Maine Medical Center
Maine Transplant Program
Policies and Procedures
Living Donor Quality Assessment and Performance Improvement Policy

Policy Summary
This policy defines the people and methods by which living donor patient care processes and outcomes are continuously reviewed and improved upon and communicated throughout Maine Medical Center.

Policy
A multidisciplinary team (see below) consisting of members representing the living donor program will be responsible for establishing and monitoring targeted performance improvement activities. Evaluation of program performance will be made using baseline performance measures, benchmarking and best practice data where available. The team will act upon results of performance improvements and track performance to ensure that improvements are sustained.

Living Donor (LD) QAPI Team Membership

<table>
<thead>
<tr>
<th>Transplant Nephrologist</th>
<th>Transplant Surgeon</th>
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<tbody>
<tr>
<td>Living Donor Coordinator</td>
<td>Transplant Program Director</td>
</tr>
<tr>
<td>Quality Business Analyst</td>
<td>Independent Living Donor Advocate</td>
</tr>
<tr>
<td>Transplant Social Worker (ad hoc)</td>
<td>Living Donor (Ad hoc)</td>
</tr>
<tr>
<td>Medical Office Assistant</td>
<td>Transplant Unit RN Manager or Represent.</td>
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Procedures
The LD QAPI Team will be responsible for the following:

- Develop Annual LD QAPI Plan in cooperation with QAPI Committee, Adult Medicine Service Line Leadership Council and hospital and hospital Annual Implementation Plan
  - Reviewing program data: Collect, present, and review transplant data to reflect practices throughout the transplantation pathway
  - Monitor compliance with regulatory body requirements (e.g., UNOS, CMS)
  - Analyze and track measures that are not meeting or exceeding expected standards
  - Analyze and track all adverse events and actions resulting in critical review

- Utilize program data, adverse event analyses and standard level deficiencies found during surveys to identify key quality improvement initiatives.

- Collaborate with other departmental teams involved in the transplant process to identify, monitor, and analyze process and outcomes data

- Establish outcomes and process measures to be used in quality improvement activities. The LD QAPI Team will annually establish objective process and outcome measures that address all three phases of living donation (pre-donation, donation and post-donation). The LD QAPI dashboard will reflect these measures (see Appendix A).

- Analyze and track all adverse events and actions resulting in critical review (see below for specifics on adverse event)

- Review standard level deficiencies cited in surveys and ensure that policies, procedures, protocols and staff work reflect changes necessary

- Monitor progress made in quality initiatives

- Assign working subgroups with improvement work as appropriate.

- Report LD QAPI and subcommittee activities to the Transplant QAPI.
Frequency of Meeting and Performance Evaluation
The LD QAPI team will meet at least every other month. Subcommittees of the LD QAPI may meet more frequently. Meetings will be used for multidisciplinary review of Living Donor Dashboard (Attachment A), LD QAPI committee will use Microsystems approach (with ongoing activities fitting into the Plan-Do-Study-Act method) to study and implement improvement activities.

Communication of LD QAPI Activities (see Appendix B: Quality Reporting Structure) and Interface with Maine Medical Center Quality and Risk Management
- The LD QAPI Committee will report at least quarterly to the MTP QAPI Committee
- Adverse events will be reported in the RL Solutions Event online system and reviewed by the Maine Medical Center Risk Management team.
  - LD QAPI will review details of reported adverse events, and will include members of the Committee during meetings to formulate corrective action plans and monitoring processes
  - The Maine Medical Center Risk Management team will collaborate with the transplant team to review select significant events and any event requiring a Root Cause Analysis.
  - The RL Solutions system includes a mandatory identification of each Maine Medical Center event entered as “yes” or “no” involving a transplant patient; all events involving a transplant patient will be automatically forwarded to the Director of Transplant Services for review
- LD QAPI will monitor Living Donor QAPI metrics and performance improvement activities
- LD QAPI will review working subgroup activities
- LD QAPI will ensure that transplant policies are reviewed at least once every three years, and updated more frequently as needed
- LD QAPI will oversee the creation and ongoing use of Dashboards, Living Donation website, transplant and living donation data reports, and balanced scorecards to communicate the performance and improvement related activities of the Living Donation team.

Definitions
Centers for Medicare and Medicaid Services, Organ Transplant Program Interpretive Guidelines, Regulations 482.70: Adverse Event Definition: “an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.”

References
Maine Transplant Program’s QAPI Policy
Maine Transplant Program’s Adverse Event Policy
Maine Medical Center’s Sentinel Event Policy and Procedure
Maine Medical Center’s Reporting Patient Safety, Concerns, Incident Reporting and Prevention Policy
Maine Medical Center’s Annual Implementation Plan

Original Date: March 14, 2012

Approval Committee(s) and Dates: Maine Transplant Program Living Donor QAPI Committee, 3/14/12, 9/9/12, 6/8/15, 8/10/15

Review Date: 11/15/18
Sponsoring Director:   

John P. Vella, MD, FACP, FRCP, FASN
Transplant Program Director

Date: 12/7/2018
### Appendix A: Living Donor QAPI Dashboard

<table>
<thead>
<tr>
<th>2015 Living Donor Dashboard</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Septembe</th>
<th>October</th>
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<tbody>
<tr>
<td>Living Donor Kidney Volume</td>
<td>Kidney</td>
<td>27</td>
<td>53</td>
<td>81</td>
<td>136</td>
<td>230</td>
<td>344</td>
<td>596</td>
<td>788</td>
<td>909</td>
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<td>Donor Volume</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>KPD as Percentage of Living Donor Surgeries</td>
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<td>100</td>
<td>100</td>
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<td>100</td>
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<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>4</td>
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<td>8</td>
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<td>7</td>
<td>14</td>
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#### Process Indicators

**Pre to Donation Process**

- Records requested with 1 week of registration: 80%
- Records reviewed within one week of receipt: 80%
- Test ordered within 7 days of record review: 80%
- Test results received within 1 week of test: 80%
- Clinical appraisal within 2 weeks of test result: 80%
- Patient reviewed at TCR immediately following test review: 80%
- OR scheduled within week of TCR Acceptance: 80%

**Time of Donation Process**

- ILDA Evaluation prior to discharge: 100%
- SW evaluation prior to discharge: 100%
- Discharge planning note prior to discharge: 100%
- Nutrition evaluation prior to discharge: 100%
- Pharmacy evaluation prior to discharge: 100%
- ABO verification: 100%

**Post Donation Process**

- Outstanding Prior Month UNOS LD forms: 0
- MTF Transplant Center Process: 99%
- MTF Transplant Center Survey: Explained Things: 99%
- MTF Transplant Center Survey: NA: 0

#### Patient Outcome Indicators

**Pre Donation Outcomes**

- Donor Evaluations: 4
- TCR Presentations with Donor: 60%
- TCR Acceptance: 100%
- Decision from testing to TCR: 100%

**Time of Donation Outcomes**

- Surgical Complications: 0
- DGF rate for Recipients of LD's: 0

**Post Donation Outcomes**

- Readmission within 30 days: 0
- Change in Diastolic BP: 0
- Change in Systolic BP: 0
- Serum Creatinine: 0
- Protein/Creatinine Ratio: 0
- Percent donors attending 2 week follow up: 100%
- Percent of donors attending 6 month follow up: 100%
- Percent of donors attending 12 month follow up: 100%
- Percent of donors attending 2 year follow up: 100%

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Data: Monthly

Status: Data not reported in time period

Below Target: Below Target

Meeting Target: Meeting Target

Above Target: Above Target
Appendix B – Quality Reporting Structure

BOARD PERFORMANCE IMPROVEMENT COMMITTEE

SERVICE LINE EXECUTIVE COUNCIL

SERVICE LINE LEADERSHIP COUNCIL

AMSL LEADERSHIP COUNCIL

MMC PATIENT SAFETY TEAM

MTP QAPI COMMITTEE

MTP QAPI SUBCOMMITTEE/WORK GROUP

LIVING DONOR QAPI