**Increasing the Number of Organs Available for Transplant**
**Region 4 OPOs' Successful Practices**
**Recorded webinar release**
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**Moderator:**

Hello and welcome to this recording that focuses on the experience and success of Region 4 OPOs in increasing the number of organs available for transplant.

In June 2015, the OPTN/UNOS Board of Directors approved an updated strategic plan. The plan's number one goal is to focus efforts that will increase the number of organs available for transplant. In previous years, organ donation and transplantation rates had been stagnant. However, an increase in the number of transplants is a trend identified through routine UNOS reviews of OPTN data. In 2014 OPTN data shows that 29,533 transplants took place. 2014 was the first time that more than 29,000 transplants had taken place in a calendar year. 2015 is proving to be another record breaking year with over 30,000 transplants. That's the highest number of organ transplants ever.

Through these data reviews, UNOS also identified that Region 4 had increased the number of transplants in their region by 10%, and increased the number of donors by 19%, from 2013 to 2014. This was the largest increase of all the regions during this timeframe. UNOS wanted to know how region 4 was managing to meet the goal of increasing the number of organs available for transplant. So they reached out to them to find out what they were doing differently and if they would be willing to share their successful practices.

In these discussions, Region 4 leadership shared that they have worked more closely together over the past few years to build a unified front in achieving a common goal – to maximize the gifts available to get patients transplanted. They admit that it has been hard work with many challenges, but it is beginning to pay off and their successful changes centered around four common themes:

1. Changes in leadership and organizational culture
2. Quality management and improvement
3. A specific focus on donor authorization and consent rates
4. And recovery and utilization of organs from donation after cardiac death (DCD) donors

Today Region 4 OPO leadership will begin to share their experience with you. Our first speaker is Patrick Giordano. He is the Chief Executive Officer of Texas Organ Sharing Alliance in San Antonio, Texas. Mr. Giordano has been with the Texas Organ Sharing Alliance since 1996. He has an extensive background in hospital and health care executive leadership including hospital operations, restructuring, policy analysis, business and service line development, joint ventures, productivity enhancement and quality improvement. Mr. Giordano earned his Master's Degree in Hospital and Health Care Administration from the University of Minnesota, Minneapolis and is Board Certified as a Fellow of the American College of Health Care Executives.

Next you will hear from Kevin Myer who joined LifeGift in Houston, Texas in 2012 as the President and Chief Executive Officer. Previously, he was the assistant director for the UNOS Department of Evaluation and Quality, where he oversaw policy compliance auditing, organ allocation analysis and led special projects in patient safety. Before his tenure at UNOS, he held the positions of executive director and vice president of LifeNet Health in Virginia. Mr. Myer received his Bachelor of Science degree from Cornell University in Ithaca, New York and earned his Master of Science in health administration from the Medical College of

Virginia/Virginia Commonwealth University in Richmond, Virginia. He also completed a fellowship in patient safety at Virginia Commonwealth University.

You will also hear from Patricia Niles. Ms. Niles became President and Chief Executive Officer of Southwest Transplant Alliance in Dallas, Texas in January 2013. She is the current President of the Board of Directors for Donate Life Texas. Ms. Niles was previously the Executive Director of New Mexico Donor Services. She is an active member of NATCO – The Organization of Transplant Professionals, North American Transplant Coordinators and currently serves as an At Large Member of the OPTN/UNOS Organ Procurement Organization Committee. Ms. Niles is a registered nurse who has been in the organ and transplant industry for more than 25 years and received her nursing degree from Kettering College of Medical Arts in Kettering, Ohio, and Bachelor of Science degree from Andrews University.

Our last presenter is Jeff Orlowski. Mr. Orlowski is the President and Chief Executive Officer of LifeShare Transplant Donor Services of Oklahoma in Oklahoma City. Jeff is President and Chief Executive Officer of LifeShare of Oklahoma. He has 28 years of experience in organ and tissue donation, having entered the field with then-Midwest Organ Bank in 1987. He is currently the Vice Chair of the OPTN/UNOS Membership and Professional Standards Committee and serves on the Policy Oversight Committee. He is the Past Chair of Donate Life America's Board, a member of the Donation Board of Trustees for the Musculoskeletal Transplant Foundation, is the Chair of the Governor of Oklahoma's Advancement of Wellness Advisory Council. He is also a Past President of the Association of Organ Procurement Organizations. Mr. Orlowski holds a Bachelor of Science in Biology from the University of Kansas and a Master of Science in Management from Regis University.

**First Speaker:**
**Patrick Giordano, FACHE**
**Chief Executive Officer, Texas Organ Sharing Alliance**
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We appreciate the opportunity to share with you the improvements and successes of the Texas Organ Sharing Alliance (TOSA).

In contrast to the other OPOs in Region 4, we have had the same management team in place for a number of years, and have focused upon learning and changing as a longer term development initiative. TOSA has a varied service area with challenging demographics with significant issues, serving the largest and most densely populated Mexican border area in the nation. These counties are also the poorest in the nation. This area has no non-profit hospitals of significant size and healthcare costs are the third highest in the United States. TOSA is also one of the few OPOs in the country that does not do tissue recovery. We are also the smallest the OPO in Texas by population served. One or two other things, is that TOSA was awarded the #1 and #2 Top Employer over the past two years in San Antonio which was also reflected in Austin and the border areas as well. This speaks to our staff and how we have empowered them to do their jobs. TOSA is one of the few OPOs with an active Ethics Committee that has position statements on a variety of pertinent topics in the field. We also have a very robust database where we are able to analyze processes in key result areas on a very granular level.

With regard to leadership and culture initiatives, positive culture development is intrinsic to any success and is an ongoing priority. Values and principles such as respect, transparency,

integrity, intellectual honesty, and compassion are not just words – they really define our goals in developing and maintaining a positive culture while also enabling continuous improvement. TOSA has been building this culture of trust over many years. Leadership and culture come to work together in keeping our goals and objectives out front in our communications. It takes time and the work is never done in developing a staff which can be trusted to do the right thing and to do things right to accomplish our mission. Enabling strategies in this key area includes adequate funding for useful education and training, career matters, and major internal promotion when appropriate. When people work at TOSA, we believe that most all of them can see that they can move up in the organization and there is always a chance to do better.

Organ recovery and utilization of DCD. 2014 was a very good year for TOSA. We were expected to transplant 437 organs but ended at 500 actual organs transplanted. We pay significant attention to the observed versus expected organ yield and have consistently exceeded that rate over the years. In 2014, TOSA had 134 donors which was a 13% increase over the previous year and a record in the organization's 40 year history. We also had a new organizational record for DCDs – 11. Eleven, which 175% increase. Also in 2014 to complement that 500 number in organs placed, we recovered 536 organs – another organizational record. Some of the main areas to leverage these increases included on the DCD side is working with a better commitment from our transplant partners to help with organ recovery and also to accept more DCD organs. On a case by case basis, we use two coordinators on every case, we consult with the transplant pulmonologist on every case, and we do work cases longer than we have in the past. We believe this is critical to our success in this area.

With regard to donor authorization and consent, the Texas Donor Registry places a major role. We have about 30% of our donors coming from the donor registry. And in 2015, we expect our results to show about 35%. We increased our DCDs from about 2% to 8% and we are looking at 10.5% in 2015 of total donors. We use TOSA trained and TOSA staff lead and designated requesters on all of our requests now. We have trained Spanish speaking requestors and our hospital development process has a huge potential on making sure the hospital does the right thing at the right time in terms of timely referral and effective request process. We have two Multicultural Donor Advisory Councils that help bring in the leadership from varies counties where we have had difficulty with increased consent.

On the improvement side of things, TOSA uses the F2 model for quality. It stands for "find it and fix it" but there are a lot of routines and details that go along with that model. It was utilized for review of trauma versus non-trauma Hispanic consent rates, transportation of organs, and review of various events that happen or do not happen in our donor hospitals. All staff have been trained to use this model and most of the time without having to get management involved first. This is really on example of the empowerment principle in action. Everybody should be able to have a tool to start problem solving. Obviously, we monitor their activity and do not send out staff with supervision to look at these things, but more can be done with self-management if the staff is empowered and has the knowledge base to use the appropriate problem solving skill sets in team building. This is really well illustrated in our hospital development department which we have placed under the quality department. We are one of the first OPOs, I believe, in the country to look at it that way. And one of the big reasons is, the hospitals began to get very serious of the past several years in improving quality and in using quality management. Organ donation plays right into that and was a great opportunity for us to allow our hospital development coordinators to tailor make their approach so that whatever our protocols are they can fit into any hospital, whether it's a large or small hospital. We had well over 30 hospitals with

one or two donors, which is extremely important in our service area. More and more hospitals are becoming acute care oriented in this new era that we are in where there is extreme competition in healthcare delivery. Hospitals were we did not see patients that could have been potential donors, now see potential donors because they are ventilating patients longer, expanding and merging. And so we are seeing a big push in this area as we see more potential donors in hospitals that in the old days probably would have been regarded as not very busy or without a lot of potential. There is much talk in our field about aggressively pursuing all potential cases whether defined as eligible or not. We have been developing this process for years but recently with the confluency of all the development and positive changes our referrals of interest (ROI) protocol – what we used to determine if we follow cases beyond ineligible – has been an invaluable tool to help expand the donor pool. So we try to go beyond what is obvious, and push to become very aggressive to use all the tools I have just talked about in the experience of these positive results.

It's been a good year in 2015 and it's still on the same path – we finished with 133 donors, down one from last year. And our observed versus expected yield rate is still very high. We appreciate the opportunity to share our practices with you and look forward to further discussions about how we can improve donation – individually and as a region.

**Second Speaker:**
**Kevin Myer, MSHA**
**President and Chief Executive Officer, LifeGift**
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Good afternoon from Houston, Texas. I am Kevin Myer, President and CEO of LifeGift. Today, I will provide a high level overview of what we have been working on at LifeGift to make our organization stronger with the goal of increasing organ, eye and tissue donation and transplantation. In addition, I will share our experience of the work involved in transforming LifeGift into an organization that has deeper presence and larger impact in the communities we serve, where our Core Mission is to Offer Hope.

LifeGift covers a very large geographic area which consists of the Houston area, Fort Worth area and then Northwest Texas in Lubbock and Amarillo. When we travel from office to office, we do so on Southwest Airlines. We serve 200 hospitals, 10 transplant centers and as you will see in a moment, multiple large adult and pediatric transplant programs. And in 2015, we recovered at least one organ donor across 49 hospitals with a range of being one up to 57 donors per hospital.

In looking at a snapshot from the recent SRTR report, LifeGift's donation service area (DSA) has a death rate that is 53rd among the 58 OPOs in the US according to the US Census Bureau. Again, we serve 200 hospitals. We have spent considerable time on training to improve our performance on organs transplanted per brain dead donor (DBD) donor. We also needed to improve our effectiveness in increasing DCD across our service area. Prior to 2014, the transplant programs in our DSA were low users of livers and kidneys from DCD cases and we have steady improvement in utilization of carefully selected, low cold ischemia time livers. We work cooperatively and collaboratively with our larger transplant programs to try to schedule, if we can, the DCD cases so that we are able to minimize cold ischemia time and have things organized so that it advantages acceptance of DCD livers.

It is interesting to note the steady uptick in imported organs which is a significant effort and service that we provide via kidney perfusion and fly-outs in serving the numerous major transplant programs here in Houston. While working on building our infrastructure, culture, human systems and making LifeGift a more robust organization, overall from 2013 to the end of 2015, we maintained steady performance over the course of 3 years. We did increase organ donors and organ transplanted between 2013 and 2014. We obviously want to increase organ donation and transplantation and are investing major resources in finding ways to do this, primarily in 2016 through intensive training in improving authorization and donation rates.

So we have been spending a lot of time trying to transform LifeGift and it's an evolving story. And just as Mr. Giordano pointed out, this work is never done. We have chosen to do this over a longer horizon versus a short view – to build our team, develop a transformative culture, and risk potential short term results for long term growth and improved quality performance. So we formed an Executive Leadership Team and got some help from The Table Group. The reference literature on that is the "The Advantage" by Patrick Lencioni and we formed a thematic goal at LifeGift to try to build consistency of practice across our disparate regions and increase quality and patient safety within those different areas. We re-engaged our Board of Directors, centralized our quality systems and medical records, and really spent a lot of time on building infrastructure, our people and the workplace.

As part of that work that is ongoing, we have spent a lot of time on developing our Core Purpose, Core Values, and Strategic Anchors. The core purpose of offering hope applies really to donor families and those awaiting transplant and reflects our strategic anchor of dual advocacy. One of the areas in which we are working hard to improve is choosing LifeGift as a workplace. When I arrived in 2013, the information I received was about 33% - which is quite low – and today in 2015 we are at 70%. We hope to be able to get to the place where our friends in San Antonio are as being a top choice of workplace.

In 2014 into 2015, we engaged our full-time Chief Medical Officer, who is a member of our Executive Leadership team. Dr. Pat Wood is responsible for medical quality and patient safety overall. He is involved on every organ donor case and is required for oversight on any potential allocation deviation. We invested major resources into our clinical operations to improve training, capacity and expertise. Our full-time Chief Medical Officer is involved in every organ donor case and provides medical director for all clinical operations and training. We have also methodically upgraded our critical infrastructure to support increasing ability to work remotely, train with the use of brand new videoconferencing and build a new call center and training facility which is under construction now.

These next two slides show some of our people in their clinical training developed by LifeGift, Methodica and CAE Simulators. This training is based on e-module, didactic and mentored simulation to demonstrate competency in physical examination of organ and tissue donors, for example. A major component of this training is a review of critical OPTN policies, the SBAR (Situation, Background, Assessment, Recommendation) technique and other patient safety topics. I think you can see the smiles on the faces of our staff in these pictures from Houston, Fort Worth, and also Lubbock, where we did the specific clinical training. We trained at the most recent rotation 82 organ and tissue clinical staff. Another picture using the high fidelity simulator provided by CAE and different shots of the type of training we are doing to focus on competency to improve our services.

On the leadership track, midyear 2014, with our Board of Directors and a consultant, we created a 3 year strategic plan – probably like all organizations listening in here - to guide our growth and efforts to become a more dynamic organization to increase community benefit. I think you may notice that on the 4 pillars we have major focus on the donation systems area which is pretty classic for what we are trying to do in increasing authorization, enhance the optimal donation environment and we are spending time in 2016 on developing Memorial Hermann as an OPO-like donor hospital because of the major potential there. So we have a heavy focus on increasing organ donation there. Shared services in talking about working with our friends in Dallas and Patti in developing a single infectious disease lab and also with Donate Life Texas. Research and innovation – we are beginning and early living donor collaborative across the Texas Medical Center kidney programs.

The numbers – a couple of key points. The shared services with the Dallas OPO helped us to create a single lab and improve quality and patient safety and control costs of infectious disease testing. Compliance with applicable OPTN policies is assured through this collaboration in action. The Donate Life Texas donor registry has grown from 4 million in 2013 to over 8 million, our collective goal set at the end of 2013. It is a major factor in the growth of organ and tissue donation in Texas.

I want to show an example - we had a strong end of the year performance in 2015. So the data on the screen highlights the performance of Memorial Hermann Hospital where we put lots of focus. Just one example – this is the kind of month that we really want to have. We were ten out of ten on authorizations and recoveries at this hospital. It is encouraging to see that the work we have been doing is starting to bring improved results.

One comment that I do want to make is that our strategy is a little broader than other organizations. We are involved in numerous areas in addition to organ procurement. LifeGift is part of the Texas Medical Center and there is a major push to create collaborative efforts around advancing genomic research. We contribute to this with organ and tissue regenerative medicine developments and it fits into the Texas Medical Center strategic plan. We are also a 15% owner of Allosource with is a non-profit tissue processor in the US and we spend quite a bit of resources and effort around tissue donation. For 2016, our major focus is 300/1000/1200 to drive up our performance with 300 organ donors, 1000 organs transplanted, and 1200 in tissue donation due to the major focus on authorization and consent. We had a record year in tissue donation with 1014 tissue donors recovered up from 625 last year. This slide is just a confidence builder that reminds us that when we put our minds to certain things we can accomplish them with good focus and team effort.

So in 2016 we are making major focused efforts to improve organ recovery effectiveness. Next week we are beginning an on-going training program to increase authorization with a special focus on the extremely diverse community that we serve. We have engaged an outside training agency to work with us for an entire year to drive up our organ authorization rates and get our organ effectiveness to improve.

I will close by saying that all of the work in progress is happening because of the people you see here in this slide. "Hope in Action" is what we call it, and it's our people. On behalf of the people at LifeGift I want to thank you for the opportunity to spend time with you and share our experience.

**Third Speaker:**
**Patricia Niles, RN, BS, CPTC**
**President and Chief Executive Officer, Southwest Transplant Alliance**
**patniles@organ.org**

Thank you for the opportunity to share Southwest Transplant Alliance's (STA) practices that helped to increase the number of organs available for transplant in our region. STA is the 10th largest of the 58 federally designated OPOs in the U.S. We provide services to 11 affiliated transplant centers in our donor service area. And you can see here the complexity of our geography in Texas. Our area is comprised in the green on the map. So we go from one point of the state to the other which is relevant when we talk about the geographical challenges that we have.

Back to 2013, we had a new beginning with a new CEO. The initial findings really showed that we needed a significant culture change and we set about to do that. Since that time we have made many improvements that have had a positive impact on the number of organs available for transplant.

These are the initial findings that have directly impacted organs recovered. We were having a massive turn over in our organ recovery coordinators (ORCs) – they were not staying past six months. So we never really got them fully trained before they were out the door. This was a quick fix that we needed to address. We were also having some financial hardships. We did have poor kidney and low liver utilization and we had very flat donation rates for several years. CMS metrics were not being met and we had some UNOS violations they we needed to address.

This is a snapshot of where we were and where we have come with our changes. We historically had very flat donation and organ utilization rates, especially with kidneys. In 2013 these changes began, and you can see the direct correlation. Over to the left, we had about 240-250 organ donors/year and on the right shows the organs transplanted which was about 700 organs transplanted/year and never seemed to do much more. I am happy to say that we have resolved the flat rates. We have increased the number of organ donors over 40% and the number of organs transplanted over 55% since 2012.

So we started our strategic focus and we knew that we had two big themes to address. One was the clinical department turnover. We built our strategic plan for the first year based on SWOT (Strengths, Weaknesses, Opportunities and Threats) findings, staff interviews and the SRTR (Scientific Registry of Transplant Recipients) data. It seemed quite plausible that we could reach 1000 organs based on the initial assessment. Our staff didn't initially agree, but they trusted the plan and they all got behind it. So part of our goal was to reduce that clinical turnover to 10% by 2015. We really wanted to address the staff ratio of ten cases per organ recovery coordinator FTE (full time employee), basically a 10 to 1 ratio, and provide clinical levels to provide growth opportunities as well as increasing the staff in all our regional areas that I showed you. That was to reduce some of the flying – we were flying staff all around the state where they were staying for days at a time taking them away from their families and affecting their work/life balance. And of course, we had to hire a clinical educator to train all the new staff that we had anticipated training. So our big win out of that was that we reduced our clinical turnover to 7.5 in 2014.

Our next big goal that we had to work on was solidifying our financial future. After six years of being in the red with our finances, we needed a quick fix to really address the preemptive hiring of all that additional staff. We had to have the vision and resources in order to do that. And that was to really rise our sinking ship at that point. Our business model had been designed to really lose money on each case we did further putting us in the red. So I brought in some of the great Chief Financial Officers (CFO) in our industry that really helped to identify that we needed to immediately fix some of our direct overhead costs. So we initiated the case pay with all of our donor hospitals. It wasn't an easy task; it was a little laborious and intimidating at times but we did finally get it accomplished. We also put out a request for proposal (RFP) for our air charter service which ended up saving us about $3,000,000 a year. And the win out of that was a positive next margin within 12 months.

I like to categorize our changes over the last three years into internal and external. I will start with our internal changes. Providing deep and wide transparency to the organization was helpful to the employees. They felt as if they were working with blinders on. They were unfamiliar with our data, finances and other dashboard information. We now have daily reports that are generated notifying us of any donor activity, our authorization rates and overall summaries. Every employee knows our data in real time. This really allows us to adjust our operations in real time. For example, if we see a requestor is struggling with their authorizations, we send a team mate with them and provide coaching and/or supporting in real-time.

Our first order of business was to adjust the organ recovery coordinator ratio discussed. My experience is that you need about 9-10 FTEs per organ donor per year. So if we were having about 240 donors per year we only had eight FTE or coordinators - they were doing about 30 donors per year, which meant this was leading to the burnout level. This means each coordinator had about 30 donors/year, which is a burnout level. So we had an extremely high turnover, which was alleviated by increasing this ratio.

Being clear about what we do really enabled us to have our very narrow focus of saving lives. It is easy to get distracted with seemingly good intentions, and we were very deliberate with our practices and decisions keeping this focus. We also instituted a new practice that no case could be shut down without a second administrative consult.

We hire and are committed to having and keeping staff who are excellent with our three anchors – similar to what Kevin discussed. And our folks focus on their own and STA's peak performance and can exemplify selfless service to our Core Purpose. We hire on these anchors and make this a part of our yearly appraisal system. To address our greatest asset inside STA (our people), we have concentrated on staff and knowledge retention. All of STA employees took the Strengths Finder, Gallup assessment to capture each employee's talents so we could assure maximum employee engagement at all levels. Our philosophy is:

1. A strength is a consistent behavior (a predictable part of each employee's performance).
2. No one has the strength in every aspect of his or her role to succeed.
3. One can only excel by maximizing one's strength, not by focusing on one's weaknesses.
4. It is a manager's role to build employees strengths through coaching and engagement.

STA utilized the findings from the Strengths Finders profile of the entire organization to leverage for powerful results. When a project needs attention, the strengths required to successfully

achieve success for that specific project are identified. For example, if there is a project that requires talents that need timeliness of execution, strategic thinking, communication and relationship building, we look at the list of employees who have these particular strengths and put together a team based on these strengths rather than personal preferences and likes. Projects are identified by needed strengths and employees with those strengths are assigned to a working team. We work backward identifying what we need in the project then the people that will accomplish it.

Now I'll talk about our external culture changes. STA is the third largest OPO in the country for exported organs. We have experienced a major shift in where our organs are going. Initially, we thought this could be due to the change in kidney and liver allocation. However, looking closer, we found it was because of our aggressive organ placement. In 2015 we exported almost 400 organs - that is 400 out of 1125. We are exporting more organs because we have made changes that allow us to be more aggressive in organ placement.

In previous years, we would have allowed our local transplant surgeons to tell us that the organs shouldn't be recovered or were not transplantable, and not just for their own transplant programs. To move this decision making back to the OPO, STA hired our own recovery surgeon.

Our surgeon is involved in most of our recovery cases - over half in fact. Goals were to have the recovery surgeon perform most kidney recoveries, provide immediate availability for unstable and DCD donors, and recover abdominal organs exported out of STA's donor service area (DSA) upon request. Adding the recovery surgeon has really helped to increase the number donors and organs recovered by providing an unbiased opinion in the assessment of organs for recovery and placement.

To assess the effectiveness of our recovering surgeon, we looked at the data. Our OPO surgeon had Type 2 events in 0.9% of organs recovered. All other surgeons combined had Type 2 events in 2.2% of organs recovered. Only one event resulted in organ wastage in the whole 12 month period we reviewed and was not caused by the OPO surgeon. Our surgeon is the lead surgeon in the operating room (OR), weighing medical necessity of transplant center requests against OPO needs. He can wait when intraoperative organ placement is needed and provides reliable assessment of organs being exported. Transplant centers have given very positive feedback, because our surgeon assists their surgeons, helps educate fellows and residents, and allows for transplant center surgeons to leave upon declining an organ in the operating room (OR). Our OPO surgeon also moderates weekly case debrief, gives continuing medical education (CME) presentations, and performs bedside procedures.

So in summary, having a recovery surgeon has helped increase the number of donors and organs transplanted. Savings on usual surgeon fees justify expenses associated with the OPO surgeon without considering increased revenue from additional organs transplanted. All the data support the OPO utilizing a full-time surgeon.

These next two slides shows the improvement in organ placement. As you can see in 2012, this is where we were sending livers around the country. We only placed 3 livers outside our region. If you look at the most recent SRTR report, you can see how many centers we send our livers to today. This just exemplifies how aggressive we are with placement and the advantage of having our own recovery surgeon.

As you can see from the SRTR data report in 2012, our overall organs transplanted per eligible donor was less than the national average, depicted in the line. Our kidneys were extremely low and our livers were less than you would expect. I think this picture shows the outcomes of all of our changes at STA. As you can see, our last SRTR data shows that our overall organs transplanted per eligible donor has significantly increased. While our kidneys are still slightly less, it is much higher that before. We have just implemented a plan, do study, and act (PDSA) to evaluate increasing our kidney recoveries on more extended criteria donor (ECD) cases. Just last week we placed a kidney with a creatinine greater than 7 and it was transplanted. So we will continue to work on these gaps.

In summary, I believe our success has been the result of:

1. An incredibly passionate team that is excellent at donor management and aggressive organ placement.
2. Utilizing SRTR and other data to drive our process improvement opportunities. I can't stress this enough. Knowing your gaps is extremely important.
3. Providing transparency to staff.
4. Maintaining a very narrow focus on our mission to save lives with just 2 goals of increasing the number of organ donors and the number of organs transplanted.
5. Moving organ recovery responsibility back to the OPO.
6. And lastly, adding a full-time organ recovery surgeon.

I do want to add one thing before I turn it over to my colleague, Jeff. The significance with our changes have saved an additional 782 lives in 3 years. Those are the lives, that had we kept on track with the way things had been, those are the lives that would not have been saved. A point worth making and emphasizing. Thank you so much for your time.

**<u>Fourth Speaker</u>:**
**Jeff Orlowski, MS, CPTC**
**President and Chief Executive Officer, LifeShare Transplant Donor Services**
**Jorlowski@lifeshareok.org**

Greetings from Oklahoma City and thank you to UNOS for opportunity to share our organization's strategies for saving more saves. I am honored to be presenting our results on behalf of our Board and our 100 plus staff members. To begin with, I, like my colleagues Pat, Kevin, and Patti, will begin with an overview of high level efforts we took to achieve the 2014 results while also touching on 2015's recently completed performed as well as the future direction of our organization.

When I joined LifeShare in 2012 and we began our organizational journey, we faced a lot of challenges. There were challenges of a regulatory nature, performance, and general relationship issues in our service area as well. In reality, those challenges can all be rolled up into three primary points of emphasis:

1. Establishing organizational stability
2. Enhancing performance
3. And ultimately, saving more lives.

Since 2012, we have remained focused on these goals. We've grown staff by 80% or more, purchased a new building, expanded our Tulsa location, and have revised and revamped all of our operational and quality systems as well as the supporting infrastructure. So how did we do? 2013 is a good baseline for comparison. The results that year, the year when we were making a lot of fundamental changes, were basically right at what our average performance had been the previous decade. From 2013 to 2014 as the changes started to take hold, we saw an increase in the number of organ donors recovered by 58% and an increase in organs transplanted by 54%. We saw an additional increase from 2014 to 2015 of 23% in donors recovered and 8% in organs transplanted. Looking at the bars you can see the growth from 2013 to 2014 was 89 donors to 141 and from 289 organs to 445 organs transplanted. You can see the follow up with 2015 of an additional 33 donors recovered and an additional 34 organs transplanted. Overall, from 2013 to 2015, organ donors increased by 96% and organs transplanted increased by 66%.

So with that in mind, let's talk about the strategies and changes we used to drive that growth. The first key strategy that I would point to is changing our organizational culture. "We save lives." Basically our organization boiled our mission, vision, and values down to the single core purpose that we save lives. We moved from a conservative approach to an aggressive approach, we more than doubled the consented not recovered cases as we pushed harder and harder to get every potential donor recovered, and our organs transplanted per donor dropped from 3.45 to 2.75 in 2015.

The second major shift in culture was to focus on potential rather than eligible. Potential in our organization is defined as any death within our service area where we believe a transplantable organ can be recovered. By focusing on potential rather than eligible we have been able to cast a much broader net, and to find ourselves working more closely with hospitals that historically had not had much in terms of eligible donor population. We identified opportunities in these hospitals that were historically not developed to a great degree and interestingly enough as we did that we found that we were identifying more eligible donors there as well as potential donors. Overall we shifted our focus finally from focusing on our big 4 hospitals to focusing on a larger number of our donor hospitals. Those hospitals outside the big 4 had historically produced less than 10% of our donors with the big 4 representing 90%. At this point in time, our big 4 still produce 70% of our donors but we are now doing 30% of our activity in hospitals that traditionally were not very active.

The next key strategy includes leadership development. We focused a lot on how to set and communicate expectations and accountability, and how to aid staff in process improvement. We worked with Studer, with the Table Group, and ultimately have been employing Lean Training and Certification as strategies to help our leaders become better at leading the organization. We also invested in the organization. As I have said, we increased staff by 90%, well in excess of 80%, and we are growing every day. We bought a new building and moved into the new headquarters at the end of 2013 and almost tripled the amount of space we have available between our locations in Oklahoma. And finally, we invested in new systems. A key system being Q-Pulse – a system that helps us to manage our quality and training process. Many organizations, I have found, wait to invest until they have results. I have also found that doing this only increases the likelihood that those results will never come. We made a conscience decision to invest ahead of the growth and we have seen that investment pay off in 2014 and 2015.

Another strategic approach we have taken has been to invest and spend a lot of energy into quality improvement. We made a commitment to Lean Management and have been shifting our organization model into Lean Management over the course of the last two years. We are currently pursuing Lean Certification for all of our leaders, we have Lean training for staff occurring in stages throughout the organization, and we built out what's called an Obeya room or War room for our Lean Teams where they can go and stick things on the wall and work on Lean projects at any time. The space is dedicated, it's there just for the teams to work in and it's been a really big plus to the progress of our Lean teams. We are beginning to broaden the use of Kaizen or short term interventions with our departments, and have several of those scheduled over the course of the first few weeks in 2016. And our long-term goal is to achieve the State Quality award and then to move on to Baldridge certification. One thing that is important to note here is that we have had great support from our medical community. One of our transplant centers has been very helpful to us as we have begun our Lean journey. They are part of a hospital system that is totally dedicated to Lean and they have provided us with training opportunities for our leadership team as well as free consulting from their corporate Lean leader.

Another key strategy is to focus on authorization. We believe that no matter what other strategies an OPO employs, authorization must always be focused on, measured and improved. For us, we utilize the Gift of Life training and the "Dual Advocacy" method. We have a focused all organ approach through dedicated Family Service Coordinators with some support from the In-House and Regional Coordinators when necessary due to geography. And we utilize both early interaction and re-approach. A second key thing that is very important to our growth in this area is the fact that 57% of our adult population is on the donor registry. Registered donors now represent about 55% of all donors. One point I would like to make it that in the authorization data you are about to see, registered donors have been exempted. We do not use registered donors for evaluating our staff performance rather we use strictly the approaches where they go into the room and their ability to consult with the family and support the family determines the outcome of the authorization approach. We track registered donors and work very hard to grow our registry, but in terms of evaluating our authorization rates we work very hard to focus on those authorizations where the staff member can make a difference.

With that in mind, you can see our authorization rates comparing 2014 data to 2015 data through November and it is broken into non-registered brain dead donors (BD) and non-registered DCD. In both regards we have continued to grow beyond what was very good performance in 2014 to an even higher level in 2015. One other key point that I want to make is that when we authorize a donor for DCD we also complete a second authorization for BD donation in the event the patient progress to brain death. The concern when doing live DCDs is that you could be missing BD opportunities and we want to be able to prevent that by always being able to shift to a BD donation at any time. In 2015, we experienced that about five times out of the nearly 50 DCD cases that we started.

Finally, we made a commitment to DCD. We are very aggressive about pursuing DCD. Within our service area the criteria for DCD are simply that the donor has good renal function and that they are between the ages of 0 and 65. Obviously, we look at other contraindications, co-morbidities and rule some of those out, but the key is that we are not cutting of at a low age and are not only looking at absolutely perfect DCD cases. In so doing, we have been able to grow the number of DCDs recovered dramatically over the last three years, and at the same time we have been able to put more organs into the system for transplant. We have made an increased

commitment to machine preservation, including the number of pumps and putting a dedicated perfusion suite in our building. We are recovering DCDs in all of our hospitals. We do not make a decision as to whether or not to recover a DCD based solely on the location of the donor. Rather we move the resources necessary to make that happen.

So when we look at the breakdown of our donors by type over the course of the last three years, you can see that we have had growth across the board. Our total donor growth from 89 donors in 2013, to 141 in 2014, and 174 and in 2015 - is pretty well mimicked by the growth of standard criteria donors (SCD), ECD, DCD, and those other donors that have multiple contraindications and do not meet the definition of eligible from whom we have been able to recover at least one organ. Especially large within that population are donors over the age of 70 who are primarily liver only donors at this point in time.

One thing we have had to accept about the aggressive pursuit of every donation has been the impact it's had in other areas. We have seen much longer cases. Our average case time is up to the 30 hour range. Already this year we have had a 57 hour and 60 hour case as we tried to maximize the placement of organs from a donor that had many co-morbidities. Even so we have seen our yield or organs transplanted per donor drop significantly across the board from an average of 3.4 for all donors in 2012 to 2.75 for all donors in 2015. Consented but not recovered cases have also doubled. The number of cases that we start but shut down after significant hours worked is increasing because of our aggressiveness and effort to leave no donors on the table. Basically, we have determined that if we do not look we will not find every organ that can be transplanted. The consequence of that is that we will sometimes look and there will not be a transplantable organ there.

This is where we ended up in 2015. After a great year in 2014, we again set records across the board in terms of our activity in 2015. In 2015, we recovered 174 organ donors from our population of 3.8 million. We recovered and transplanted 479 organs for an ultimate yield of 2.75 organs transplanted per donor. One thing of note is that we are now at about 24% of DCD donors with 42 DCD donor successfully recovered in 2015. We feel that there were a fair number of organs that were recovered, but not transplanted in 2015 that could have been transplanted by aggressive centers. We have exhausted the list on ECD and DCD kidneys and DCD livers and lungs. DCD liver placement in the mid-west is difficult because of the distance in geography that is sometimes in play and we pretty much have to place DCD livers with local centers as a result of this. We have had zero luck finding centers that are willing to fly in for DCD livers and lungs and even less luck in finding centers that are willing to allow us to take them out and ship the organs to them. To truly maximize the number of organs from DCD donors, we need to increase the pull from the transplant community as there are organs still available that are transplantable.

In closing, some final thoughts. Our focus going forward will remain on our core purpose of saving lives. We save lives, that's what we are about and that's what we are aggressively going to try to do every day of the year. Secondly, we routinely benchmark ourselves and hold ourselves accountable using a complex matrix of variables. Ultimately, if you don't measure it, it's not important, so we have worked very hard to identify metrics that we have felt define who we are and how we do our business. Authorization rates for both BD and DCD are tracked. The conversion of potential, not just eligible but potential, is tracked on weekly basis. Our DCD recovery rate is constantly something that we are looking at. On every case, we look at observed versus expected as well as organs transplanted per donor (OTPD) and we also look

at that on a cumulative basis as the year progresses. And finally, we track donor per million and organs transplanted per million population for our service area, and compare that against the national average for the US. We believe that it's important for us to know whether we are ahead or behind the curve as related to the national experience. Ultimately, no one variable that we track is superior. The interplay of these benchmarks provides us with, what I call, a 3D look at how we are doing, and it's very important to us to have the perspective that multiple benchmarks provides.

Thank you again for the opportunity to present today, and thank you to my colleagues for sharing this presentation. We look forward to many more years of saving lives in the future and sharing our experiences with all of you.

**Moderator:**
We specifically want to say thank you to each of our presenters, for their time and willingness to share their experience and effective practices with the community.

Throughout 2016, UNOS will provide instructional offerings where Region 4 OPOs will share detailed information and resources to help you operationalize changes for success in the areas of:

1. Leadership and organizational culture shifts
2. Implementation of quality management and improvement strategies
3. Refining a focus on donor authorization and consent rates
4. And increasing recovery and utilization of donation after cardiac death (DCD) organs.

In February, UNOS will post an article from the Region 4 perspective on the OPTN and Transplant Pro websites entitled, "Clarity, Leadership, and Trust: A Path to Success." As with the first article posted in November 2015, there will be a feedback opportunity for the community to let us know strategies that are working well and to share the challenges that are encountered to increasing the number of organs available for transplant. You may send your private feedback to education@unos.org or start a conversation with your colleagues using the Disqus feature on the OPTN website. In late March, look for another recording that will focus on how to operationalize changes in leadership and organizational culture that have been effective for Region 4 OPOs.

The OPO's in Region 4 believe in sharing effective practices, and their leadership is willing to discuss specific challenges and strategies with you related to the areas they have discussed today. Each presenter has provided their email address for this purpose. If you have questions about any of the upcoming instructional offerings, contact the UNOS Instructional Innovations department at education@unos.org.

Please complete a brief evaluation of this recording. We value your feedback and hope that you will take 5 minutes to complete the survey-https://www.surveymonkey.com/r/Reg_4_OPO_Exp. Your feedback helps us to provide quality instructional programs that meet your needs. If you would like to receive CEPTC credit for viewing the recording you will need to also complete and pass the assessment within the survey. ABTC will award 1.0 Category 1 CEPTC for this recording. If you do not wish to receive CEPTC credit, you will not be required to take the assessment. Once you take the assessment, it will be 4 to 6 weeks for you to receive your

certificate via email. The assessment survey will be open to receive CEPTC credit until June 28, 2016.

Thank you for your time and attention to today's event.