The OPO Response to the CMS Final Rule: Proactively Preparing for the Changes

TODAY'S PANELISTS

Jack Herbst
BSN, RN
Quality Lean Coach

Allegheny Health Network

Meghan Stephenson
MSN, RN, CPTC
Director, Maximize the Gift

IOWA DONOR NETWORK

THE Alliance | *Leadership & Engaged Learning in Organ Donation & Transplantation*

Thursday, October 27, 2022, 2:00pm – 3:00pm ET

Continuing Education Information

Evaluations & Certificates

Nursing

The Organ Donation and Transplantation Alliance is offering **1.0 hours of continuing education credit** for this offering, approved by The California Board of Registered Nursing, Provider Number CEP17117. No partial credits will be awarded. CE credit will be issued upon request within 30 days post-webinar.

CEPTC

The Organ Donation and Transplantation Alliance will be offering **1.0 Category I CEPTC credits** from the American Board for Transplant Certification. Certified clinical transplant and procurement coordinators and certified clinical transplant nurses seeking CEPTC credit must complete the evaluation form within 30 days of the event.

Certificate of Attendance

Participants desiring CE's that are not being offered, should complete a certificate of attendance.

- Certificates should be claimed within 30 days of this webinar.
- We highly encourage you to provide us with your feedback through completion of the online evaluation tool.
- Detailed instructions will be emailed to you within the next 24 hours.
- You will receive a certificate via email upon completion of a certificate request or an evaluation
- Group leaders, please share the follow-up email with all group participants who attended the webinar.

Deanna Fenton
Program Manager
THE Alliance

Need Assistance?

Contact Us via Zoom Chat, or
info@organdonationalliance.org
786-866-8730

Meet Our Moderator

Christy Bridwell BA, MPH
Hospital Services Liaison

NEVADA DONOR NETWORK

Meet Our Panelists

Christie Ryan

Director, Professional Services and Regulatory Affairs

CORE
Center for Organ Recovery & Education
A Pledge for Life

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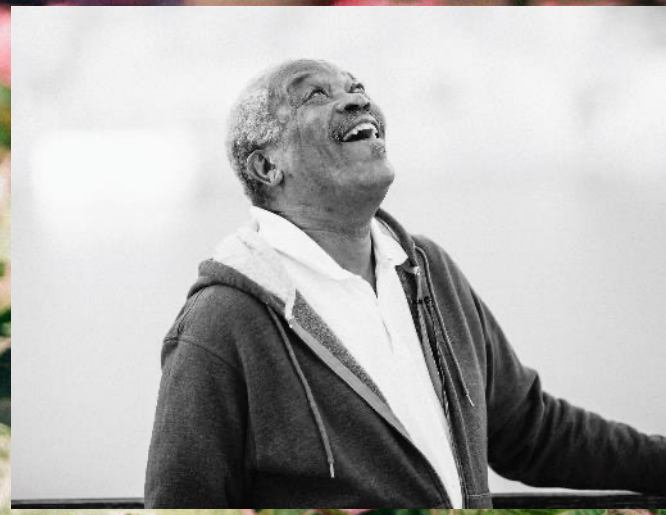

be a hero. be an organ donor.

Preventing Organ Process Breakdowns: The Right Timing Saves Lives

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Center for Organ Recovery & Education

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2019 Award Recipient

MISSION

To *Save* and *Heal* lives through donation.

VISION

Every potential donor will make *A Pledge for Life.*

VALUES

Compassion, Education, Innovation, Integrity, Life, Quality, Respect, Responsiveness.

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Situation Background

- Hospital experienced frequent process breakdowns related to extubation cases
- Extubations with potential missed donations deemed as a Sentinel Event
  - One Sentinel Event in 2021
- Recognized a need for a sustainable process improvement to prevent future occurrences

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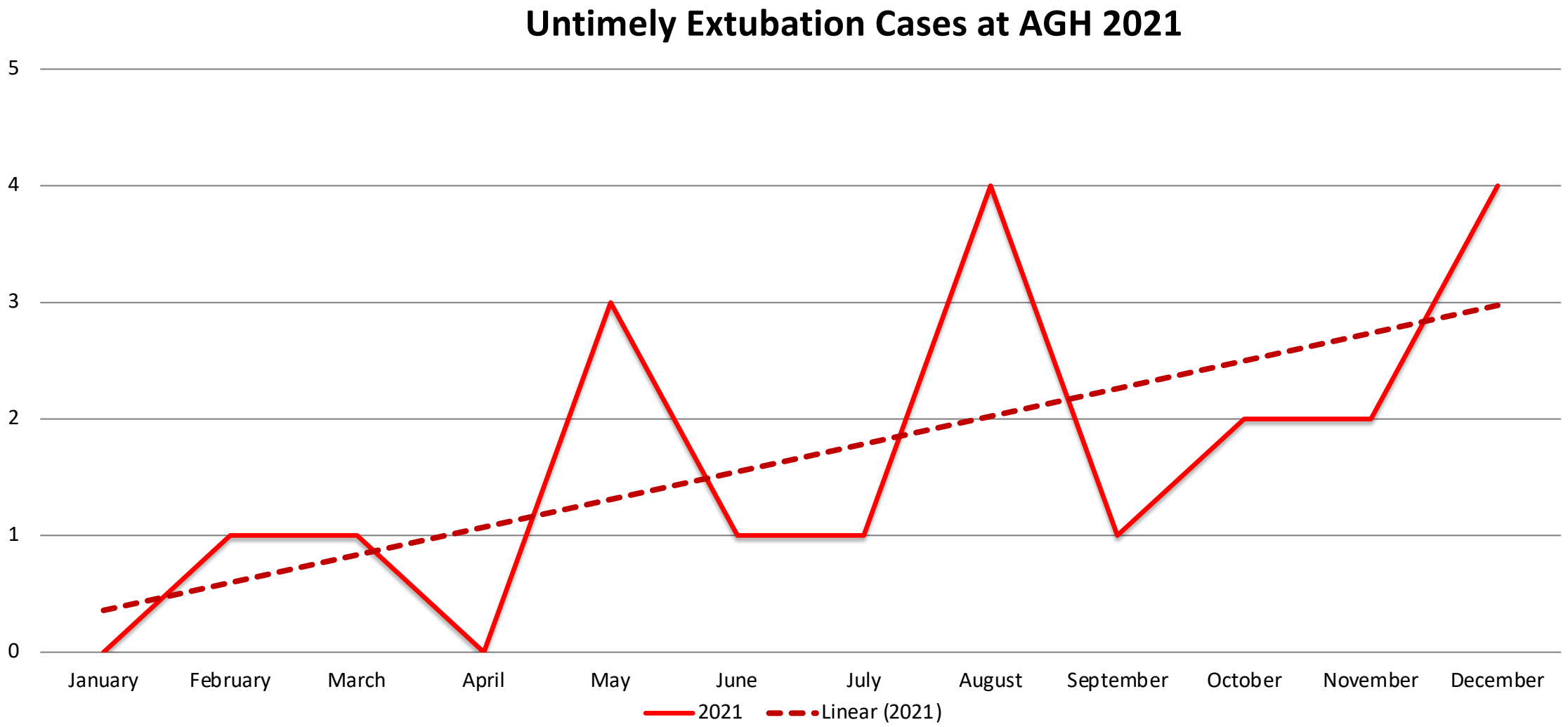
A Pledge for Life

Allegheny General Hospital



Data Analysis

A3 Thinking

Identifying the Problem

Understanding the Problem

Defining the Ideal State

Designing Countermeasures

Analyze Effectiveness/Receive Feedback

Problem Statement

- In 2021, 20 patients who met clinical criteria based on CORE guidelines were extubated without an appropriate referral.
- This may result in loss of organ donation.
- There is a regulatory requirement to support organ donation. (SOA)

Results of Extubation

- Loss of lives and decreased quality – potentially missed at least 26 donations since 1/1/2021
- Patients in waiting experience greater physical/mental demands, uncertainty in their life and relationships
- Increased costs of treating a patient waiting for transplant - $4,800 per patient per month


Per CORE advisory mtg., AGH has significantly more premature extubations than other hospitals
No RL6 about extubations
CORE not a mandatory competency
RN knowledge deficit
AGH culture is not supportive of organ donation/referrals
No standard SBAR for CORE handoff
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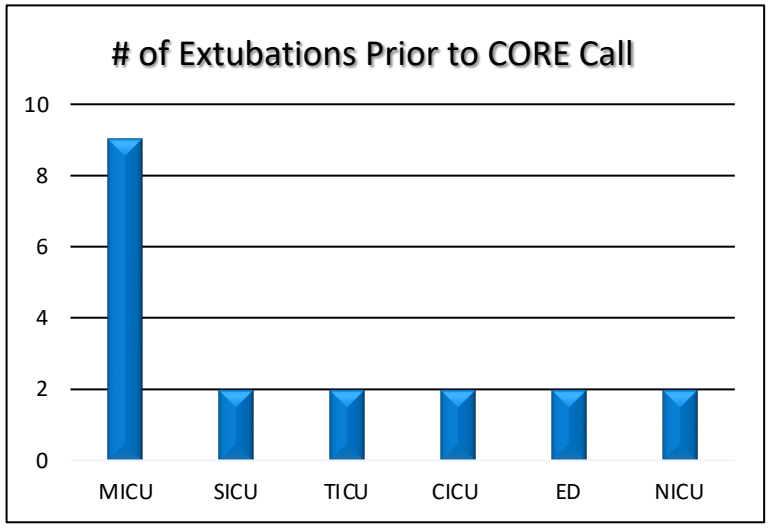
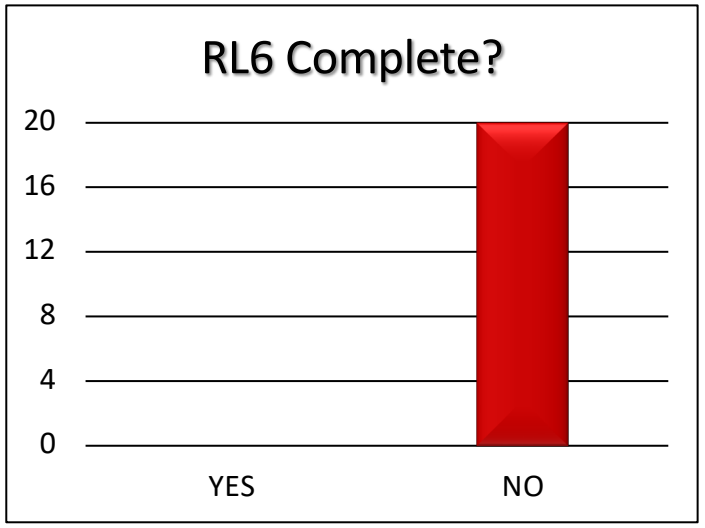
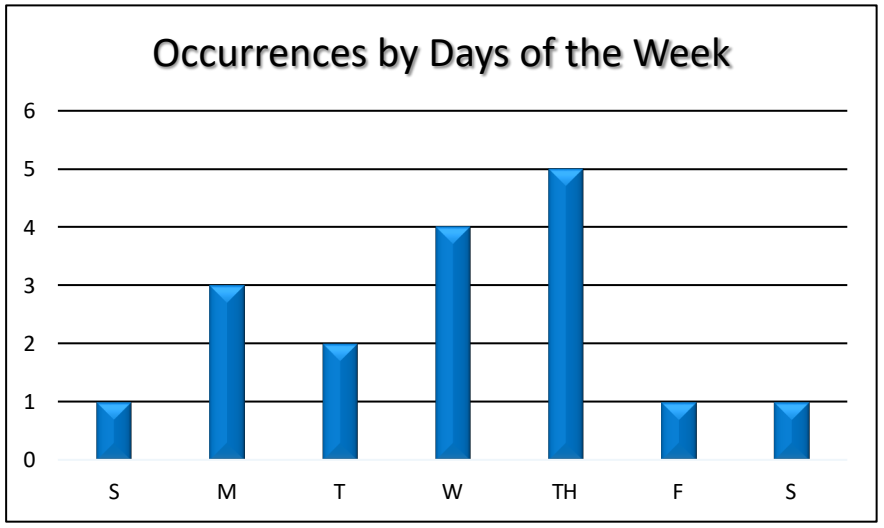
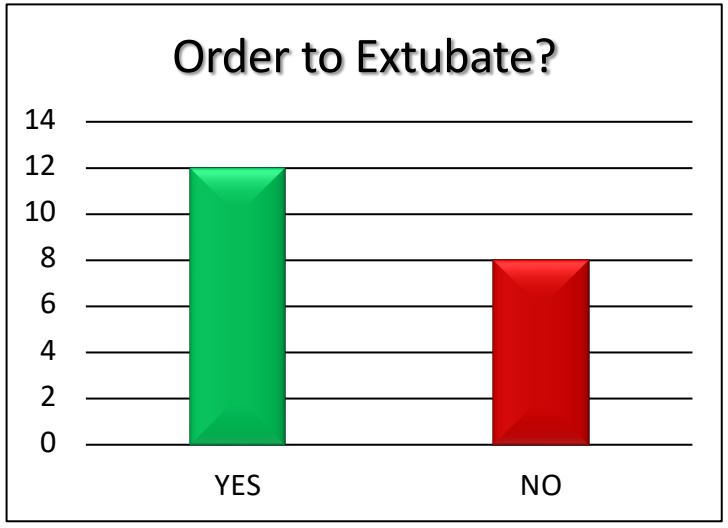
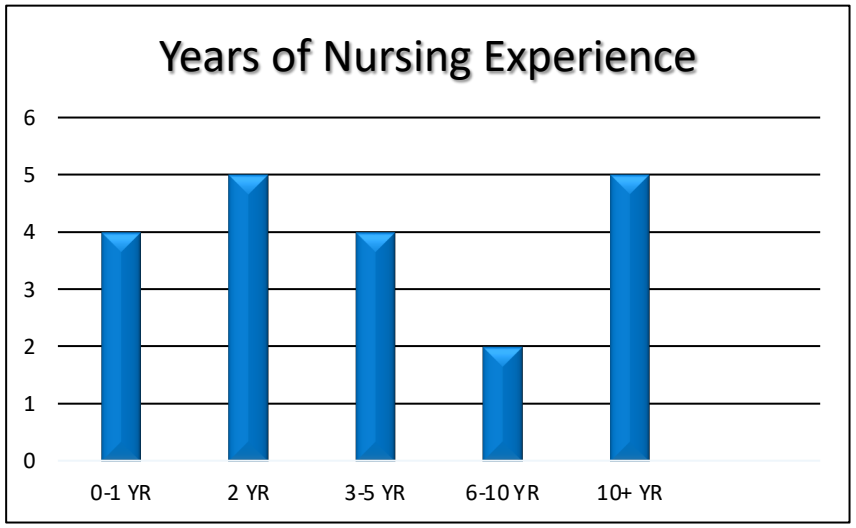
No CORE education for senior staff nurses
RNs don't always call CORE during CMO discussion
3 different CORE coordinators in the past two years.
Change in practice/ siloed work between CORE and Patty
Allegheny General Hospital
NMs/ANMs don't consistently hold staff accountable for CORE breakdowns
CORE triggers not clearly apparent in EPIC
Admission code fast-paced, causing poor accomplishment of task, remembering
High staff turnover
NMs have no way to track CORE patients on the unit
Travel/ Agency RNs do not get CORE education
No hard stop on Epic for notifying CORE
RNs don't always call CORE when triggers happen
NMs not aware of CORE referral criteria
CORE criteria not reported in report (SBAR)

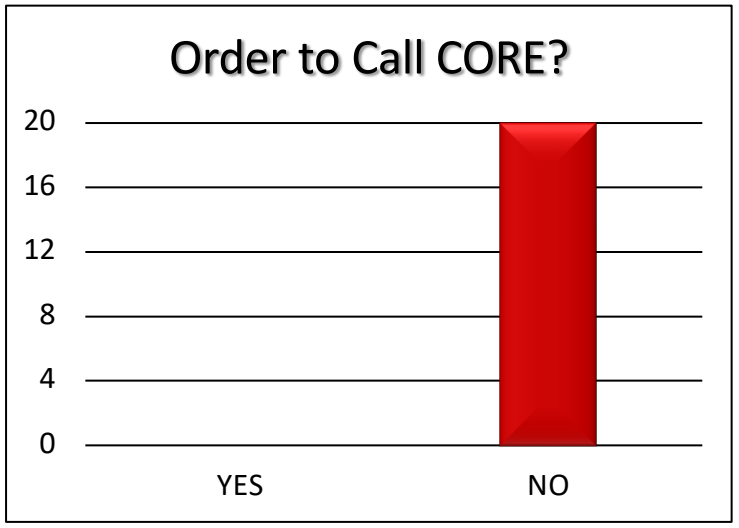












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Data Analysis – 2021 Cases

n = 20

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Future Statement

- CORE will be notified when clinical triggers for referral are met. (Extubation)
- There will be zero sentinel events secondary to CORE referrals not being completed.

Implementations – Phase 1

Heightened Awareness

- Single-point informational poster to present this issue directly to nurses in affected departments via Gemba
- Education and awareness to stakeholders: Unit-based teams, physician teams, respiratory therapy
- In-house Presentations open for additional staff and leadership

Implementations – Phase 1

EPIC Optimization

- Implemented revised, pre-existing triggers in EPIC when patient has certain documented CORE triggers

Continuous, Ongoing Education

- Collaboration with RN Educators – new onboarding section that includes CORE for Travel RNs

We missed the call to CORE... so what?

What happens when we remove mechanical ventilation or extubate a patient without notifying CORE first?

What it means to **Patients**

- In 2021, we missed 13 potential donors
- AGH transplanted an average of 2.1 organs per donor
- At least 26 life-saving organs could have gone to patients in need, but now they're still waiting...
- Research has shown pre-transplantation costs account for 41% of total healthcare expenses for patients waiting on donors

What it means to **Our Hospital**

- Failure to call CORE before withdrawing mechanical ventilation or extubation:
  - Violates CMS guidelines
  - Places the hospital's transplant services in jeopardy
  - Results in a Sentinel (Never) Event if a donor is missed
- Loss of CMS reimbursement
  - Fiscal Year Ending 2021 total reimbursement: $8,800,000

What should we do? **Nurses**

- **DO NOT** remove mechanical ventilation/extubate before calling CORE for *all* cases
- Regardless of code status, notify CORE when a vented patient meets criteria:
  - GCS of 5 or below
  - Irreversible Brain Injury
  - Ventilator Dependent w/ anticipated death
  - Code Status Change
- CORE can be reached at either:

800-366-6777 or **412-963-3550**

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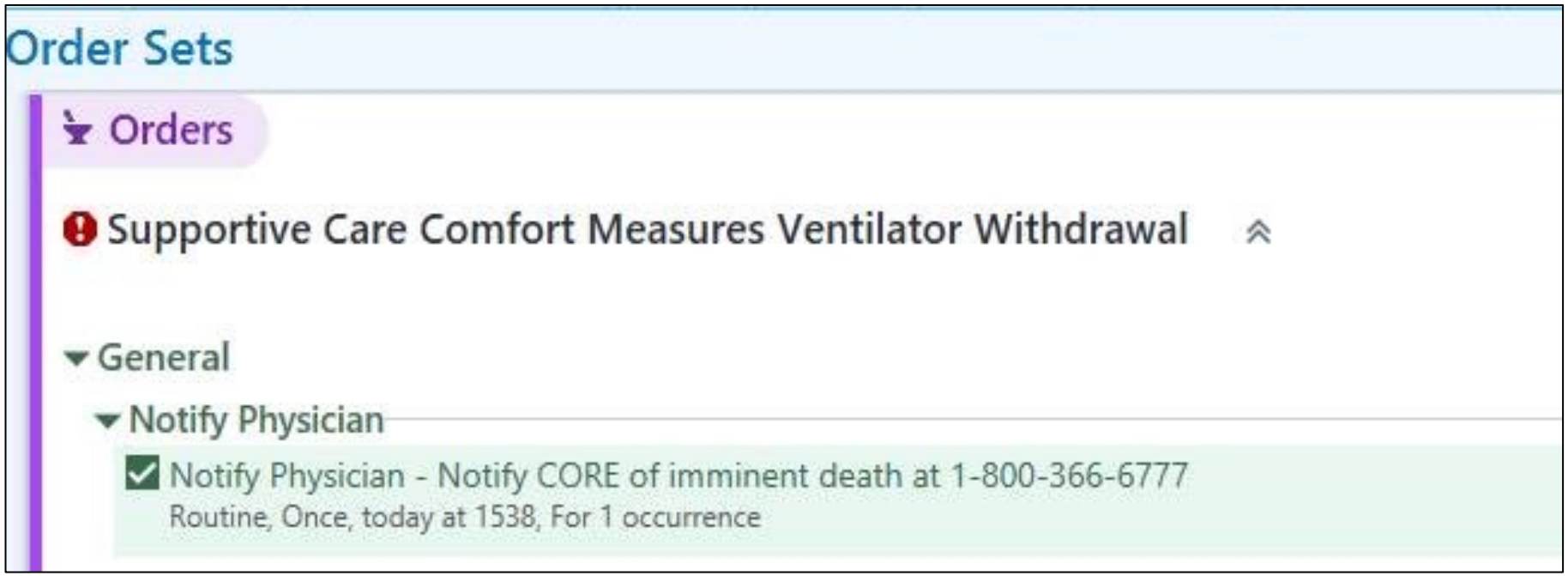
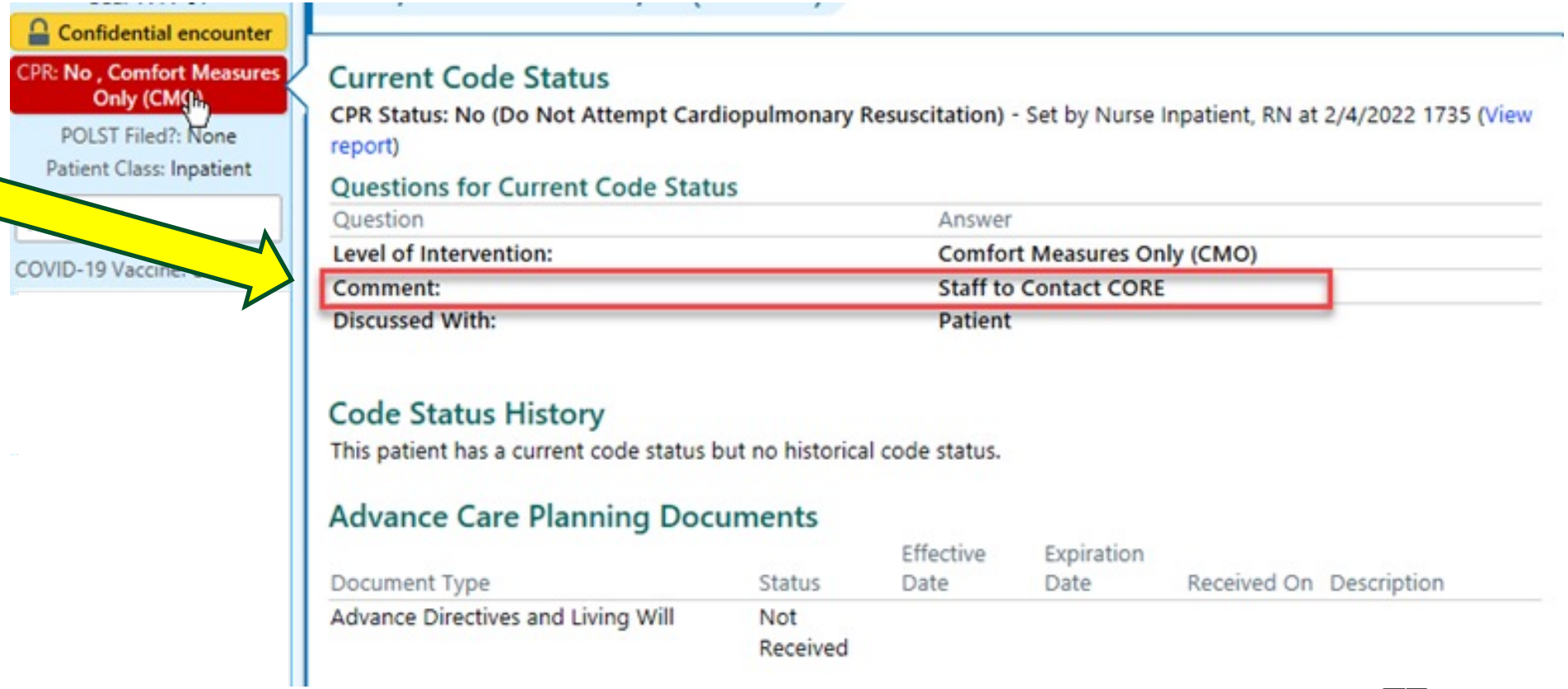
- Order to call CORE will now be pre-selected in CMO order set

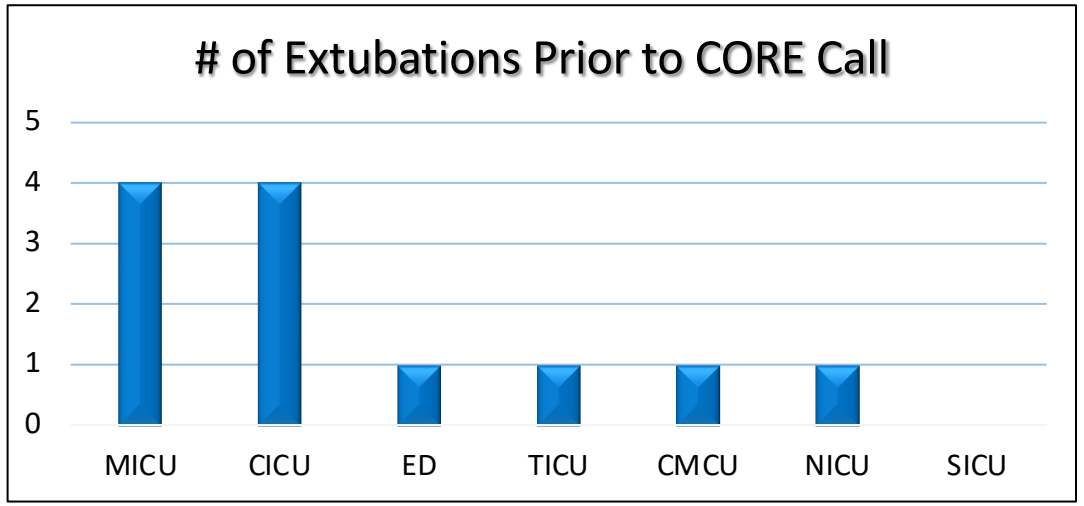


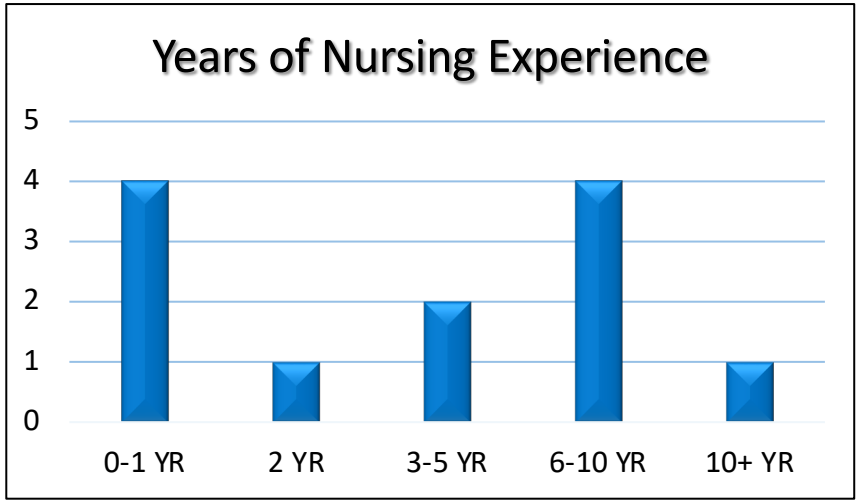
- Ordering code status requires comment: Staff to Contact CORE

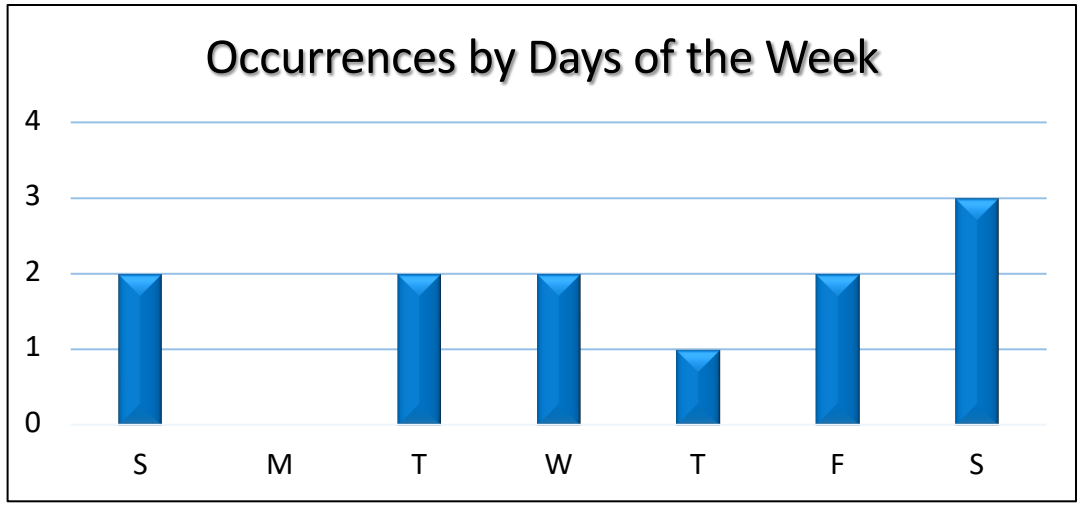


Clinical Nurse Educators & CORE Collaboration

- Developed special comprehensive education for weekly travel RN onboarding
  - Participation in new hire RN orientation
  - Implemented throughout AHN
- Daily rounds by on-site coordinator in ICUs and ED
- As-needed education on potentially relevant units







- No new trends in data

n = 12

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Data Analysis – 2022 Cases (May YTD)

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Data Analysis – 2022 Cases (May YTD)

- Begin reviewing RCAs by CORE In-House Coordinator
  - **Win:** Nurses recognizing breakdowns immediately after occurring
  - Multiple missed triggers for CORE referral on early extubation cases
  - Process was known, but not followed
- Involvement of Director of Nursing
- New opportunities for enhanced compliance by accountability to current process

Implementations – Phase 2

Continuous & Ongoing Education

- Remediation Module in MyLearning
  - Intended to establish basis of AGH's "culture of donation"
- CORE Unit Champions for additional support

Implementations – Phase 2

Unit Leadership Involvement

- New RCA tool and process to keep unit management informed and involved with breakdowns
- MyLearning Remediation PRN for staff breakdowns

EPIC Optimization

- EPIC patient report for leadership to identify patients who need CORE referrals, promotes proactive engagement with CORE

Process Breakdown Evaluation

Referral Number:	
Date of Process Breakdown:	
Process Breakdown Type:	
Hospital/Hospital Code:	
Hospital Unit/Department:	
Hospital Class:	
Was there potential for organ donation with this patient?	
How was this PBD identified by CORE? (DRR, DRC, self-reported by hospital, etc.)	
PSL:	
Parties Involved (RN, Physician, RT, Etc.). List ALL Involved:	

1. Problem Statement

2. Sequence of Events and Background Information

3. Error Precursors (Document "Error Precursors" that were present that had an impact on the Process Breakdown and explain how they influenced the event)

-

4. Failed Defenses (Document the defenses that should have prevented the process breakdown and describe how they were either flawed, missing, bypassed or incorrectly implemented. For a missing defense, describe the type of defense that would be needed to prevent future breakdowns)

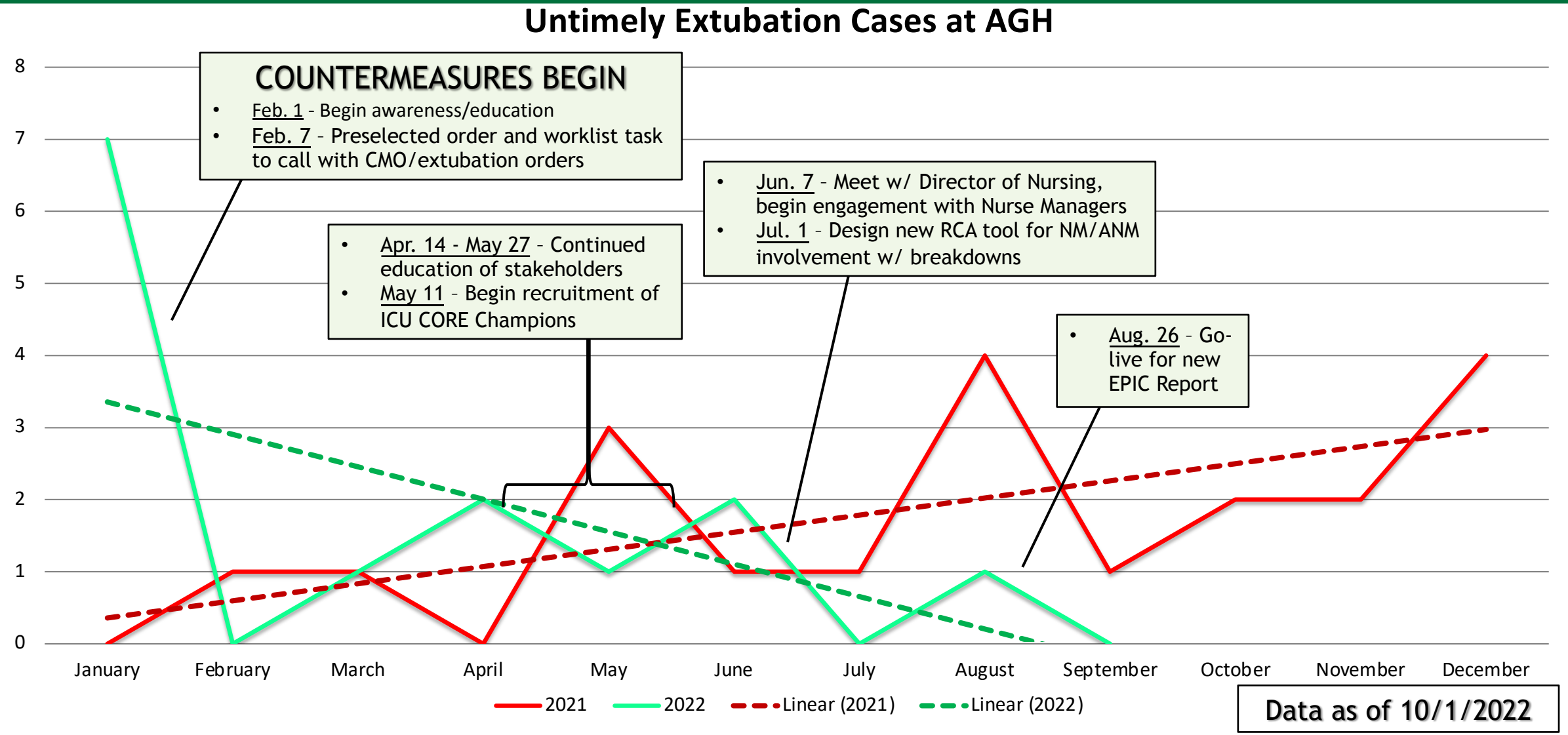
-

5. Actions Already Completed

Completed Action	Item(s) Addressed	Date Completed

6. Corrective Actions Needed or in Progress

Corrective Action	Item(s) Addressed	Commitment Owner	Due Date
1.			
2.			



Data Analysis: Comparison Post Implementations

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Thank you!

Questions?

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IOWA
DONOR NETWORK

Driving DCD Donation:

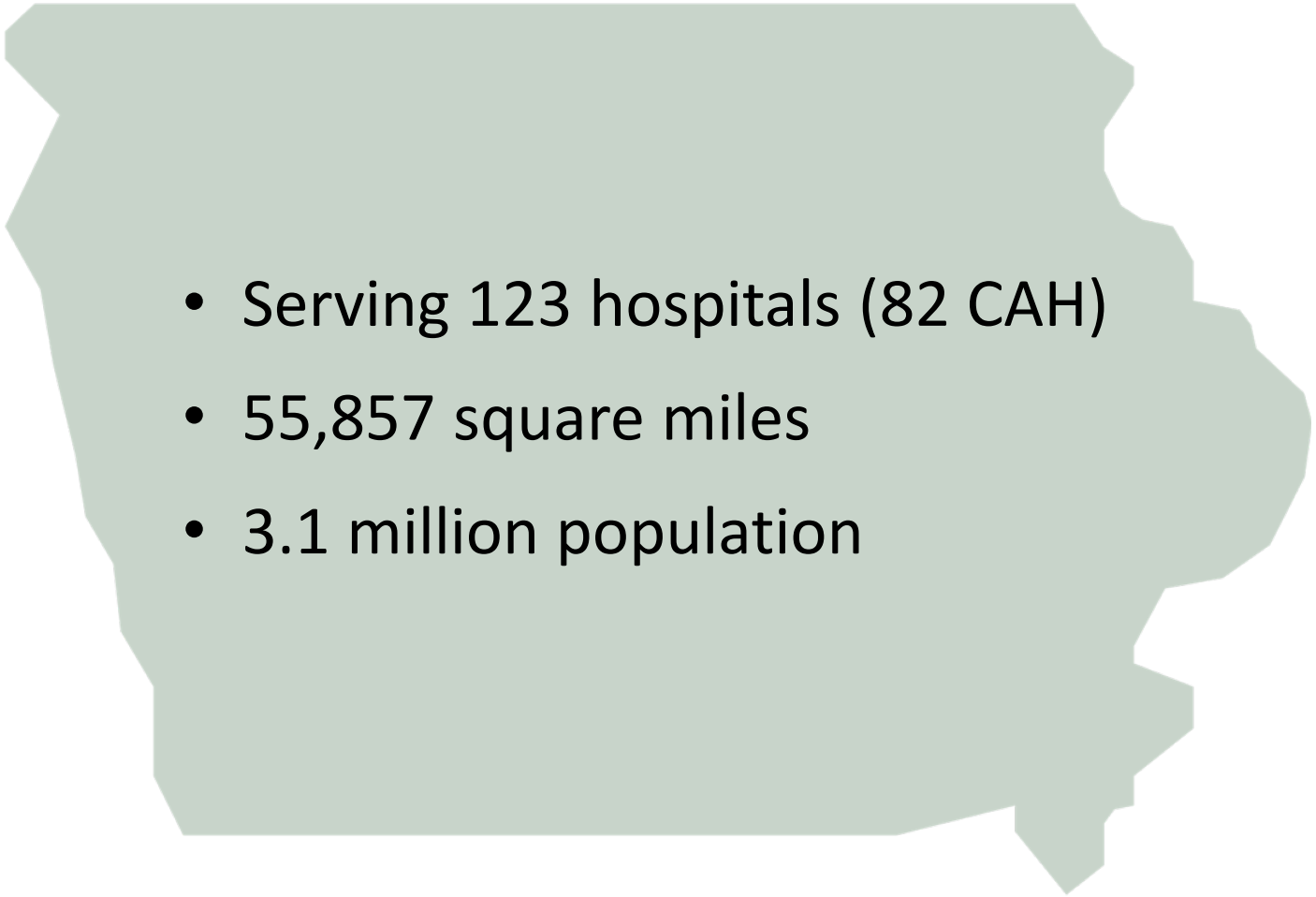
Identifying the Gaps

About Iowa Donor Network

IOWA DONOR NETWORK

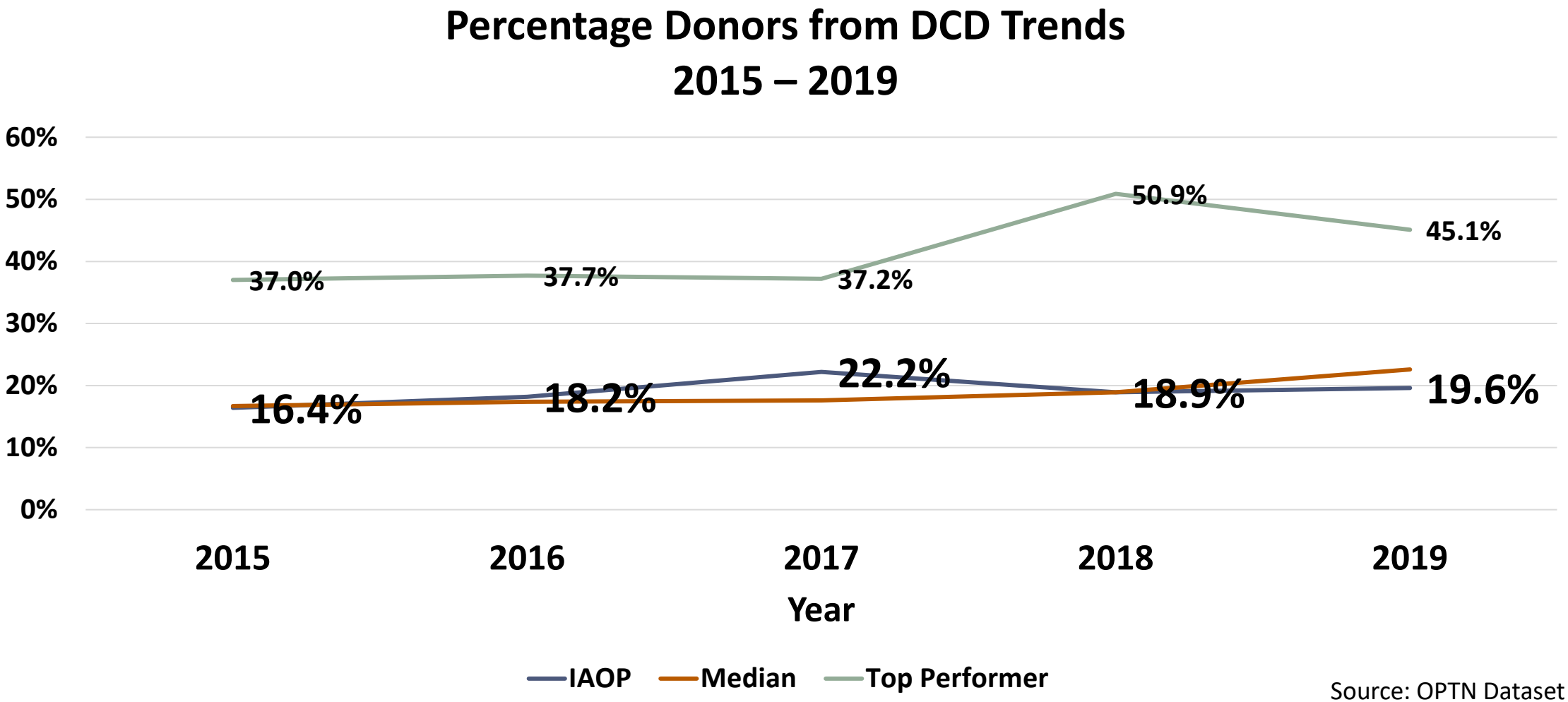
MISSION *Working together to transform lives through organ and tissue donation*

VISION *All are inspired to donate life*



- Serving 123 hospitals (82 CAH)
- 55,857 square miles
- 3.1 million population

Where did we start?



Source: OPTN Dataset

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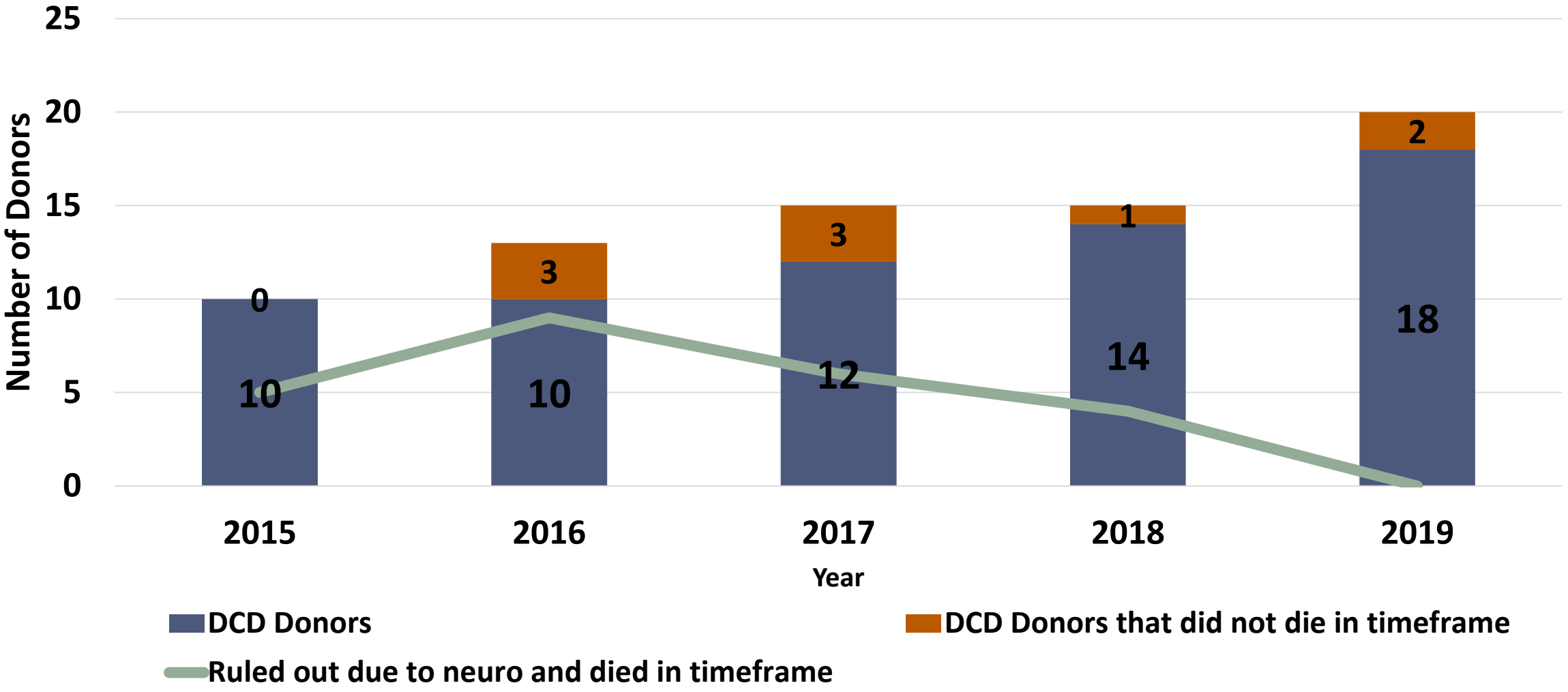
Historical DCD Trends



Where is the Gap?

IOWA DONOR NETWORK

Phase 3

- Were they referred?
- Did we have time to evaluate?

Phase 2

- Were they medically suitable?
- Were they likely to expire in timeframe?

Phase 1

- Was family approached and did we obtain authorization?

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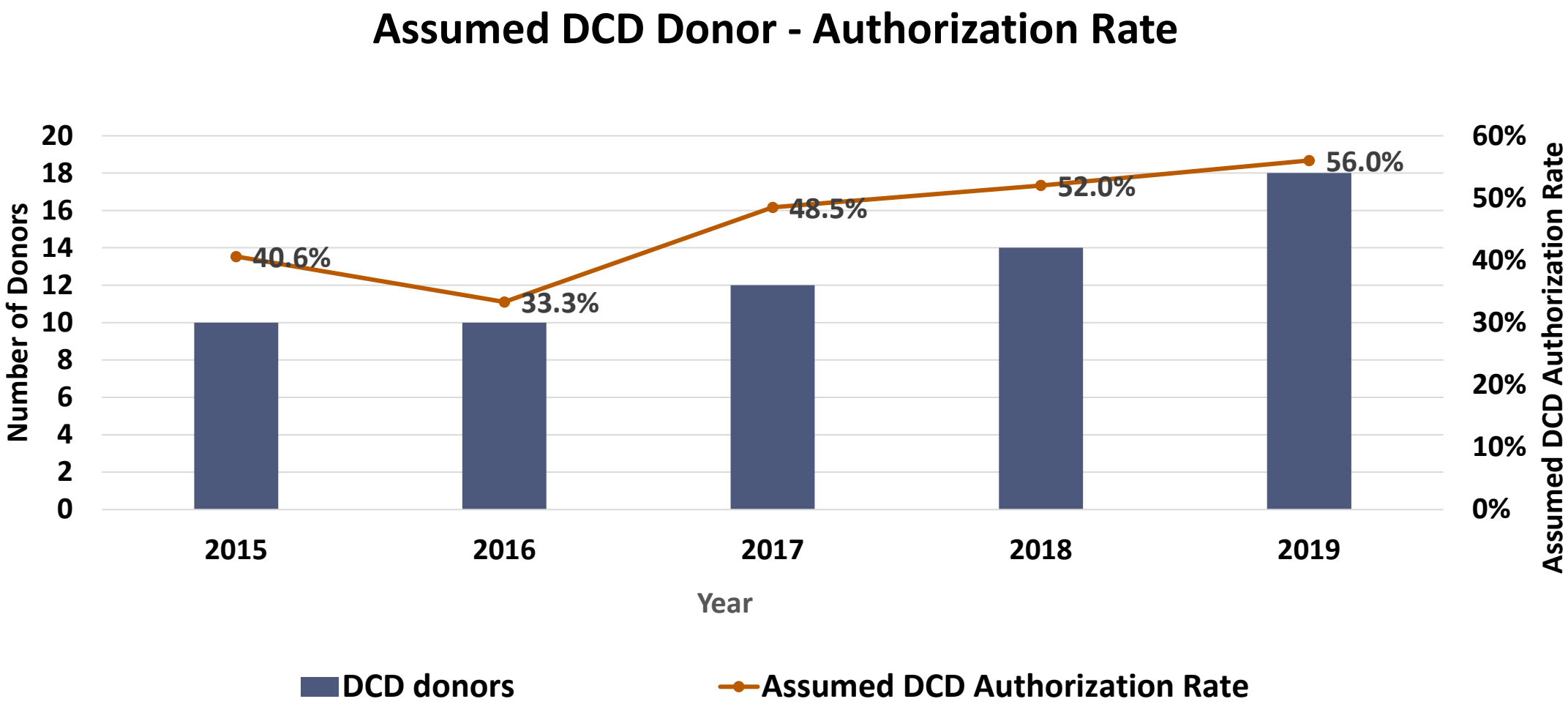
Approached and Authorized:

Changing the way, we talk about DCD



Where is the Gap?

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Phase 3

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Phase 2

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Phase 1

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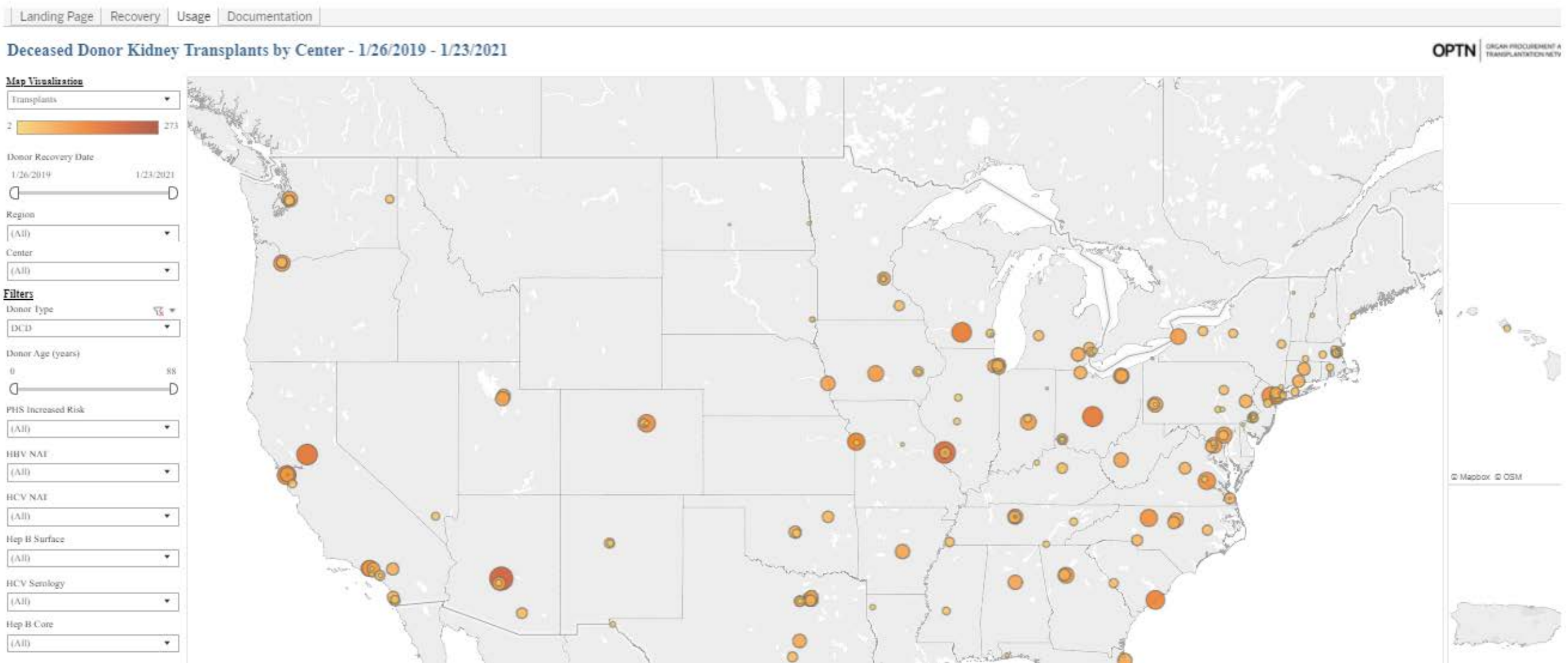
Who is a Suitable DCD Kidney donor?



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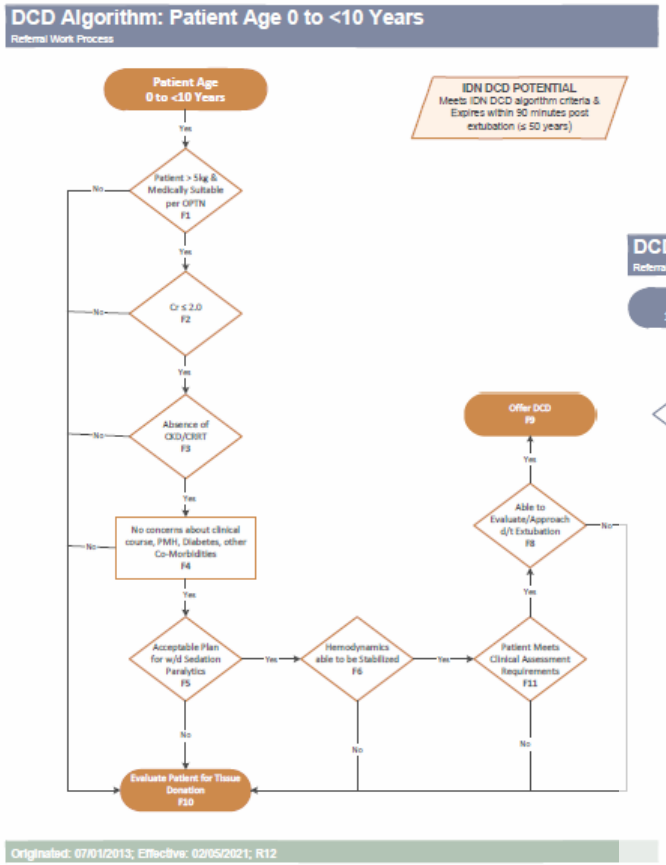
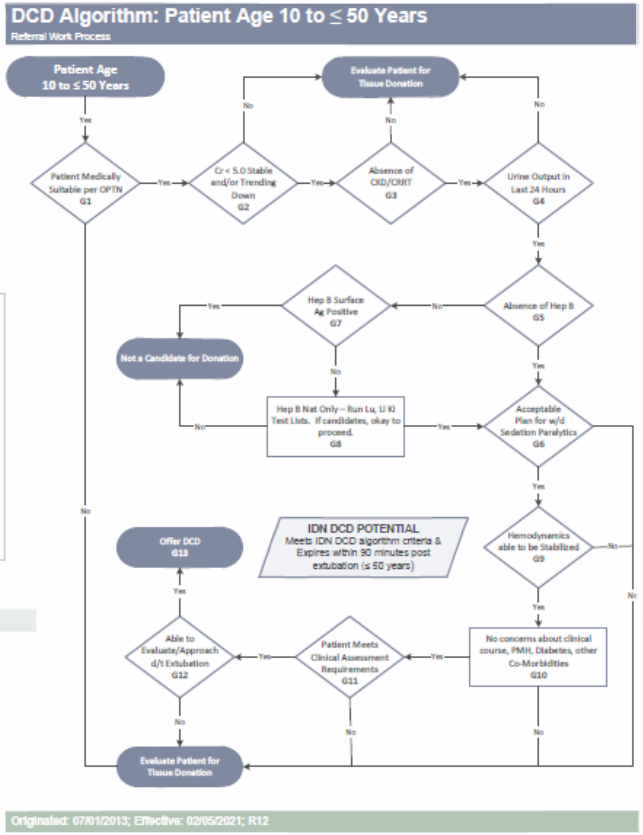
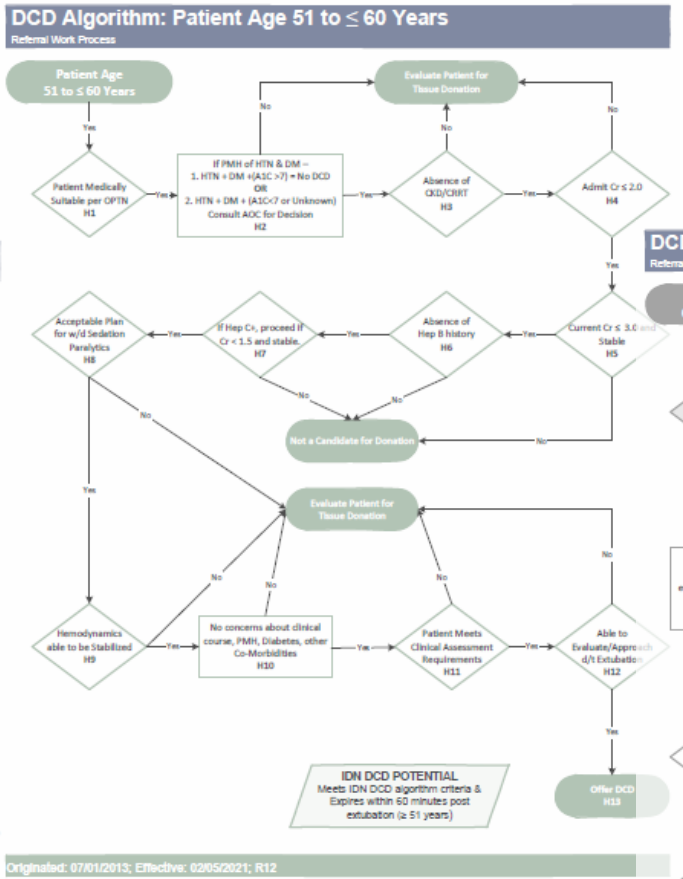
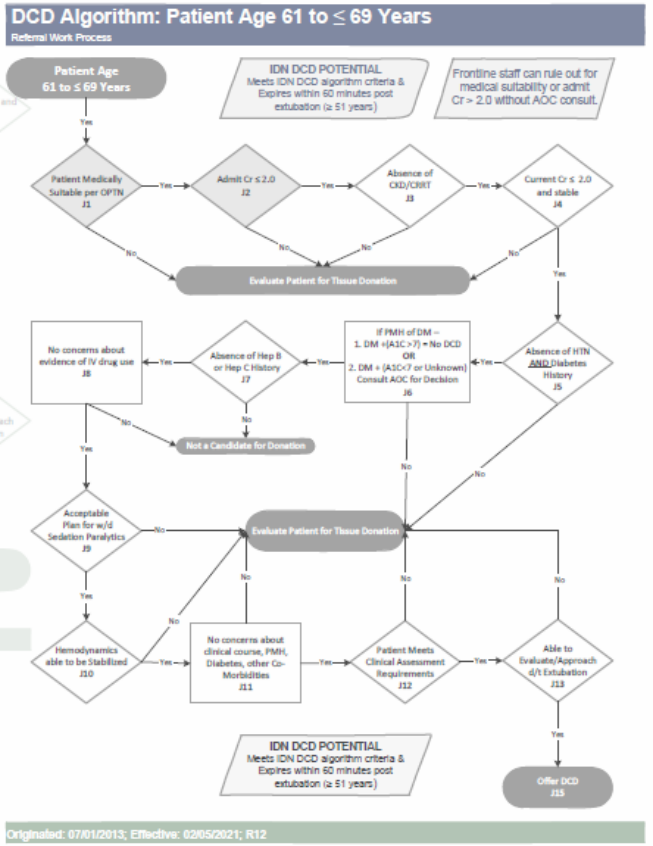
Revised DCD Algorithm









Revised DCD Algorithm

IOWA DONOR NETWORK 550 Madison Avenue North Liberty, IA 52317	Standard Work Title: SW-REF-13 DCD Algorithm		Reference Number: SW-REF-13
	Effective Date: 09/08/2022	Last Review Date: 09/08/2022	Version Number: 6
Primary Editors: Director Organ Procurement			
Primary Consumers: ORS, QIS			

Purpose: Determine DCD suitability
Instruction:

- Any * require a 2nd clinical review (ORS or Max the Gift Leader) to rule out
- If renals are ruled out, screen for liver, lungs, and heart exclusive. If non-renal organ screened in, document the final code as the renal code+ and describe organs ruled in or out in comments field of iTx) (Example: M3+)

Age: 0 to 9 years

Rule Out Criteria	Final Code
Medically Ineligible (CMS)	NMS
Creatinine > 3.0	K1
CKD or HD/CRRT > 7 days	K2
Concerns about entire PMHx, clinical and/or current medical picture*	K3
Evaluated for DCD and deemed suitable	DCD+
Family approached for DCD donation	DCDP
Patient declared BD	BD

Age: 10 to 50 years

Rule Out Criteria	Final Code
Medically Ineligible (CMS)	NMS
CKD or HD/CRRT > 7 days	L1
Concerns about entire PMHx, clinical and/or current medical picture*	L3
Evaluated for DCD and deemed suitable	DCD+
Family approached for DCD donation	DCDP
Patient declared BD	BD

Age: 51 to 60 years

Rule Out Criteria	Final Code
Medically Ineligible (CMS)	NMS
History of HTN and DM and A1C > 7	M1
CKD or HD/CRRT > 7 days	M2
Admit Creatinine > 2.0 and trending up	M3
Current Creatinine > 3.0 and trending up	M4
Concerns about entire PMHx, clinical and/or current medical picture*	M8
Evaluated for DCD and deemed suitable	DCD+
Family approached for DCD donation	DCDP
Patient declared BD	BD

Age: 61 to 69 years

IOWA DONOR NETWORK 550 Madison Avenue North Liberty, IA 52317	Standard Work Title: SW-REF-13 DCD Algorithm		Reference Number: SW-REF-13
	Effective Date: 09/08/2022	Last Review Date: 09/08/2022	Version Number: 6
Primary Editors: Director Organ Procurement			
Primary Consumers: ORS, QIS			

Rule Out Criteria	Final Code
Medically Ineligible (CMS)	NMS
CKD or HD/CRRT > 7 days	N1
History of HTN *and* DM	N2
History of DM *and* A1C > 7	N3
Admit or Current Creatine > 2.0 (clinical discretion)*	N4
Concerns about entire clinical and/or medical picture*	N6
Evaluated for DCD and deemed suitable	DCD+
Family approached for DCD donation	DCDP
Patient declared BD	BD

Age: 70 years and older

Rule Out Criteria	Final Code
Medically Ineligible (CMS)	NMS
Age 70 years old or older	AGE70

Non-Renal Screening

This section is used to screen vented organ referrals for liver-only and/or thoracic-only DCD donors. This screening is only completed only after a vented organ referral is screened out for DCD kidney donation.

Rule Out Criteria
Liver • Age > 69 years old • BMI > 50
Lungs • Age > 60 years old • COPD/Emphysema, Pulmonary Fibrosis, Smoking Hx > 20 pack years (PPD x years smoked) • ECMO
Heart • Age > 50 years old • DM (does not include DI) > 10 years, CHF, prior valve replacements or coronary artery bypass surgeries, any stent placements, pacemakers • Cardiac Assist Devices (inclusive of ECMO, balloon pumps, impellas, etc.)

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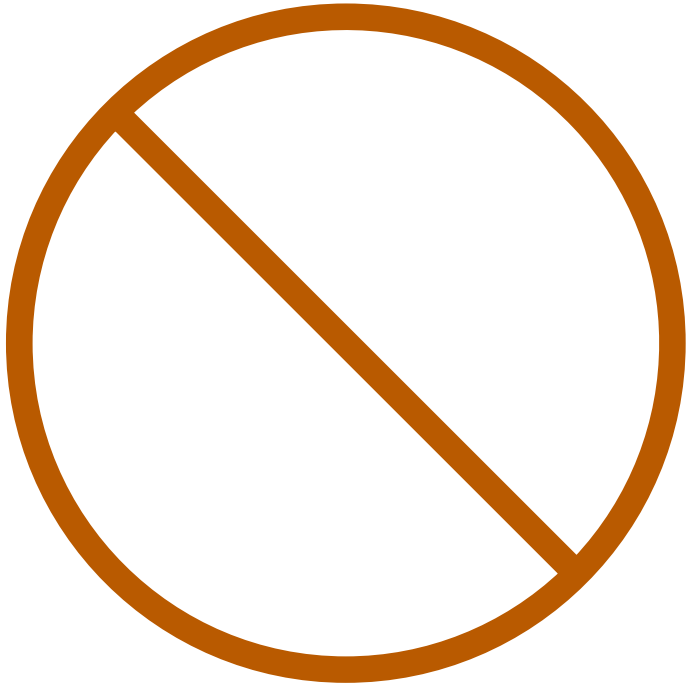
Donor-Death Prediction

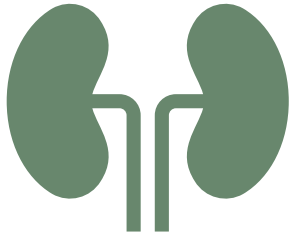


- Eliminate use of Donor-Death Prediction Tools*
- Eliminate emphasis of brain stem reflexes

* Hobeika, MJ, Glazner R, Foley DP, et al. A step toward standardization: Results of two National Surveys of Best Practices in Donation after Circulatory Death Liver Recovery and Recommendations from The American Society of Transplant Surgeons and Association of Organ Procurement Organizations. Clin Transplant. 2020;00:e14035. https://doi.org/10.1111/ctr.14035

Allocation Practice Changes

Aggressive Centers

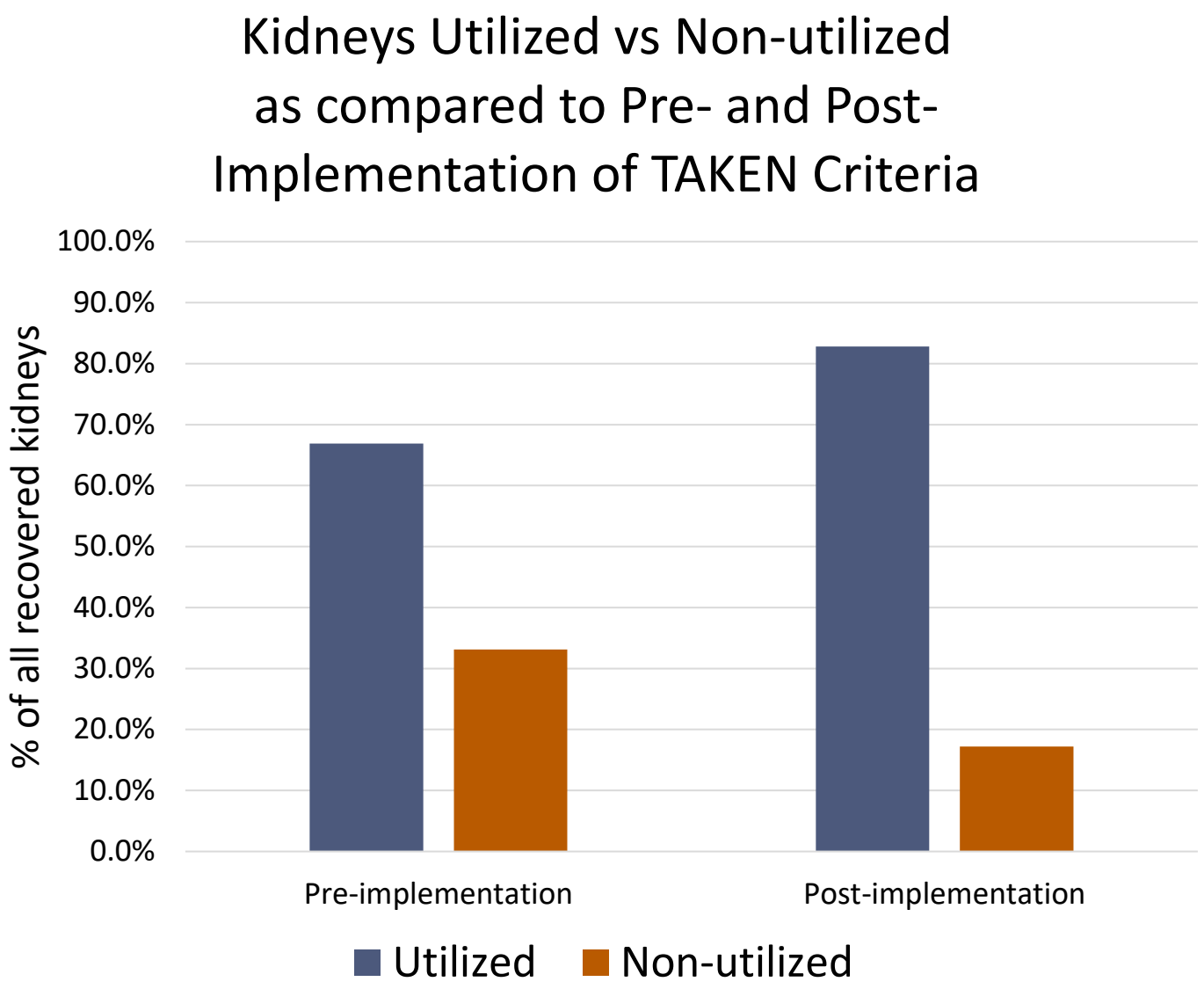


TAKEN Criteria for Kidneys

Outcomes: Utilization Rate vs Non-Utilization Rate

Pre-implementation timeframe:
07/01/21 – 12/31/21

Post-implementation timeframe:
02/01/22 – 07/31/22



Where is the Gap?

IOWA DONOR NETWORK

Phase 3

- Were they referred?
- Did we have time to evaluate?

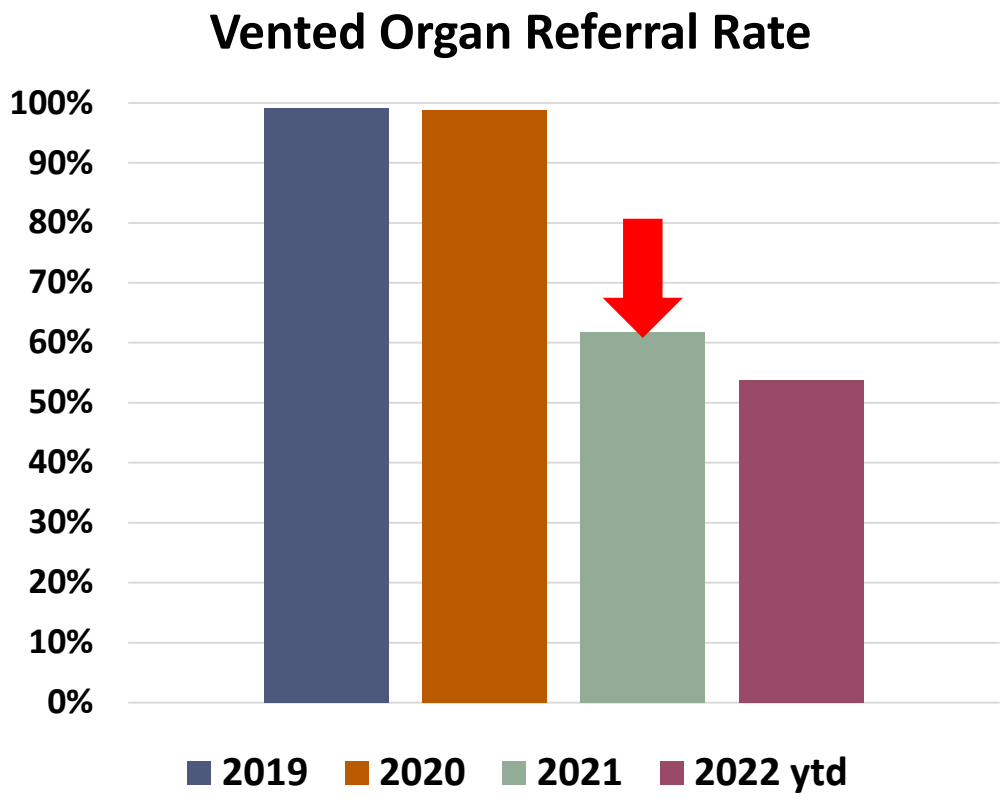
Phase 2

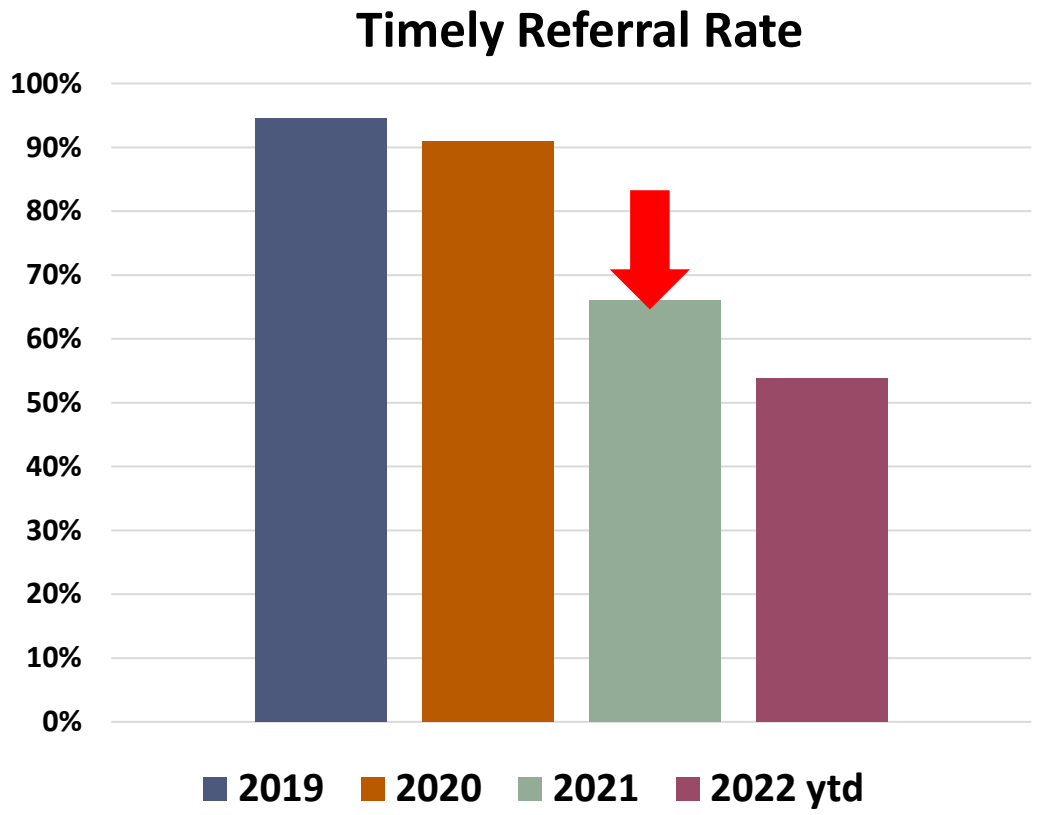
- Were they medically suitable?
- Were they likely to expire in timeframe?

Phase 1

- Was family approached and did we obtain authorization?

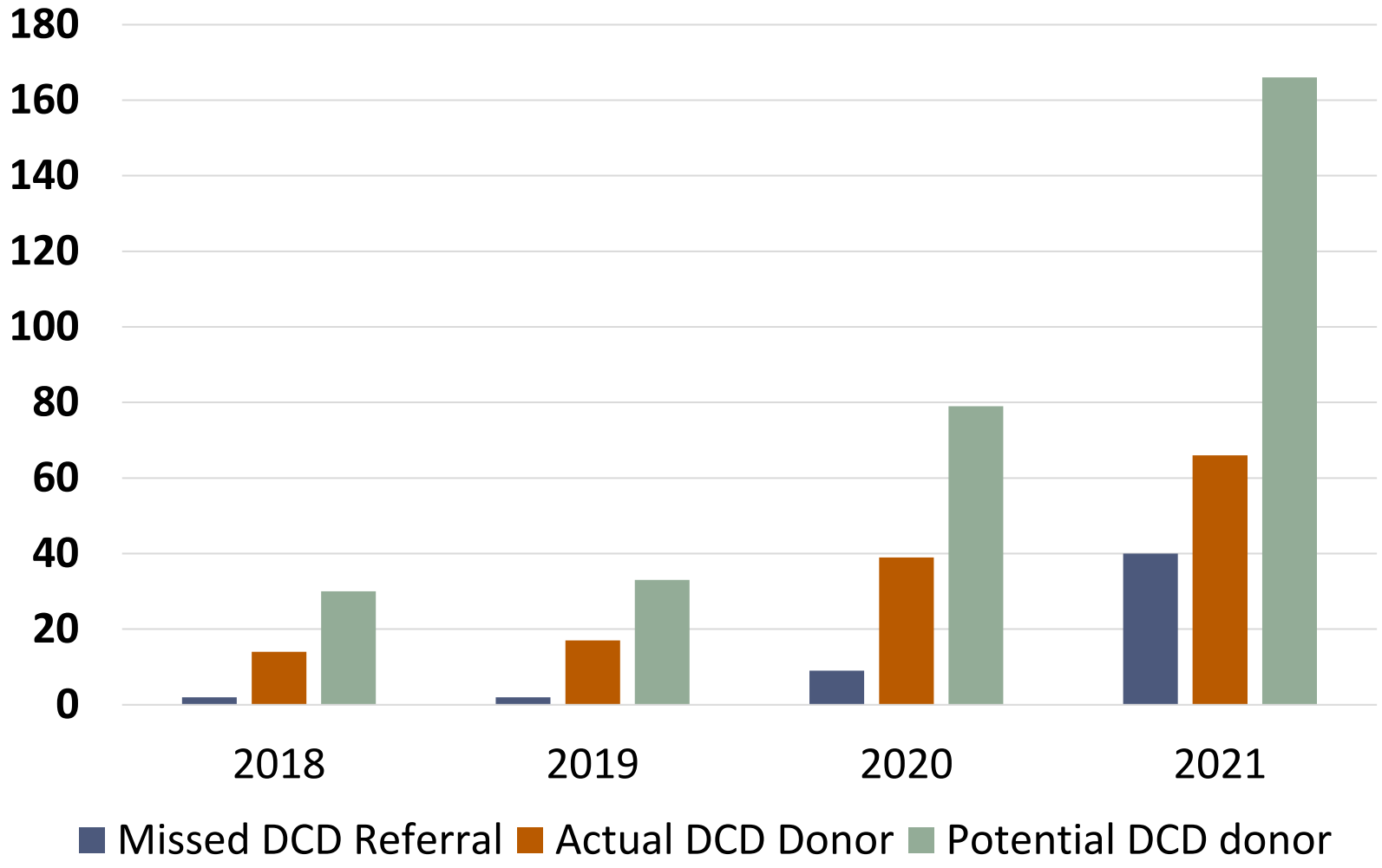
Were they referred and timely?





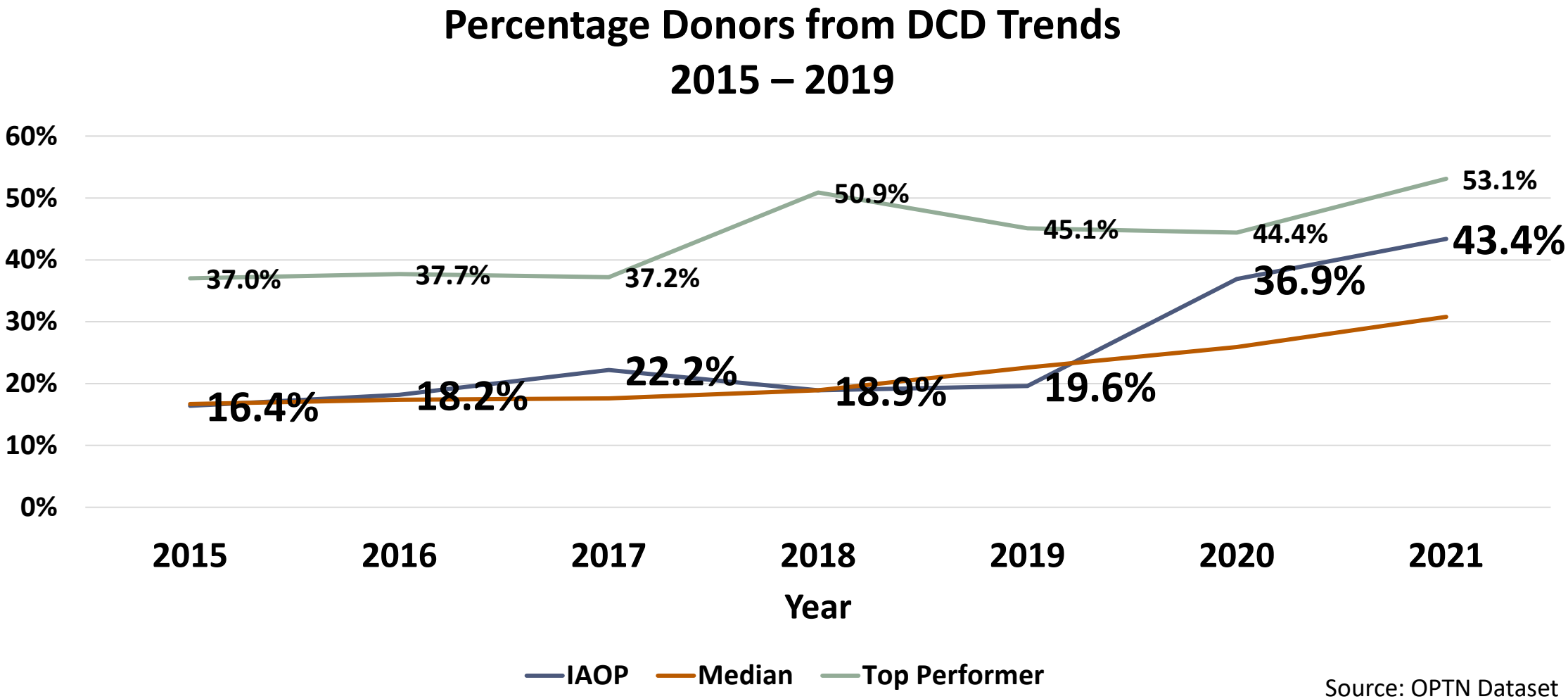
IOWA DONOR NETWORK

Impact



IOWA DONOR NETWORK

Where are we now?



Source: OPTN Dataset

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Q&A
QUESTIONS & ANSWERS

THE Alliance

Leadership & Engaged Learning in Organ Donation & Transplantation

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