John E. Sullivan • Research Statement

The focus of my scholarly work is generating applied research to eliminate health inequities for marginalized populations with chronic health conditions. In particular, I work to develop solutions for reducing disparities in mental health/health service delivery for racial/ethnic minorities with chronic kidney disease (CKD), groups disproportionately affected by renal failure in the United States.

The prevalence of CKD in the U.S. is approximately 15%, and kidney disease is among the top 10 leading causes of death nationwide. Over 700,000 people in the U.S. are currently being treated for end-stage renal disease (ESRD). The prevalence of ESRD among Black/African Americans is almost four times higher compared to whites; and ESRD prevalence among Latin Americans is about 50% higher as compared to non-Latina/o/x whites in the U.S. Upon progression to this final and irreversible stage of chronic kidney disease, patients and caretakers encounter many psychosocial challenges. For patients diagnosed with ESRD, dialysis or kidney transplant is necessary for survival. In-center hemodialysis is the most common renal replacement therapy in the U.S., usually involving thrice weekly trips to outpatient dialysis centers for treatment sessions lasting 3 to 5 hours. Stressors related to both illness and life-sustaining treatment are often physically and emotionally taxing for patients; post-dialysis fatigue, sexual dysfunction, employment and financial worries, limited access to transportation, marital discord, and difficulties navigating insurance and social services are common. These stressors are associated with mental health challenges that can impact psychosocial well-being as well as patient medical trajectories. Among mental illnesses affecting those with ESRD, depression is highlighted by clinicians and researchers as the most common and debilitating, albeit frequently undetected and untreated. Depression affects approximately 30% of ESRD patients and is associated with increased risk of hospitalization and mortality.

Research into this subject is important to the profession for several reasons. First, the Social Security Amendments of 1972 extended Medicare coverage to people under age 65 with ESRD. In 2016, Medicare expenditures for ESRD program beneficiaries were about $35 billion, or 7.2% of total Medicare spending. With an eye on both cost and metrics that go beyond physical health, the Centers for Medicare & Medicaid Services have implemented performance-based reimbursement schemes for dialysis centers that evaluate the psychosocial well-being of ESRD patients, including screening for depression. Second, Black and Latina/o/x populations are less likely to have health insurance, receive nephrology care prior to diagnosis of ESRD, and are underserved by existing mental health service systems. Lastly, Medicare requires licensed masters-level social workers in dialysis and kidney transplant centers, the only such Medicare mandate for social work. To this end, I have collaborated with Dr. Namkee Choi and social workers from local dialysis centers to refer dialysis patients with depressive symptoms to an ongoing NIH-funded randomized controlled trial (“Telehealth treatments for depression with low-income homebound seniors”). As data manager for this project, I assist Dr. Choi (PI), interventionists, and community partners with participant recruitment, data collection, and analyses.

My three-article dissertation is entitled Depression, Depression Care, and Healthcare Utilization among Hemodialysis Patients, with Attention to Racial/Ethnic Minority Groups in the U.S. and comprises 1) a meta-analytic study of the effectiveness of psychosocial intervention trials for treating depression among dialysis patients; (2) a cross-sectional study of hemodialysis patient hospitalizations in the U.S. to evaluate the association between depression (and/or co-occurring serious mental illness and substance use) and hospital length of stay; and (3) a retrospective cohort study of the relationship between depression and risk of hospital readmission among first-year hemodialysis patients. I employ structural vulnerability and Andersen’s sociobehavioral model of health utilization as frameworks for examining non-pharmacological depression interventions and analyzing nationally representativeUSRDS administrative health data, which includes nearly all U.S.-based patients enrolled in the Medicare ESRD program. These quantitative analyses focus on the effectiveness of psychosocial interventions for treating depressive symptoms in dialysis patients and mental health/health service utilization patterns among adults undergoing hemodialysis in the
U.S., with attention to racial/ethnic minority groups, especially Latina/o/x and Black/African American hemodialysis patients.

As principal investigator, I was awarded funding (2019-2020) from the Social Security Administration for a research project entitled, “Workforce Participation and Healthcare Access among Working-Age Adults in the U.S. with Chronic Kidney Disease,” which examines associations between sociodemographic, health/mental health, occupational history, and healthcare access with employment status. Collaborators include Dr. Diana DiNitto and Dr. Namkee Choi at U.T.-Austin, and Dr. Mark Kunik, a psychiatrist at Baylor College of Medicine. Ability and independence to work is a top priority for individuals with renal failure. Findings from this research will help policymakers and healthcare professionals improve work-preserving or re-entry interventions for people with CKD. To illuminate the value of interprofessional practice and serve as a potential model for other health professionals, I am working with Dr. Teri Browne (University of South Carolina) and Dr. Joe Merighi (University of Minnesota) on the research project “Influencing federal health policy: Lessons from nephrology social work,” with a manuscript to be submitted to the journal Social Service Review.

I value multiple disciplinary approaches for advancing health equity, especially in conditions where xenophobic and discriminatory socio-political discourse gives way to harmful policies, such as the devaluation and separation of migrant families. Global/local neoliberal interests have also increasingly constrained or denied access to health and social services for marginalized groups. To better understand service delivery for Latina/o/x communities in the U.S., I collaborated with Dr. Yolanda Padilla and researchers from U.T.-El Paso to conduct a scoping review on the perinatal experiences of Latina women and their perceptions of healthcare systems. I also drew attention to the role of social work in providing services to undocumented clients, discussing the ethical challenges for medical social workers carrying out discharge planning with chronically ill undocumented/uninsured patients in the article “Passport Biopsies: Hospital Deportations and Implications for Social Work,” published in the journal Social Work. I am finalizing two articles for publication based on ethnographic fieldwork in south-central Mexico. This research, funded with a Fulbright-Garcia Robles fellowship, examines the impact of medical repatriation on patient and family wellbeing. U.S. hospitals reported high costs when treating undocumented/uninsured patients with chronic conditions in acute care settings; hospitals have repatriated undocumented patients requiring long-term care to their country of origin. I used ethnographic methods to understand immigrants’ experiences of medical repatriation and to consider how vulnerability to structural forces in the U.S. and Mexico shaped medical care and the illness experience. One paper in progress, co-authored with cultural anthropologist Dr. Lauren Gulbas, shows that patients experience pressure from U.S. providers and administrators to seek care in Mexico. Findings also show that families are separated, which taxes familial and community support systems. Additionally, older parents in Mexico often unexpectedly take on the role of caretaker for their ill adult child.

My future work will continue to align with research into service delivery, especially for marginalized populations with chronic medical conditions. This agenda includes piloting an empirically-supported psychosocial telehealth depression intervention for dialysis recipients in the U.S. and developing secondary data analysis projects with administrative health information. I will also continue work into issues related to border-crossing and healthcare. With collaborators in Mexico, I am developing an ethnographic study of healthcare-seeking experiences among migrants with chronic medical conditions. To pursue support for these investigations, I will seek funding opportunities from the National Institutes of Health Small Grant Program, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Mentored Research Scientist Development Award, and Mexico’s National Council of Science and Technology.

Given the complexity of healthcare systems and the key role of social workers in improving services for marginalized groups, methodologically-diverse quantitative and qualitative approaches, as well as collaborative efforts with social work peers and colleagues from other disciplines, are best suited for these endeavors. I am committed to producing applied research to eliminate health inequities and advance the knowledge base of social work practice and research.