2020 TMF Abstracts

Category 5- Regulatory

ABSTRACT C5-A

EXTRA VESSELS DISPOSITION: QUALITY INITIATIVES TO MEET REGULATORY REQUIREMENTS

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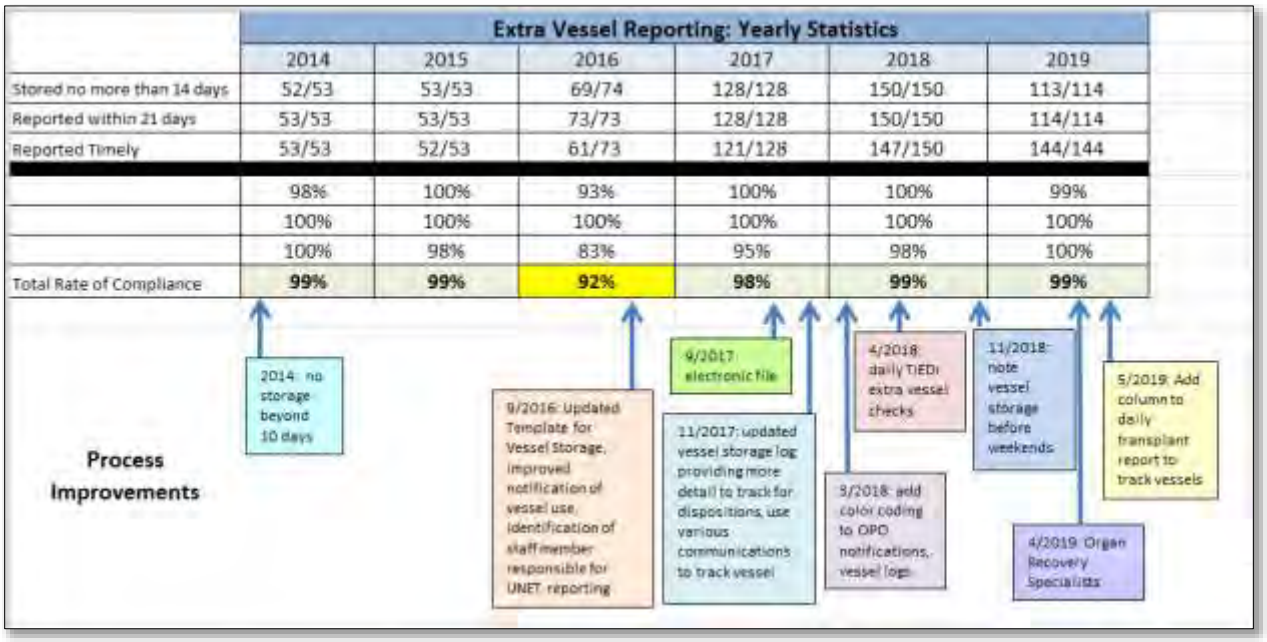
Purpose: OPTN/UNOS Policy 16.6 sets forth requirements for transplant hospitals to report extra vessels dispositions. This Policy provides parameters for reporting extra vessels in the TIEDI section of the UNET electronic platform maintained by UNOS, including time restrictions, use/destruction information, and program sharing arrangements. Implementation of Policy 16.6 is left entirely to the discretion of transplant program management to develop through internal policies and process. Yet UNOS data indicates that transplant programs on a whole are not meeting 100% compliance. To address similar deficiencies in vessel reporting for our transplant program, we implemented several process improvement measures over the past 2 years to increase compliance with Policy 16.6.

Method: OPTN/UNOS has reported that between January 1, 2017 and June 30, 2017 (a 6-month period), there were 4,775 vessel dispositions reported in TIEDI and 444 (9.3%) outside of the seven-day reporting requirement. (OPTN/UNOS Operations and Safety Committee. Extra Vessels: Reducing Reporting Burdens and Clarifying Policies. OPTN/UNOS Board Briefing Paper, June 2018:1-29. https://optn.transplant.hrsa.gov/media/2531/OSC_BoardReport_201806_vessels.pdf.) Data from TIEDI tracking our own vessel dispositions indicated a drop in the rate of compliance in 2016 (8%). Starting in September 2016, the Quality Manager and Transplant Compliance Manager implemented a series of internal quality process improvement measures based on Plan-Do-Check-Act (PDSA) methodology to increase compliance with OPTN/UNOS Policy 16.6. These process improvement measures included setting an internal division goal of meeting 100% compliance on all vessel reporting activities, amending the vessel storage policy to provide accurate and detailed procedures for storing vessels, and increasing communication to all team members responsible for vessel handoffs. Additional tools were developed to assist in completing vessel dispositions. These tools included development of an internal storage log to provide greater tracking detail, development of an electronic record keeping process, use of color coding and standardized auditing activities, completion of pre-weekend storage checks, and use of electronic spreadsheets for transplant record matching. In April of 2019, Organ Recovery Specialists were assigned to oversee operations involving organ recovery and provide our program with additional opportunities to enhance communications among the different members of the transplant team during vessel handoffs and vessel storage activities. These process improvements have been pivotal in maintaining compliance with OPTN/UNOS regulations, since our transplant program has experienced a three-fold increase in vessel storage since 2015.

Results: After initiating various internal quality process improvements to address a drop in vessel reporting compliance in TIEDI in 2016 (92%), our program experienced increased and sustained compliance with reporting requirements in OPTN/UNOS Policy 16.6 in years 2017 (98%), 2018 (99%) and 2019 (99%). We attribute our increased compliance with OPTN/UNOS Policy 16.6 to several quality process improvement measures aimed at achieving an increased awareness of the extra vessel disposition regulations and championing a division goal of 100% compliance. We provided continuous opportunities for staff education and enhanced communication among team members on proper vessel use and disposition requirements, and we implemented robust tracking methods using various tools, such as vessel logs, electronic record keeping, and standardized audit methods. We also added dedicated Organ Recovery Specialists, which allows for enhanced communication during vessel handoffs. These various

process improvements are periodically reviewed by team members and additional opportunities for streamlining vessel disposition reporting activities are regularly considered for implementation.



Conclusion: Transplant programs would benefit from regularly auditing their vessel reporting compliance rate in TIEDI to determine whether they are meeting vessel disposition reporting requirements in OPTN/UNOS Policy 16.6. Transplant programs experiencing compliance levels under 100% should consider implementing internal vessel storage and reporting policy changes and/or quality process improvement measures. All transplant team members who are involved in the vessel use and storage process must be familiar with vessel storage and disposition requirements. Transplant program management can champion the division goal of 100% compliance and engage transplant team members through additional education and communication activities. Multiple methods for tracking vessel storage and disposition can be implemented and used successfully for transplant programs to achieve and sustain100% compliance with OPTN/UNOS Policy 16.6.

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ABSTRACT C5-B

IMPROVING REGULATORY READINESS THROUGH A COMPLIANCE DASHBOARD

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Purpose: After our center's last CMS site survey in June 2016, we received a conditional-level citation, which was the result of missing staff documentation in transplant phases of care. Prior to the survey, only transplant coordinator regulatory metrics were tracked, and these metrics were reviewed at quarterly organ-specific QAPIs (Quality Assessment Performance Improvement presentations). In addition, this information was easy to overlook among all of the other elements presented and staff engagement with regulatory readiness was low. In order to be compliant with regulatory requirements, a new process was needed that both monitored all transplant center staff metric compliance and improved staff engagement.

Methods: A compliance dashboard was developed in May 2017 (Figure 1). Instead of reporting out on each organ's regulatory compliance individually during quarterly QAPIs, the compliance dashboard was designed to show all organs' compliance with regulatory metrics in a given month at the same time. New metrics were added, including documentation requirements for pharmacy, nutrition, and social work departments. The compliance dashboard was sent out monthly via email to all transplant center staff and administration, as well as hospital quality and leadership teams.

Results: The compliance dashboard was a success, both in terms of improvement in regulatory metric compliance and staff engagement in regulatory readiness. By looking at all metrics for all organs in a given month at the same time, it was much easier to identify regulatory deficiencies or trends that were beginning to occur, and act on them quickly and appropriately. For example, at the beginning of 2019 a new metric was added – clear documentation of a listed patient's primary diagnosis. In January of 2019, kidney's compliance with this metric was only 6%. However, as staff realized this was a deficiency almost immediately, compliance increased the next month to 71%, followed by 85% in March, and reaching 100% in April. Additionally, there were many gaps in knowledge regarding regulatory readiness and what is required of us to remain in compliance with both CMS and UNOS. Through the dashboard, these gaps were able to be identified and remedied. Transplant center staff enjoyed participating in "healthy competition" with their coworkers in other organs, and we saw improved engagement and buy-in from all organ programs. The compliance dashboard has been published monthly since May 2017 and continues to be a useful tool for identifying regulatory issues or deficiencies. The dashboard has become even more effective over time, as metrics that are consistently at 100% have been removed (for example, waitlist removal within 24 hours post-transplant). Also, new metrics such as HCV NAT+ consent and Medicare Time Sheet compliance have been added as needed (Figure 2).

Conclusion: Following our last CMS site survey, there was limited staff engagement in regulatory readiness and room for improvement in metric compliance. Developing and publishing the compliance dashboard has both improved compliance with regulatory metrics as well as increased staff buy-in through healthy competition among organ groups, ultimately improving our center's regulatory readiness.

Jenna Lawson, MS; Lindsay Smith, MSN, RN

Figure 1: May 2017 Compliance Dashboard

PHASE	METRIC	PROGRAM							
		HEART	LUNG	LIVER	KIDNEY KP	LIVING DONOR	PED HEART	PED LIVER	PED KIDNEY
PRE TRANSPLANT	Number of patients	2	3	16	22	6	4	3	3
	2 ABOs prior to listing	100%	100%	100%	100%	100%	100%	100%	100%
	Patient notification letters	100%	100%	100%	100%	-	100%	100%	100%
	Updated informed consent	100%	100%	100%	100%	95%	100%	100%	100%
	Patient selection forms	100%	100%	100%	100%	100%	100%	100%	100%
	Pharmacy screen	100%	100%	100%	100%	50%	100%	100%	100%
	Nutrition screen	100%	100%	94%	100%	100%	100%	100%	100%
TRANSPLANT	Number of patients	8	3	9	14	6	0	2	1
	OR ABO verification	75%	100%	100%	79%	83%	-	50%	100%
	Waitlist removal < 24 hours	100%	100%	100%	89%	-	-	100%	100%
	Average removal time (hrs)	8.62	4.66	8.56	35.22	-	-	7.58	15.82
	Social Work	100%	100%	100%	100%	100%	-	100%	100%
	Pharmacy	100%	100%	100%	100%	100%	-	100%	100%
	Nutrition	100%	100%	100%	100%	100%	-	100%	100%
	ILDA	-	-	-	-	100%	-	-	-
DISCHARGE	Number of patients	8	3	9	14	6	0	2	1
	Coordinator education / planning	100%	100%	100%	100%	100%	-	100%	100%
	Social Work	100%	100%	100%	93%	100%	-	100%	100%
	Pharmacy	100%	100%	100%	100%	100%	-	100%	100%
	Nutrition	100%	100%	100%	100%	100%	-	100%	100%
	ILDA	-	-	-	-	100%	-	-	-
OTHER	PHS consent	Data unavailable at this time							
	Skin cancer education	88%	100%	89%	100%	-	-	-	-
AVERAGE OF ALL METRICS		98%	100%	99%	97%	95%	100%	97%	100%

KEY	
	At or above metric
	Up to 10% below metric
	More than 10% below metric

Figure 2: June 2019 Compliance Dashboard

PHASE	METRIC	PROGRAM							
		HEART*	LUNG	LIVER	KIDNEY KP	LIVING DONOR	PED HEART*	PED LIVER	PED KIDNEY
PRE TRANSPLANT (listed / approved patients)	Number of patients	5	2	10	31	6	4	2	1
	ABO verification documentation	100%	100%	70% (7/10)	100%	100%	100%	100%	100%
	One discrete ABO in chart	100%	100%	90% (9/10)	100%	100%	100%	100%	100%
	Informed consent	100%	100%	100%	100%	100%	100%	100%	100%
	SRTR outcomes form	100%	100%	90%	84%	100%	100%	100%	100%
	Selection committee doc.	100%	100%	90%	74%	100%	100%	100%	100%
	Selection forms - SRTR risk adj.	-	-	-	97%	-	-	-	-
	Pharmacy screen	100%	100%	100%	100%	100%	100%	100%	100%
	Nutrition screen	100%	100%	100%	100%	100%	100%	100%	100%
	Epic - primary diagnosis	100%	100%	100%	100%	-	100%	100%	100%
TRANSPLANT	Number of patients	5	3	7	18	7	2	0	1
	OR ABO verification	100%	100%	100%	100%	100%	100%	-	100%
	Surgical consent - HCV NAT+	100%	-	100%	100%	-	-	-	-
	Surgical consent - PHS inc. risk	67%	100%	100%	100%	-	-	-	-
	PHS labs < 90 days (May txp)	100%	100%	100%	100%	-	100%	100%	100%
	Social work	100%	100%	100%	100%	100%	100%	100%	100%
	Pharmacy	100%	100%	100%	100%	100%	100%	100%	100%
	Nutrition	100%	100%	100%	100%	100%	100%	100%	100%
	ILDA	-	-	-	-	86%	-	-	-
DISCHARGE	Number of patients	5	3	7	18	7	2	0	1
	Coordinator education / planning	100%	100%	100%	100%	100%	100%	100%	100%
	Rounding note	100%	100%	100%	100%	100%	100%	100%	100%
	Social work	100%	100%	100%	100%	100%	100%	100%	100%
	Pharmacy	100%	100%	100%	100%	100%	100%	100%	100%
	Nutrition	100%	100%	100%	100%	100%	100%	100%	100%
	ILDA	-	-	-	-	71%	-	-	-
TIME SHEET	Nursing (RN / NP / MA)	97%	100%	100%	96%	100%	50%	100%	100%
	PSE	67%	100%	67%	100%	100%	-	-	-
AVERAGE OF ALL METRICS		90%	100%	96%	97%	98%	97%	100%	100%

TIME SHEET		
	Finance	100%
	Social work	86%
	Pharmacy	86%
	Admin	100%

KEY	
	At or above metric
	Up to 10% below metric
	More than 10% below metric
	* = still have inpatients at time of audit