

[MUSIC PLAYING]

**COLLEEN**

I actually would like to start off introducing my colleagues. So I'm here as a transplant social worker, but I'm really part of a team. And so many of you have probably spoken with my colleagues. So I just thought I would give you the opportunity to have a face to the name.

**SATARINO:**

So Christin Carthage is one of my colleagues. She previously-- maybe about five or six years ago, she was our inpatient social worker. She left our team for a while, and now she's back. And she goes to all of the outreach clinics. So there was a time when we were all sharing the outreach clinics, and now this is Christin's main assignment.

And then Laurie Dunn. Laurie has been with our team for about 11 years now. So this is Laurie. Ebony Rogers is one of our newest members of our team. She's actually our inpatient social worker. She was previously with Henry Ford Health System. And there's me. Then Lauren Smitherman. She has been with our team, I think, three, probably going on four years. And she was previously with Oakwood.

Deb Valentino has been with our for about two years, and she came from our inpatient team. And then here's also Darsh. So he does not work with recipients, but I didn't want to leave him out, because he is a social worker with our team. So he's our living donor social worker and independent living donor advocate. So there you are. You've met everyone.

So I'm going to go back. So really this is an overview of what I'm going to talk about. I'm going to just give an overview of the psychosocial assessment, talk about partnering with all of you as dialysis staff, talk a little bit about surgery and recovery, some post-transplant issues, and then some resources that I'd like to share with you.

So really, when patients come to our transplant center for their evaluation, we see many emotions that they will display and their family will display on that day. Oftentimes, they come in, and they're quite worried and anxious. Sometimes patients say, I didn't sleep the night before. Oftentimes, of course, they're very curious about transplant.

And in the end, they're really very hopeful. And these are just some of the statements that I've heard from patients as I go out to dialysis centers and meet with them. You know, really, in the end, they just want their life back. They want the energy and the time that they have to give to dialysis. They want all of that back. And certainly, transplant is the treatment of choice for patients with end-stage renal diseases, as it provides an improved quality of life and life expectancy compared to dialysis.

And while we're dedicated to helping patients achieve the goal of transplant, the transplant community is also keenly aware of our responsibility to the donor families and to the living donors who give this amazing gift of life. So as a social worker who meets with patients and their support people during their evaluation, it's my responsibility to do a thorough psychosocial assessment to assess patient readiness for transplant, and also to identify any psychosocial barriers to transplant success.

So as Dr. Sung mentioned, CMS is a big part of transplant care in providing guidelines for transplant care, defining all of the different roles of all of us on the transplant team. So this is just a direct quote from the interpretive guidelines. It talks about how it's important to assess the patient's suitability for transplant, as you can see.

And then it also gives very specific topics that we need to address. Certainly, their overall psychosocial picture, coping, risks and benefits of transplant, really assessing their ability to provide informed consent, ability to adhere to a therapeutic regimen-- so adherence-- and then mental health and substance abuse issues.

So this is really an overview of how we organize our assessment. It's probably similar to the assessments that you do in the dialysis center. And we're also looking at their understanding of their disease, how they're managing their care. So I will talk with them, do you manage your medication independently, or does someone in your family or in your life help you? What do you know about transplant? Was transplant your idea, or was there someone else who wanted you to come? So really understand their own motivation to move forward with transplant.

So the overall psychosocial assessment takes about 45 minutes. And we're gathering information from the patient, from the-- if their care support person came with them. As Trish said, we also receive records. So we will review the records. If we have an adherence form, we will review that. But we've also added some psychometric tools to help standardize some portions of our assessment.

So this is the list. Some of these tools we use routinely, some we just use as needed. But really, the first tool, the Stanford Integrative Psychosocial Assessment for Transplant, that was something that I was introduced to in about 2012 when I heard Dr. Jose Maldonado from Stanford gave a talk about this tool that he had developed.

And really, there were tools that were developed-- psychosocial tools-- probably about 10 or 15 years ago, and they never really caught on. They were very long, or just not very conducive to clinic work. So that was really his goal was to develop something that would be useful. And in the end, it is an assessment that we use in addition to, really, our own clinical assessment.

It doesn't necessarily trump our own clinical skills, but it provides an understanding of the level of risk. So it actually gives us a score of overall psychosocial risk. The four domains in the SIPAT are patient's readiness level and illness management, psychosocial support, psychological stability, and substance abuse.

There are also certain absolute contraindications. So someone could have an adequate SIPAT score, but if they don't have any support, or if they don't have any transportation, then that's an absolute contraindication. So it's just sort of a way that we use this to help us to, as I said, understand overall level of psychosocial risk.

In addition, we've added the PHQ-9 and the GAD-7. So that actually goes out to patients in their new patient questionnaire that we ask that they fill out before they even come for their evaluation. So I use that tool when I'm talking to a patient about their mental health history.

The other one that I do want to also mention to you is the REALM, the Rapid Estimate of Adult Literacy in Medicine. So we've also started just becoming more aware of the importance of understanding our patients' health literacy. Really, many patients, they'll come in, and they'll say, yes, I have a high school level of education. But they may not have a high school level of literacy. And they may not have a high school level of health literacy.

So this REALM short form, it's very brief, and we are doing it on every patient that we see. We're essentially asking them to read out loud six words. They are six medical terms. And depending on how many they miss, that gives us a good indication of whether they have a high school literacy or lower than that. And then it goes to seventh or eighth grade, and then fourth to sixth grade, and then lower.

**AUDIENCE:** What are the words?

**AUDIENCE:** [INAUDIBLE]

**COLLEEN** Well, I know the last one is jaundice. I'm not remembering what the other one's are. I'm sorry. I see them all the  
**SATARINO:** time. I should have them committed to memory.

**AUDIENCE:** Can I ask you another question?

**COLLEEN** You know what, Jill? I'm so sorry. I'm going to wait till the end.

**SATARINO:**

**AUDIENCE:** Oh, sure.

**COLLEEN** But write it down and remember.

**SATARINO:**

**AUDIENCE:** Yeah, yeah.

**COLLEEN** OK, thanks.

**SATARINO:**

**AUDIENCE:** I'm sorry.

**COLLEEN** No, that's fine. So now I'm going to talk about the five different aspects of the psychosocial assessment. And the  
**SATARINO:** first one I'm going to discuss is social support. So why is social support so important? And as social workers, this is sort of our neck of the woods. It's because it's really hard to manage health care on our own.

Whether it is any sort of a new diagnosis, any sort of a treatment that causes anxiety, or even just having your colonoscopy, you have to have somebody take you. So we all deal with this in our daily lives. But our patients have a much higher expectation as far as how many times they have to interact with the health system as a dialysis patient, and then also as a transplant patient. So we're really invested in helping patients develop their support plan.

And also this study by Chilsholm in 2009 saw a significant relationship between social support and medication adherence. Certainly, that is something that we have experienced. I've seen many times in the transplant center, when I meet a patient in the clinic after a transplant, we'll say, are you remembering to take your medication? And the patient's wife or husband will say, well, I'm reminding them to take their medication.

So having those people in our lives really does boost adherence and bringing that into someone's daily routine. Also, I thought it was interesting that it's both affectionate and instrumental support that is most important. So it's not just getting you to that doctor's appointment, but it's having someone there if that test didn't go well. And so that's also very important.

So this is a slide that just talks about our expectations as far as post-transplant support. So we want there to be at least two people who are willing to do each of these tasks. So that someone is in a patient's home for two weeks after transplant, and that's around the clock. That isn't, my husband will be home in the evening after he gets home from work. That's not going to be adequate support. Typically three to four weeks of transportation and accompaniment to clinic visits, and medication assistance as needed.

So many times, I will meet patients who are very independent with their dialysis and other medication, but after transplant, we're really giving them a lot of new information, a lot of new medication to learn, and that can be really overwhelming if you're in pain and you're just trying to get your bearings. So having someone there just as a check and balance certainly can be very helpful. And then also there are biopsies throughout the first year, so transportation is necessary for that.

And really, my colleague wanted me to mention that those are minimal expectations. Because, if a patient does have complications, then they may need more help than that. They may need someone in their home a little bit longer. They may not be able to drive for a longer period of time. Or, if they have complications, they may have more than just that weekly visit for the first six weeks. We may be seeing them weekly for a while. Or maybe they need to come in for additional biopsies or ultrasounds. So that is minimal. I'm glad I wrote that down. OK.

So this is our process to help patients ultimately complete their care and support plan. So we'll meet whoever a patient brings to the evaluation. And if, say, they bring their spouse, but they say, oh, my son will also help-- so then I would get on the phone, and talk with the son, and really go over, essentially, what I went over in clinic with the patient and their spouse to explain what the expectations are and ask questions like, so, do you work full time?

Can you get time off from your work? If it's an immediate family member, do you have access to FMLA? Another question we've been asking sometimes is, do you mind driving on the highway? Sometimes we find that patients are nervous about that. So we really try to have a pretty thorough conversation to be sure that the support people really are not only willing but are able to provide these different tasks.

Now, there are also times when we will actually ask patients to come in for a family meeting. Say there are multiple caregivers, and we want to be sure everyone's on the same page. Or maybe we're concerned that a caregiver says, yes, I can do this, but it seems like they have a lot on their plate. And we want to have an in-person conversation about this. So if you hear that we've asked a patient to come in for a family meeting, it's just because we want to really delve into this a little bit further and be sure that everyone is on the same page and is able to provide the support the patient will need.

OK. So I'm going to move on to mental health. So in talking with patients about their mental health and their coping, sometimes I will just ask, have you ever experienced depression? Have you ever experienced a lot of anxiety? Sometimes if I review the PHQ-9 and I see that the patient has a moderate to higher score, then I'm going to understand this might be a little more in-depth conversation, and ask a little more detailed questions.

But oftentimes I'll also ask how they coped when they received their, say, stage four CKD or ESRD diagnosis. That, really, I think, is a good litmus test to see, how does a person cope when they've received a diagnosis? Where did they turn to receive support? Or what did they do to cope? And sometimes a patient may say that, I just am very prayerful, and people at church were praying for me.

Or maybe someone says, I just knew that my colleagues at work were really supportive. Even though I was stressed about that, when I heard that they were supportive, I felt a lot better. But sometimes patients may be quite honest and say, it was really hard. It was very difficult, and might even indicate that they were using substances to cope with that. And so those are the avenues that we will explore in this discussion.

So now I want to talk a little bit about, say a patient does have some history or is presenting with some symptoms that we are concerned about, just so you can understand some of the terminology and understand what the recommendation is. So there are a couple of different categories. So the first one is require versus recommend. It's important that there is a distinction there.

So say I met a patient who started dialysis not very long ago, but they're still feeling a lot of grief and loss about being on dialysis. They're not quite as socially engaged as they were, but they don't have-- they're not suicidal, they don't have any mental health history. They just feel sort of stuck. OK? So for that patient, I may recommend counseling and say, it might be helpful for you to talk about this with someone.

Because, frankly, sometimes, while we have a lot of people in our lives, maybe they don't want to burden their family about how they're feeling. And it might be helpful for any of us to talk to someone who is outside of our family, just to get some affirmation that these feelings are very normal, and let's look to how you're going to move forward. So this is a recommendation. It's not a requirement for listing. It's just, really, a suggestion. We're recommending that you consider this.

But a requirement would be for a patient who, say, has been on dialysis for a year. They're feeling depressed most days. They're not engaged with their family. They have a past history of depression, and they're not under anyone's care right now. I would be concerned about that patient. And so, in that situation, we would require a mental health evaluation.

If they had a past history of depression and had previously been on medication, I would probably recommend that they see psychiatry first. But sometimes patients are much more resistant to seeing psychiatry first. Sometimes they want to see a therapist first. And I think that's totally fine. We would say, we require that you start counseling. And then, typically, the therapists would then refer on to psychiatry if they felt strongly that medication was necessary.

So then that leads us into psychiatry versus psychotherapy. So really, psychotherapy, as we know, is a way to provide support, helping patients cope and learn different coping strategies to help them adjust to their illness or whatever stressors that they are experiencing. And psychiatry, when we look at a patient, is really for a patient who has higher severity of symptoms, a longer duration of symptoms, and who we think that medication might really benefit.

So lastly, a local provider versus Dr. Winder. So Dr. Scott Winder is our transplant psychiatrist. He started with our team probably about a year and a half ago. And previous to Dr. Winder, we really only relied on local providers. So this is really sort of another layer of resource for our patients. And so patients who have a complicated psychiatric history, they're on a lot of medication, and it seems to contradict each other, and we really just need a fresh set of eyes to have a look at this patient.

Or we really feel like starting psychiatric care would be helpful, and we're not sure how quickly they can get into a local provider, then we might recommend that they come to see Dr. Winder. But we realize that, for distance, for many patients, this is really not feasible. So then we are looking to local mental health providers to provide all of this care.

And how long really depends on the severity of the symptoms that are being presented. So I don't really feel that I could make a blanket statement. Oftentimes, we will look in three, six month chunks. Maybe check in at three months, see how things are going. And then at six months to see, has enough progress been made to state that they are stable?

So these are just a few statistics about patients who experience depression. Depression really does increase the risk for post-transplant mortality. And it also increases the risk for non-adherence to medication. And it's a surprising number of patients who experience depression after transplant. So it's certainly something that we need to check in before, but also post as well.

So I am going to speak briefly about cognition. So if any member of our team is concerned about a patient's cognition, about their memory, about their ability to provide informed consent, then we may have them see Dr. Winder [INAUDIBLE] appropriate, or may possibly make a direct referral for neuro-psychological testing.

OK. On to substance abuse. So as far as use of alcohol, we really use NIH guidelines for alcohol use and what they consider moderate use. So it's essentially one drink a day, or seven drinks, for a woman. 14 a week, or average two a day, for a man. And no more than, I think, three in a day. So those are the types of conversations that we will have with patients.

And if we are concerned that they have a significant history of substance abuse, they have maybe had a lot of treatment in the past, and maybe it hasn't been a long time that they've been sober, or if they have a heavy active use, then, of course, we're going to require them to have a substance abuse evaluation. And then we would need to understand what the plan would be after that. We also talk about whether patients have negative consequences due to their substance use, or, as I mentioned earlier, if they're self-medicating untreated mental health issues.

So I'm going to talk briefly about opioid use. So we review what's called a Michigan Automated Prescription Service report for every patient that we see in the clinic. And that tells us if patients are being prescribed any opioids, any benzodiazepines, and then any other controlled substances. So that's really very helpful, because, as you know, this is something that is an epidemic in our country.

And we really started this process probably about eight years ago. And it helps us understand the patient who comes in and says, I have chronic back pain, and I take two Norco a day. And that's fine. And we'll check the MAPS to see if that's actually the case. Sometimes that is the case. They're getting it from their PCP, and it's longstanding, and it's stable.

Or sometimes we'll review the MAPS, and it shows they're getting it from their primary, but then they're also getting it from their orthopedist, they're going to the emergency room. So that's really misuse, and they seem to potentially be drug seeking. So we may ask that patient to go to a pain clinic for a pain management assessment.

Now, let me just take a quick drink. For the patient who is just taking those two Norco a day, we have what's called a pain agreement that we ask them to sign and their treating physician to sign. And really it's just an information sheet that we're sure that the patient and the physician see this information that states that Dr. Sung and the surgeons are only going to treat pain for one month after transplant.

And after that one month, the patient needs to return to their previous provider who will then take up their pain management. So that's something that we've also had in place for a while. I'm not going to have time to talk about the Opioid Prescribing Engagement Network, but if anyone's interested in things like medication take back- - I don't know if any of your communities have had that-- just see me afterwards, and I'll talk to you about it.

So when the substance abuse assessment is completed, then there will be recommendation. Is treatment necessary? Is treatment not necessary? Maybe they just suggest a few sessions of relapse prevention counseling for a little while. Now, I also want to mention-- and Cindy's going to talk about this, related to insurance-- there are some insurances that require completely negatives screens. OK? And she'll talk about that when she comes up and shares her information with you.

OK. Getting on to dialysis adherence. So as a transplant social worker, I told you we spend-- I don't know if I told you how long-- probably about 45 minutes with each patient. OK? And I can get quite a good sense of a patient, their history, their coping. But I only have what I see in that 45 minutes.

So really, it's so helpful to reach out to all of you to understand what you're seeing in your setting. Because you get to know your patient so much better than we do. So that's really why we decided to go to more of a formal reporting system of understanding dialysis adherence. And Trish mentioned that a little bit earlier.

So just try to be a little more objective as far as how many missed treatments, how many shortened treatments, and all of that. This also is a work in progress, and I am happy, afterwards, if you want to provide any sort of input. I know our form is not necessarily as user-friendly for PD as it is for hemo. If anybody has any ideas for that, I'd be happy to hear it.

But essentially, if we identify that a patient really is not adherent appropriately to their dialysis treatment or to their medication, typically we will want them to improve over a six month period, because it's really hard. I mean, if a patient is missing four or five treatments a month, it might take them a little while to get it down to a reasonable-- get them back online.

Now, in severe situations, we may actually require 12 months. So this oftentimes is a patient for whom, say, we have had multiple iterations of giving them the six months, and they've really not been able to get it, get their dialysis adherence on track. Then we may close their evaluation and say, you can come back when you've demonstrated 12 months of continuous adherence.

We also pay attention to patients who are being re-transplanted. So certainly understanding, were there psychosocial issues related to their graft loss? Did they have challenges with accessing their medication, challenges with insurance? Oftentimes that is part of their experience.

OK. I'll talk about this very quickly. This just is a study that talked-- they talked to 40 or 50 post-transplant patients. They were like 10 years post-transplant. And what made you successful? And so these were the four aspects of their self-management that helped them be successful.

Reminder methods for their medication, whatever that is; being able to consistently maintain their access to their medication; maintaining routines-- routines for medication, routines for labs. That's really, really important. That's one thing that oftentimes does fall off of a patient's plate, and then they end up in rejection. They had no idea they were in rejection, because they were taking their medicine, but they weren't having their labs; and lastly is problem solving strategies.

So gosh, I'm on vacation, and I am without my medication, or I am lower than I thought. What am I going to do in that situation? Patients who have good problem solving strategies would be able to work through that. A patient who is challenged in that area may just end up going two weeks without their medication.

OK. So by a show of hands, dialysis transplant coordination-- so dialysis, you guys, transplant, us-- improves patient care. Is this a true statement? Oh, oh, oh, wait. I guess I didn't say-- first, let's say, is this false? Anybody say it's false. Is this true? Yay. OK, all right. Excellent. I agree.

And I have to say, I love working with patients, but I also really love working with you guys because, really, it's all about really establishing good communication between transplant centers and dialysis centers to help our patients get through the evaluation process and listed. So these are just some of the ideas that I had.

We're promoting adherence. We are saying, you need to be adherent to dialysis. And as dialysis providers, you can say, hey, have you been following up with your testing for your transplant listing? We can support each other in our patient's goals, communicate to try to be sure that the patients know where they're at, encourage follow through. And then, in the end, you are there to provide support if we decide that a patient is not appropriate for transplant, and either their evaluation is closed or they're de-listed.



So briefly, I'm going to talk a little bit about inpatient stay and then a few post. So when patients are called in or they have their living donor surgery, the inpatient social worker provides assistance. I talked with Ebony, and these are some of the common topics that come up. Really coping with the reality that, oh my gosh, this actually happened, and the realization that someone is deceased, and their family agreed to have their organ transplanted.

Sometimes that actually hits patients as they're sitting in their bed. Sometimes it hits them a little bit later. And also even the reality of a living donor. Like, gosh, my sister just gave me her kidney. This is amazing. So those are the things that patients think about. Certainly caregiver support. Financial concerns start to come up. And then Ebony also provides information to help patients to communicate with their donor family through Gift of Life.

So the patient is typically in the hospital for three to four days, then they go home. And then a couple of days later, they're here in clinic. So we typically will become involved from social work if there are complications and a patient gets very stressed. Also, typically, if there are complications, the caregiver becomes very stressed.

And that can stress their abilities. They thought they were going to go back to work in two weeks, and maybe they can't. And how do they navigate that? Certainly, role changes within a family. And just really support both the patient and the caregiver, and provide some coping strategies and encouragement.

So as far as long-term chronic issues, transplant is a wonderful opportunity. Patients who get a deceased donor transplant, it could last 10 to 15 years on average. That's fantastic. Living donor transplants last 15 to 20 years. That's an amazing gift that our patients receive. But there certainly are bumps in the road. Patients can have difficulty becoming employed. Or once they are employed, if they happen to have, say, a rejection episode, and they're in the hospital a lot, that could-- their employment could be at risk. So that can be a point of stress

Also, insurance is a huge part of the post-transplant stress, I would say. And then, in the end, also that nagging worry like, how long is my kidney going to last? And that's not anything that our team can answer. But really, the way the patient has a part in that is doing all the things that we need them to do to keep their kidney healthy, which are take their medication on time, never go without it. If they go on vacation, have an extra supply. Be sure they have it.

Have labs. Labs are so important. It's heartbreaking when we meet a patient in evaluation who we transplanted 10 years ago. Their kidney could have lasted longer, but they fell by the wayside as far as their labs. Kept taking their medication, and then they're in rejection. So in any way, if you ever have opportunities to talk about what it's going to be like after a transplant, really, it's a three-legged stool. It's the medication, the labs, and coming to see their transplant nephrologist.

So lastly, I want to-- I'm not going to be able to do the case studies. Just a couple of things patients say about transplant-- I feel like I have my freedom back. I'm so happy to have more energy. I'm so thankful for their gift. So lastly I just want to talk briefly about some resources. So you have three brochures in your bag. And two of them-- actually, I'm going to skip ahead. Two of them are transplant-specific fundraising organizations.

So Help Hope Live and National Foundation for Transplants-- those are both organizations that, if you have a patient who's very motivated, they want to fundraise, they have some matching funds that would actually increase the total amount that a patient would be able to have access to. There's lots and lots of guidelines, and it's very structured. And I would suggest that they look into it in a lot of detail before they would make this decision.

But it does help a lot of people. And if you go on their website, they're going to show you all of the benefits, certainly. OK. I also want to talk about the National Living Donor Assistance Center. So say you have a patient who has a sister who lives in Florida, but the sister in Florida really can't afford to pay for the flight to come here, or the lodging once they get here, or they just have very limited financial resources.

This is a federal grant that, if both the recipient and the donor qualify, the donor and a caregiver would be able to get a flight to their transplant center, also lodging while they're here, and some money for food. So this has benefited many of our patients. And so, if you hear of patients who talk about, well, I have a donor, but they live so far away, and it's never going to work, this program might really help them.

Also Second Chance at Life. I wanted to highlight the fact that Second Chance at Life is actually an organization that was started by a U of M post-lung transplant family. And it's grown in it's, I think, about 10 years in existence. And they provide \$1,000 grants for-- the only thing they help with pre-transplant is dental assistance, but that's huge.

Because sometimes patients do need dental clearance, and that's the last thing they need before we will list them. Post-transplant, they'll also help for out-of-pocket medical expenses too. So that's helpful to know. What else? Then there are some other grants. The Gift of Life grant. We have our own emergency grant. And then we all have access to the NKF Emergency Grant as well. OK, those are my resources. Thank you so much.

[APPLAUSE]

I know this is our break time. We maybe just can take a couple of questions. Yes, right here.

**AUDIENCE:** I actually just had one comment on the substance abuse assessments. I've seen a lot of assessments where they ask about how many drinks they have and so on. But they never ask what they drink or how big the drink is, which is crucial.

**COLLEEN** Yeah, absolutely.

**SATARINO:**

**AUDIENCE:** Seven drinks could be seven very large drinks, or two-finger drinks. [INAUDIBLE] And the beers could be 12-ouncers or 40-ouncers. So that's a very crucial question to ask, especially when you're talking about dialysis and kidneys.

**COLLEEN** Absolutely. Thank you very much.

**SATARINO:**

**AUDIENCE:** It was just a reminder [INAUDIBLE].

**COLLEEN** Well, in the NIH guidelines, you can pull them up, and they do a great job laying all of that out. How much liquor is actually one drink, and--

**SATARINO:**

**AUDIENCE:** Yes. And that's something to remember.

**COLLEEN** Right, thank you.

**SATARINO:**

**AUDIENCE:** I have just a curiosity question. In your mental health psychosocial assessment, there's a statistic there-- do I need that? I'm loud anyway. There's a statistic there that says up to 65% of post-transplant patients experience depression in the first years after transplant.

Now, I can make a projection from my standpoint as a social worker to believe that fear of rejection would be one, and then, two, the loss of your dialysis staff as a support. But is there something else there that you can give us a heads up that maybe we can be working on with our patients on that?

**COLLEEN** No. That's a really good question. Typically, anyone who has a chronic illness, there's typically about 40% across the board. 40% of patients who have a chronic illness have experienced depression at some point. So that's really sort of 25% on top of that 40%.

So some of it could be the fact that their kidney is only going to last if they have an insurance that is going to cover their medication. That's very stressful. Worry about rejection. So it could be that there's just some very transplant-specific stressors that also increase that. That's my guess. Yes?

**AUDIENCE:** Are any of the post-transplant medications have a [INAUDIBLE]

**COLLEEN** Not to my knowledge. Not to my knowledge. You can ask Dr. Park, who's a pharmacist who's coming this afternoon. Yeah. Yes, Deb?

**AUDIENCE:** What about [INAUDIBLE] diagnosed with depression before they ever [INAUDIBLE]?

**COLLEEN** Yeah. I mean, it really depends on how well they're functioning now. I mean, a patient could have a history of depression, and it could really be a single episode that has not recurred. They seem to be coping fairly well through the stress of starting dialysis. So a history doesn't necessarily mean that I would automatically require something. Yes?

**AUDIENCE:** The question I have is, do they look at potential donor workup? Do they look at the substance abuse screening tool for them also?

**COLLEEN** So you're asking about the living donor workup?

**SATARINO:**

**AUDIENCE:** Yes.

**COLLEEN** Really, there are many similarities between the recipient and the living donor assessment. But then the living donor assessment has many other aspects. It's actually probably even more rigorous than a recipient evaluation, because they have to assess things like coercion and decision making and things like that.

But certainly, a living donor assessment does include a very thorough mental health assessment and a very thorough substance abuse assessment. And there is a level of risk for post-donation depression. And so that is discussed as well.