Rethinking Organ Intake: The Effects of Allocation Changes and Staffing Shortages on Clinical Productivity

TODAY'S PANELISTS

Karleen DeGroodt
RN, MSN, CPTC, CCTC
Clinical Program Coordinator
Cedars Sinai Medical Center

Angie Korsun
Executive Director of Advanced Organ Management
Banner University Medical Center

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

Tuesday, October 11, 2022, 2:00pm – 3:00pm ET

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Deanna Fenton

Senior Manager, Educational Program Development & Operations

THE Alliance

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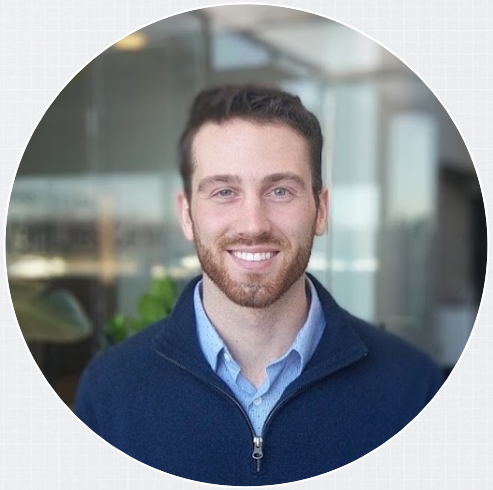

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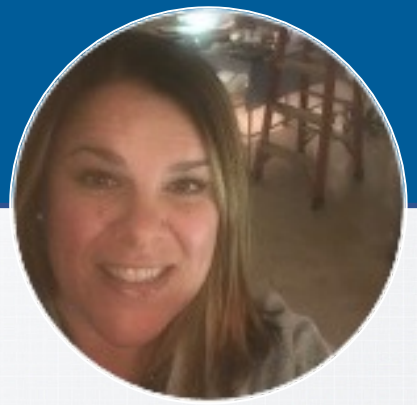
Meet Our Panelists



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Banner University Medicine

Angie Korsun, RN, MSN,MPA
Executive Director,
Transplant/MCS Services
Banner University Medical Center; Phoenix & Tucson

Oct 11, 2022

Re-thinking Organ Intake

- **The effect of Allocation Changes and Staffing shortages on Clinical productivity**

Donor call team management history

- Transplant Coordinator is key transplant team member
- Historically the transplant coordinator, usually an RN, routinely had on call responsibilities that included fielding and managing organ offers made to the program.
- This also included fielding sick patient calls therefore being very busy while on call. While the coordinator role is interesting and attractive in many regards; certain job aspects become difficult to deal with over time.

Challenges

- As organ allocation models changed, as there were more regulations and time pressures while handling organ offers as well as all the other clinical workload, questions arose about staffing and overall workload.
- Increasingly issues arose about what is the right model for managing call responsibilities and its impact on staffing, effectiveness and transplant center expenses.

Factors to consider

- The work environment and caseload will vary from program to program.
- Union environment vs non-union setting impacting work rules
- What is the MD process for handling organ offers. Expectations of what is needed can vary amongst the team.
- What are on call responsibilities, how often, does this include; assessment of organs, handling imports, call to set up transplant vs sick patient call.
- Single organ program vs multiple programs

More factors to consider

- The coordinator job is challenging since it is central hub of the transplant program.
- Programs vary as to caseload that each coordinator carries. Do all coordinators take call, or just pre transplant coordinators?
- Are coordinators able to take the following day off if they have had a very busy on call night, come in late? Or do they still have a full workload facing them in am?
- What organizational systems are in place to support efficient processes?

Possible solutions

- This is not a “one size fits all” process
- Some programs feel that its important that the clinical coordinator, who knows the patients, MD’s and process, is the on-call person (**status quo**)

- Second option: contract with a third party coordinator group to handle donor offers to the program
- Third option: Set up internal Donor Call Center to manage all organ offers and could also manage sick patient calls.

Pros and cons of each model

- **Status Quo**:
- Staffing – do you have enough coordinators to handle the workload? How is the workload documented to track volume increases?
- Compensation concerns relative to being up all night. Are the staff salaried, hourly, paid stipend for each transplant, etc.
- On call frequency and intensity, impacted by FTE numbers
- Ability to manage multiple offers and set up cases overnight and then still come into work in the am and be able to function in clinic or in office?

Status quo issues

- Is the on-call workload contributing to staff dissatisfaction with the role and turnover?
- Are there issues with staff being overtired and productivity in office/clinic being impacted?
- Is documentation being done as needed for the transplant and other activities ?
- Are there support staff on the team to assist the coordinators in workload, processing phone calls, documentation of information for OPO; TIEDI forms, etc.
- Are there OT cost concerns? Can you combine call between programs and reduce frequency

Option 2: Third party handling organ offers

- Outsource call duties to one of several coordinator call companies available nationally.
- Cost issues as well as contract approval process to consider. Getting buy in from multiple stakeholders (MD's, coordinators, OR, OPO, etc.)
- Need to define the scope of what is to be handled by the contractors
- Screen offers and once accepted by MD, turn over to coordinators? Still need coordinator call
- Screen offers and coordinate the transplant admission and case? Can they access your EMR and document in the record as if they were a team member?
- Need to have team consensus on their scope of duties and SMT approval for access into the EMR

Option 2 con’t

- Can augment your staffing and reduce workload.
- Need process to review work done by contractor and provide regular feedback on what is working or not
- Security concerns may arise with areas such as IT when access to the EMR is requested
- Consistency of the staff assigned to work with your organization is important so they can become familiar with your organization, team members and preferred process

Option 3: Internal Call Center

- Does the case volume and organ offers volume justify the new FTE's?
- Can you utilize existing FTE's by re-allocating some work from the coordinators?
- What is the right staffing mix: all RN's; mix of RN's and other category?
- May need justification to SMT for FTE's that could be offset by eliminating OT, cost of third party contract and staffing turnover costs.
- Need to consider scope of work expectation, training of personnel, MD's need to support this effort and participate in training
- Who supervises and supports the team?

Option 3 continued

- Often, eliminating call pay for the coordinator team can cover cost of several FTE's, if there are contracts with the OPO to handle expanded call responsibilities, that cost can be reduced or eliminated.
- Training is challenging; need leader for the group; need solid orientation to ensure comfort with screening and communication process.
- Involve the OPO in the training process, where possible. Excellent resource.
- When such a Call group is present, they often quickly identify discrepancies in process amongst programs which can lead to confusion.
- Byproduct of this process is a push for more standardization for how offers are screened and handled

Option 3 con’t

- Need to look at tools available to facilitate the work (UNeT filters)
- What reports are available in your EMR that can be used to summarize pertinent data on your listed patients?
- How are you ensuring that the communication done amongst team members is documented, is done in HIPAA secure manner?
- External options that can facilitate communication (Omnilife Software)
- Multiple communications needed to all stakeholders when coordinating a transplant and some items repeated multiple, esp when there are delays

Option 3, con’t

- Need to document some of these communications to ensure consistent message is heard by multiple parties
- Also need to ensure that message is consistent and not deteriorating due to human factors such as tiredness or confusing cases
- Personnel in these roles need to be very organized and able to juggle multiple cases simultaneously
- Important to have trusting relationship with the medical team working on these organ offers so that communication is clear and concise

Summary

- Model has to work for your facility and situation
- Can vary based on your circumstances
- Need to leverage tools to support the work, regardless of the model chosen (EMR, reports, clinical alerts, communication software, etc.)
- Is expensive regardless of what model is chosen as allocation changes have resulted in far more offers being made and they need to be touched one way or the other
- Few people outside of transplant realize the time pressure and constraints that much be dealt with in managing organ offers
- But this is a critical investment, regardless of the model

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KARLEEN DEGROODT MSN, RN, CPTC, CCTC

HEART/LUNG TRANSPLANT COORDINATOR, CEDARS SINAI

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Old vs. New Allocation-Heart

OLD ALLOCATION SYSTEM	
STATUS	CRITERIA

1a	• MCS with hemodynamic decompensation
	  ○ VA ECMO
	  ○ IABP
	  ○ TAH
	  ○ VAD
	• MCS with device related complications
	• Continuous mechanical ventilation
	• Continuous IV inotropes with hemodynamic monitoring

1B	• Continuous IV inotropes without hemodynamic monitoring • Stable LVAD/ RVAD
2	• All other candidates

NEW ALLOCATION SYSTEM	
STATUS	CRITERIA
1	• VA ECMO • Non-dischargeable Bi-VAD • MCS with arrhythmias
2	• Dischargeable RVAD/ Bi-VAD • Non-dischargeable LVAD • IABP or other percutaneous MCS • MCS with malfunction • Sustained VT/VF
3	• Continuous IV inotrope with hemodynamic monitoring • 30-day exception time for LVAD • MCS with complication
4	• Continuous IV inotrope w/o hemodynamic monitoring • Stable LVAD • CHD • Restrictive cardiomyopathy • Re-transplant
5	• Multi-organ transplant
6	• All other candidates

Old vs. New Allocation-Heart

Old

- 3-tiered system
- Inadequate risk assessment
- Resulted in pts with a lower mortality risk being transplanted before sicker pts. Ex: LVAD with driveline infection (status 1A) vs. ECMO (also status 1A)
- Did not require objective measurements to justify the listing

New

- 6-tiered system
- Narrows risk assessment to better highlight sickest pts
- Pts with the highest risk of mortality are transplanted first Ex: ECMO (status 1) transplanted before LVAD with driveline infection (status 3)
- Required objective measurements to justify listing

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Shore, S., Golbus, J. R., Aaronson, K. D., & Nallamothu, B. K. (2020). Changes in the United States Adult Heart Allocation policy. *Circulation: Cardiovascular Quality and Outcomes*, *13*(10). https://doi.org/10.1161/circoutcomes.119.005795

Implications of Allocation Changes-Recipients

- Increase in offers for sickest pts and narrow down the mortality risk from a 3-tiered to a 6-tiered system
- Increase in activity for transplant centers that have recipients that are sicker or can place IABP instead of VAD and sending pt home
- Decreased wait times for sickest patients

    -Status 1 transplanted typically within one week

    -Status 2 is the most common status to be transplanted

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Dedicated Call Team Heart/Lung History-Cedars Sinai

- Prior to 2018, office-based staff (pre/post-transplant) took call on random days of the month while juggling inpatient and office responsibilities
- In 2018 Cedars developed a dedicated remote team started with four RNs that made up the heart/lung call team. After two months of training went live on February 1, 2019
- Late 2019 it was recognized that a 5th person was needed for the call team
- 2022 due to an increase in activity because of more aggressive lung acceptance and the initiation of the DCD heart program, a 6th person was added to the call team
- Dedicated call team has been successful-kidney/panc has developed their own call team and liver plans to asap

Implications of Allocation Changes-Staff

- Difficult to manage the in-office job duties while receiving offers and setting up cases
- Multiple staff taking calls, challenging to streamline the process
- Late night organ offers = tired unproductive staff the next day
- Need for dedicated staff due to increase in offers

Benefits of a Dedicated, TXC Hospital Based Call Team

- Call team is made up of fellow hospital employees who understand the inner workings of the facility and the transplant program
- Call team knows the minute details of each of the sickest recipients. Age, height, medical hx, family dynamics, VS, labs, personalities, etc.
- Patient safety is maintained as a top priority with the call team attending selection, and ad hoc meetings, and are viewed as a critical member of the transplant process
- Initiation of guidelines and workflows that are streamlined and standardized
- Better data tracking due to standardized job functions
- No distractions during the review of offers-clinic, rounds

Benefits of a Dedicated, TXC Hospital-Based Call Team

- Can respond to offers in a timely manner, while following UNOS rules
- Each team member has taken on additional projects that relate to the improvement of the transplant process

  -Guidelines on covid acceptance criteria, workflows that streamline tasks, development of checklists, and collaboration with internal and external stakeholders to improve process flows: pharmacy, OR, procurement, NPs/PAs, OPOs

- Promotion of work/life balance and retention. In the 4 years, since the call team started, we have only had one RN resign

Questions?

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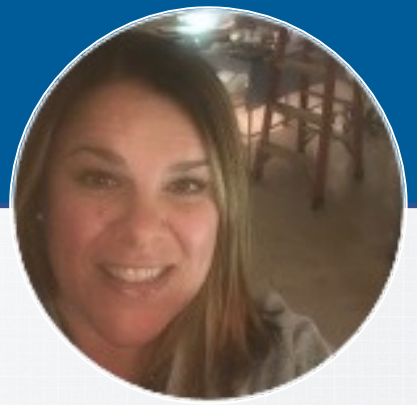
A Special Thanks to Our Panelists



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Q&A
QUESTIONS & ANSWERS