI interventions after one brief DVD training. STI training will now be easily accessible to all nephrology social workers.</td>
</tr>
<tr>
<td>Social workers and dialysis clinics are not reimbursed for psychotherapy.</td>
<td>The Medicare prospective payment for dialysis reimburses a dialysis clinic for the services of an MSW to reduce psychosocial barriers to treatment outcomes.(^2) MSW plans of care must reflect these efforts. Cognitive behavioral therapy (CBT) is a brief and effective method used in most primary medical care settings. CBT is not analytical, nor does it involve a psychodynamic exploration of a patient’s past. Motivational interviewing (MI) is technique currently used by MSWs, RNs and RDs in dialysis settings. CBT is similar to MI in its psychotherapeutic implications and scope.</td>
<td>STI is based on CBT and other models of mental health intervention that have been provided in primary care settings. STI interventions are designed for the dialysis setting and are ideal interventions for addressing mood barriers on the patient plan of care.</td>
</tr>
<tr>
<td>Dialysis clinics are supposed to treat kidney failure, not provide mental health treatment.</td>
<td>Disease management models integrate behavioral and medical practices to maximize health outcomes. CMS requires the interdisciplinary team (IDT) to monitor patients' physical and mental functioning through the use of a standardized health related quality of life survey. Mental composite scores from that survey must be integrated into the patient’s plan of care to help patients to achieve and sustain an appropriate psychosocial status. Low mental component summary (MCS) scores predict death and hospitalization. Patients with low MCS scores are more likely to be depressed, skip or shorten dialysis sessions, and have poorer outcomes. Studies show that patients prefer to seek mental health treatment from their social worker at the dialysis clinic due to barriers in accessing community mental health treatment.(^6)</td>
<td>STI was well received by dialysis patients in the pilot and is a brief treatment method well-suited to the dialysis clinic to improve MCS scores.</td>
</tr>
<tr>
<td>Antidepressant medications can be used to reduce depression.</td>
<td>Referrals to psychiatry for medication management lack patient follow up. Barriers to accessing psychiatry include transportation, time, cost/ inadequate coverage, lack of community psychiatrists and the stigma associated with seeking mental health services. Nephrologists are called upon to prescribe antidepressant therapy, but often prefer to offer counseling first or in conjunction with medication for depression. CBT has been shown in many chronic illnesses, including ESRD, to effectively manage depressive symptoms alone or alongside antidepressant medication.</td>
<td>STI uses CBT to manage depression.</td>
</tr>
</tbody>
</table>

\[VIEWPOINT, continued on page 32\]
Table 1 displays points from the ongoing debate of whether we should treat depression in the dialysis clinic. The table also demonstrates how the availability of Symptom Targeted Intervention impacts this debate. Nephrology social workers are anxious to have their skills re-directed toward improving fiscal and quality outcomes.

The field might be wise to support their use of STI to manage depression. We have little to lose while our patients have so much to gain. Could treating depression on-site do more than just reduce hospital days and improve health-related quality of life scores? Could it also promote rehabilitation and the energy to consider dialysis at home? Now, with the introduction of STI, this may be the time to find out.

—Stephanie Johnstone, LCSW

References

[STI, continued from page 33]

more than one brief intervention to resolve the symptom. The patient-social worker partnership supports an important sense of patient empowerment and self-efficacy, where the patient is in control of his or her own mental health outcomes.

**Symptom-targeted interventions**

Various cognitive and behavioral techniques are utilized, including behavior activation, cognitive restructuring, relaxation techniques, and mindfulness. STI interventions usually include psycho-education, instruction, and patient homework.

Several studies demonstrate that cognitive behavioral therapy is an effective intervention in treating depression in people on dialysis. Mindfulness-based cognitive therapy (MBCT) is an approach that has been proven to bolster recovery from depression and to prevent relapse. While cognitive therapy techniques seek to change automatic thoughts, the goal of MBCT is to attend to cognitions fully as they arise. This by itself is healing.

The case examples (see page 37) demonstrate the features of STI. The social worker uses multiple interventions to assist the patient in addressing their targeted symptoms. The sessions are collaborative and brief, averaging 30 minutes each. The nephrology social worker chooses interventions that apply to the patient’s unique situation.

References

www.nephronline.com

May 2011 • Nephrology News & Issues

Social Work_NN&I_0511_FINAL.indd 35
4/11/11 6:08 PM
A nephrologist’s perspective

It’s time to collaborate on depression
By Dylan Steer, MD

“Yeah, I take my binders,” says “Joe” to me on rounds.

Joe is a somewhat withdrawn, 28-year-old patient, two years into dialysis. The problem is, despite the engagement of an enthusiastic dietitian and support from his nurse and physician, Joe’s phosphorus is sky-high and it is clear that he is disengaged and not taking much of anything.

The frustrations and challenges surrounding this common encounter for the team members (including the patient and family) are complex. Although many factors can be at play, depression, an under-recognized disorder in the dialysis population, clearly lays the foundation for non-adherence to therapy. Integrating depression management into core clinical treatment measures for end-stage renal disease could improve patient outcomes.

Depression is common in the ESRD population but remains difficult to diagnose and treat. It is insidious in its effect and reach. Various studies estimate that 20%-25% of prevalent ESRD patients have a co-morbid diagnosis of depression. ESRD patients with low depression scores enjoy a significantly improved quality of life (QOL) over patients with high depression scores. From a longitudinal perspective, patients with

Dr. Steer is affiliated with Balboa Nephrology Medical Group, San Diego.

2006; 2(12):678-687.
Case studies using STI

Case #1
Jason is a 43-year-old male on in-center dialysis after a failed transplant. During his annual assessment he had a low MCS score on the KDQQL-36. While reviewing the scores with Jason, the social worker discovers that he has been unhappy for the last few months. Jason has been isolating himself, watching TV all day and rarely leaving the house. There are no acute psychosocial stressors involved. Jason is not interested in going to a psychiatrist or therapist outside of the dialysis center, so the social worker suggests he try STI to treat the symptoms. Jason agrees to work with the social worker.

Targeted symptom: Social isolation
Intervention: Working together, the patient and social worker conduct an analysis on how Jason is spending his time outside the dialysis unit. The social worker then educates the patient on the thought-mood-behavior connection using the Beck Cognitive Triad. After the psycho-education, the social worker and patient develop a plan for behavior activation, creating an alternate daily schedule.
Outcomes: A week later, the social worker and Jason discuss the results. Jason is following the new schedule; he is feeling much more hopeful, less isolated, and more confident in his ability to help himself. His depressive symptoms demonstrate significant improvement.

Case #2
Sue is a 55-year-old female who has a low MCS score on her KDQQL-36 administered with her annual assessment. After speaking with her more in depth, the social worker notes that high levels of depressive affect have an associated increase in mortality.

There are several hurdles to treating the ESRD patient with depression. First and foremost is proper identification and screening of at-risk patients throughout their life cycle. Patients with high depressive affect scores typically have multiple somatic complaints that often-mimic uremia and can mask the underlying depression. Diagnosing depression can be difficult, time-consuming, and inconvenient for the nephrologist, particularly when managing a wide variety of other “core” ESRD clinical measures. Good, valid screening tools, administered longitudinally in the dialysis clinic by trained social workers at important patient-derived time points, could both identify depressed patients and provide an initial entree to treatment.

But who should provide treatment? As we move closer to integrated comprehensive care of the ESRD patient—after all, nephrologists have become principal care providers for many ESRD patients—treatment of depression will move from a back-burner issue to a core measure. A dialysis clinic-based approach to treatment makes sense, and a robust platform of social worker-initiated depression management interventions combined with medication management by the nephrologist serves as a good start toward treating mental health in ESRD patients.

The impact of this ongoing collaboration between the nephrologist and social worker may be measured in terms of QOL, adherence to therapy, fewer missed treatments and, perhaps, an overall reduction in the cost of care. Screening at-risk dialysis patients for depression throughout their life cycle, combined with a dialysis clinic-based approach to treatment, can serve as a model for collaborative integrated care. NN&I