

TONYA I am going to talk to you a little bit about the journey that the patients have to go through. I know you guys have had a long morning. I'll try to [MOUTH CLICKING SOUND] keep you awake. So you heard a little bit about what happens in our triage process during the evaluation. So I'm going to pick up at the time that the evaluation appointment ends.

So all of our patients are assigned a coordinator based on the physician that they see in clinic. That coordinator will then prep all the records that we have to be present at our meetings, which happen on Mondays currently. So at that time we discuss all of their physical findings, all of their psychosocial findings, and determine at that point what they need to go forward. What are we missing? What can this patient benefit from?

So sometimes the patients are looking for information right after this meeting. It does get delayed periodically because of holidays. It gets delayed if most of our staff is out of town for conferences, if we have had a lot of patients in clinic, and then we just don't have the time to get through all of them, which happened recently. So sometimes it happens right away. Sometimes it does get delayed. If the patients are wondering about that they can always call, but we will-- as soon as we talk about them we will get back with them.

So this meeting does consist of our surgeons, our social workers, our nephrologists, our coordinators. Our dietitian is there. We have people from pharmacy. Financial staff is there as well. So there are quite a few people in the room all discussing that patient's case.

Within 10 days of that meeting we are required to send them some kind of information regarding what happened with that. So they definitely will get a letter in the mail. That is sent within 10 days. The coordinators also try to call each and every one of these patients to let them know that this letter is coming, and what their status is, and what they need to do from there.

So in that letter, which also goes to the dialysis center-- it goes to the referring physician, along with the patient. It does have their status. Are we just continuing with the evaluation, or are we listing that patient, or we do not think that they're a good candidate for a transplant?

So that will be in there, as well as the list of things that need to be accomplished, or completed before we can move forward. The contact information for their coordinator, for the medical assistant, for the social worker, as well as the financial coordinator are also all within that letter. So they'll have phone numbers. All of that will be in that letter.

So there's four different options that will come along with that letter. One of them is an open evaluation or they're not yet listed, actively listed, they're listed on hold, or we found that they weren't a candidate and we closed or ruled them out.

So the open evaluation or not listed is most often what we send out. Rarely do we have somebody that walks in the door that has absolutely everything that we're looking for. So this letter will say, thank you for coming, and it will have a list. These are the things that we need from you before we can move forward.

If they're diabetic it's going to be a stress test, a CT scan. Those kind of things are pretty uniform across those letters. It will be sent again to the dialysis center. It will be sent to the patient, to the referring physician.

Our goal is to have all of that completed within six months. We do have patients that come in and they do one test, and then they wait five months and they do another test. And so things can kind of drag out. Well, by the time you finish the last one the first test we might be looking at going, well, this probably isn't up-to-date anymore. And we're starting all over. So our goal is to have all of that testing in so we can get it reviewed, and make a decision on that patient within six months.

They are instructed and encouraged to call us each and every time they have a test done. We always get calls. Well, I had it done five months ago. Why don't you have it? They said they were going to fax it. 99% of the time when they say they're going to fax something from another hospital it does not find its way to us.

My theory is there are so many fax machines throughout the university that they've picked one that they faxed up to the university before. I don't know where that fax machine is but it never finds it to me. So if they call and they let us know that they had that stress test, and they tell us where they had that stress test, then I know that I have to track that down, and I know where to find it.

So it kind of takes it off of the patient and onto us. And if we have trouble finding it we can call them and say, hey, are you sure? But a lot of times if they know where they had it we can find it fairly quickly and it's not dragging out.

They're also informed that if these test results come back to us-- that they had a stress test and that stress test is not normal-- they may have to go for a heart catheterization. They may need cardiac clearance. So just because you completed what was on the list doesn't mean that that list isn't going to grow if one of those tests does not come back the way we need it to. They are told they can have those tests done either locally if they're not from around here, or we're happy to schedule them here.

If they're actively listed that means that they have completed everything that we gave them to do. Everything has been looked at. Everything has been reviewed and found it's OK for them to move forward. So with that time we do put them on the kidney list. They start getting time. They are active. They could get a call at any time.

And they will be seen back here every six months to once a year, depending on their age and depending on some other factors. So every six months to a year they'll come back to see us here or at one of our outreach clinics. It's sometimes an option for them. They also have to return a blood sample every single month.

So working at the dialysis centers I'm sure you see those kits come in. Those kits need to come back. And so the antibody levels that we're checking for can change. If we do not have an updated sample they will not be eligible for a transplant and that goes above our heads.

There's nothing that we can do to override that because of the patient's circumstances. It's beyond us. It has to come in once a month or they get skipped, so that's very important.

They have to keep us updated with testing, again, that's been completed. We need to know about it. If something changes in their health, if they need a blood transfusion, if they've been hospitalized for an infection, something happened with their heart, whatever it is-- they're admitted locally.

We need to know about that. I can't go to another hospital and bail them out to bring them here for a transplant. Whatever has happened to them has got to be resolved before we can move forward with transplant. So very important that they let us know that. We don't want to call them and find out, oh, hey, you got out of the hospital yesterday. We need to know about that.

Any changes in their insurance, obviously, and Cindy just finished talking about that. If you don't have it that's a problem.

Changes in demographics. If I don't have a telephone number for you I can't call you with a kidney offer. So very important that you keep those phone numbers up-to-date, that you keep us up-to-date with your family members, your friends that you have as your backup. So we know who we can find, and we can find them quickly.

And they are educated at the time of their evaluation about the wait times in Michigan. Obviously those can change. They are also instructed that these are averages. So we're looking at between four and seven years. Depending on your circumstances it can be longer, it can be very short.

So we need to know where they are at all times. Not just four years from now where you're going to be-- some people are like, well, I didn't keep my phone on because you told me four years. So the minute I call and say, I have you active, you need to have your phone ready. Because I'm not going to call you to the day four years from now and say, hey, your four years is up. It's not how it works. It would make things easier, but it's not how it works.

So they are instructed-- phones all times no matter where they are. If they know they are someplace-- if their dialysis center, for instance, does not have good cell phone service. We know Monday, Wednesday, Friday most of our patients are sitting in the dialysis unit. If it's during the day we're going to call the dialysis center-- hey, is a patient sitting there?

Any place else. If they're still working full-time and they know they can't carry their cell phone with them during work hours, or they don't have cell service, then we need a work number so we can call your place of employment and find somebody to find you. So just as long as we have a way to get a hold of you, family member. It doesn't matter.

The other big problem we have are voicemails. I had problems with five patients today where I tried to call and I can't leave them messages because their voicemail is full, or their voicemail has not been set up. So then we get the call saying, well, nobody called me. Well, we did. We just can't find you.

So the voicemail is definitely a big thing. And they need to check the messages. Not just have the voicemail. If it says you have one, you need to listen to it.

If they're listed on hold. So this is the one that patients get confused most often. So you're listed, but you're on hold. So how I describe it to them is you're on the list, you're getting time towards transplant, but your name is invisible. So the people who are actively listed all show up. You're just kind of hanging out in the background.

So you're still going up on the list, you're still getting the time that you need, but you're not eligible for a transplant for whatever reason. So the reasons listed are the most frequent things that we do. We haven't been able to contact them. That happens a lot, unfortunately. That blood sample is outdated. At some point we skip over them. We're like, OK, we're going to put you on hold until you can get it together.

There's testing that's abnormal.

Vacations. So that's not something that they did wrong. They want to go on vacation. They don't want to be bothered with a call. Or they're going to be someplace, they can't make it back. That's fine.

We're not asking you to end your life and sit here for the next four years. Go on vacation. We'll put you on hold. When you come back give me a call.

If they have a required weight-loss. So we do have patients that come in. I'm sure Karen talked to you. They were seen last year. They come in this year. They've gained 15 pounds, and it's all right where we need to put the kidney. Well, until we can get that kidney in there we're going to have to put you on hold. So we may call you guys just for updates on weights and those kind of things on those.

Blood transfusions are an automatic three-month-hold. Those are the biggest things that mess with the antibodies that we test for monthly. So we will put them on hold for three months. And then we will check that sample again to see what we're working with to make sure we can find them a good kidney.

If their kidney function is too high, we may have a low-enough value to put them on the list. It has to be at 20% or below. If they come in and they have a value that was 19% three months ago that's fine. But since that time they've bounced back up to 24%.

That's OK. We're going to wait for that kidney to kind of bounce around. Once you've hit 20% and are consistently at 20% or below we'll get you active. But until that point we'll put you on the list, let you get some time, and carry on that way.

Financial clearance. When those lovely ladies call us and tell us you don't have the correct insurance you go on hold until they give us that green light. And then psychosocial concerns or clearance. So sometimes that can be something as simple as show us for three months that you can turn in that blood work.

You check in with your counselor. It's been a while since you've seen your therapist. We need to make sure that you're doing that. So things like that. Could be support problems. If your main support person is sick, or no longer available, we may have to find a backup plan for you. So something like that could put you on hold as well.

While they're on hold, like I said, they may or may not need to send in that monthly bloodwork. So if they're going to be on hold for a long period-- cancer holds can be multiple years depending on what we're looking at.

During that time period we may say, you know what? You're going to stay on the list. You're going to get time. When this is completed we can put you back, but we don't need a monthly sample. We're not going to be moving forward with you. We can't do anything. So why get poked once a month? So at that point we may say, hold off on that.

Or if they've had that stable kidney function for quite a while we also may say, hold off. We'll watch it. Six months from now if you're kind of trending down we'll get those samples started again.

The frequency of the required visits to clinic may also be determined based on that hold status. So again, if you're going to be on hold for two years because you have breast cancer, we don't need to see you until that time period is up. You're going to be following with your normal doctors.

When that time period is up we'll bring you in, make sure that nothing else has changed, that cancer clearance has been obtained, and that you're ready to go forward. But we don't need to bring you in every six months or once a year until that time period is up.

It is important that they remain in contact with us during that time period. They don't have to call me every day. They don't have to do anything like that. But we do need to know that they're still in the same place, that nothing else has changed in their health, and that they're still willing to go forward with transplant.

There are people who get put on an extended holds, and during that time period they just decide they don't want to go forward with a kidney anymore but they don't tell us that. So just check in with us periodically. Let us know that everything is still going OK for you.

Oftentimes the patients do misinterpret this. So we tell them that they're on hold for whatever reason, whether it be-- most often they misinterpret it as because of some psychosocial concern. But a lot of times they call and they'll say, you took me off the list. We didn't take anybody off the list unless we sent a letter saying we took you off the list.

So we put you on hold, so you're just in that invisible stage. And then once we have the resolution for whatever put you on hold you will go back right where you were. So "on hold" and "removed" are two very different things. And again, once that specific issue has been resolved away we go. We pick up where we left off.

So they're closed or ruled out. So that can also be de-listed. So if they've been listed, something changes in their health, or they come in for their evaluation and they're just too frail, they're too sick, something that we know we can't work with at this point, that is when we send that letter saying we don't think the transplant is in your best interest.

So it could be functional status. If they've been in the eval status for a while, we don't hear from them for six months, we try to find them, we send them letters-- hey, you still need to send this test to us, and we don't get that, at some point we give up. And we say, we can't get a hold of them. They're not responding to us. And they may get closed for that as well.

Psychosocial concerns. We give you a chance. We will see for three months if you can do this. Well, at the end of that three months we may say, OK, we'll give you two more months. At some point we say, OK, it's obvious that this task that we're asking them to complete they're having trouble doing that. So at that point we may have to close that door as well.

If they have that required weight loss. Over 30 pounds is generally an automatic close for us. It usually takes people a little while to lose that. So at that point we may close them and say, hey, when you reach our goal weight come on back and talk to us.

So if they have been given a goal weight of 20 pounds, and a year from now they're still at that same 20 pounds, or now they need to lose 25 pounds-- which happens as well-- at that point we may say, you know what? When you reach that goal weight come on back to us, because it's not working for you right now.

And then vasculature. Our surgeons, when they get those CT scans they take a look at those. If they get calcifications in those blood vessels that we need to use to put that kidney in there's nothing that we can do about that. And if our surgeons can't find the blood vessel that they need to sew that kidney then we do have to close people for that as well. And unfortunately, there's nothing we can do to reverse that. So that one would be a close. And try maybe a bigger center. They may be able to help you.

If our team looks at someone and says, you know what, their functional status isn't great, but they just got out of the hospital from an extended stay, and this and this and this is going on, we may say, work on your functional status. Come back in six months. We'll see again. So if it's something that they think has an end or a quick resolution, we may give them a step program. Complete these things and then come back and see us, and we'll take a look at them again.

So frequently asked questions. So traveling around, Colleen gets a lot of questions. Myself, I get a lot of questions. We have dialysis centers that call us with questions. So I've put a few of these up here so we can kind of cover some of them.

Again, how does the patient know what to do? That list of requirements is sent with that letter. So they're going to get that letter. It's going to have step-by-step-- these are the tests you need. An updated list is given to them at every appointment that they come see us for. When they check out they are given a copy of what the things are that are pending for this year, so they'll get an updated list at that time.

If we receive that stress test, the stress test is abnormal, we're going to call that patient and say, hey, your stress test was abnormal. Are you seeing a heart doctor there? Are they ordering a catheterization? So whatever we've added on because of that test result we're going to notify them of that as well.

So we're going to send them a letter, most likely, and call them as well. If we can't get them on the phone we're going to send that letter that says, you need this. And by the way, we can't find you.

The patient says that they have the testing done. Why are we still asking for it? Because it's somewhere in that fax machine throughout the university and we haven't found it. So that's most likely-- I hear it all the time. They told me they faxed it.

I'm sure that they did. But they didn't fax it to the correct place, which is why the patient just calls and says I had that stress test done. I had it done at Henry Ford. Fantastic. We'll call for it. So as long as I know that it's done, I know where it's done, we'll call for it. So they just need to let us know.

So the other part is stress test. We ask for a stress test a lot of times. The patient thinks they had a stress test when it's an EKG or it's an echo. So they had some kind of heart test done but it's not the correct heart test, so that happens as well.

So we're still asking for it because we didn't receive what we really asked for. So at that point they just call for clarification. Or at some point we're going to say, what's happening with the stress test?

Since the U of M wants to test why aren't we ordering them? Good question. So what happens when we send out orders to other facilities, those orders get entered into the system, the patient shows up for a test, the test is complete. We don't get those records.

So if there's an abnormal test out there our physician doesn't know about it. Our physician is liable for those results and we don't even know that it happened. So our physicians are happy to order stuff within the university where they are paged if something is abnormal so they can follow up on it.

But outside they do ask them to go through their primary care physician, to go through their nephrologists. Some of the dialysis centers are able to help with testing. And the coordinators are more than happy to walk you through exactly what we need and exactly what we're looking for. But that's one of the reasons that we do not order those outside of the U of M.

And we're always, always happy to have them if they want to make the trip. We can schedule as many tests as we can possibly do in one day to get them done here if they want to do that. It's going to be a long day, but we're happy to do that for them.

Why is the patient able to do most of the testing locally but has to come to the university for some? So most times everything can be done outside. A lot of times urological concerns. Our urology team works very close with our transplant team. They know exactly what we're looking for.

And sometimes we actually have those urologists in the operating room with us when we're doing those cases, so things are hooked up correctly and they know what they're looking at. So urology or liver disease. Again, our liver transplant team knows exactly what we're looking for as far as kidney and what is safe. So they do prefer that our patients come here if they have liver disease.

Our HIV patients. Those also come to see Dr. Kaul in our infectious disease department. He manages their medications. He will adjust those medications after transplant. Some of them do not interact very well with the transplant meds so he keeps a very close eye on them. And so they are followed closely.

And vascular concerns. So that one-- if they have to route things around, move stuff around, our surgeons like to be able to talk directly to that vascular surgeon if they need to. So they know what they're getting into when they take that person into the operating room.

And the ever, where am I on the list? We hear it all the time. I've been on the list forever. Where am I? What number am I? We do not have a 1, 2, 3, 4, 5 list. Some of the organs do. Kidney does not. So it goes by a lot of different things.

So it's based on their wait time-- their dialysis time if they were on dialysis. If they were not then it would go by the date that they were listed. That PRA, the antibody level that we check once a month, their blood type, their hepatitis status, their eligibility for other programs. So all of these factor in for each and every offer.

So we may have a patient come up as number one on an offer today, and tomorrow they're number 20, because there's 19 other people that are a better match for that kidney. So it goes back and forth every day. It's very unpredictable, and we just have to take it.

And we've tried to predict it. We've tried to put systems together so we can guess, and they have not worked. So the best we can do are those estimates. Four to seven years.

We know that our A2B program-- I will plug that. If you have anybody that's B blood type that has not returned that, that program is working out phenomenally. People are getting transplanted very quickly. So if they are eligible for that program definitely push them to do that. So the best we can do is basically give them those time frames.

The other thing we tell them is you may come up for an offer today, that kidney doesn't work out. I can't guarantee you're going to get called tomorrow. I can't guarantee next week. I can't guarantee a year from now. Because it is kind of hit and miss.

So that part does get frustrating for the patient. Well, I came up for one before. Why am I not coming up again? And it's difficult. But it's not something, unfortunately, that we can make a guess on.

What happens when there's a match? So it's a very complicated system. The patient just knows, I got a phone call. Before we ever call the patient we actually have to look at that organ. Each and every organ is looked at individually.

So we have to look at the suitability of that kidney, where it's coming from, who it's being matched for. So we have to look at both the donor and the recipient to make sure that it is going to be a good match for them. So it takes us a little while to do that.

We then have to discuss that kidney with the surgeon. So the surgeon then has to also review all the information, make sure that they're OK with that organ, and OK with the recipient's status as well. Once that they have provisionally accepted that kidney they're going to say, go ahead and call that recipient. And make sure that nothing has changed, that everything is OK.

So that's the point where we really need to get in touch with someone. We need to know before we have a kidney driving down the street-- they don't drive by themselves, they're in the back seat-- that we have a recipient, that they've answered the phone, we can find them, that they're not in the hospital somewhere, they don't have gaping wounds, that nothing has changed, and that they're OK to take this kidney.

So if we can't get a hold of them we try for about an hour. After that we start getting people that are breathing down our necks-- what are you doing with this kidney? What are we going to do? So we may have to skip over them if we cannot find them. So we don't like to do that. And when the coordinator finds that patient the next day they're generally not a happy person.

So it is, again, very important that they answer the phone. A lot of times it does come up as an 800 number. People think it's a telemarketer. They don't answer the phone. I tell the patients, you know what? Answer the phone, tell them you don't have any money, and wait for the next 800 call. It's all you can do.

When we get a hold of the patient we go through a checklist of things. We ask them, have you had any recent immunizations? Has anything changed in your health? Is your support person around? Do you have a way to the hospital? Those kinds of things are asked. If everything checks out then they're then given the instructions.

What do you need to do? Most of the time it's sit by your phone. We need some more information about this kidney. We'll give you a call. We'll tell you where to go. We'll tell you where you need to check in at. And what you need to do from there, what to bring to the hospital. All of those things will be explained to them.

There are rare time constraints sometimes that comes up for someone. When we get all of the information we need we find out that the kidney is not a good match for that person. So we do have to call them and say, sorry, but-- what that does is then push us onto the next person. So if we have done that for a few people the time that we have gets shorter and shorter.

So there are times that we have called dialysis centers and said, hey, I know that they're on the machine right now and they're not supposed to be done for an hour. Can you wrap that up a little quicker for us and get them out of there?

It's very rare that we do it, but we have called. We have called to say, is it possible to get them out of there a little quicker? Otherwise we just say, finish your run, go home, get your stuff, and do your thing.

When things don't work out. So that does happen. I'm sure you guys hear about it. If you've ever had a patient that has shown up for a kidney and sent home I'm sure it's not a pleasurable conversation for you. It's not for us, either.

We do try to reassure our patients that if they were sent home-- if it was a kidney issue, obviously we don't want to give you a kidney that we are questioning. We want to give you the best kidney that we can give you. So if we sent you home because of the kidney quality or something going on with the kidney, it's a good thing that we found it. That's how I put it.

If it's an issue with the patient-- a lot of times if something has changed in their status-- they've shown up and they're diabetic. They now have ulcers all over their feet. They have gaping wounds we didn't know about. They have infections that they should have told us about-- we're going to find it.

So it's best not to hide it. Just let us know about it, and we'll take care of it at that point. A lot of times it's on hold, but we can't transplant you with big holes in your feet so make sure you let us know.

The other thing is the location of the recipient. So we do have some people that summer-- or winter in Florida, sorry. They have to be able to get on a flight. They have to be able to get here. If we don't have that kind of time on that kidney then we can't obviously move forward with that one. So we'll have to find someone that's closer. So we do let people know that.

If they're going to spend time out of the state, if they're going on vacation and they still want to make that travel, first we have to let them know if you're going to be in Florida driving back is not an option. You're going to have to pay top dollar for that flight. You're going to have to hop that flight and you're going to have to be here. So they have to know that as well.

So we have some people-- put me on hold. I'll be reactivated when I get back. But then there's the people that, hey, I'm going to try it. And those people-- if we don't have the time, we just don't have the time.

Sometimes when they take the donor to the operating room something happens in the OR. I'm not there. I don't know what. But things have happened. There's been damage to that kidney while they're trying to remove it.

Obviously we don't want to transplant a damaged kidney. So at that point, even if the patient has already made it to the hospital, unfortunately we're going to have to send you back, because this kidney is no longer something we can use.

Sometimes there's cysts, or something that's suspicious that the surgeons don't feel comfortable moving forward with. We obviously don't want to transplant you with a kidney that the surgeons are suspicious may have cancer in it. That's not going to do you much good, either. So those times we would send someone home as well.

How can the dialysis center help? We love our dialysis center. staff. You guys see them a lot more than we see them. So one of the biggest comments I get from dialysis center staff is when they finally call us to talk to us they say, I just can't understand why you guys would be willing to transplant them.

Now if you're ever sitting at work and you think that about a patient, please call and explain to us why you feel that way. Because obviously if you feel that way, and you can't figure it out-- or you know about it-- you can't figure out why we're moving forward, that we may not know what you know.

So you have more knowledge than we do. Please let us know what that may be. So if they're missing treatments and doing all of that, we don't see them, we don't know that this is going on, if you call and let us know then we can put them on this compliance hold. We can make them demonstrate that they're going to do what they need to do for you, because we need them to do what they need to do for us after they get that kidney.

So if they can't show up for a life-saving treatment, how are you going to show up to clinic after you have that kidney? How are you going to take your medications the way you're supposed to? So if you guys see that going on and you're questioning, call us and let us know.

Testing. If you are a center that your physicians are willing to work and help us with that testing that is a great, great, great help. And then we know we have that contact at the dialysis center as well who may be able to tell us where that stress test is. Patient-- oh, I had it done.

Where? I don't remember. There's a lot of "I don't remembers" in the state of Michigan. So if you guys know and you remember that's helpful for us.

Reminding the patients to communicate. If you know, hey, yesterday Bob went and he had that stress test done, great. Hey, Bob, did you call your coordinator and tell him that you had that stress test done? So if you guys are having that conversation with them, remind them to do so.

Will they remember to call us? Will they call us? Maybe. But at least they have that extra poke. Somebody is reminding them to do so.

Keep the patient focused on the goal. If a patient is sent home it's bad. I mean the patients usually-- they don't respond well to that even if we tell them. You guys see them, you see what kind of shape they're in, just let them know, again, that it was the best decision. And it wasn't the best kidney for you. They're going to find something else for you that's better, that's going to work for you that's a better option.

So just kind of keep them. If it's been a long wait, if they're highly sensitized, they get discouraged. They get frustrated. They've been hanging out for a long time. If they had somebody that they thought was going to be a living donor and the living donor didn't work out-- all of that stuff, it weighs on you.

When you're sitting around forever and ever, having to show up three days a week for dialysis, we get it. We get it. We do. Unfortunately, none of us keep kidneys in our desk. Even though we're asked on a regular basis we don't have them. So the best we can do is just try to keep them focused on the goal, let them know that we're trying, and to keep doing what they're doing.

Encourage them to find living donors. If they found a living donor and the living donor didn't work out find another one. Ask the church people. Ask your friends, your family. Just ask around. Somebody may be willing to do that.

We also have programs going where if the patient themselves isn't comfortable talking, isn't comfortable asking, we do have programs where they can help train someone-- a wife, another family member-- that can be that spokesperson for them, that can help ask those questions.

So the contacts and updates. Like I said, everything is going to be sent to you. Every update, you know, they send out quarterly status. If something on that form that you get at the dialysis center doesn't look right, by all means, call the coordinator and let them know.

Hey, why are they on hold? Why aren't they listed? What is going on? Why does it say they need this? Call us and ask us.

800 number. If you're not able to figure out exactly who the coordinator is-- we have had some coordinator changes, some physician changes. So if you can't figure out who that coordinator is, by all means, give us a call and we'll help you out.

So if you can't find the specific coordinator information you can call whatever coordinator. We'll get you to the right one. But the 800 number, they can direct you to the right person as well. Any questions?

AUDIENCE: Do you ever text or other types of communication?

TONYA Do we what? I'm sorry.

WALDER:

AUDIENCE: Do you ever text or other forms of communication--

TONYA We do not text. We do not text. We do email. Some of us do. Not all of us. I will answer emails 24 hours a day,

WALDER: seven days a week, no matter where I am in the continental US.

If I don't have to have specific information from the patient's chart I will answer you and get you back a question.

AUDIENCE: I was meaning regarding the transplant offers.

TONYA We do not. So those are all going to come via that 800 number. So they have to answer the phone. There's no

WALDER: texting. They have to keep that ringer on.

AUDIENCE: I have--

TONYA We got one back there. Hold on. Yep. And it's Rob. Hey, Rob.

WALDER:

ROB: Working in Flint, I tend to have-- more likely to maybe have patients that are deaf.

TONYA
WALDER: OK.

ROB: Do you guys have any difference in mode of communication with deaf patients? Especially amongst the younger [INAUDIBLE] deaf persons that don't have [INAUDIBLE]

TONYA
WALDER: This is a good question for Colleen. We have made some accommodations. We do have interpreter services through the university. So I know previously we have had other options. I think we were trying to Skype with somebody at one point, but I don't think it worked out well.

COLLEEN
SATARINO: Interesting.

TONYA
WALDER: I think it's just the TTY.

COLLEEN
SATARINO: Yeah. I think the-- yeah. You think TTY is outdated?

AUDIENCE: Yeah. And now they call that number [INAUDIBLE].

COLLEEN
SATARINO: Oh, right. Right, right, right. The video service.

AUDIENCE: Yeah.

COLLEEN
SATARINO: We certainly have used that.

TONYA
WALDER: Yes.

AUDIENCE: [INAUDIBLE]

COLLEEN
SATARINO: Yeah, yeah. That is probably for the older generation of deaf individuals. But yeah. No texting. But it is true that we really are becoming a very mobile society, but we've not quite made that leap yet, I guess.

AUDIENCE: I think some people are still on the fence on texting and HIPAA.

COLLEEN
SATARINO: True. Yes. Very true.