ERIKA DUDLEY: We are going to talk about the first steps. We're going to talk about referral and the evaluation appointment. Trish will have an opportunity for you guys to ask questions. Ask as many as you like, because being able to get your feedback will also help our process. So first I just wanted to talk about the need. In November 2015, we realized that we needed to do some restructuring with our triage process.

We heard very loud and clear from our stakeholders that there was a change that needed to be made. And so, after some review, having conversations with our administrators and our directors, we decided that it was time to make a change. And adding the nurse back into triage was one of the first things that we decided to do. And the purpose for that is to improve our referral process so that we can offer increased satisfaction to our stakeholders, which are our patients, our dialysis centers, and our referring physicians.

And we wanted to improve our communication with them. We do meet at dinner with some of our stakeholders, and it was very clear that we needed to make some changes to increase their satisfaction. So we decided that we would develop a triage process and establish criteria that would be used to select the most appropriate candidate that would have the greatest likelihood to having a transplant. So with that, I am going to turn it over to Trish Berberet and she is going to take it from there. We'll switch back.

TRISH BERBERET: OK. So I'm Trish. I started on the triage, like Erika said, in September of last year. We currently have the nurse in the office, two MAs, Kristen and Alexa, who are here today, and then a PSA and a data specialist, Liz, who is probably upstairs answering the phone for us. So we are just a continual work in progress. We are trying to just kind of improve our role in our transplant center here as the triage office, then also really help with the patient's role as they go through the referral process, and making that as easy for them as possible.

We're going to explain the referral process today and what you can expect when you send that referral to us, and then also give you a view of what the patient's going to experience as they go through the process themselves. So when we receive your referral, you can expect that the patient will be contacted within the first 24 hours of getting that referral. If we get it on a Friday, it probably won't be till Monday that they hear from us. But Liz will be the first contact person that they hear from, and she kind of explains our process and what they can expect from us.

She'll check their demographic data with them and their insurance, and then she'll put that all into one of our systems. We have a couple data systems that we can pull medical information on the patients from, and Liz takes care of that and then hands it over to Alexa and Kristen when the patient's chart is ready. So when Kristen and Alexa have the chart, they're going to call the patient next and do an intake form with the patient. That intake is a questionnaire, and it takes about 30 to 40 minutes, probably, to complete with the patient.

It goes through their whole medical history. It kind of starts with what caused the kidney disease, is the patient on dialysis, where is their dialysis center. You know, do you have a primary care provider, do you have an oncologist if that was needed, do you have a cardiologist. We get all of those phone numbers. We try to find out when the patient was seen last at those places, and then we're going to retrieve that data and the last clinic note from each one of those places.

So once Kristen and Alexa have finished their role with that, they send the chart to me, and then I call the patient. And this one I just briefly go over, the information they've already given us. And we just kind of try to start determining, are they an appropriate candidate for a transplant evaluation now, or are there some things we need to work on or clear up. If there's a medically complex patient-- I think somebody wants to join us. If there is a medically complex patient, then our medical directors have a meeting with me weekly, and we kind of go over that patient and try to look ahead to see what are they going to need, and is it more than we can do right now, and should we hold off on scheduling that evaluation, or are they actually appropriate to go ahead and bring in, and then we'll work it out.

The same thing goes with the social aspects while I'm talking to the patient. We talk about transplantation to Ann Arbor or one of our outreach centers, and a lot of patients will have transportation to the actual evaluation, but that's a one time ride, and so they don't understand the big commitment, they're making the transplant. So we just kind of start talking about that very early on with them, and they're required to bring a support person with them to our evaluation day. And so the earlier they start thinking about that.

Sometimes it's a spouse and it's very straightforward, or a daughter. Sometimes those are real hurdles that patients have to get over, and so we consult with the social workers even before the evaluation appointment is set if that's something that needs to be discussed as well. So I think we can go to the next slide. So once we feel that the patient is probably pretty appropriate to be scheduled for an evaluation appointment, our financial coordinator Cindy Stammering will start doing the financial review for the patient. And she's going to talk later in the day, but she kind of goes over the entire insurance part with them.

Are they going to be able to pay for their medications, are they going to be covered all the way through transplant? She'll give us the clearance to schedule them, and then we'll call the patient and get them scheduled. So we have our outreach clinics, but they're not appropriate for all patients. But we are in Muskegon, Kalamazoo, Lansing, Rochester and Midland. And most patients can go there, but if there is a social work concern, or maybe it's a patient that has already been through the process here and was closed, and so that would be a concern. We're going to bring that patient in to Ann Arbor.

So not all patients can be seen in the outreaches, which I think in some conversations with patients, they just assume if we're in Midland, they can go to Midland. But there are some qualifications to be seen in an outreach, and that will probably be discussed later too in the day. So once we get that appointment scheduled with them in Ann Arbor, we're going to see them on Tuesdays and Wednesdays. There are some patients that we know, going into it, that are going to have to have some testing. So we're able to schedule like a stress test prior to the evaluation appointment.

They can have it done in the early morning hours, and then start their evaluation after that. So they'll pick the day. Sometimes, patients want to be seen right away, so maybe it's two weeks out. But it's definitely the patient's preference, and they can maybe choose to not be seen for a couple months or the next month. Completely up to them. So the evaluation day itself is a very, very long day for them, and especially if you tack on some testing prior to the appointment. So the evaluation itself takes about seven hours. We can easily stretch that into a seven and a half hour day without any problem.

When the patient comes in, they're going to first check in in our clinic downstairs, which I think on the tour, you probably saw that area. We're going to send them to the lab. They're going to have their blood drawn and then get a chest x-ray. After that, they're going to come in to an education class. And I teach the first part of that class. It's about 45 minutes, and that's the entire overview of the transplant process. The patients are served lunch during that time, and their support person, so they like that. They're given a kidney, pancreas education book that's theirs to keep.

We stress that we'd like that book to come back with them to all of their future appointments, so you could definitely help with that part of it. So when I'm done with the 45 minutes or so that I've taken, then Cindy comes in and goes over the financial part with them again. She'll talk about the medication after transplant, and the co-pays and the co-pays for the appointments, and she takes about another 45 minutes, I would say.

So when that part is done, then we're going to go back downstairs for the clinical part of the evaluation, and that's where the patient is roomed in one of our clinic rooms, and then they start meeting the whole transplant team. So they'll meet their transplant nephrologist, transplant surgeon, social work will come on and consult with them. Our dietician Karen Greathouse will meet with them. They kind of stay put in that room, and we rotate around them during that time. That period is about two and a half hours. And I'm kind of behind the scenes now.

As the providers come in and out of the room, they'll come and let me know what the patient might need if they're going to go forward. So maybe we know a patient's going need a CT scan, or maybe that patient didn't have a stress test. We're going to get a stress test on them. So I just kind of keep a running list going for what's needed for each patient. When they're all done, and you know, they've seen all the providers, I go back into the room and just kind of do a wrap up with them. If we have an anticipated plan for the patient, we for sure let them know that.

So some patients that are straightforward, we know are going to go right to listing, or maybe they're going to be listed on hold. Some patients will need more testing, so we would consider that like a continuing with the evaluation. And some patients actually do end up being closed during their evaluation. So if we know that, or we have a good feeling that that's what's going to happen, then I let them know that that's an anticipated plan, but the final decision wouldn't be until the next week, after our committee meeting.

So some of the benefits we've already realized in the change since September is a decrease in the notional rates to the evaluation clinic. And that's both outreach and here at Todman. I'm not sure exactly what to contribute that to, but I think a big part of it is the communication. So immediately, the patient's hearing from us, then they're talking to Kristen or Alexa, and then I'm talking to them.

AUDIENCE: I have a question. How do they know, we get a lot of questions from our patients about their access coordinators, and they never seem to know who their transplant coordinator is. And we have a very hard time figuring that out. I think that would help in the communication substantially, because it actually takes us a while to figure that out.

TRISH BERBERET: Yeah. Let me go back a slide for you. So I kind of left that out, and I shouldn't have. But the last one there. So what we have just started doing, so the patients have not really experienced this yet, is if we have a plan for them, and we know they're moving forward, whether it's going to listing, listing on hold, or just continuing with the eval, we're trying to call the pre-kidney coordinator down that day, so they have a face to face. It is definitely something we're still in the process of working out. They wouldn't hear from their pre-kidney coordinator for about 10 more days after the appointment, so that's a good gap right there. We can do better in that area for sure.

AUDIENCE: Right, because we try to look through the chart to figure out who they can contact when they'll say, we need to call somebody, and then we'll try to transfer them.

TRISH BERBERET: And you're an internal?

AUDIENCE: Right, [INAUDIBLE].

TRISH BERBERET: So I can give you some tips afterwards where you can find the actual name. The patients are told in the eval, regardless of if they meet the coordinator face to face or not, who their coordinator is going to be going forward. But I think that day is so big for them that, you know, maybe it should be a handout. Maybe that's something we could consider. Because there's no way they're going to remember everything we've told them.

AUDIENCE: I've been the person, if you can find a letter as well, because the evaluation letter is sent to the [INAUDIBLE].

TRISH BERBERET: So yeah, even before that, if you are internal, I was just going to say, and you can go into OTIS.

AUDIENCE: Yeah, they had told us to do that.

TRISH BERBERET: Yeah, So OTIS should be very clear with the pre-kidney coordinator. So like up until the evaluation day, it'll save Trish Berberet, and then after the evaluation day, it'll say a coordinator.

AUDIENCE: I'm going to support that from the referral dialysis clinic, that even six months later, after they're finished, I would say, you know, you found one. You should communicate with your transplant coordinator. Well, who is it?

AUDIENCE: OK, I believe that she-- and I don't say this stuff like that, but you know, I know that you were given information, and did you ever put it in your phone. That might be how you want it listed in there, transplant coordinator.

AUDIENCE: Well, sometimes I think it's changed as well, because they'll get one name one time.

TRISH BERBERET: You guys got the big boss coming in now.

AUDIENCE: This is a big area that we really feel needs improving for customer satisfaction, because it's very--

TRISH BERBERET: I think a quick fix that, I mean, we'll have to talk about more, but one way is to, we could have a written document when they're leaving eval. That is not something that would be hard to handle.

ERIKA DUDLEY: Right, and I think the other piece too, is, one, you know, it does come with the letter that the coordinator sent out. But you know, if you guys too could remind the patients, because just like Trish said, like, they get a lot of information. And sometimes, I know for me, when I get information from my doctor's office, like it goes in my front seat, and then it makes it to the back seat, and then it makes it to the counter in my car, and then I don't know where it goes after that.

So like there is a lot, and this is the purpose of being able to present this information so that you guys can give us some feedback, so that we can take that back. If you can, though, just kind of like table it until the end, so that we can, you know-- because she might answer the questions, but like, we did reserve like a lot of time because we really want to get your voice and we really want to hear what you have to say because that's the only way that we're going to make the process better for our patients.

TRISH BERBERET: I do think that's a good idea, getting something in writing with that. Yeah. All right, let me go back forward. You got it? Good. So the no show rates, like I was saying, we think that maybe they're decreasing because of the communication that the patients have before the evaluation appointment, so it seems like they're more invested in being here, It has been a significant decrease, so that's been a good thing. So increasing the communication and reestablishing positive relationships with our referring providers and the dialysis centers. So still, that's a work in progress. I do feel like we've made some headway as far as, you know, communicating more via the phone or with the referring nephrologists, we're sending a lot of e-mails back and forth with them.

But that is just going to be an ongoing thing that we can always work and improve on for sure. But I know you'll have our contact information leaving today, and everyone is welcome to just give us a call if there's something that we can do to make the process easier for you. And then the patient satisfaction has increased with the anticipated plan when they're leaving that day. So prior to doing this, the patient might be evaluated on a Tuesday, and then we have a committee meeting on that following Monday where the absolute decision is made for the patient going forward.

By giving them that anticipated plan, like this is what you can expect, has seemed to really increase their satisfaction with that process coming in for eval. And then to decrease time between evaluation, decision. So before this process, the patient would come in for evaluation, and then we would spend the next couple of weeks as coordinators getting all those records that we now get beforehand. And so the decision just couldn't be made because we didn't know.

So now the providers have a pretty good idea going into the evaluation appointment what's going on with the patient. They have a pretty good idea of what we need going forward, and a decision has been made a little bit sooner. So this is the part that you guys can really help us out with. So this is our referral form, and hopefully you've all seen this updated when it came out last September, October, I think we mailed it out. But we know that there's a lot of different forms out there, and it's hard to keep up with them.

But this is the one that helps us out the most. It starts off there with informing the patient of the referral. So we do actually call a lot of patients. So Liz being that first contact will call patients, and it is the first time they're hearing that they've been referred for a kidney evaluation. So that makes it a little bit awkward on that end. So if the patient and you can just work together before that referral is sent in, and so they know to expect a call from us, that's very helpful.

When you send in the referral form, along with their current demographic information, just checking to make sure you have the most current phone number for the patients, because the numbers change so often that sometimes we actually cannot contact a patient initially, just because of the wrong phone number. And then the insurance information being accurate on there really helps Cindy out, and she'll talk a lot about that later, I'm sure. But then when you send the referral in, there is those three boxes there where it says most recent office note, most recent labs, and if you have any recent testing results.

So we know you might not have recent stress results, but if you do have them, it helps us out a ton. It really cuts down that time where we're going to start looking for things. There are recent labs, so sometimes we get cumulative labs from you. But we unfortunately can't use that. So then we're calling you a second time and nagging you, can we just get one set of labs. And so just the most current lab that you ran for that patient, we just need that one run on those. And then an office note. So that's also a hard one, because I know the nephrologists do a rounding sheet on the patients, and that just doesn't give us enough history on the patient. And so we're always asking for, do you have a clinic note, do you have a H&P. So that would be helpful with that.

And then the dialysis adherence form is a newer form that social work actually kind of rolled out about a year ago, I would say. And just recently, we've been trying to have this completed on every patient that comes in for eval. This form is an extremely useful tool and already gives us a good picture on the patient, and how are they, you know, with coming to dialysis treatments. Are they leaving early, are they missing them, are they taking their medications? Have they developed a therapeutic relationship with the center? Because what they do there is what we're going to do here, and we know that. So if we have a good picture going into it, that's helpful.

OK. Here are some questions. So time frame from referral to appointment. So this can vary quite a bit. So on a very complex patient, whether it's socially or medically, they're definitely being contacted within that 24 hours, if they answer the phone, right. So that can be a little bit of a delay. So we can play phone tag on that end. And then the chart gets to Kristen and Alexa, and they might play phone tag with them for a little bit. Then it comes to me, and they might play phone tag with me as well.

But if all goes perfectly, and we contact that person on the first time, I think we're offering the patients an appointment within about a week to 10 days, sometimes maybe two weeks, but not much longer than that. We kind of have a good picture pretty quickly whether or not the patient's going to be appropriate for evaluation, and we'll offer up a schedule. If they're going to wait for an outreach appointment, it might be that the patient comes back to the dialysis center and says, I'm not going to be seen for two months.

Well, it might be because they've chosen to be seen maybe in Muskegon, where we're only out a few times a year. Or it could be their preference to come to Ann Arbor, but they don't want to come until maybe a family member is in town or something's happening, and so they've chosen to be seen quite a few weeks out. Should all patients be referred? We appreciate every referral. I don't think there's a situation where we don't want a referral. Just feel free to always send them in, and then we can work on it from there.

Patients with a history of cancer, we want those referrals. There are some guidelines that we have to follow. There might be a wait time for certain cancers, but we are definitely happy to have the conversation with the patient after we receive the referral for that. A previous transplanting patient, we absolutely want to see them too. Those are going to be patients that will probably come to Ann Arbor and not be seen in our outreach centers. Patients that are obese. So I know some centers have a strict guideline on that, and we're not super strict. We want to evaluate a patient regardless. If the BMI is above 50 when we get that referral, we'll call the patient and we'll just let them know, this is what we need.

We're going to keep that referral open, you know, give them three to six months and then call them back and see how the progress is. And patients that have been closed before, so yup, we want those too. So maybe they were closed last year due to transportation issues, and their situation has just completely changed. They have a new car, or maybe they got married and they have somebody that can take them back and forth. So we always want to look at all of those referrals. Can you think of some questions for us?

AUDIENCE: You didn't mention age.

TRISH BERBERET: So we don't have a firm cutoff on age. When we approach 80, I always discuss those patients with our medical directors, and then it's up to them whether or not we're going to see that patient. An 80 year old would most likely be required to have a living donor, and so just have a good conversation on the phone. The wait time in Michigan is five to seven years, so at 80 years old, are you really-- you know, that's probably not going to happen for you. And just having that conversation, the patient, I haven't had any negative response on that. So we would still want that referral.

ERIKA DUDLEY: Yes, ma'am.

AUDIENCE: Smoking or medicinal marijuana.

TRISH BERBERET: So both of those can be OK. I shouldn't say they're always OK, but both of them, it's not an exclusion for a transplant.

ERIKA DUDLEY: Wait, right here. Yeah.

TRISH BERBERET: I just want to ad lib to that. I know what Cindy is going to say. Some insurances, that's an exclusion. You like how I'm reading your mind?

AUDIENCE: What about nursing home patients?

TRISH BERBERET: So those are very difficult sometimes. So what we have started doing for a patient that lives in a nursing home or on assisted living, is we have a care and support plan filled out ahead of time. But we would still want that referral, and then we just have the care and support plan to see what kind of support that patient has before we move forward.