

Changes in Dialysis Social Workers' Caseloads, Job Tasks, and Hourly Wages Since the Implementation of the 2008 Conditions for Coverage

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This study examined the job-related experiences of dialysis social workers since the implementation of the 2008 Centers for Medicare and Medicaid Services Conditions for Coverage for End-Stage Renal Disease Facilities. Data were obtained from 231 part-time and 1,091 full-time dialysis social workers (N = 1,322) who responded to an online survey conducted in 2010 by the National Kidney Foundation Council of Nephrology Social Workers (NKF CNSW). Findings indicated that 41.2% of part-time and 50.1% of full-time social workers reported an increase in their patient caseloads. Similarly, 80.2% of part-time and 85.9% of full-time respondents reported an increase in job tasks, and 70.4% of the part-time and 76.6% of the full-time workers reported that they had insufficient time to provide psychosocial services to patients. Approximately one-half (49.2%) of full-time social workers indicated being somewhat or very dissatisfied with their caseloads, and more than one-half of part-time (50.4%) and full-time (52.8%) social workers indicated being somewhat or very dissatisfied with their job tasks. No differences in hourly wage changes were found between part- and full-time respondents since the implementation of the 2008 Conditions for Coverage. Implications for nephrology social work practice and research are discussed.

INTRODUCTION

Nephrology social workers are central to the provision of biopsychosocial services that are mandated by the Centers for Medicare and Medicaid Services Conditions for Coverage (CfC) for End-Stage Renal Disease Facilities (Federal Register, 2008). The CfC are federal regulations that ensure the health and safety of people who require dialysis or a kidney transplant as life-saving interventions. As patients with end-stage renal disease (ESRD) begin their dialysis care, they often face difficulties such as managing intensive treatment regimens and coping with the social, vocational, and mental health challenges that result from being on a renal replacement therapy. Social workers in dialysis facilities are specifically trained to provide practical and psychological support to help patients manage the treatment process (Browne, 2012). Some of the primary interventions offered by social workers include patient and family education, supportive counseling, crisis intervention, provision of information and community referrals, interdisciplinary care planning and collaboration, and patient advocacy (Browne, 2012; Dobrof, Dolinko, Lichtiger, Uribarri, & Epstein, 2001; McKinley & Callahan, 1998; McKinley, Schrag, & Dobrof, 2000; Merighi & Ehlebracht, 2004a, 2004b, 2004c; Russo, 2002; Wolfe, 2011). These interventions help renal patients to cope with the physical and mental health consequences that are often associated with a diagnosis of ESRD (Browne, 2012; Cukor, Peterson, Cohen, & Kimmel, 2006), and can help promote treatment adherence and self-management (Browne & Merighi, 2010; Cukor, Rosenthal, Jindal, Brown, & Kimmel, 2009). Studies have documented the positive effect that social work interventions such as clinical counseling and education have on ESRD patients' psychological well-being and quality of life (Beder, 1999; Dobrof et al., 2001; McCool et al., 2011; Sledge et al., 2011).

Health care environments in the United States are increasingly driven by consumer demands, corporate streamlining, cost containment, and state and federal regulations. The cumulative burden of these workplace factors, in addition to increasing caseload size and patient acuity, can affect health care providers' job satisfaction, and consequently, patient outcomes and quality of life. Research on overall job satisfaction of social workers in health care settings has shown that the majority of these professionals are either satisfied or very satisfied with their work (Gellis, 2001; Merighi & Ehlebracht, 2004c; Siefert, Jayarante, & Chess 1991). However, a study on the effect of organizational reengineering on job satisfaction indicated that hospital-based social workers reported higher levels of dissatisfaction as a result of organizational changes that were implemented to reduce costs and streamline service delivery systems (Neuman, 2003). Although this research provides information about the job satisfaction of health care social workers in general, relatively little is known about *nephrology* social workers' job satisfaction, especially since the implementation of the 2008 CfC.

To assist patients with end-stage renal disease, nephrology social workers must have adequate time and resources to complete required documentation and provide their patients with psychosocial support services as mandated in the 2008 CfC. Previous research, which was conducted prior to the implementation of the 2008 CfC, has documented the high prevalence of nonclinical tasks that are required of dialysis social workers (Merighi & Collins, 2011; Merighi & Ehlebracht, 2002, 2004a, 2004b, 2004c). From this research, we discovered that 94.9% of the dialysis social workers surveyed indicated that counseling was an appropriate use of their social work training. Despite the importance of providing counseling to patients and their families, only one third of these social workers (33.7%) reported that they had ample time to provide clinical social work services (Merighi & Ehlebracht, 2004c).

Counseling and psychosocial assessment were maintained as key social work activities in the 2008 Conditions for Coverage. However, the CfC final rule now requires a “psychosocial status” component in a patient’s plan of care. This component outlines how professional social work services are provided to ESRD patients and how standard mental and physical health assessments, e.g., the Kidney Disease Quality of Life-36 (KDQOL-36) survey, are used to evaluate their functioning (Federal Register, 2008). A plan of care needs to be developed within 30 days of a patient’s admission to a dialysis facility (or within 13 dialysis sessions) and updated regularly in accord with CfC guidelines. In addition, social workers are expected to participate in an interdisciplinary team, which is comprised of at least an ESRD physician, registered nurse, social worker, dietitian, and patient (if feasible). This team is charged with preparing a written, individualized, and comprehensive plan of care that outlines the specific mental and physical health needs of the patient, as determined by an interdisciplinary assessment. A social worker’s involvement in an interdisciplinary team is not a new role in an ESRD setting; however, the implementation of the 2008 CfC has markedly increased the social worker’s level of responsibility on this team (e.g., having to administer the KDQOL-36). It is unclear if fulfilling all CfC-mandated tasks leaves nephrology social workers with sufficient time and opportunities for essential clinical work with patients and their support systems.

High caseloads can hinder dialysis social workers’ ability to provide adequate clinical services to their patients (Merighi & Ehlebracht, 2002). Nephrology social workers’ caseloads in dialysis units often exceed the National Kidney Foundation Council of Nephrology Social Workers (NKF CNSW) recommendation of 75 patients per full-time social worker (CNSW, 1998, Merighi, Browne, & Bruder, 2010; Merighi & Ehlebracht, 2004a). Although study findings have shown that large patient caseloads are associated with decreased patient satisfaction and less patient access to rehabilitation services (Callahan, Moncrief, Wittman, & Maceda, 1998), dialysis social workers continue to be responsible for caseloads that exceed the CNSW recommendation. Further, as the population of patients on dialysis comes to include a greater proportion of medically and psychosocially complex cases, social workers will be further challenged to provide essential services to their patients in accordance with the 2008 CfC. Between 2007 and 2010, the mean caseload size for outpatient dialysis social workers in the United States increased 8.2% for part-time employees (20–31 hours per week) and 7.1% for full-time employees (32–40 hours per week) (Merighi et al., 2010). These increases in patient caseloads, in addition to changes in job responsibilities and expectations, highlight the need to examine the experiences of dialysis social workers since the implementation of the 2008 CfC.

Study Aim

The aim of this study is to examine the influence of the 2008 Centers for Medicare and Medicaid Services Conditions for Coverage for End-Stage Renal Disease Facilities on part-time and full-time dialysis social workers’ caseloads, job tasks, and hourly wages.

METHOD

Study Design

A cross-sectional survey research design was used to assess caseload, hourly wage, and other job-specific issues of nephrology social workers employed in the United States. For the purpose of this article, only data from respondents employed in dialysis facilities were analyzed.

Respondents

More than 88% ($N = 1,322$) of the 1,495 social workers who responded to the CNSW online survey were employed in a dialysis facility either part-time (20–31 hours per week, $n = 231$) or full-time (32 or more hours per week, $n = 1,091$). The majority of survey respondents (99.2%) had a Master of Social Work degree, were women (91.1%), licensed in their state (83.7%), employed full-time (82.5%), and worked for a for-profit dialysis facility (79.9%). The sample was 85.7% White, 9.6% Black/African American, 2.9% Asian American/Pacific Islander, 1.0% American Indian/Native American, and 0.8% multiracial. Less than one-tenth of the social workers (7%) identified as Hispanic/Latino. The respondents’ mean age was 46.9 (standard deviation [SD] = 11.6) years and their mean length of nephrology social work practice experience was 8.8 (SD = 7.3) years. See Table 1 for a demographic comparison between the part-time and full-time respondents and the total sample. When comparing the part-time and full-time social workers, part-time respondents were older [$t(1,278) = 4.4, p < .001$] and had more renal social work experience, [$t(1,312) = 3.0, p < .01$]. In addition, part-time and full-time social workers differed in terms of their geographic location as measured by National Kidney Foundation (NKF) region [$\chi^2(4, N = 1,321) = 11.75, p < .05$]. No other differences between part- and full-time respondents were found. This study received Institutional Review Board approval from Boston University and was conducted in accordance with the guidelines on evaluation and research described in the Code of Ethics of the National Association of Social Workers (NASW, 2008).

Measure

The 2010 NKF CNSW Salary and Caseload Survey was comprised of 130 open- and close-ended questions that examined social work respondents in the following domains: demographic characteristics, work environment issues, caseloads, hourly wages, professional tasks, job satisfaction, emotional exhaustion, workload demands, and negative affectivity. Survey items were developed by several

Table 1. *Dialysis Social Workers Sample Demographics*

	Total sample <i>N</i> = 1,322 <i>M</i> (<i>SD</i>)	Full-time <i>n</i> = 1,091 <i>M</i> (<i>SD</i>)	Part-time <i>n</i> = 231 <i>M</i> (<i>SD</i>)
Age (years)	46.9 (11.6)	46.3 (11.7)	49.9 (10.9)***
Years with current employer	7.1 (6.5)	6.9 (6.4)	7.8 (7.2)
Years worked in renal social work	8.8 (7.3)	8.5 (7.1)	10.1 (7.8)**
	%	%	%
Gender			
Female	91.1	90.4	94.7
Male	8.8	9.5	5.3
Transgender	0.1	0.1	—
Race			
African American/Black	9.6	10.5	5.5
American Indian/Native American	1.0	1.0	0.9
Asian American/Pacific Islander	2.9	3.1	1.8
White	85.7	84.5	91.3
2 or more races	0.8	0.9	0.5
Hispanic ethnicity (Yes)	7.0	7.2	6.1
Primary employer type			
For-profit dialysis facility	79.9	80.7	76.1
For-profit hospital	1.3	1.1	2.2
Non-profit dialysis facility	9.4	8.8	12.1
Non-profit/public hospital	9.0	9.1	8.7
Other	0.4	0.3	0.9
Licensed in state (Yes)	83.7	82.9	87.3
MSW degree (Yes)	99.2	99.2	99.6
NKF Region			
1	19.8	19.1	22.9*
2	24.4	25.2	20.4
3	25.2	23.8	32.0
4	11.8	12.3	9.5
5	18.8	19.6	15.2

Note. U.S. states that comprise the five NKF regions are defined as follows: 1 (CT, DE, ME, MD, MA, NH, NJ, NY, PA, RI, VT); 2 (AL, DC, FL, GA, KY, MS, NC, SC, TN, VA, WV); 3 (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI); 4 (AR, LA, NM, OK, TX); and 5 (AK, AZ, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY). Significant differences were found between full- and part-time respondents for NKF region (* $p < .05$), years worked in renal social work (** $p < .01$), and age (***) $p < .001$).

representatives of the CNSW Executive Committee in collaboration with the author. For the purpose of this article, only demographic, work environment, caseload, hourly wage, professional tasks, and job satisfaction variables were analyzed. The majority of these domains were measured using forced-choice questions. For example, "Overall, how satisfied are you with your job tasks: *very dissatisfied*, *somewhat dissatisfied*, *neither satisfied nor dissatisfied*, *somewhat satisfied*, or *very satisfied*." Only two variables (caseload and hourly wage) required a unique response from respondents. For example, "How much do you get paid on an hourly basis? If you are a salaried employee who works full-time (40 hrs/wk), please take your yearly salary and divide it by 2080. [Example: \$60,000 divided by 2080 = \$28.85.]"

Data Collection Procedure

The survey instrument was administered online by the NKF between March 21 and June 21, 2010. The NKF distributed announcements about the survey to its CNSW members via a membership email LISTSERV, which reaches the majority of CNSW members. The announcements included information about the study aims, instructions on how to access the survey, and requests to distribute the announcement to other nephrology social workers (including non-CNSW members). Prospective respondents were informed of the confidential and voluntary nature of the survey and no incentives were offered for participation. The survey took approximately 25 minutes to complete. All data were initially sent to NKF and housed on their secure server prior to their release for statistical analysis. Once the data were de-identified by NKF staff (i.e., by removing email addresses and other information that could potentially reveal the identity of an individual respondent), the author received them in an Excel spreadsheet. All the data sent to the author are stored on a secure network at Boston University.

Data Analysis

Chi-square tests and independent samples t-tests were used to assess all descriptive variables for differences between part- and full-time respondents. In addition, chi-square tests were used to analyze all categorical variables (e.g., job tasks) for differences between part- and full-time respondents. Yates continuity correction was used for 2 x 2 contingency tables when performing chi-square analyses. One-way analysis of variance with Bonferroni post hoc comparisons were used to test for differences in means for two continuous variables (i.e., caseload and hourly wage). To reduce the risk of Type I errors, adjusted p-values were computed to take into account multiple comparisons. Individual sample sizes are reported to identify where data were missing at random. Statistical analyses were performed using SPSS 10.0 (Chicago, IL).

RESULTS

Changes in Caseloads, Job Tasks, and Hourly Wages

Since the implementation of the 2008 CfC, 41.2% of part-time and 50.1% of full-time dialysis social workers reported increases in their patient caseloads, with a greater proportion of full-time respondents reporting an increase in caseload size [$\chi^2(2, N = 1,290) = 6.12, p < .05$]. See Table 2. Bonferroni post hoc tests were performed to test, within group differences, mean caseload between respondents who indicated "decreased," "stayed the same," or "increased" as a result of the 2008 CfC. Significant main effects were found for both part-time [$F(2, 208) = 7.1, p < .001$] and full-time respondents [$F(2, 1,010) = 38.8, p < .001$], which justified the use of post hoc analyses. For part-time respondents, the mean caseload for those who reported that it increased (87.1) was significantly higher than those respondents who reported that it stayed the same (73.2; $p < .001$). For full-time respondents, differences in mean caseload were found for all possible group pairings. The highest reported caseload was found for those full-time respondents who indicated an increase since the implementation of the 2008 CfC (130.9), compared to those who reported that it stayed the same (111.9) or decreased (95.7). See Table 3.

With regard to job tasks, 80.2% of part-time and 85.9% of full-time respondents reported an increase in job tasks, with a greater proportion of full-time workers reporting more tasks being performed since the implementation of the CfC [$\chi^2(2, N = 1,286) = 10.59, p < .01$]. Differences in the proportion of responses between part- and full-time respondents were also found for authorized work hours [$\chi^2(2, N = 1,280) = 24.92, p < .001$] and non-paid hours [$\chi^2(2, N = 1,272) = 18.53, p < .001$]. See Table 2.

No differences were found in the proportion of part- and full-time social workers who reported changes in their hourly wages. Significant main effects were found for only full-time respondents [$F(2, 1,029) = 9.2, p < .001$], which supported within group comparisons using a Bonferroni post hoc test. Specifically, a significant difference in mean hourly wage emerged between full-time respondents who reported that it stayed the same (\$26.90) and those who indicated that it increased (\$28.55). See Table 3.

Level of Satisfaction with Job-related Factors

In addition to assessing the influence of the 2008 CfC in key job domains, respondents were asked to report their current level of satisfaction with the following: caseload, hourly wage, benefits, job tasks, and work environment. With regard to caseload, 37.1% of part-time and 49.2% of full-time dialysis social workers reported being either somewhat or very dissatisfied, with a greater proportion of full-time respondents reporting dissatisfaction [$\chi^2(4, N = 1,312) = 17.58, p < .001$]. See Table 4. Bonferroni post hoc tests were performed to test for within group differences in mean caseload between respondents who indicated that

Table 2. Changes Since the Implementation of the 2008 Medicare and Medicaid Conditions for Coverage for Full- and Part-time Dialysis Social Workers

	Decreased (%)	Stayed about the same (%)	Increased (%)
Caseload*			
Full-time (<i>n</i> = 1,062)	3.1	46.8	50.1
Part-time (<i>n</i> = 228)	3.1	55.7	41.2
Hourly wage			
Full-time (<i>n</i> = 1,058)	4.3	79.9	15.8
Part-time (<i>n</i> = 228)	4.4	79.8	15.8
Job tasks**			
Full-time (<i>n</i> = 1,059)	0.3	13.8	85.9
Part-time (<i>n</i> = 227)	1.7	18.1	80.2
Authorized work hours***			
Full-time (<i>n</i> = 1,054)	7.5	85.1	7.4
Part-time (<i>n</i> = 226)	16.4	71.7	11.9
Non-paid hours***			
Full-time (<i>n</i> = 1,052)	2.6	58.3	39.1
Part-time (<i>n</i> = 220)	6.8	65.9	27.3

p* < .05. *p* < .01. ****p* < .001.

Table 3. *Caseload and Hourly Wage by Perceived Change Since the Implementation of the 2008 Medicare and Medicaid Conditions for Coverage for Full- and Part-Time Dialysis Social Workers*

	Decreased M (SD)	Stayed about the same M (SD)	Increased M (SD)
Caseload			
Full-time (<i>n</i> = 1,013)	95.7 (24.5) ^a	111.9 (28.5) ^b	130.9 (46.5) ^{ab}
Part-time (<i>n</i> = 211)	72.4 (27.2)	73.2 (22.6) ^a	87.1 (30.7) ^a
Hourly wage (in U.S. Dollars)			
Full-time (<i>n</i> = 1,032)	28.04 (3.69)	26.90 (4.56) ^a	28.55 (5.69) ^a
Part-time (<i>n</i> = 222)	26.21 (4.17)	28.10 (4.70)	29.20 (5.86)

Note. Pairs of superscripted letters within an employment category (full-time or part-time) represent significantly different pairs of means. Bonferroni post hoc test, $p < .001$.

they were either “somewhat or very dissatisfied,” “neutral,” or “somewhat or very satisfied.” Significant main effects were found for both part-time [$F(2, 209) = 12.5, p < .001$] and full-time respondents [$F(2, 1,026) = 62.6, p < .001$], which justified the use of post hoc analyses. For part-time respondents, the mean caseload for those who reported being somewhat or very dissatisfied (88.5) was significantly higher than those respondents who reported being somewhat or very satisfied (68.6; $p < .001$). For full-time respondents, significant differences in mean caseload were found for all possible group pairings. The highest reported caseload was found for those respondents who indicated being somewhat or very dissatisfied (133.4), compared to those who indicated being neutral (118.2) or somewhat or very satisfied (103.9). See Table 5. With regard to job tasks, slightly more than half of the part-time (50.4%) and full-time (52.8%) respondents reported being somewhat or very dissatisfied, with a greater proportion of full-time workers reporting dissatisfaction [$\chi^2(4, N = 1,311) = 10.22, p < .05$].

No significant differences in satisfaction with hourly wage were found between part- and full-time respondents. Significant main effects were found for only full-time respondents [$F(2, 1,050) = 20.2, p < .001$], which supported within group comparisons using a post hoc test. Specifically, a significant difference in mean hourly wage emerged between full-time respondents who reported being somewhat or very dissatisfied (\$26.13) and those who indicated being somewhat or very satisfied (\$28.08). See Table 5.

Responsibility for Job Tasks

Respondents rated their level of responsibility for 22 job tasks in dialysis facilities by indicating “not responsible,” “partially responsible,” or “solely responsible.” The majority (> 50%) of part-time and full-time social workers indicated that they were “solely responsible” for the following six tasks: 1) completing the KDQOL-36 survey; 2) individual counseling; 3) family counseling; 4) assisting outgoing transient patients; 5) coordinating transportation; and 6) administering patient satisfaction surveys. No statistically significant differences were found between part- and full-time social workers. See Table 6.

Employer-provided Benefits

Social workers in this study indicated the availability of employer-provided benefits by responding “yes,” “no,” or “don’t know” to a list of 19 benefit categories. The majority of part-time and full-time social workers (> 50%) indicated that their employers provided the following seven benefits: 1) health insurance; 2) vacation/sick pay; 3) 401K/403B retirement plans; 4) gas/mileage reimbursement; 5) paid time off to attend conferences; 6) holiday pay; and 7) merit increases. Significant differences between part-time and full-time respondents were found for two benefit categories: health insurance [$\chi^2(2, N = 1,303) = 48.35, p < .001$] and gas/mileage reimbursement [$\chi^2(2, N = 1,305) = 14.62, p < .001$]. See Table 7.

Supplemental Analyses

Two supplemental analyses were performed to test for differences between part- and full-time respondents with regard to the following questions: 1) Do you have enough

Table 4. *Level of Satisfaction for Full- and Part-Time Dialysis Social Workers*

	Very dissatisfied (%)	Somewhat dissatisfied (%)	Neither satisfied nor dissatisfied (%)	Somewhat satisfied (%)	Very satisfied (%)
Caseload***					
Full-time (n = 1,083)	21.0	28.2	16.8	24.0	10.0
Part-time (n = 229)	14.8	22.3	23.1	23.1	16.7
Hourly wage					
Full-time (n = 1,084)	10.1	29.4	11.7	37.5	11.3
Part-time (n = 230)	8.7	24.8	11.3	42.2	13.0
Benefits					
Full-time (n = 1,084)	5.0	20.0	13.5	42.5	19.0
Part-time (n = 229)	6.6	18.8	18.3	40.6	15.7
Job tasks*					
Full-time (n = 1,081)	15.6	37.2	14.5	28.3	4.4
Part-time (n = 230)	15.2	35.2	17.9	23.0	8.7
Work environment					
Full-time (n = 1,082)	9.1	17.9	15.9	35.5	21.6
Part-time (n = 228)	7.0	19.7	13.7	34.2	25.4

* $p < .05$. *** $p < .001$.

Table 5. Caseload and Hourly Wage by Level of Satisfaction for Full- and Part-Time Dialysis Social Workers

	Very or somewhat dissatisfied <i>M (SD)</i>	Neither satisfied nor dissatisfied <i>M (SD)</i>	Very or somewhat satisfied <i>M (SD)</i>
Caseload			
Full-time (<i>n</i> = 1,029)	133.4 (43.1) ^{ab}	118.2 (27.3) ^{ac}	103.9 (34.0) ^{bc}
Part-time (<i>n</i> = 212)	88.5 (27.1) ^a	81.2 (28.6)	68.6 (22.3) ^a
Hourly wage			
Full-time (<i>n</i> = 1,053)	26.13 (4.36) ^a	27.01 (4.59)	28.08 (4.96) ^a
Part-time (<i>n</i> = 224)	27.28 (4.94)	27.69 (4.84)	28.79 (4.83)

Note. Pairs of superscripted letters within an employment category (full-time or part-time) represent significantly different pairs of means. Bonferroni post hoc test, $p < .001$.

Table 6. Level of Responsibility for Job Tasks by Full- and Part-Time Dialysis Social Workers

	Work status	<i>n</i>	Not responsible (%)	Partially responsible (%)	Solely responsible (%)
KDQOL-36	FT	1,087	1.6	3.9	94.5
	PT	230	0.4	3.9	95.7
Individual counseling	FT	1,081	4.9	21.6	73.5
	PT	225	4.9	25.3	69.8
Family counseling	FT	1,077	10.1	25.2	64.7
	PT	228	11.8	26.3	61.9
Assisting outgoing transient patients	FT	1,083	11.0	28.3	60.7
	PT	228	8.3	30.3	61.4
Transportation	FT	1,082	3.4	37.7	58.9
	PT	230	2.6	41.7	55.7
Patient satisfaction survey	FT	1,077	20.1	28.9	51.0
	PT	229	20.5	24.0	55.5
Behavioral contracts	FT	1,073	3.6	51.5	44.9
	PT	230	4.8	56.5	38.7
CMS Form 2728	FT	1,075	32.4	24.7	42.9
	PT	228	31.6	23.7	44.7

(continued)

Table 6. *Level of Responsibility for Job Tasks by Full- and Part-Time Dialysis Social Workers (Continued)*

	Work status	<i>n</i>	Not responsible (%)	Partially responsible (%)	Solely responsible (%)
Medicaid paperwork	FT	1,078	22.4	37.7	39.9
	PT	229	21.8	35.8	42.4
Support groups	FT	1,067	44.1	22.3	33.6
	PT	224	46.4	21.0	32.6
Incoming transient patients	FT	1,079	38.6	35.6	25.8
	PT	226	39.8	36.7	23.5
Educational groups	FT	1,071	37.3	42.1	20.6
	PT	227	42.3	37.9	19.8
Scheduling care plan meetings	FT	1,085	41.6	44.6	13.8
	PT	226	50.0	36.7	13.3
Patient social activities	FT	1,067	32.1	54.4	13.5
	PT	227	36.6	48.0	15.4
Staff counseling/support	FT	1,072	17.5	69.4	13.1
	PT	227	17.2	73.1	9.7
Insurance verification	FT	1,079	47.3	39.7	13.0
	PT	226	46.9	44.7	8.4
Pre-dialysis education	FT	1,072	43.7	48.6	7.7
	PT	227	53.3	39.2	7.5
Staff education	FT	1,069	10.9	82.5	6.6
	PT	219	16.0	80.8	3.2
Quality improvement	FT	1,077	13.2	82.4	4.4
	PT	227	18.1	78.4	3.5
Hospital discharge planning	FT	1,067	79.2	16.7	4.1
	PT	224	79.5	18.3	2.2
Collecting copays	FT	1,071	81.4	14.8	3.8
	PT	226	84.1	13.7	2.2
Treatment scheduling	FT	1,073	59.3	37.7	3.0
	PT	227	67.0	32.6	0.4

Note. FT = full time. PT = part time. *n* = subsample.

available time to provide psychosocial services to your patients as required by the Conditions for Coverage? and 2) Do you have clerical assistance on a regular basis for non-clinical tasks? No significant differences were found between the two groups of respondents. However, 70.4% of part-time and 76.6% of full-time workers reported insufficient time to provide psychosocial services as required by the CfC. In addition, 56.1% of part-time and 58.7% of full-time respondents indicated that they do not have clerical assistance on a regular basis.

DISCUSSION

This article examined the influence of the 2008 CfC on dialysis social workers' caseloads, job tasks, and hourly

wages. In addition, it assessed their levels of responsibility for specific job tasks and their satisfaction with key work-related factors. The findings from this national study demonstrate clearly that part-time and full-time dialysis social workers have experienced notable increases in their patient caseloads (> 40%) and dramatic increases in their required job tasks (> 80%) since the implementation of the 2008 CfC. Together, these work demands represent a continuing challenge and area of concern for dialysis social workers (Browne, 2012; Merighi & Ehlebracht, 2004a, 2004b, 2004c; Wolfe, 2011), and have become more salient since 2008 (Merighi & Collins, 2011). Workload demands such as high caseloads ($M = 130$ for respondents who perceived an increase since 2008) and mounting job responsibilities as identified in this study make it difficult for

Table 7. Employer-Provided Benefits for Full- and Part-Time Dialysis Social Workers

Does your employer . . .	Work status	<i>n</i>	Yes (%)	No (%)	Don't know (%)
Provide health insurance***	FT	1,080	99.2	0.8	—
	PT	223	91.5	8.5	—
Provide vacation/sick pay	FT	1,073	98.3	1.7	—
	PT	224	96.0	4.0	—
Provide 401K/403B retirement plans	FT	1,075	92.4	7.6	—
	PT	221	87.8	12.2	—
Pay for gas/mileage*** reimbursement	FT	1,079	82.1	15.9	2.0
	PT	226	71.3	24.3	4.4
Provide paid time off to attend conferences	FT	1,078	77.6	22.4	—
	PT	227	67.8	32.2	—
Provide holiday pay	FT	1,076	58.2	41.8	—
	PT	222	53.2	46.8	—
Provide merit pay increases	FT	1,063	57.2	42.8	—
	PT	222	54.5	45.5	—
Provide profit sharing	FT	1,072	57.3	42.7	—
	PT	223	45.7	54.3	—
Pay for local educational conference registration	FT	1,077	51.4	40.9	7.7
	PT	224	44.7	45.5	9.8
Provide bonuses	FT	1,076	45.9	54.1	—
	PT	220	37.3	62.7	—
Provide yearly cost-of-living raises	FT	1,076	40.1	59.9	—
	PT	223	43.0	57.0	—

(continued)

Table 7. Employer-Provided Benefits for Full- and Part-Time Dialysis Social Workers (Continued)

Does your employer . . .	Work status	<i>n</i>	Yes (%)	No (%)	Don't know (%)
Pay for national education conference registration	FT	1,078	30.7	51.7	17.6
	PT	224	25.4	56.3	18.3
Provide a traditional pension plan	FT	1,073	16.7	83.3	—
	PT	218	20.6	79.4	—
Pay for online continuing education units	FT	1,084	15.6	62.8	21.6
	PT	227	15.0	64.3	20.7
Provide increased pay for licensure	FT	1,061	15.0	85.0	—
	PT	219	14.6	85.4	—
Pay for professional association dues	FT	1,079	12.4	77.1	10.5
	PT	226	14.2	75.6	10.2
Pay for NKF-CNSW Nephrology Social Worker Certification fee	FT	1,084	7.6	67.9	24.5
	PT	227	7.9	66.5	25.6
Pay for state licensure dues	FT	1,083	4.7	87.3	8.0
	PT	224	1.8	92.8	5.4
Provide increased pay for NKF-CNSW Nephrology Social Work Certification	FT	1,087	1.1	71.8	27.1
	PT	227	0.9	72.2	26.9

Note. FT = full time. PT = part time. *n* = subsample. ****p* < .001.

social workers to satisfy CfC mandates, given that their job expectations were already arduous prior to implementation of the 2008 CfC regulations. Additional work is needed to understand how the new CfC and ever-changing social worker-to-patient staffing ratios (see Wolfe, 2011 for an analysis of staffing ratios) affect patients' quality of care and health outcomes.

With regard to hourly wages, full-time dialysis social workers who reported an increase in their wages made significantly more per hour than social workers whose wages stayed about the same since 2008 (difference = \$1.65 per hour). Interestingly, full-time social workers who reported a decrease in their caseloads reported making slightly less than those whose wages increased, \$28.04 vs. \$28.55 (see Table 3). It is unclear why this discrepancy exists, and why social workers who did not experience a change in their wages reported making the least per hour on average (i.e., \$26.90). As expected, when examining hourly wage by level of satisfaction with pay, social workers who were dissatisfied made significantly less than social workers who were satisfied (difference = \$1.95).

Mounting job tasks, increasing caseloads, and limited time to provide psychosocial services to patients and their families can manifest in job dissatisfaction for social workers in dialysis settings. It is evident from the survey findings that a substantial percentage of dialysis social workers (37%–49%) are dissatisfied with their caseloads, and that more than half are dissatisfied with their job tasks (50%–53%). Research on dialysis social workers prior to the 2008 CfC indicated that the majority of social workers reported average-to-high levels of overall job satisfaction (Merighi & Ehlebracht, 2004a). Current levels of satisfaction may be declining as the demands associated with the 2008 CfC challenge social workers to meet time-consuming Federal mandates and provide more services to a greater number of patients.

More than 70% of part-time and full-time respondents in this study reported that they do not have enough time to provide psychosocial services (including counseling) as required by the CfC. This finding may be due in part to the time needed to administer the KDQOL-36 and work closely with the interdisciplinary team so that all CfC-mandated tasks are completed. The 2008 CfC seem to have created an exponential increase in required tasks and

constrained opportunities for social workers to develop supportive or therapeutic relationships with their patients. These relationships are an essential part of effective social work practice because they provide the foundation for improving patients' health outcomes and quality of life. The overemphasis on non-clinical tasks erodes dialysis social workers' practices and results in suboptimal care for ESRD patients because there is little opportunity for their complex psychosocial needs to be addressed by social workers. Research has demonstrated how nephrology social work interventions can help improve patients' psychological well-being and psychosocial adjustment (Beder, 1999; Dobrof et al., 2001; McCool et al., 2011; Sledge et al., 2011). It is clear that efforts are needed to rethink dialysis social workers' current job responsibilities (see Table 6) and caseload sizes so that they can use to full advantage their specialized knowledge and skills in order to provide comprehensive psychosocial services that are in the best interests of patients' physical health and psychosocial well-being.

The three main limitations of the current study include: 1) the cross-sectional research design; 2) selection bias; and 3) an inability to conclude with absolute certainty that changes reported by the respondents are a direct result of the 2008 CfC. This investigation used a cross-sectional design, which is a common practice in survey research studies. Unfortunately, it obtained information at one point in time and did not capture social processes or change. Social workers may have responded to items based on their experiences on the particular day they completed the survey, and these experiences may not be reflective of their usual work in their dialysis facility. Also, obtaining participation from only one professional organization limits the external validity of the findings. There may be selection bias with our sample because data on non-respondents are not available. Finally, it is assumed that respondents attributed changes in their practice to the implementation of the 2008 CfC. However, the increasing prevalence of dialysis patients, changing patient and family expectations, organizational restructuring, and new policies and procedures in dialysis facilities could have influenced the respondents either positively or negatively, regardless of the 2008 CfC. Despite these limitations, this remains an important national study of the state of nephrology social work practice in dialysis facilities since the implementation of the 2008 CfC. As such, this study provides important data for future investigations.

Additional research efforts are needed to monitor how the 2008 CfC will continue to influence social workers' job-related experiences, workload demands, and satisfaction in dialysis facilities. The findings reported here clearly demonstrate that many dialysis social workers are burdened with large caseloads and an increasing number of job tasks since the implementation of the 2008 CfC. Studies are needed to assess the degree to which these factors are affecting, either positively or negatively, the delivery of psychosocial services to dialysis patients and their families.

Also, it is unclear if a greater number of dialysis social workers are experiencing feelings of burnout or thoughts of leaving their jobs as a result of the increased work-related demands associated with the 2008 CfC. Empirical investigations are needed to examine these critical issues so that interventions can be developed to protect the occupational well-being of social workers in nephrology settings. In addition, researchers, nephrology social work practitioners, and dialysis administrators need to join together to develop effective ways to meet Federal mandates and workplace requirements without jeopardizing dialysis patients' psychosocial needs or social workers' abilities to provide high-quality social services and clinical counseling. More innovative approaches are needed to create healthy, supportive, and collaborative work environments that enable social workers to provide essential psychosocial services to people with end-stage renal disease in the most effective and compassionate manner possible.

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