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| **PROTOCOL TITLE:** Kidney and Pancreas Transplant Waitlist Management | | | | | |
| **APPLICABLE FACILITIES:**  ☐EHC ☐EDH ☐EHH  ☒EUH ☐EUHM ☐EUHS | ☐EHI  ☐EUOSH | ☐EHN  ☐EWWH | | ☐EJCH  ☐RJV-ERH | ☐ELTAC ☒ESJH  ☐RJV-ESOP ☐TEC/ESA |
| **EFFECTIVE DATE:** | | | **ORIGINATION DATE:** 8/5/2014 | | |

**CATEGORY:** Diagnostic/Therapeutic/Preventive

**LEVEL:** Independent

# SCOPE:

Kidney and Pancreas Transplant Waitlist Clinical Team

# PURPOSE:

The Centers for Medicare and Medicaid Services Conditions of Participation for Transplant Centers state that transplant centers must keep their waiting lists up to date on an ongoing basis, including, the updating of waiting list patients’ clinical information” as outlined in the program’s policies and procedures, to ensure those listed on the OPTN/UNOS waitlist are clinically ready to accept an organ offer. The following document highlights the important factors for inclusion and exclusion of patients on the Emory Transplant Center (ETC) Kidney and Pancreas waitlist.

# POLICY STATEMENT:

Waitlist Management is coordinated and facilitated by Clinical Transplant Coordinators utilizing transplant center and kidney & pancreas program policies - with the support of a dedicated transplant surgeon and transplant nephrologist and in adherence with American Nurses Association Standards of Practice and Performance. Waitlist management requires multidisciplinary expertise. Each member of the transplant team is required to participate and provide discipline expertise to allow for optimal transplant candidate selection, patient safety, patient access, customer service and collaboration.

# PROCEDURES:

**LISTING PROCEDURE:**

***Patients who are deemed suitable for candidates for renal transplantation, renal and pancreas transplantation, or pancreas transplantation per the renal and pancreas selection committee will be activated on the UNOS waitlist by the Renal Pre Transplant Evaluation Team. Please see attached Listing Procedure and Listing Checklist.* Patients may be listed with outstanding health maintenance testing, activation paperwork and/or insurance clearance.**

# Waitlist Management Policy:

We expect patients will be actively engaged in the waitlist process. The patient should continuously provide any updated medical history or new contact information, as well as any changes regarding their nephrologist and/or their dialysis unit.

Patients listed inactive will be reviewed with an ETC physician prior to status change. Patients will require updated HLA antibody testing per the HLA sample procedure. In general, patients should complete missing items within ninety days from the date of listing.

Patients listed active will be reviewed with an ETC physician at re-conference on an as needed basis if any ETC team member finds concerns with the patient’s transplant candidacy or change in health status from the initial evaluation.

Active and inactive waitlist patients may periodically require updated testing (see waitlist medical testing/consults below) and it will be considered the patient’s responsibility to complete these tests and also to communicate results of testing when completed by an outside provider.

# Waitlist Medical Testing/Consults 1-4:

1. **Cardiac Testing and Risk Assessment:** periodic testing as dictated by the patient’s clinical situation:
   * **Transthoracic echocardiogram If normal (preserved systolic and diastolic function, no valve abnormalities, preserved right heart pressure) and** the patient’s age <45 years with no medical history of diabetes mellitus, SLE, HIV, prior heart disease or family history of premature CAD may be seen by a transplant nephrologist for cardiac risk assessment.
   * **Stress Test** (Adenosine Thallium\* or Cardiac PET\*\*) **if one of the following are present:**
     + Age > 45 years old
     + Abnormal EKG suggestive of ischemia
     + History of diabetes
     + History of MI or known coronary artery disease
     + History of HIV, autoimmune disease, amyloid, or sickle cell disease
     + Low functional status
     + Symptoms of chest pain and/or dyspnea
     + Prior organ transplant
     + Significant family history of premature CAD
     + On dialysis > 10 years
     + Greater than 10 pack year history of tobacco/vaping

# \*Adenosine Thallium Scan with Transthoracic Echocardiogram if BMI<38.

\*\***Cardiac PET** for patients with a BMI >38 or otherwise indicated.

1. **Nephrology Consult:** If patients have had a major medical event or progression of their medical history that may impact candidacy (e.g. stroke, amputations, major surgery, etc.)

# The following patients may be seen by transplant cardiology consultant:

Patients with the following medical history:

* + Known coronary artery disease (history of CABG, PCI)
  + Peripheral vascular disease
  + Atrial fibrillation or any cardiac arrhythmia
  + Valvular heart disease (moderate or severe valvular dysfunction) on echo or h/o valvular heart disease s/p valve repair /replacement on anticoagulation

 EF < 40

* + Diastolic dysfunction grade 3
  + Presence of pacemaker or defibrillator
  + Any defect noted on Stress testing
  + Aortic root dilatation greater than 4.0 cm (consider referral to CT Surgery)
  + Restrictive cardiomyopathy
  + Type 1 Diabetes

1. **Health Maintenance Testing:** Additional testing at Emory or a local hospital/office should be obtained based on age, sex and medical guidelines. The patient will need to have these records sent to their coordinator via mail or fax. It is the patient's responsibility to communicate results.
2. **Colorectal cancer screening:** We recommend that patients have a screening colonoscopy per American Cancer Society guidelines at the age of 45. We require a screening colonoscopy is completed by at least age 50. For high risk patients, screening should be earlier. Discontinue screening at age 75 or when the life expectancy is less than 10 years.

In 2018, the American Cancer Society updated its guidelines for screening people at average risk for CRC to add a “qualified” recommendation to begin screening at age 45 years (compared with the previous starting age of 50 years) and a strong recommendation to screen those age 50 years and above.

Patients at increased risk including those with a personal history of colorectal cancer or adenomatous polyp, a first degree relative with colorectal cancer or inflammatory bowel disease for greater than 8-10 years should be referred to GI to discuss earlier screening that can start as early as 40.

1. **Breast Cancer screening:** We will require all women starting at age 45 to receive at least one screening mammogram per the American Cancer Society Guidelines. They should have a repeat mammogram every 1 year. Discontinue screening at age 74 unless expected life expectancy is at least 10 years.

Patients at increased risk including those with a family history of breast cancer in a first- degree relative but do not have a known genetic syndrome should start screening at 40 especially if the family member had premenopausal breast cancer.

Patients with a genetic syndrome should have yearly mammogram and MRI scheduled six months apart.

1. **Prostate Cancer screening:** In average risk patients, discussion should start regarding screening at the age of 50. In those with family history of prostate cancer, discussions should be started earlier. Digital rectal exam is no longer recommended. USPSTF just released newer guidelines encouraging discussions between ages 55-69. New data

suggests screening offers a small potential benefit for reducing prostate cancer mortality and metastatic disease although many men will experience harm. Recommends against screening past 70.

When the decision is made to screen, we would recommend getting PSA starting at the age of 50 every 2 years.

1. **Lung cancer screening.** We recommend that patients who are at high risk should undergo annual low-dose computerized tomography (LDCT) per US Preventive Services Task Force (USPSTF) recommendations. (Patients can get this done with their local physicians.) Patients are considered high-risk if they are adults 55 to 80 years old with a 30 pack-year smoking history who are currently smoking or have quit within the past 15 years. Screening can be stopped when the patient has not smoked for 15 years.
2. **GYN/PAP**: We recommend that women between the ages of 21-29 undergo a gynecologic exam and pap smear every 3 years and for women between the ages of 30-64, a pap smear every 3 years or pap smear + HPV testing every 5 years. Screening is no longer recommended after age 65.
3. **Abdominal imaging:** Based on the results of original evaluation imaging, the patient’s health history since evaluation, and the patient’s current clinical condition further imaging may be required.
4. Social Worker consultations may occur at the time of waitlist re-evaluations or may be requested due to identified psychosocial changes.
5. Financial Coordinator evaluations will be requested at the initiation of a waitlist re-evaluation or as changes are identified in the patient’s financial status.

**Waitlist Management Procedure:**

Reference the Waitlist Workflow Procedure for details.

A periodic review of the population of inactive candidates will occur to evaluate candidate statuses.

Clinically significant abnormal results and follow-up scheduling recommendations will be faxed to the referring nephrologist and dialysis unit for review/follow-up. The patient will be contacted and instructed to follow-up with his or her referring nephrologist.

Newly listed Active status patients will also be provided education concerning their responsibilities while listed for transplant. (See Kidney Transplant Waitlist New Patient Education)

Active patients who do not complete required updated testing and consultations when requested will be changed to inactive status. The patient will receive a letter notifying of status change to inactive. Patients will then have 30 days to comply with testing, requirements, and consultations.

Inactive and active waitlist patients requiring updated testing and/or consultations will be notified by phone and an itinerary will be mailed to the patient’s home address. A copy of the itinerary will be faxed to the patient’s dialysis provider and referring nephrologist.

# Waitlist BMI Procedure:

At the time of waitlist addition, patients will be educated of the expectation to maintain weight within allowable BMI based on Emory Transplant Center’s BMI policy. Failure to do so will result in removal from the ETC UNOS waitlist. Weight will be documented by the ETC team in EeMR. Patients may remain inactive after the initial missing item deadline date for weight loss only. Patients who meet BMI requirement will have the item notated on the missing item list and will be re-conferenced when the missing item list is completed. Patients who fail to meet the requirement of the acceptable BMI within two years of their listing date will be processed for de-listing for failure to meet the BMI policy. **(See the Kidney and Pancreas Pre-transplant Body Mass Index (BMI) Guidelines)**

# Waitlist No Contact Procedure:

Patients will be educated concerning their obligation to keep in touch with the transplant center during initial evaluation education, in the text of their activation paperwork and during the initial waitlist education. Generally, patients are educated to contact the transplant center at least once in a six month period.

The ETC team member will:

1. Phone patient X 2 and document each attempt over course of at least two consecutive occasions (over several days).
2. Call dialysis unit/referring physician for updated contact numbers and use them in the attempts to reach patient. Verify that the address in EeMR is correct. Document all contacts.
3. Send No Contact letter to patient with fax copy to dialysis unit and referring MD. Copy and paste letter to EeMR letters.
4. If patient does not respond in 30 days (Active or Inactive) the chart will be presented for physician re-conference for de-list for failure to stay in contact with the transplant center.

# Waitlist No Show/Cancellation Procedure:

All scheduled appointments must be cancelled at least 24 hours in advance. No show or cancellation of two scheduled appointment dates will result in de-listing. (See Kidney Transplant Waitlist Appointments Instruction Sheet)

# WAITLIST COMMUNICATIONS PROCEDURE:

1. All patients referred for transplant evaluation will be notified of their transplant candidacy in writing within 10 business days of determination of listing status; this letter will be copied to the patient’s referring nephrologist and dialysis unit and documented in the medical record. This notification will detail:
   1. The patient’s approval for placement on the waitlist; or
   2. Our decision not to place the patient on the waitlist; or
   3. Our inability to make a determination regarding the patient’s placement on our waitlist because further clinical testing or documentation is needed.
2. Documentation will occur in the medical record for those individuals not placed on the waitlist, including the rationale for the decision. The coordinator will discuss with the patient any individual changes that he/she could make to meet the program’s selection criteria. This information will also be conveyed to the patient’s dialysis unit after the initial selection conference with updates via fax. If a patient on the waitlist is removed from the list for any reason other than death, communication of the removal will take place no later than 10 business days after the date the patient was removed from the waitlist. The medical director will dictate a letter to the patient and referring nephrologist concerning the delisting and the reason(s) for the decision, and this letter will be copied to the dialysis unit. Dependent upon the circumstance of the delisting action, the patient may be contacted by the coordinator and informed verbally of the delisting. Documentation will be placed in the medical record that the patient and dialysis facility were notified. A coordinator will be available for patient questions and concerns upon receipt of the waitlist removal letter.
3. Should a patient’s waitlist status change from one of active to inactive (status 7) the coordinator will discuss the change with the patient and notify the dialysis facility within 10 business days of such change. The physician will dictate a letter to the patient and referring nephrologist concerning the status change and the reason(s) for the change, and this letter is copied to the dialysis unit.
4. Should a patient’s waitlist status change from one of inactive to active the coordinator will discuss the change with the patient and notify the dialysis facility within 10 business days of such change. A letter is NOT required for this status change.
   1. The transplant coordinator will re-conference the patient with the transplant selection committee prior to a waitlist status change from inactive to active, except as outlined below.
   2. There are 2 situations in which the transplant coordinator may change the patient’s status on the waitlist from inactive to active without discussing with the transplant selection committee:
      1. Return of activation paperwork – If the patient was listed inactive for paperwork only and it is returned, the transplant coordinator may change the patient’s status to

active.

* + 1. Insurance authorization – If the patient is inactive on the waitlist for insurance issues only and the transplant coordinator is notified by the transplant financial coordinator that insurance authorization has been obtained, the transplant coordinator may change the patient’s status to active.

1. Patients are notified at the time of listing that it is our recommendation that they call the program every 6 months and speak with a waitlist coordinator. During this conversation, the following items may be discussed:
   1. Verification on UNet of the patient’s status and accrual days and calculated panel reactive antibody.
   2. A review of Histotrac and the status of monthly antibody samples.
   3. Verify address/phone/emergency contacts/nephrologist/dialysis unit.
   4. Changes in health since last phone contact.
   5. Review of current SRTR (Scientific Registry of Transplant Recipients) data.
   6. Informed consent issues including the re-evaluation process, right to refuse, risks of transplant, alternative treatments available, surgical procedure, recipient risk factors and Medicare Part B.
   7. If the patient is currently status 7, the coordinator will review all outstanding issues with the patient.

# RELATED POLICIES / PROCEDURES:

Approved for Listing Check list

Kidney Transplant Waitlist New Patient Education Kidney Transplant Waitlist Pending Items Letter

Kidney Transplant Waitlist Appointment Instructions Sheet

Kidney and Pancreas Pre-transplant Body Mass Index (BMI) Guidelines for Kidney Transplant Candidates

# DEFINITIONS:

EeMR – Emory Electronic Medical Record UNOS – United Network for Organ Sharing ETC – Emory Transplant Center

HLA – Human Leukocyte Antigen

# REFERENCES AND SOURCES OF EVIDENCE:

Final Rule: Hospital Conditions of Participation Requirements for Approval and Re-Approval of Transplant Centers to Perform Organ Transplants; Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 405, 482, 488, and 498 Medicare

Program; Federal Register, Vol. 72, No. 61, Friday, March 30, 2007, pgs. 15198 – 15280.

American Nurses Association Scope and Standards of Practice, 3rd Edition, pgs. 4-6

# https://[www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-](http://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-) cancer-society-guidelines-for-the-early-detection-of-cancer.html