

**Maine Medical Center
Maine Transplant Program
Policies and Procedures
Kidney Transplant Multidisciplinary Patient Management Policy**

Purpose

To describe the multidisciplinary care of candidates and recipients throughout the transplant and discharge phases of transplantation.

Policy

It is the Policy of Maine Transplant Program to provide and document comprehensive multidisciplinary care and patient management through all phases of transplantation. Multidisciplinary care involves a team approach to patient management through the use of standardized protocols and clinical practices, as well as defined roles and responsibilities in the patient management process.

Transplant Care Phases*:

Transplant Phase: begins when the potential candidate is evaluated for transplantation and continues through completion of transplant surgery. During this phase, the candidate completes a comprehensive evaluation, and is waitlisted for transplantation. During the waitlist period, the candidate is reevaluated for suitability. Admission for surgery and completion of the transplant completes this phase.

Discharge Phase: begins at the candidate admission to the hospital and continues through to his/her discharge from the inpatient stay. During this phase, the candidate will be admitted, complete his/her surgery, and recover from surgery in the hospital. Discharge from the hospital will complete this phase.

Patient Management during the Transplant Phase:

The *Transplant Nephrologist* leads the team in evaluating and caring for the patient during this phase. S/he provides clinical direction, comprehensive patient assessment, patient education, patient care, and leads the clinical care plan during the inpatient transplant stay.

The *Transplant Surgeon* provides surgical assessment, patient education, and leads the surgical team during the ABO verification and transplant surgical procedure. S/he also obtains patient consent for the procedure and educates the patient regarding risks/benefits, alternatives, side effects, and anticipated outcomes.

The *RN Clinical Coordinator* plays a pivotal role in coordinating the evaluation of the transplant candidate, managing his/her care on the waiting list, and assuring ongoing suitability for transplant. S/he provides intensive patient education, obtains informed consent for participation in the Program, and reviews multiple sources of information with the patient including SRTR references. The RN Clinical Coordinator acts as the key liaison with the patient's dialysis center and referring nephrologist, and acts as a communication link regarding patient status and readiness for transplantation.

The *Transplant Social Worker* is an expert in the psychosocial evaluation and care of the transplant candidate/recipient. S/he provides comprehensive assessment, referral to psychiatry as needed, and care recommendations to the transplant team. S/he participates in the patient selection process, and is a voice in determining the psychosocial suitability of the patient for transplantation. If barriers to transplantation exist, the Transplant Social Worker collaborates with needed resources to address concerns.

The *Transplant Pharmacist* is crucial to the education and care of the patient from evaluation through the transplant surgery. S/he provides assessment of candidate pre transplant medications, candidate adherence

risk assessment, and education to the candidate on the complex medication regimen required following transplantation. In planning for the transplant surgery and post-transplant recovery, s/he advises the transplant team on medication dosages, availability, and interactions.

The *Transplant Nutritionist* plays an active role in assessing the candidate's nutritional status and educating him/her about proper nutrition prior to and after transplant. S/he provides recommendations regarding nutritional changes needed prior to transplantation, and participates in the Patient Selection Process. S/he advises on any interventions needed to achieve the required BMI to meet transplant criteria.

The *Transplant Financial Coordinator* oversees the financial clearance process and educates the candidate about the financial impact of transplantation and needed financial resources. She educates the candidate on insurance coverage, options, and copays. If needed, she assists the candidate in obtaining needed coverage, and acts as a liaison with the insurance company in providing any needed information for insurance authorization. Prior to transplant surgery, or as soon as possible thereafter, s/he confirms needed coverage and works with the recipient to address any gaps. The *Transplant Financial Coordinator* also links patients to any financial resources that they may be eligible for such as the American Kidney Fund, and as appropriate, advises on private fund raising options.

Patient Management during the Discharge Phase:

The *Transplant Nephrologist* leads the team in caring for the patient during this phase. S/he leads the clinical care plan during the inpatient transplant stay, provides bedside patient care, and advises all multidisciplinary team members on daily care issues. The *Transplant Nephrologist*, in collaboration with the multidisciplinary team, directs the patient discharge plan and follow -up after transplant surgery.

The *Transplant Surgeon* provides pre surgical assessment, and leads the surgical team during the ABO verification and transplant surgical procedure. S/he also obtains patient consent for the procedure and educates the patient regarding risks/benefits, alternatives, side effects, and anticipated outcomes. The Transplant Surgeon continues patient follow up and monitoring during the inpatient stay and leads the surgical follow up portion of the discharge plan.

The *Transplant Nurse Practitioner* oversees the day to day care of the recipient immediately following surgery up to the date of discharge. S/he develops and monitors the care plan, orders needed services and testing, and coordinates team member involvement. The *Nurse Practitioner* provides bedside care, education, and support, and leads development of the discharge plan.

The *Transplant Social Worker* provides psychosocial assessment and support immediately following surgery up to the point of and after discharge. In collaboration with the hospital *Care Management Social Worker*, the Transplant Social Worker assesses patient needs for support and resources during and following the hospital stay, and facilitates needed services.

The *Care Management Social Worker* focuses on a timely and successful discharge for the recipient and addresses any service or support needs that will facilitate a positive post discharge outcome. S/he may arrange in home or community services, and works closely with the patient's insurance carrier to access benefits available and educate the recipient about services covered. On occasion and depending on the timing of the transplant (example: weekend or holiday), the *Care Management Social Worker* may provide the psychosocial assessment in lieu of the *Transplant Social Worker*. In these cases, the *Care Management Social Worker* will document the assessment and communicate any needed follow up to the *Transplant Social Worker*.

The *Transplant Pharmacist* is a pivotal member of the transplant team during and following the transplant surgery. S/he oversees the patient medication plan, addresses side effects and drug interactions, and advises the *Surgeon* and *Nephrologist* on any needed pharmaceutical interventions. The *Transplant Pharmacist* provides patient education regarding medications, and develops and implements the medication discharge plan.

The *Transplant Nutritionist* provides comprehensive assessment and consultation to the recipient and transplant team following admission and prior to discharge. S/he develops a nutritional plan for the recipient while in the hospital, as well as a plan to be implemented following discharge. Any special nutritional needs or support are addressed, as well as a plan for nutrition services follow up if needed.

References

Centers for Medicare and Medicaid Services, 2019 Organ Transplant Program Interpretive Guidelines 482.90

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