Maximizing Donation Outcomes: Centralized DCD Recovery Strategies

TODAY'S PRESENTERS

Sara Angle
RN, BSN, CPTC
Organ Team Supervisor

DONOR CONNECT
GIVE HOPE. HEAL LIFE.

Thalisa Callaghan
BS, CTBS
Hospital Development Manager

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Jeff Pace
RN, EMT-P
Manager of Transplant Services

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WE RESTORE LIVES

THE Alliance | *Equipping a Modern Profession of Lifesavers in Organ Donation & Transplantation*

Tuesday, May 7 2024, 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

Senior Manager, Program Development and Operations

THE Alliance

Need Assistance?

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

Meet Our Moderators

Jaclyn Russe

MSN, RN, CPTC, CCRN

Manager of Organ Services

NEVADA DONOR NETWORK
— Hope · Strength · Life —

Sara Bowman

RN, BSN, CPTC

Director, Organ Recovery Services

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Maximizing Donation Outcomes: Centralized DCD Recovery Strategies

Thalisa Callaghan, Hospital Development Manager

Objectives

- Review how Lifesharing implemented DCD transfers to our CTC.
- Explore challenges in implementing the process and how we navigated solutions that have allowed this process to be successful.
- Explore hurdles experienced by families with donor transfers for DCD recovery.
- Learn about successful strategies and best practices in centralized DCD recovery.

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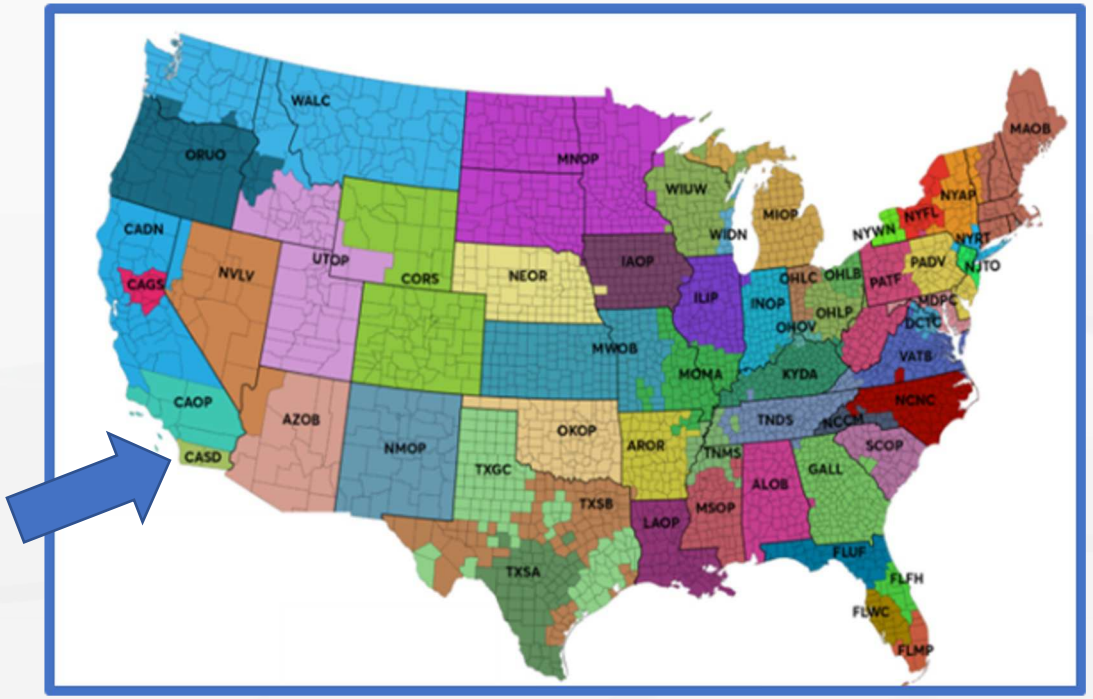
Lifesharing

- DSA: 2 counties, 28 hospitals, 4 transplant centers
- Roughly 3.5 Million Population
- Hospital Based OPO (UCSD)
- 2023 Metrics:
  - 171 Donors Recovered
  - 494 Organs Transplanted



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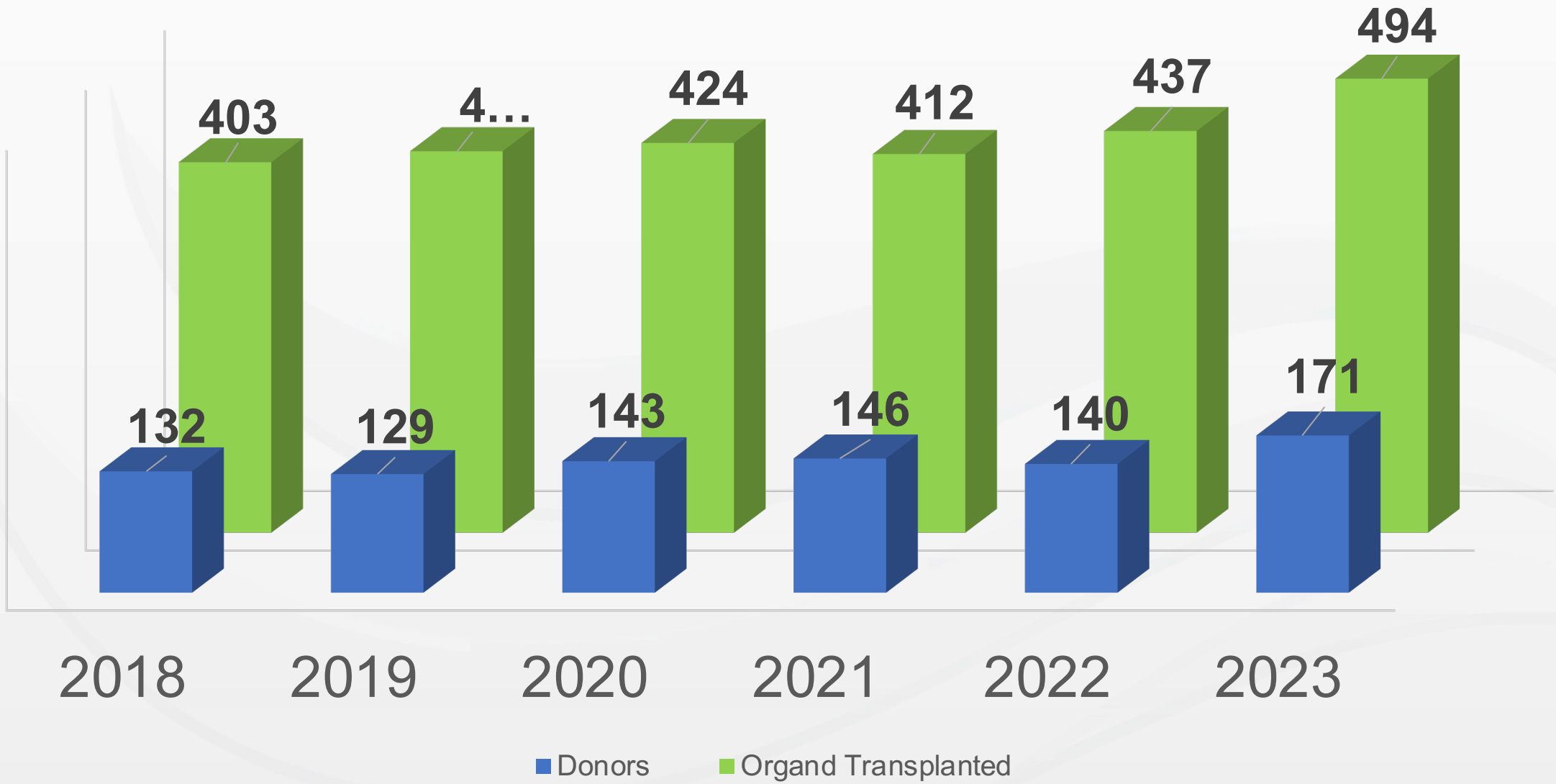
Lives Saved


403
4…
424
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143
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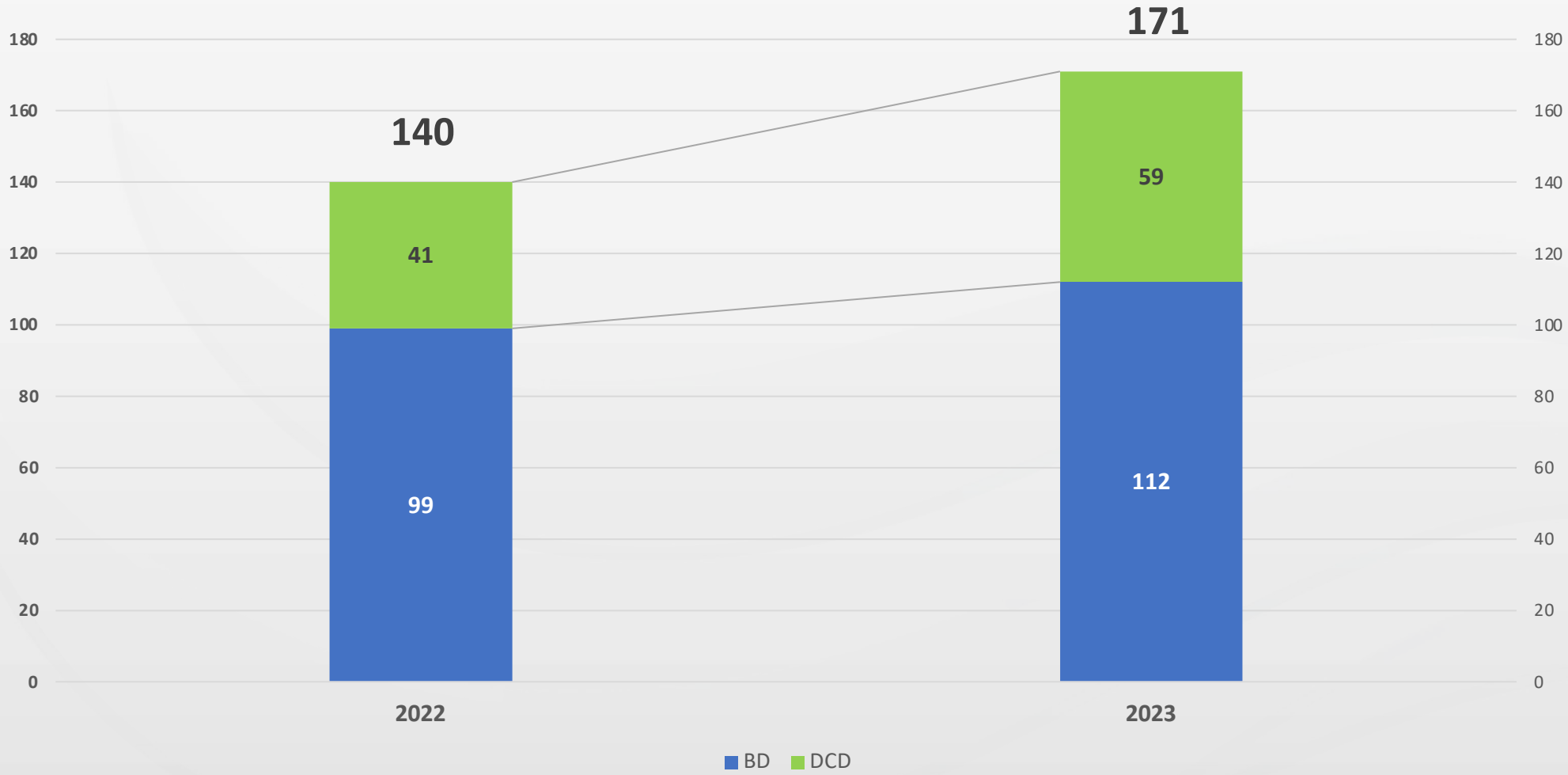
171
2018
2019
2020
2021
2022
2023
Donors
Organd Transplanted

Lifesharing total number of donors
2022 vs. 2023



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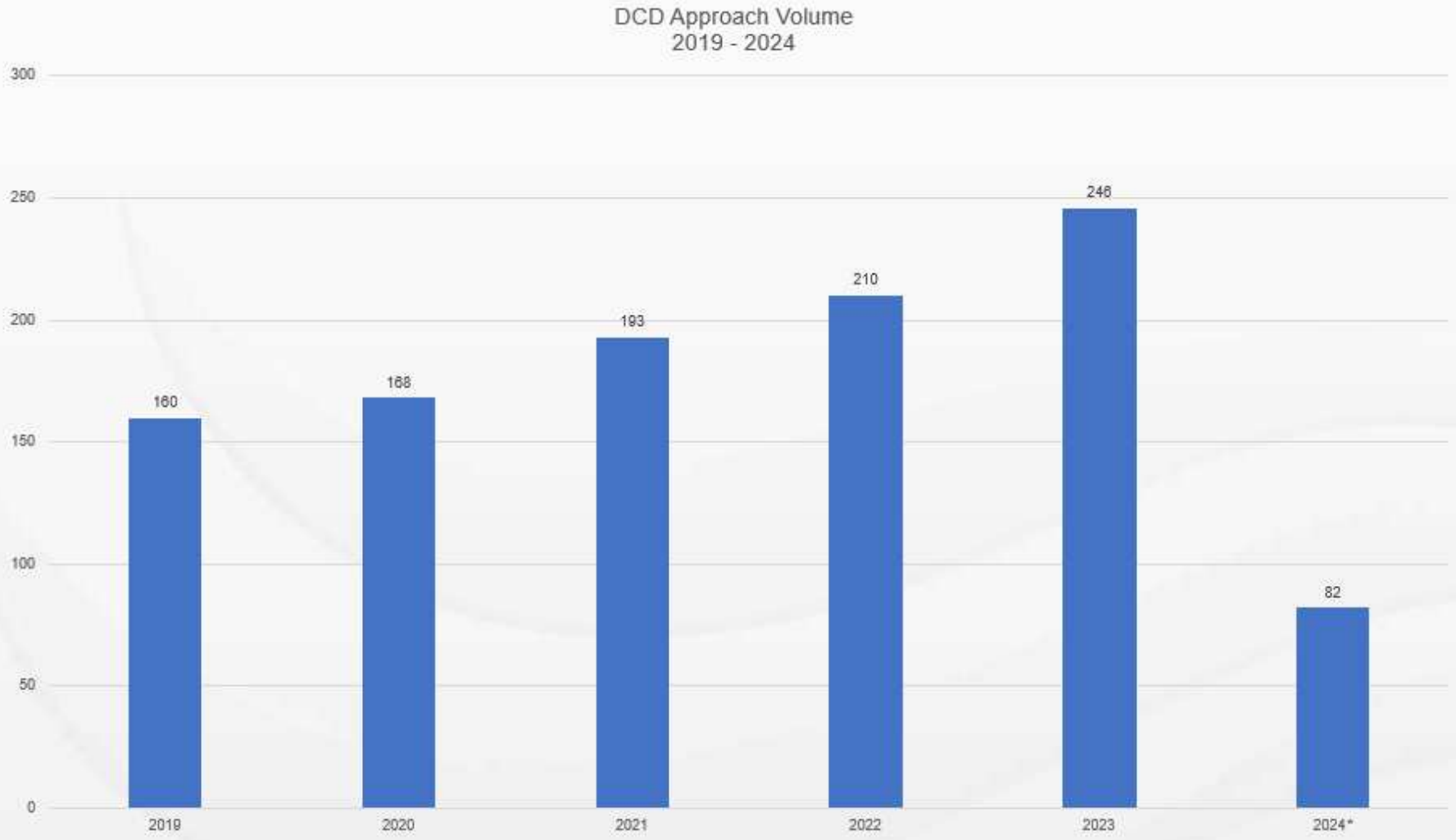

* Note: As of 4/30/2024

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Scripps Launches Region's First Centralized Organ Recovery Center

September 1, 2020

Goal is to help save more lives by increasing number of donated organs for transplant

In a move designed to increase the number of viable organs available for patients who need life-saving transplants, Scripps Health today has launched a centralized system for retrieving organs from deceased donors.

Scripps Green Hospital in La Jolla will serve as the new single location for managing the complex process of collecting organs from deceased donors for transplant. Deceased donors will be transferred to Scripps Green, where a dedicated organ recovery program has been established to offer the specialized medical management that is needed for optimal organ recovery.

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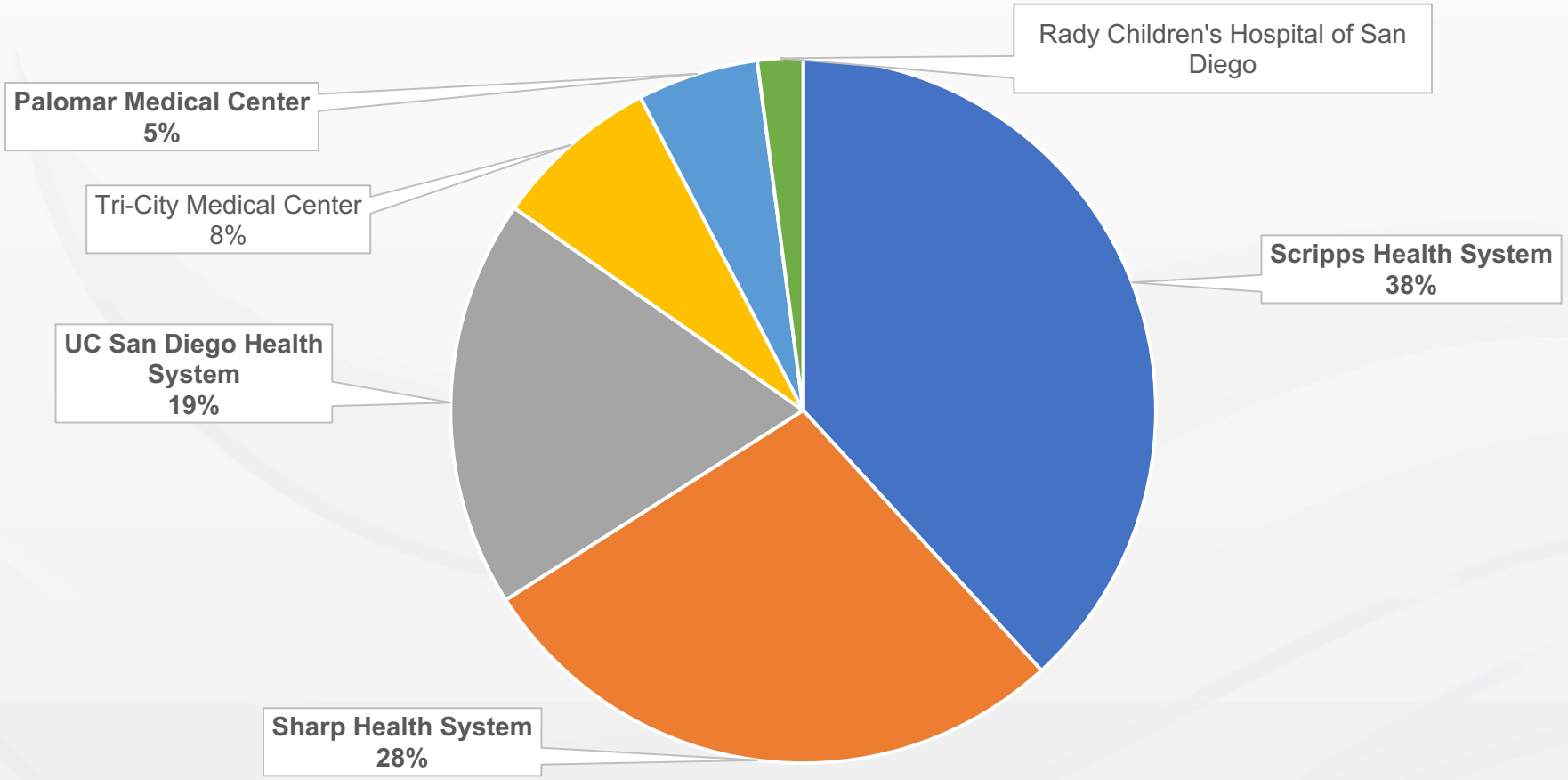
Donors Recovered by Hospital: 2023



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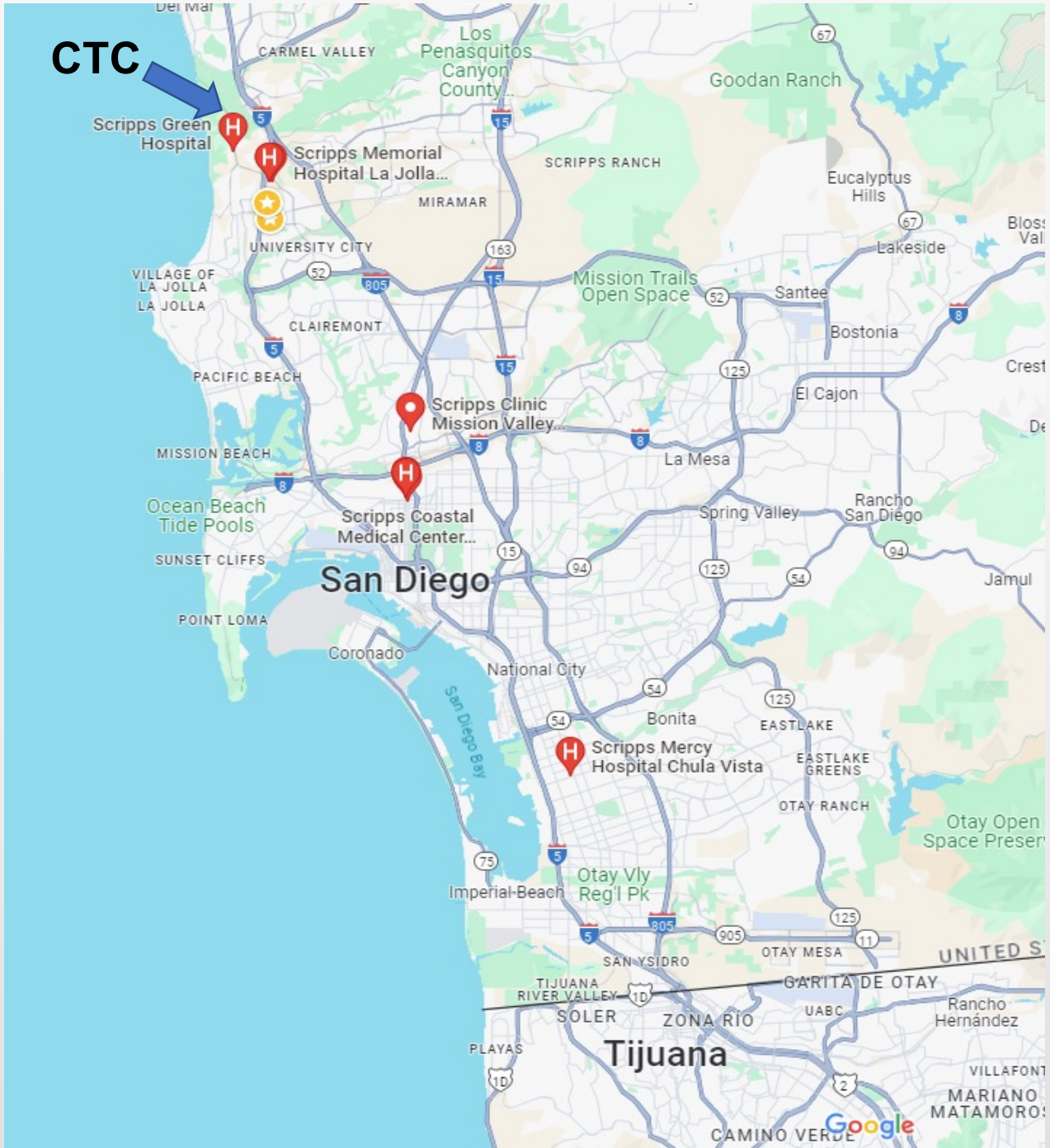

CTC
Scripps Green Hospital
Scripps Memorial Hospital La Jolla...
Scripps Clinic Mission Valley...
Scripps Coastal Medical Center...
Scripps Mercy Hospital Chula Vista
CARMEL VALLEY
Los Penasquitos Canyon County...
Goodan Ranch
SCRIPPS RANCH
MIRAMAR
Eucalyptus Hills
Lakeside
UNIVERSITY CITY
VILLAGE OF LA JOLLA
LA JOLLA
Mission Trails Open Space
Santee
Bostonia
CLAIREMONT
PACIFIC BEACH
El Cajon
MISSION BEACH
La Mesa
Ocean Beach Tide Pools
Spring Valley
Rancho San Diego
SUNSET CLIFFS
San Diego
Jamul
POINT LOMA
Coronado
National City
Bonita
EASTLAKE
EASTLAKE GREENS
OTAY RANCH
Otay Open Space Preserv
Otay Vly Reg'l Pk
Imperial Beach
San Diego Bay
OTAY MESA
SAN YSIDRO
TIJUANA RIVER VALLEY
GARITA DE OTAY
SOLER
ZONA RIO
UABC
Rancho Hernández
PLAYAS
Tijuana
VILLAFONT
MARIANO MATAMOROS
CAMINO VERDE
Google

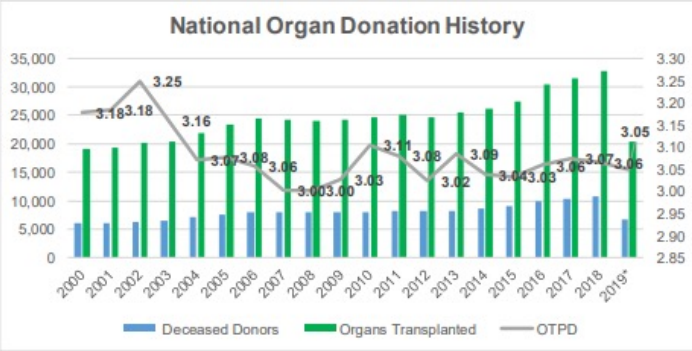
But why??

ORGAN DONATION REGIONAL RECVERY CENTER

More than 112,000 Americans are currently on the national waitlist, with over 7,000 of them dying each year while waiting on an organ. Organ Procurement Organizations (OPOs) are federally-designated non-profit entities charged with preserving and maximizing donation options when they occur. OPOs seek and implement new and innovative ways to increase donation. One of the most successful of those innovations in recent years has been the **Regional Recovery Centers.**

The physiologic management of the organ donor and the process of organ donation has changed very little over the last 20 years. While trauma care, ICU care, wound care, diabetes care and transplant medicine have all experienced dramatic improvements in patient outcomes over the last 20 years, the management of organ donation has changed little.

One measure of successful organ donor management outcomes is the number of organs transplanted per donor. Effective physiologic management of the donor should be reflected in more organs transplanted per donor but the number has as actually gone down over the last 20 years. As the organ transplant waiting list has increased dramatically and the number of donors has increased slightly, the organs number of transplanted/donor has not changed. **Organ donor management must be viewed as "specialty medicine".**



Why must organ donation be treated as Specialty medicine?

Organ donation is very rare. Only 1.5% of deaths in the entire U.S. are eligible to become organ donors. In San Diego there are only about 100 organ donors/year and they are spread over 18 hospitals. Only six hospitals have more than 10 donors/year, the remainder have between 1-4 donors/year. These donors are additionally spread over several ICUs within the hospitals. Even the busiest donor hospital has only about 20 donors/year, or 2/month across three ICUs. It is impossible for physicians, nurses, respiratory therapists and other clinicians to maintain expertise with organ donor management. The physiologic management of an organ donor is complicated

* Organ Donor Recovery Performed at an OPO Based Facility Is an Effective Way to Minimize Organ Recovery Costs and Increase Organ Yield. *Journal of the American College of Surgeons*, April 2016 (Vol. 222, Issue 4, pp. 591-600). DOI: http://dx.doi.org/10.1016/j.jamcollsurg.2015.12.032.

and vastly different than of the treatment protocol in place for patients prior to brain death. The responsibility has been left to the Organ Procurement Organizations.

Organ Procurement Organizations hire nurses as Organ Procurement Coordinators (OPC) and train them on the process of physiologic management of the organ donor. It is their responsibility to direct the bedside nurse and other medical professionals about the goals of treatment and donor evaluation. Every 12 hours the OPO staff must then re-train the bedside nurse, respiratory therapist, charge nurse and relief nurse about the process of donor management. The OPO must rely on the physician groups at the Donor Hospital to insert lines and perform diagnostic tests and procedures, all on a patient that has died. The OPOs and physician groups find it difficult to get these lines and tests accomplished in a timely manner because the priority is on the living patients and thus the OPO's deceased donors typically have to wait until the end of the day or the next day for these physician services. This is not efficient or effective. It prolongs the process and puts the donor organ systems at risk due to postponed procedures and tests. **Regional Recovery Centers have been shown to successfully improve donor outcomes.**

Why a Regional Recovery Center?

Once organ donation is authorized, a brain-dead donor is transferred to the Regional Recovery Center (RRC) for donor management and organ recovery. These Centers can be hospital-based or free-standing. Hospital-based Regional Recovery Centers have their Intensivist group admit the donor to the ICU, implement donor protocol, place lines, order testing and stabilize the donor. The organ recovery times are pre-determined for ease of scheduling. Independent Regional Recovery centers have donor care units, operating rooms for organ and tissue recovery, point-of-service laboratory services and diagnostic testing capability. Donors are attended to by specially-trained critical-care nurses, all under the guidance of the OPO's Medical Director. Most importantly, the overall donor management and organ recovery processes are essentially the same as those performed in the hospital where the donor originated – **but with significantly improved outcomes**. With thousands of donors transferred to these Centers to date, significant increases in organ transplants have been achieved.

Studies* have shown that Organ Recovery Centers:

- Reduce the time spent between organ recovery and transplantation;
- Improve outcomes for transplant recipients;
- Increase the average number of organs recovered from each donor;
- Reduce the overall costs associated with organ recovery;
- Reduce donor operating room delays at the originating hospital; and
- Reduce errors and increase quality in the organ recovery process.

* - Organ Donor Recovery Performed at an OPO-Based Facility Is an Effective Way to Minimize Organ Recovery Costs and Increase Organ Yield. *Journal of the American College of Surgeons*, April 2016 (Vol. 222, Issue 4, pp. 591-600). DOI: http://dx.doi.org/10.1016/j.jamcollsurg.2015.12.032.

There are a dozen or more successful Regional Recovery Centers actively managing the donation process in the U.S.

Regional Recovery Centers (RRC):

Non Hospital Affiliated RRC	Hospital Affiliated RRC
Los Angeles, California (CAOP)	Houston, Texas (TXCG)
Denver, Colorado (CORS)	San Francisco, California (CADN)
New Orleans, Louisiana (LAOP)	Dallas, Texas (TXSB)
Jackson, Mississippi (MSOP)	
St. Louis, Missouri (MOMA)	
Ann Arbor, Michigan (MIOP)	
Cleveland Ohio (OHLB)	
Pittsburgh, Pennsylvania (PATF)	

How does it help the Donor Hospital?

Once donation is authorized, the donation process puts additional burdens on the hospital ICU and staff. The average time from authorization to completion of the organ recovery in San Diego is 50 hours. At a busy donor hospital this can capture 41 ICU bed days/year just with organ donors. The donor requires the Medical Staff to perform procedures and diagnostic testing, a 1:1 nursing ratio with an experienced ICU nurse and focused attention from Respiratory Therapy. The care of the donor immediately moves forward very rapidly with:

- Complete change in medical management and order sets
- Line placement
- Advanced hemodynamic monitoring
- Weaning off of all drips
- Extensive hourly pulmonary toilet with serial bronchoscopies
- Extensive lab draws
- CT Scan
- Echo – possibly serial
- Cardiac Cath
- Bed side liver biopsies

The transfer of a donor to the Regional Recovery Center allows the Donor Hospital to focus on the authorization process without worry about staffing or beds, continue "own" the donor as a patient, celebrate the authorization and support the family prior to transfer. The transfer of the donor opens up ICU beds at the donor hospital, reduces stress on the hospital staff and avoids challenging O.R. times, changes, bumping cases and extensive overtime.

The donor family continues to receive focused support by the OPO Personnel and the RRC personnel including private waiting/sleep rooms. The outcome of the donor is reported back to the Donor Hospital to celebrate the lives saved by their patient.

* - Organ Donor Recovery Performed at an OPO-Based Facility Is an Effective Way to Minimize Organ Recovery Costs and Increase Organ Yield. *Journal of the American College of Surgeons*, April 2016 (Vol. 222, Issue 4, pp. 591-600). DOI: http://dx.doi.org/10.1016/j.jamcollsurg.2015.12.032.


Geisel Pavilion

Who doesn’t like a room with a view?!

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First Steps

- Streamline process
- Simplify process
- Implement process

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It takes a village!

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EMR transfer process

Scripps Epic Training

Organ Procurement Quick Summary

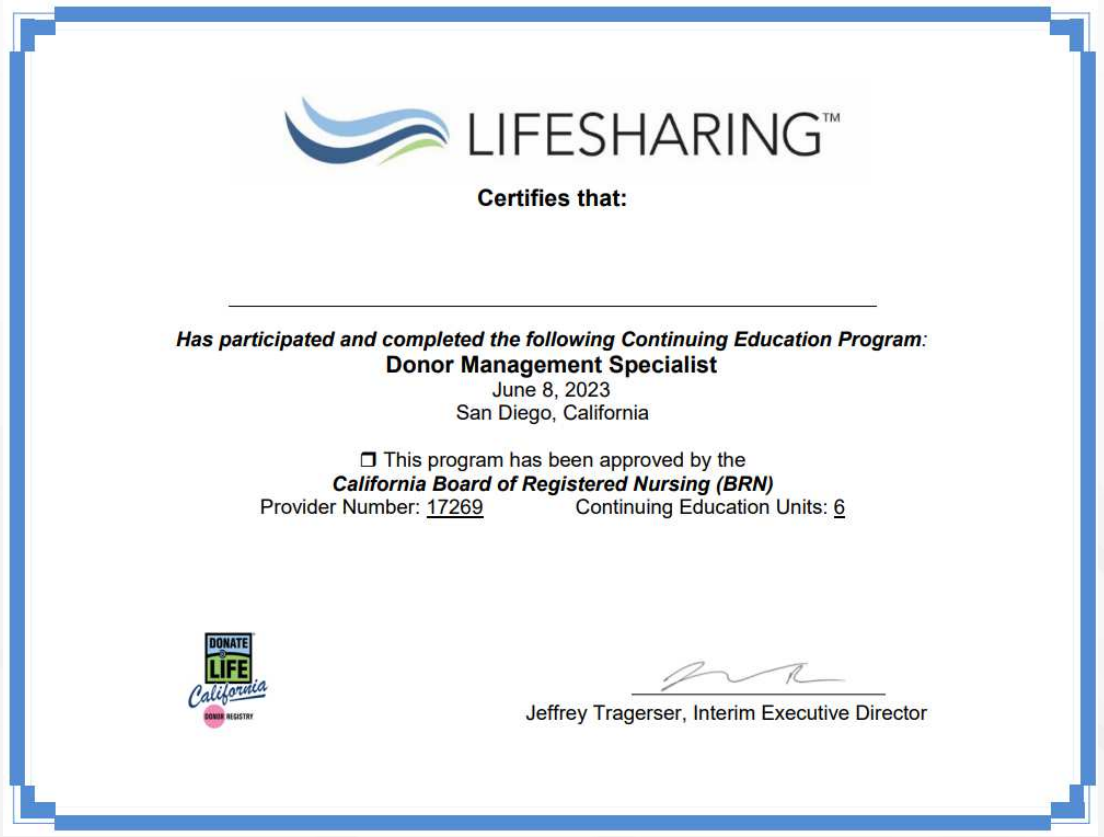
There are a few scenarios in which a patient may be designated a Lifesharing patient. You will find step by step details for the process that will be outlined below in further detail throughout this document.

Scripps Green Hospital (SHGH) is our designated organ procurement facility. Most admitted patients at a Scripps facility that expire of Brain Death and is a candidate for organ procurement, will be transferred to Green Hospital. Circulatory death (DCD) procurement patient may be transferred to Green prior to DCD or may be procured at same site.

Same Site Procurement	Transfer to SHGH Prior to Expiration (DCD Case)	Transfer to SHGH After Expiration (Brain Death Case)
Complete patient expiration documentation	Provider completes Discharge Readmit workflow	Complete patient expiration documentation
Pend discharge in unit manager	Arrange transport to SHGH	Pend discharge in unit manager
Send to OR	Discharge Patient	Order Leave of Absence (LOA)
OR completes discharge	Green accepts admission	Arrange transport to SHGH
	Complete patient expiration documentation	Put patient on LOA in unit manager (do not hold old bed)
	Pend discharge in unit manager	Green ICU receives patient
	Send to OR	Green pends discharge in unit manager
	OR completes discharge	Send to OR
		OR discharges patient
		OR calls CTC to discharge LOA encounter

Next Steps…

- Family Services Resource
- Donor Management Training
- EDUCATION!!
- Resource guides



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Certifies that:

_____

Has participated and completed the following Continuing Education Program:

Donor Management Specialist

June 8, 2023

San Diego, California

❒ This program has been approved by the

California Board of Registered Nursing (BRN)

Provider Number: 17269 Continuing Education Units: 6

DONATE LIFE California DONOR REGISTRY

Jeffrey Tragerser, Interim Executive Director

Guidance doc:

PROCESS FOR TRANSFERING SCRIPPS BRAIN DEAD/DCD ORGAN DONORS TO SCRIPPS GREEN RECOVERY CENTER

Goal: Transfer Donor ***within 3-4 hours of authorization***

1. **PRIOR TO APPROACH:** **Lifesharing OPC will** ensure that there are two signed brain death notes **BEFORE** commencing the transfer process for BD patient. Please refer to Brain Death Navigator EPIC Workflow Doc in Teams for correct BD note.

   Lifesharing AOC/OPC will contact on call Scripps Green Navigator **prior** to a BD/DCD approach at a Scripps hospital to prepare for navigation. They will be OPC's point person during entire process.

   Families will be approached by Lifesharing for donation and the Scripps transfer process will be explained. If needed Scripps Navigator can be onsite to assist (when available).

AUTHORIZED DONOR:

2. **Lifesharing OPC** complete the Lifesharing Transfer Handoff Form if needed for Green report (see attached).
3. Obtain Cardiac Cath at hospital (if needed) prior to transfer. Ask Film Library to push images to Nucleus. Film Library: (858) 626 6883. Notify Scripps Green Navigator to assist with burning a disc if done at Green.
4. **Lifesharing OPC will** call the Central Transfer Center CTC (858-678-6205) to arrange transfer and receive bed #. Notify them if patient is BD or DCD.
5. **Scripps CTC will** call Scripps Green ICU charge nurse (858 554 4640) and confirm ICU bed is ready and accepting CCMD. Complete patient report hand-off RN to RN and MD to MD prior to transfer.
6. **Scripps CTC will** call back Lifesharing OPC and provide the Scripps Green bed assignment and accepting CCMD.
7. **Lifesharing OPC will** call Scripps CCT (Critical Care Transport) 858-322-9058 to set up transfer, if not available, call AMR (858-492-8111), for BD and DCD donors.
   ***If using AMR please remember to ask to "flag or note" the transfer as a Lifesharing case for finance reasons.
8. **Lifesharing OPC will** call back the CTC and Scripps Green ICU to notify them of transport's ETA.
9. **Lifesharing OPC** will inform bedside RN of CCT/AMR ETA to prepare for transfer out Honor Walk (if applicable). Factor in for HW timing, approx. 45-60 minutes is needed for transport to prepare patient for transport out of unit.
10. Prior to transfer **Scripps donor hospital bedside RN/MD** will complete patient expiration paperwork (PLEASE DO NOT discharge pt as deceased for BD or DCD!).
    FOR BD: Complete patient expiration documentation. Pend discharge in unit manager. Put patient on (LOA) Leave of Absence in unit manager (do not hold bed)
    For DCD: Provider completes Discharge Readmit workflow. Discharge patient as Scripps Transfer.
    *Please have Scripps bedside RN print the AVS transfer report for AMR. (including Facesheet, Discharge summary and expiration paperwork with TOD and MD who declared).
11. **BD only:** ***BEFORE** leaving donor hospital*, **Lifesharing OPC will** send admit blood to MEO (when applicable.)
12. **BD only:** ***BEFORE** leaving donor hospital*, **Lifesharing OPC** will obtain copy of Scripps COD/Expiration Doc form printed from EPIC and completed by pronouncing physician.

*Also obtain Cardiac Cath disc from Radiology if done and unable to push to Nucleus.

REGISTERING DONOR IN UNET and dD: BD and DCD

Lifesharing OPC will:

1. List donor hospital as the hospital the donor was transferred from.
2. Select "Alternate Facility' as the "Recovery Facility"
3. In Digital Donor (dD) change Organ Recovery Facility to Scripps Green, in IntraOp tab

ADMISSION TO GREEN ICU:

1. **Scripps Navigator will** meet the donor family at Scripps Green to escort them to the dedicated donor family room. The Scripps Navigator will provide instructions on hospital access and will assess any other family needs. The Scripps Navigator is a supplemental service for the families and does not take the place of the Lifesharing Family Services Specialist. Lifesharing Family Services will still provide EOL donor bereavement services.
2. If Cardiac Cath is needed page on call CCMD at Green who will call the Cardiologist to alert the Cath Lab team coordinator. Notify Green navigator to assist with disc burning and process.
3. Let Blood bank know asap (858-554-8113) if any blood is needed for any pumps prior to case. Have BsRN complete "Prepare/Transfuse" order.

PRIOR TO OR:

Lifesharing OPC will provide the following information to the OR nurse to complete discharge after recovery

- Date and Time of death from sending facility
- Preliminary Cause of death
- Medical/Legal status at time of death

Lifesharing OPC will enter EPIC OR case request under LS order set, under physician choose "Organ Procurement: Generic Surgeon". Refer to Scripps OR case request doc in Teams

Lifesharing OPC will communicate with Scripps Navigator OR time frame so that the Navigator can implement the Scripps Honor Walk.

Discharging patient:

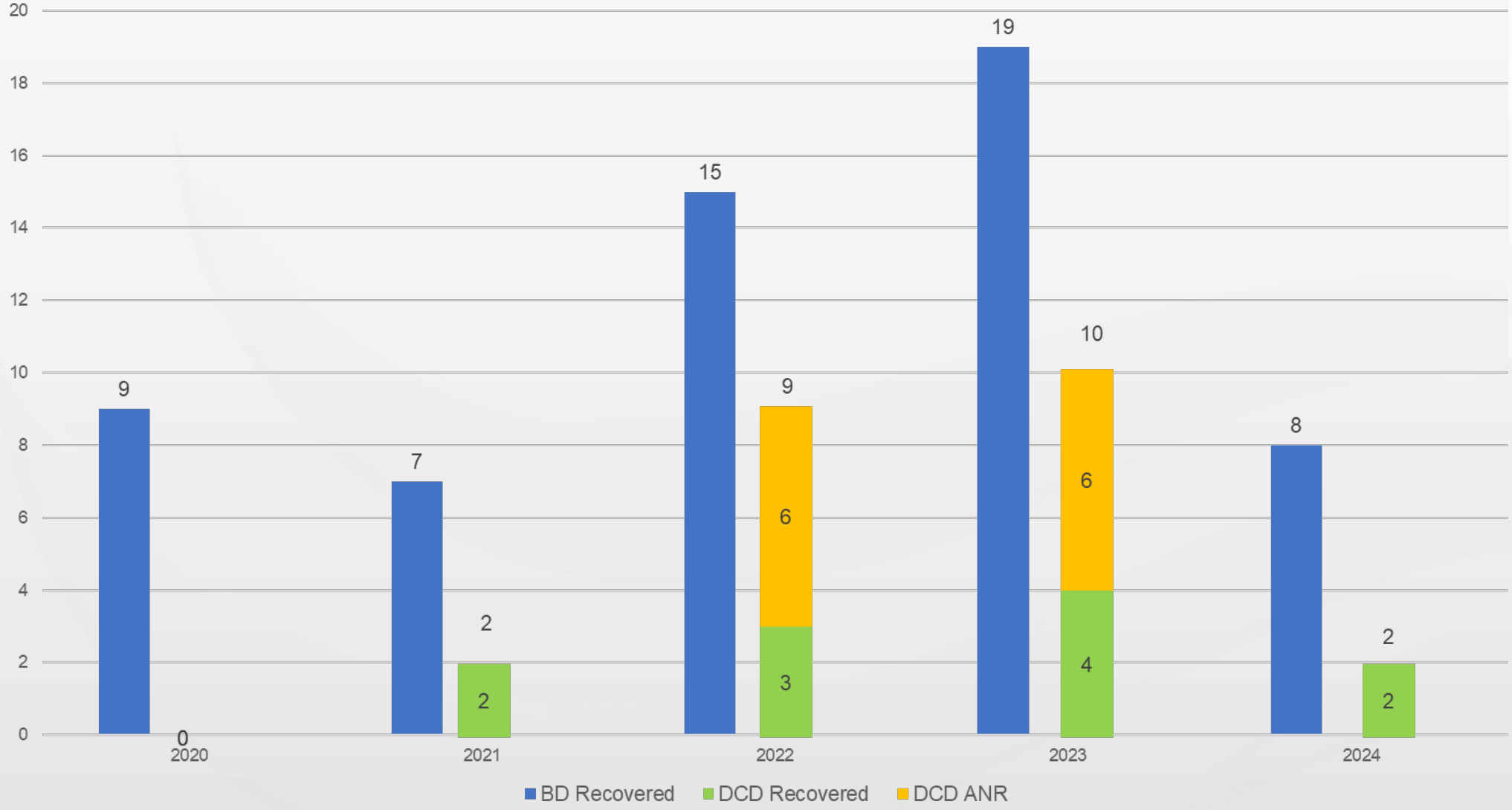
For DCD: complete pt expiration documentation. Pend discharge in unit manager. After recovery, OR completes discharge

For BD: pend discharge in unit manager, after recovery OR discharges pt, OR calls CTC to discharge LOA encounter.

OR: Lifesharing Surgical Services will remind OR to discharge the patient in EPIC so that the bed can be released.

Important Numbers	
Scripps Green ICU Manager Elaine Hennig	631-664-8335
Scripps Green Tx Director (Michelle Meyer)	858-436-4712
Scripps CTC (Central Transfer Center)	858-678-6205 (Fax) 858-678-6456
Scripps Green ICU	858-554-4640
Scripps CCT (Critical Care Transport) Use first	858-322-9058
AMR	858-492-8111
Scripps Green Navigators: Danielle Tunak Joanna Mateo	 619-907-9267 619-907-9287
Scripps LJ Cath lab normal hrs 7am-7pm	858-824-8240
Cath lab after hours	858-626-4123
Scripps La Jolla Film Library daytime hrs(can push images to Nucleus)	858-626-6883
Scripps LJ Radiology after hrs to push to Nucleus	858-280-6860
Scripps Green Blood Bank	858-554-8113

Total Number of Scripps Transfer Donors 2020 - 2024



81 Scripps transfer donors

58 BD donors

23 Scripps transfer DCD donors (ANR + Recovered) from

Note: Data for 2024 as of 4/30/2024

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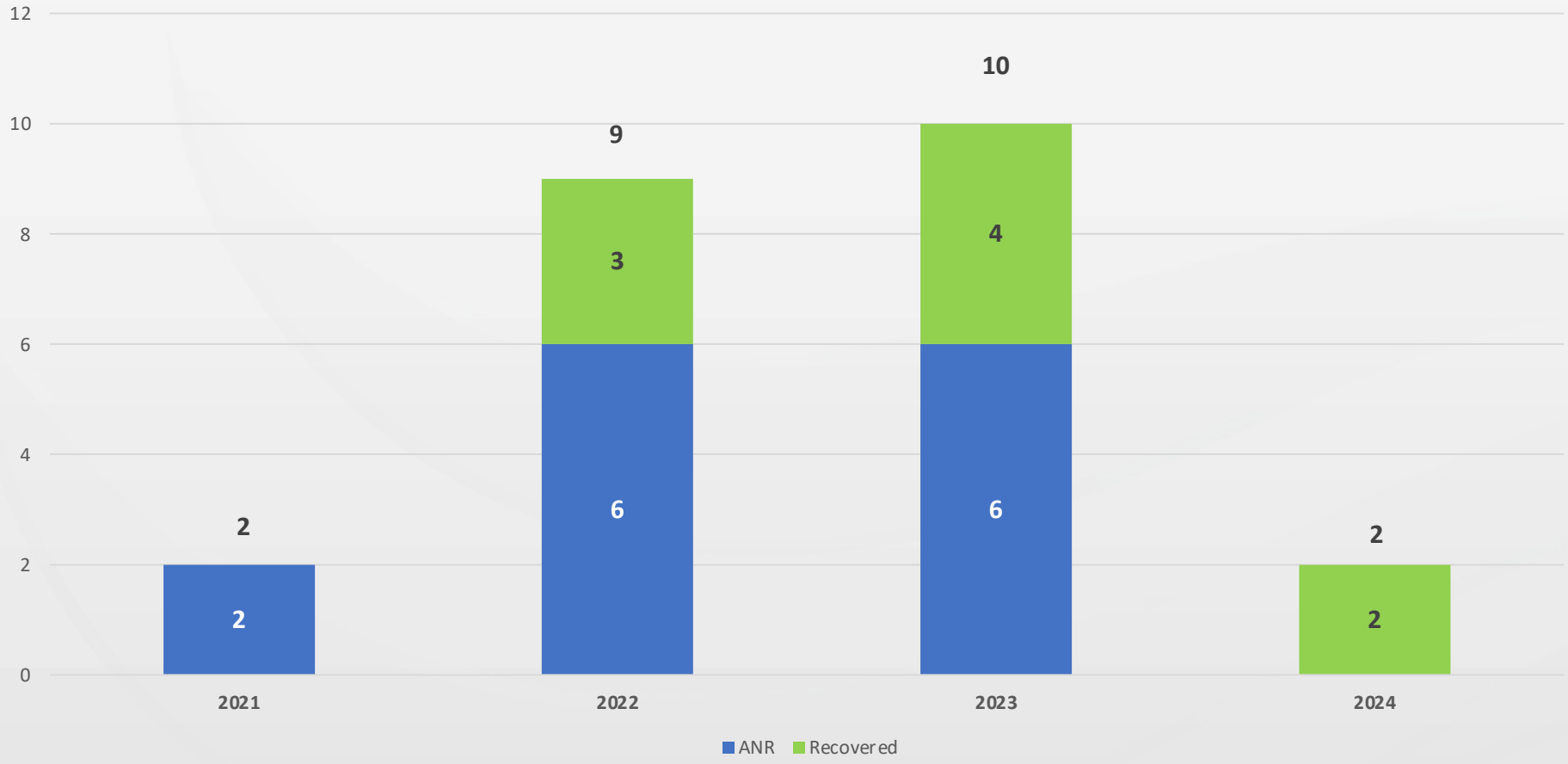
Total Number of Scripps transfer DCD donors 2021 - 2024



23 Scripps transfer DCD donors from 2021 – 2023

Note: Data for 2024 as of 4/29/2024

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Obstacles we encountered:

- Family authorization/resources, demographics
- CTC internal challenges
- Timing of transfer
- Transport process
- Heparin authorization
- Pronouncing pt?
- Reintubation of DCD lungs
- Admin Auth DCD’s-to move or not to move

DCD Wish-list

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ADULT ORGAN DONOR WORK-UP
Donation after Cardiac Death (DCD)

Requests and Recommendations

Labs Q6:

- ☐ CBC
- ☐ CMP
- ☐ Liver Panel (if not included in CMP)
- ☐ PT/INR
- ☐ PTT
- ☐ Magnesium level
- ☐ Phosphorous level
- ☐ Amylase
- ☐ Lipase
- ☐ CK, CKMB, Troponin

Additional Labs:

- ☐ Direct Bilirubin x1
- ☐ ABG x1
- ☐ UA with micro
- ☐ AFB
- ☐ Sputum Gram Stain and Culture
- ☐ 12 hr urine creatinine clearance
- ☐ CXR in AM

Management Recommendations:

- ☐ Maintain MAP >65. Add Neosynephrine as first choice vasopressor.
- ☐ If available, monitor stroke volume variation and maintain SVV 11-13
- ☐ Appropriate antibiotics as needed
- ☐ Maintain urine output >30 ml/hr with fluid boluses or diuresis as needed
- ☐ End of life orders to include comfort medications, extubation, MD/RN to pronounce etc.
- ☐ Heparin 30,000 Units IVP 5 minutes prior to extubation (separate consent obtained by Lifesharing to include witness signature from hospital staff)
- ☐ Additional requests (if needed):

_____

_____

Additional Orders Requested When Pursuing Thoracic Organs for Donation:

- ☐ Bronchoscopy
- ☐ A-line
- ☐ 12 lead ECG
- ☐ Transthoracic cardiac echo (CD of study to Lifesharing staff)
- ☐ Q6 hour ABG x2 on 40% and 100% each time (30 minutes apart)
- ☐ Q6 hour CXR
- ☐ Pulmonary toilet (suction, turnQ2) to maximize oxygenation
- ☐ Vent settings to maximize oxygenation (Maintain PF ratio >300)

DCD Guidelines

Bedside Nurse DCD Guidelines

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Thank you so much for being available to help our team save lives! We could not do this without you, so please know how much we appreciate you and your team. In order to prevent any miscommunications, we have put together this handy reference for you to refer to at any time during this process. If you have further questions, please reach out to any member of the Lifesharing team so we can assist you as best as we can.

Prior to transfer to PACU:

- The goal is to transfer the patient down to PACU 30 minutes prior to withdrawal time.
- Minimize all cords and pumps. Remove SCDs and excess pillows/blankets. Discontinue unneeded medications/interventions upon LS coordinator's instruction (ex: clamp EVD, disconnect chest tube, etc.)
- Ensure you have more than enough comfort medications to last the duration of the withdrawal period (≥ 90 minutes). Bring syringes, needles, flushes, etc. to draw up & administer all medications.
- Have heparin dose (30,000-50,000 units) via IVP ready. Dosage of heparin depends on the patient/organs being procured. LS coordinator will prompt you when to administer (5 minutes prior to extubation in PACU).
- Complete the hospital death packet as much as possible. Bring to PACU during transfer. LS coordinator can assist with any questions.

In PACU

- Settle patient, hook up to a monitor visible to LS coordinator. LS timekeeper will be recording vital signs every minute after extubation.
- Set monitor on comfort mode if possible.
- Know where to disconnect IVs, monitoring equipment, and bed PRIOR to extubation. Place A-line on the bed.
- Administer the dose of heparin upon LS coordinator's instruction (5 minutes prior to extubation).
- Continue comfort care treatment.
- Once cardiac standstill takes place and the patient has been pronounced, disconnect EVERYTHING. Un-attach all IV lines and monitoring equipment. We will transfer the patient as quickly as possible to OR once cardiac death occurs.
- Assist in transfer to OR.

Please remember, above all else, the goal is the comfort of the patient and the family. We believe that every patient deserves a dignified death and IF donation happens, that is a bonus. Lifesharing is not able to be involved in end-of-life medication decisions but we do ask that you treat this patient as you would treat any other ICU patient who was moving to comfort care. All patients deserve a comfortable death regardless of what the plan is for after they pass.

Thank you again for your collaboration with our team, you are so appreciated!

Pronouncing Provider DCD Guidelines

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Thank you so much for being available to help our team save lives! We could not do this without you, so please know how much we appreciate you and your team. In order to prevent any miscommunications, we have put together this handy reference for you to refer to at any time during this process. If you have further questions, please reach out to any member of the Lifesharing team so we can assist you as best as we can.

- First, we understand this is a significant time commitment. We cannot predict when a patient will pass, but we do ask that you please be available for the entire 90 minutes of withdrawal of care.
- Prior to extubation you may want to listen to the patient's heart tones so that you are aware of the exact areas to listen to. While this may seem redundant, time is very valuable to our team once a patient has potentially passed.
- Watch for pulseless electrical activity as it commonly occurs in our donors. Most of our donors have an A-line to help you differentiate cardiac activity from electrical activity, if not you can also use the pulse oximeter waveform as another guide to potential PEA. If you believe the patient to be in PEA it is ok to pronounce cardiac standstill at that point.
- Be prepared to enter the OR to reconfirm the cardiac time of death & cardiac standstill. It is okay to auscultate over surgically prepped areas, our surgical team will guide you and may offer you a glove to place over your stethoscope. A member of our team will remain with you and assist you with timing so you know exactly when to listen again in the OR in accordance with your hospital's policy.
- Once you have confirmed and re-confirmed cardiac standstill and the official time of death, you will need to write a death note. Documentation needs to include the following times: cardiac time of death as well as the time of reconfirmation of cardiac standstill. Please include the assessment needed for a death note per your hospital policy.
- Remember that our staff will be with you the entire time and are there to support and guide you. Please let them know if you need help or have questions.

Thank you again for helping us in our mission to honor the lives of our donors and save lives through organ transplant!

Respiratory Therapy DCD Guidelines

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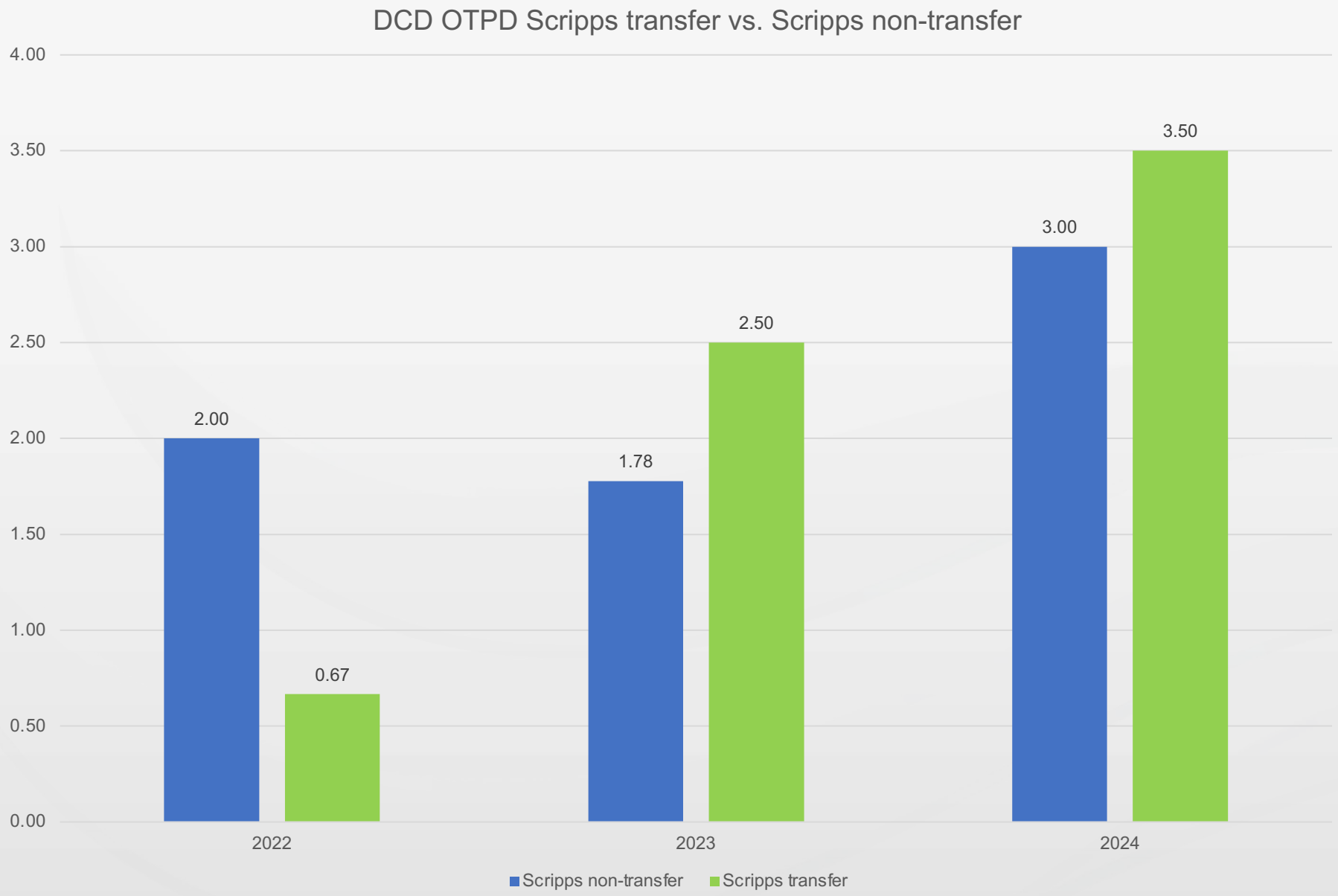
Thank you so much for being available to help our team save lives! We could not do this without you, so please know how much we appreciate you and your team. In order to prevent any miscommunications, we have put together this handy reference for you to refer to at any time during this process. If you have further questions, please reach out to any member of the Lifesharing team so we can assist you as best as we can.

- We know you are busy so please let us know how we can assist you as well, but we ask that you have a transport ventilator prepared in case it is not feasible to have the patient's ventilator brought down to PACU with us.
- You will transport to PACU with our team approximately 30 minutes prior to the scheduled withdrawal of care time. Please bring extra towels, face wipes, a syringe to deflate the cuff, and any other supplies you may need for extubation with us as we will not be returning to the unit prior to extubation.
- Once we are settled in the PACU we will be giving the family some time to say goodbye. Once our OR team is situated we will instruct the bedside nurse to give a large dose of heparin. We will then start a timer for 5 minutes. Around 4 minutes, please feel free to begin to loosen the Hollister or other endotracheal ties and prep for extubation. Do not extubate until our staff says it is time.
- Once the patient is extubated it is always great if you are able to clean their face a bit, suction them, and take any supplies with you. After the patient is extubated you are free to leave.
- Again, we know you are busy and staffing is a challenge, but please ensure that you are available to assist for the duration of time it takes to complete the extubation.
- Our staff is here to assist you as best we can, please do not hesitate to ask questions if further clarification is needed.

Thank you again so much for collaborating with us and assisting us in our mission to honor our donor's gifts and save lives!



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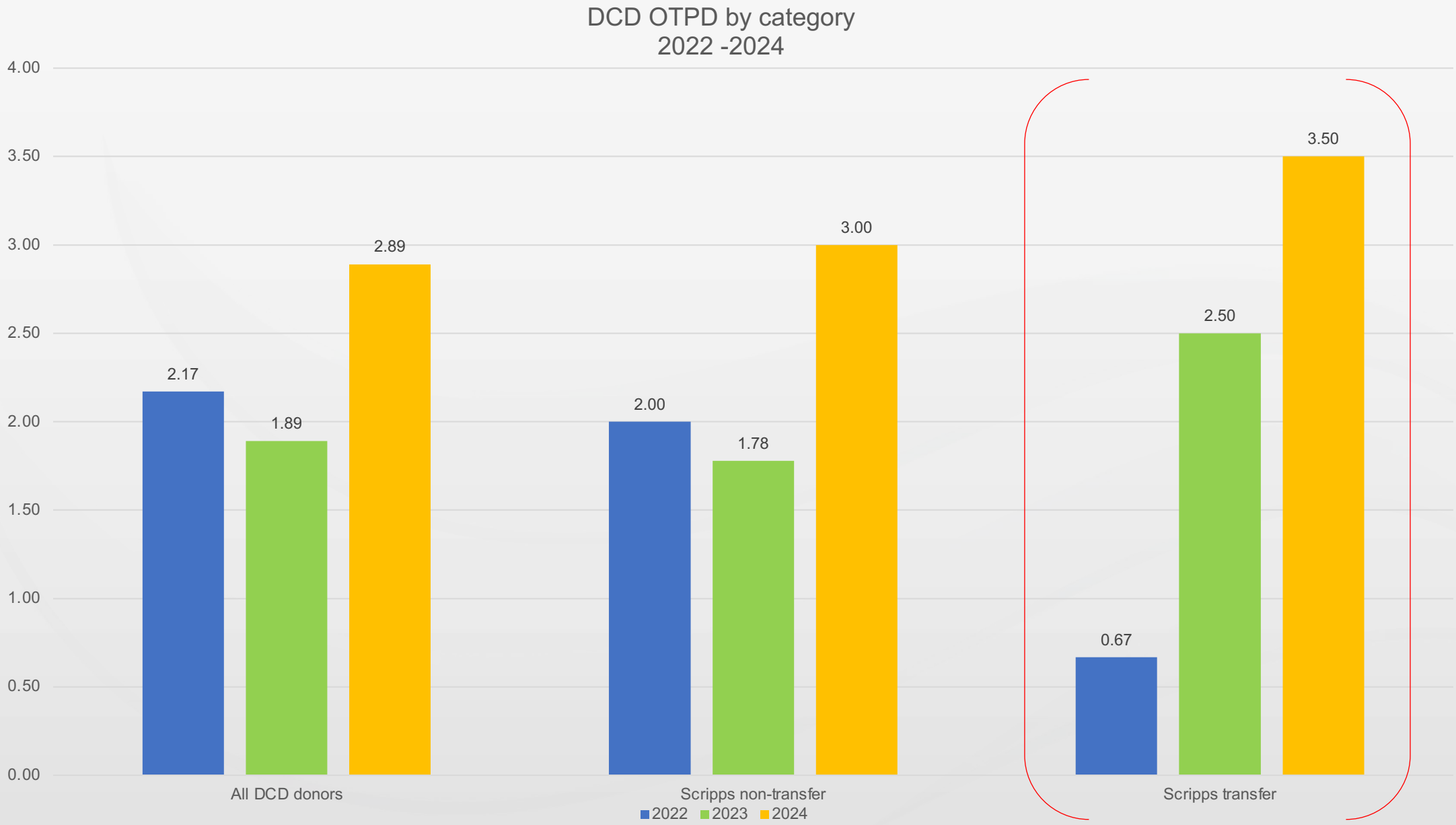
DCD OTPD by category
2022 -2024
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
2.17
1.89
2.89
2.00
1.78
3.00
0.67
2.50
3.50
All DCD donors
Scripps non-transfer
Scripps transfer
2022
2023
2024

What is working for us!

- Navigators - essential to process!
- Over communication!!!
  - Developing communication model that works for both sites: phone report, Epic chat, OPC facilitated these in the beginning, now self driven
- MD’s/staff on board with process
- Staff competency
- Staff consistency
- NRP-multiple centers

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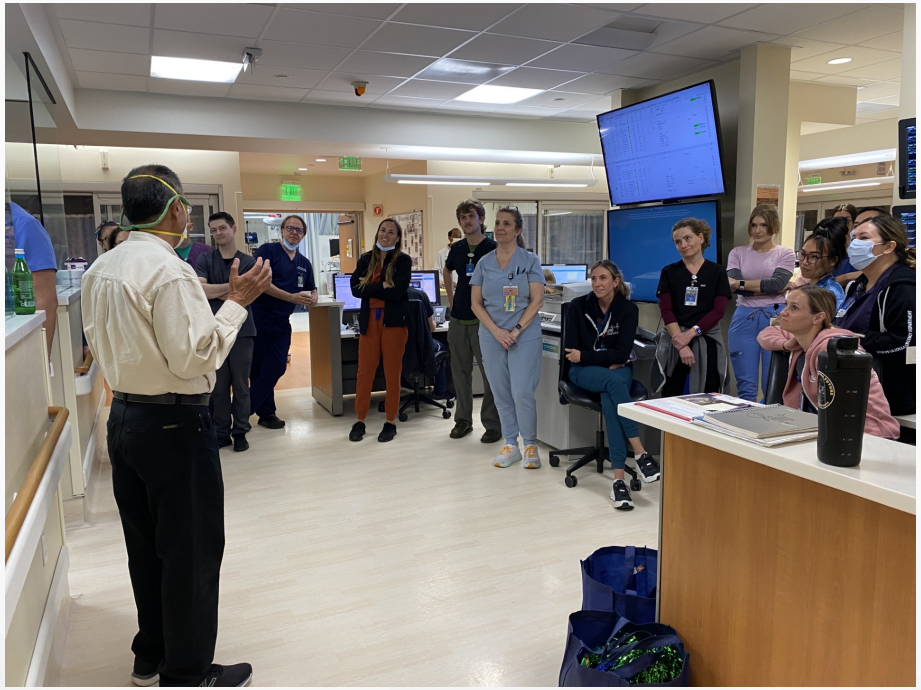
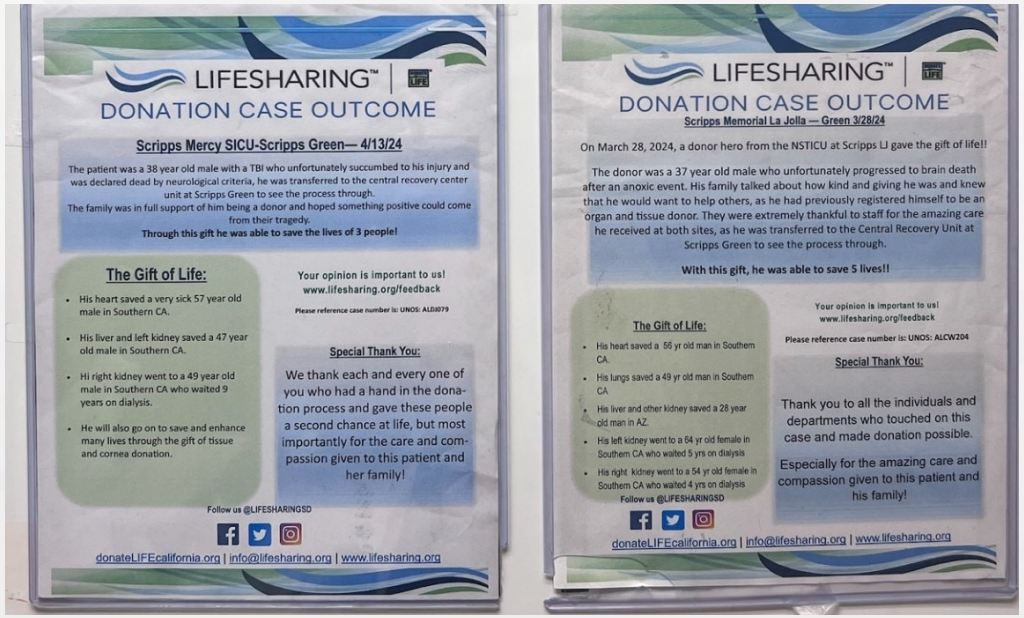
DCD Hearts

Recovery D/T	Referring Hospital	Recovery Hospital	Age	Gender	Donor Type	Organs Transplanted
4/11/2023'	Scripps Mercy Hospital San Diego	Scripps Green Hospital	44	Male	DCD	
						Heart
						Left Kidney
						Liver Whole
						Right Kidney
5/28/2023'	Scripps Memorial Hospital La Jolla	Scripps Green Hospital	46	Male	DCD	
						Heart
9/9/2023"	Scripps Memorial Hospital La Jolla	Scripps Green Hospital	31	Male	DCD	
						Heart
						Left Kidney
						Liver Whole
						Right Kidney
2/17/2024'	Scripps Memorial Hospital La Jolla	Scripps Green Hospital	48	Male	DCD	
						Heart
						Left Kidney
						Liver Whole
2/19/2024'	Scripps Mercy Hospital San Diego	Scripps Green Hospital	30	Male	DCD	
						Heart
						Left Kidney
						Liver Whole
						Right Kidney

Continued collaboration





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DONATION CASE OUTCOME

Scripps Mercy SICU-Scripps Green— 4/13/24

The patient was a 38 year old male with a TBI who unfortunately succumbed to his injury and was declared dead by neurological criteria, he was transferred to the central recovery center unit at Scripps Green to see the process through.
The family was in full support of him being a donor and hoped something positive could come from their tragedy.
Through this gift he was able to save the lives of 3 people!

The Gift of Life:

- His heart saved a very sick 57 year old male in Southern CA.
- His liver and left kidney saved a 47 year old male in Southern CA.
- Hi right kidney went to a 49 year old male in Southern CA who waited 9 years on dialysis.
- He will also go on to save and enhance many lives through the gift of tissue and cornea donation.

Your opinion is important to us!
www.lifesharing.org/feedback

Please reference case number is: UNOS: ALDJ079

Special Thank You:

We thank each and every one of you who had a hand in the donation process and gave these people a second chance at life, but most importantly for the care and compassion given to this patient and her family!

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donateLIFEcalifornia.org | info@lifesharing.org | www.lifesharing.org

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DONATION CASE OUTCOME

Scripps Memorial La Jolla — Green 3/28/24

On March 28, 2024, a donor hero from the NSTICU at Scripps LJ gave the gift of life!!

The donor was a 37 year old male who unfortunately progressed to brain death after an anoxic event. His family talked about how kind and giving he was and knew that he would want to help others, as he had previously registered himself to be an organ and tissue donor. They were extremely thankful to staff for the amazing care he received at both sites, as he was transferred to the Central Recovery Unit at Scripps Green to see the process through.

With this gift, he was able to save 5 lives!!

The Gift of Life:

- His heart saved a 56 yr old man in Southern CA.
- His lungs saved a 49 yr old man in Southern CA
- His liver and other kidney saved a 28 year old man in AZ.
- His left kidney went to a 64 yr old female in Southern CA who waited 5 yrs on dialysis
- His right kidney went to a 54 yr old female in Southern CA who waited 4 yrs on dialysis

Your opinion is important to us!
www.lifesharing.org/feedback

Please reference case number is: UNOS: ALCW204

Special Thank You:

Thank you to all the individuals and departments who touched on this case and made donation possible.

Especially for the amazing care and compassion given to this patient and his family!

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"Life is beautiful because it's a story, and in stories, endings matter"

-Atul Gawande

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Thank You!

Questions?

Thalisa Callaghan

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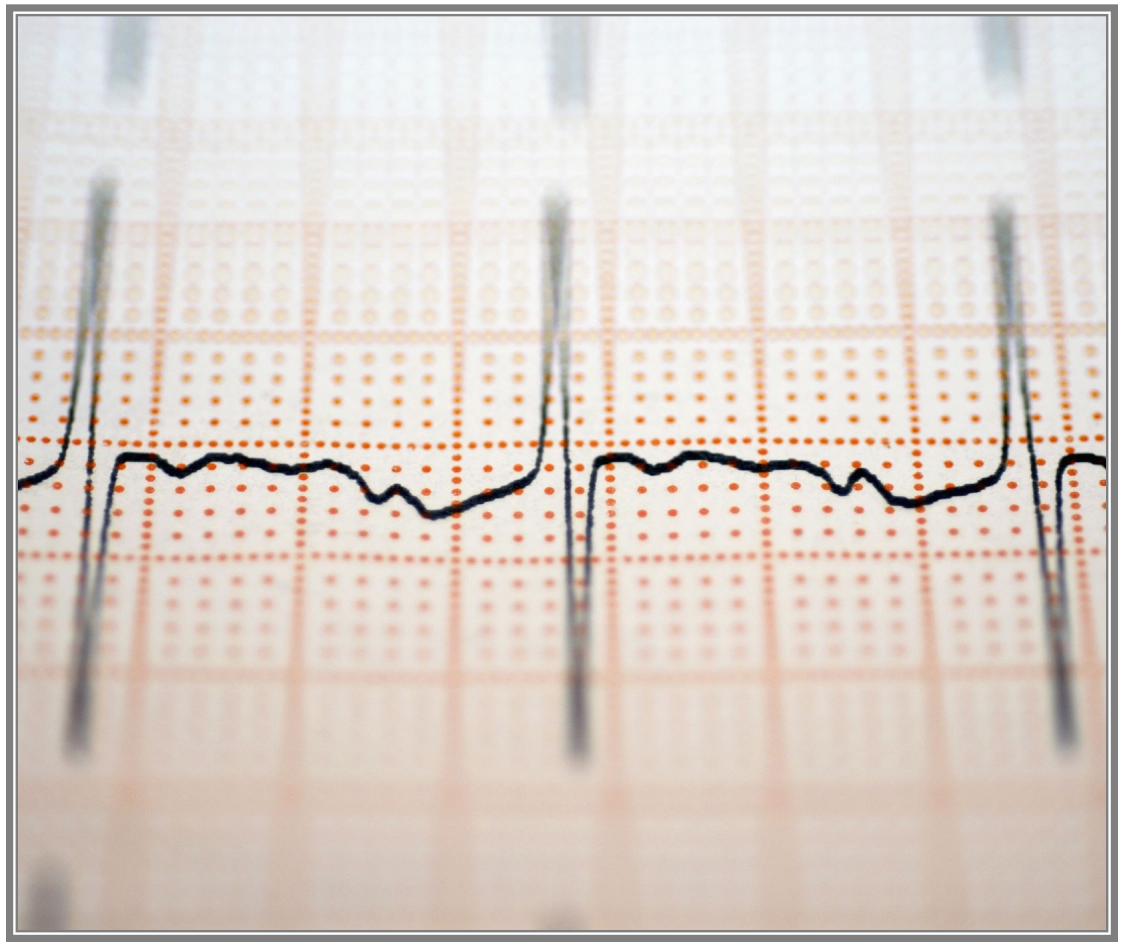
CENTRALIZED DCD RECOVERY

Internal Process Networking

The Goal of DCD Centralization

- Improve organ outcomes
  - Increased standardization of medical care
  - Increased hospital staff understanding of donor management
  - Quicker donor processes (i.e., quicker turnaround on CT reads)
  - More organs per donor

2024 Facility Transfers



- 7 University of Utah Hospital transfers
- 6 Intermountain Health (IMED) transfers

Year-to-Date Transfer Data 2024

Hospital Challenges

Hospital staff (nurses & MDs) upset: “taking their donor patients and giving them to someone else.”

“They aren’t dead yet, there has to be a law against what you are doing.”

“What’s wrong with our care, why can’t you do this process here?”

Receiving attending pushing back on accepting transfers.

A DCD patient is added work. Concern about their mortality rate.

Accepting MDs express frustration over the added procedures, line placements, bronchs, etc

Donor Family Hurdles

- Family-driven process - Can decline transfer
- Financial hardship due to the transfer
  - Travel and lodging costs
- Visitation rules at new hospital
- Prolonged case time

Successful strategies & Best Practices

- Transfer is discussed by the Family Support Coordinator during DCD discussion when applicable
- Strategic networking with county coroners
- BTP paperwork for Utah crossing state lines from Idaho
- Maintain consistency with the transfer process
- Educate your staff about the why behind the transfer and the goal
- Utilize Hospital Development teams to keep up with the education that hospitals require
- Provide hospitals data showing organ recovery outcomes

Ethical and Legal Framework

Every Organ, Every Time

What is your organization doing to ensure that the gift of organ donation is utilized to its fullest potential every time?

The family often plays a crucial role in the decision-making process, wanting to know the 'outcome' and the 'how' of organ donation. If transferring protects the gift and thus allows more lives saved, then the ETHICAL choice would be to offer the transfer.

The UAGA empowered people to donate organs at the time of their death (Brain death or cardiac death). Transferring the donor to a centralized facility will protect the gift and increase organ utilization.

QUESTIONS?

CENTRALIZED DCD RECOVERY

Jeff Pace RN

ARORA Manager of Transplant Services

ARORA
WE RESTORE LIVES

How it started

In 2019, we started by moving BD donors to our local Level 1 Trauma Center. This is also our Liver/Kidney/Panc Transplant Center.

In 2021, we started moving DCD's to the same location.

We partnered with Anesthesia / Critical Care MD's to pronounce in the OR. (previously used Trauma MD's)

Developed transfer policies and procedures (Donor Pathways for DCD and DBD Admissions).

Used the same 1-2 MD's to Admit / Treat / Pronounce

Donor Resuscitation started at the OSH (Fluids, Meds, Radiology)

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Challenges

- Hospital Resistance to moving DCD patients
- Making a Donor Pathway for all patients
- Family discussions regarding transfer. (The "why")
- Finding MD's to Pronounce (2-3 hour commitment)
- Hospital Reimbursement

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Hospital Reimbursement
DRG vs Z-code

- Hospital needs to understand the coding & billing rules. This will also include the mortality log for the DCD Donors.
- DRG vs Z-code: Can not use them at the same time.
- Use the admitting DRG if the donor originates in house, or from any hospital under the same Hospital System. (sister hospital). The DRG will transfer and the death remains in the system.
- Use the Z-code (52.9) if a patient is transferred from an OSH for donation after cardiac death to your facility.

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Z-code

- Z-code will reimburse 65-75% of the DRG diagnosis
- Ensure H&P lists ALL diagnosis that the patient presents with.
- The admission and care CAN be billed to Medicare or commercial insurance.
- Only organ donor workup can be billed to OPO and not insurance (ie. CT scan, LHC/RHC, echo etc)
- OPO will assume care of the patient if pronounced in the OR/PACU or wherever the facility brings the DCD donor.

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WE RESTORE LIVES

A Special Thanks to Our Presenters

Sara Angle

RN, BSN, CPTC

Organ Team Supervisor

DONOR CONNECT

GIVE HOPE. HEAL LIFE.

Thalisa Callaghan

BS, CTBS

Hospital Development Manager

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Jeff Pace

RN, EMT-P

Manager of Transplant Services

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Q&A
QUESTIONS & ANSWERS