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

Transplant Program Director	Administrative Director of Transplant
Transplant Nephrologist	Transplant Surgeon
Living Donor Coordinator	NorDx HLA Laboratory
Quality Business Analyst	Independent Living Donor Advocate
Transplant Social Worker (ad hoc)	Living Donor
Medical Office Assistant	Transplant Unit RN Manager or Rep.

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
- Charge 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 quarterly. 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
Nelson, Batalden, Godfrey. Quality by Design: A Clinical Microsystems Approach. 2007.
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, 8/16/21

Review Dates: 11/15/18, 8/16/21

Updated: 10/15/20, 9/2/21

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Appendix A: Living Donor QAPI Dashboard

Maine Transplant Program
Living Donor Dashboard

2015 Living Donor Dashboard	Benchmark	Frequency	January	February	March	Q1	April	May	June	Q2	July	August	September	Q3	YTD Current Actual	2015 Target	2014 Outcomes
Living Donor Kidney Volume Kidney	27	M	2	1	3	6	3	2	3	8	4			4	18	27	27
Exchange Donor Surgeries	3	M	0	0	0	0	0	0	0	0	0			0	0	3	
KPD as Percentage of Living Donor Surgeries	10%	M	0	0	0	0	0	0	0	0	0			0	0	10%	
Number of Active KPD Pairs											4				4		
Preemptive Living Donor Transplants		M	1	1	2	4	3	1	1	5	4			4	13		
New Donor Referrals		M	14	12	8	34	13	7	14	34	8			8	76		115
Process Indicators																	
Pre to Donation Process																	
Records requested within 1 week of registration	80%	S															
Records reviewed within one week of receipt	80%	S															
Testing ordered within same week of record review	80%	S															
Test results received /reviewed within 1 week recpt.	80%	S															
Clinic appt. scheduled within 2 weeks of test review	80%	S															
Patient review at TCR immediately following test review	80%	S															
OR Scheduled within week of TCR Acceptance	80%	S															
SW Eval prior to TCR	100%	M	100	100	100	100	100	100	100	100	100				100	100	
Nutrition Eval prior to TCR	100%	M	100	100	100	100	100	100	100	100	100				100	100	
ILDA Eval prior to TCR	100%	M	100	100	100	100	100	100	100	100	100				100	100	
Pharmacy Eval prior to TCR	100%	M	100	100	100	100	100	100	100	100	100				100	100	
Signed selection criteria by PreOp	100%	M	100	100	100	100	100	100	100	100	100				100	100	
Outstanding 90 day Delinquent UNOS Registration	0%	M															
Time of Donation Process:																	
ILDA evaluation prior to discharge	100%	M	100	100	100	100	100	100	100	100	100				100	100	
SW evaluation prior to discharge	100%	M	100	100	100	100	100	100	100	100	100				100	100	
Discharge planning note prior to discharge	100%		100	100	100	100	100	100	100	100	100				100	100	
Nutrition evaluation prior to discharge	100%	M	100	100	100	100	100	100	100	100	100				100	100	
Pharmacy evaluation prior to discharge	100%	M	100	100	100	100	100	100	100	100	100				100	100	
ABO Verification	100%	M							100		100						
Post Donation Process:																	
Outstanding Prior Month UNOS LD forms	0	M	0	1	1	2	1	0	6	7	0			0	9	0	
MMP Surgeon: Courtesy and Respect	90%	M					95	100	100	98	100				97	NA	
MMP Surgeon Survey: Explained Things	90%	M	100	NA	98	99	95	100	95	96	100				97	98%	
Patient Outcome Indicators																	
Pre Donation Outcomes:																	
Donor Evaluations	4	M	2	5	5	12	5	3	6	14	2			2	28	48	46
Number of TCR Donor Presentations		M	9	4	5	18	6	6	12	24	1			1	43		95
TCR Presentations with Donor	50%	M	33	50	20	33	50	33	50	48	100			100	43%	50%	43%
% Decision from testing to TCR/decision	baseline	M															
Time of Donation Outcomes:																	
Surgical Complications	0	Q				0				0					0	0	0
Donor Average LOS	2.5	Q				2.8				2.8					2.8	2.5	2.5
DGF rate for Recipients of LD's	3%	M	0	0	0	0	0	0	0	0	0				0%	3%	7%
Post Donation Outcomes:																	
Readmission within 30 days	0	Q				0				0					0	0	0
Change in Diastolic BP		S															
Change in Systolic BP		S															
Serum Creatinine		S															
Protein/ Creatinine Ratio		S															
Percent donors attending 2 week follow up	100%	Q				100				100					100		
Percent of donors attending 6 month follow up	100%	Q				88				88					87		
Percent of donors attending 12 month follow up	100%	Q				50				86					75		
Percent of donors attending 2 year follow up	100%	Q				100				0					75		

S = Semi-annual
M = Monthly
M* = Rolling 24 month data
Q = Quarterly
Q* = Rolling 12 month reported quarterly

Status:	
Data not reported in time period	
Status To be determined	
Below Target	
Meeting Target	
Above Target	

Appendix B – Quality Reporting Structure