Maine Medical Center
Maine Transplant Program
Policies and Procedures
Quality Assessment and Performance Improvement (QAPI) Policy

Policy Summary
This policy defines the people and methods by which transplant recipient and 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 who are involved in the care of kidney transplant patients will be responsible for establishing and monitoring targeted performance improvement activities. Performance improvement activities will be established based upon the review of outcome and process measures as well as identified program deficiencies and reported adverse events and their corrective action plans. 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.

Transplant Program QAPI Team Membership

Medical Director of Transplant	Transplant Surgical Director and Surgeons
Administrative Director of Transplant	Transplant Coordinators
Nursing and/or Adult Medicine Service Line Leadership Rep. (Ad Hoc)	Anesthesiologists
Cardiology (Ad Hoc)	Quality Business Analyst
Pharmacy Specialist for Transplant	Living Donor Coordinators
Transplant Unit RN Manager or Rep.	Clinical Dietitians
Psychiatry (Ad Hoc)	NorDx HLA Laboratory
Transplant Social Worker	Maine Medical Center Risk Management (Ad Hoc)
Nephrologists	

Procedures
The QAPI Team will be responsible for the following:

- Develop Annual Transplant QAPI Plan in cooperation with 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 QAPI Team will annually establish objective process and outcome measures that address all three phases of the transplant process (pre-transplant, peri-transplant and post-transplant). The kidney transplant dashboard will reflect these measures (see Appendix A).

- The QAPI team will assure that the Living Donor (LD) QAPI team establishes outcome and process measures for all three phases of living donation. The measures will be reflected in the LD QAPI Dashboard (refer to Living Donor Quality Assessment and Performance Improvement (QAPI) policy for specifics)
- 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.

Frequency of Meeting and Performance Evaluation
QAPI team will meet at least 8 times a year. Meetings will be used for multidisciplinary review of the transplant dashboard (see Attachment B), review of all adverse and critical events, and other issues as identified by Committee members. The 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 QAPI Activities (see Appendix B: Quality Reporting Structure) and Interface with Maine Medical Center Quality and Risk Management

- The QAPI Committee will report at least annually to the Maine Medical Center Adult Medicine Service Line Leadership Council
- Adverse events will be reported in the RL Solutions Event online system and reviewed by the Maine Medical Center Risk Management team.
    - 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
- QAPI will monitor Living Donor QAPI metrics and performance improvement activities
- QAPI will review working subgroup activities
- QAPI will ensure that transplant policies are reviewed at least once every three years, and updated more frequently as needed
- QAPI will oversee the creation and ongoing use of Dashboards, Nephrology website, transplant data reports, and balanced scorecards to communicate the performance and improvement related activities of the Maine Transplant Program.

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 Medical Center's Sentinel Event Policy and Procedure
Maine Transplant Program's LD QAPI Policy
Maine Medical Center's Sentinel Event Policy and Procedure
Maine Transplant Program's Adverse Event Policy
Maine Medical Center's Reporting Patient Safety, Concerns, Incident Reporting and Prevention

Maine Medical Center's Annual Implementation Plan

Review Dates: 9/11/13, 2/13/12, 5/26/15, 9/25/18

Updated: 10/15/20

Approval Committee(s) and Dates:
Maine Transplant Program QAPI Committee: 11/14/11, 10/11/13
Institutional Policy Review Committee: 12/2/13, 9/14/15

Policy Champion: John P. Vella, MD, FACP, FRCP, FASN, FAST – Director, Nephrology and Transplantation

Appendix A: QAPI Kidney Transplant Dashboard

Maine Transplant Program
Kidney Transplant Dashboard

2015 Kidney Dashboard	Benchmark	Frequency	January	February	March	Q1	April	May	June	Q2	July	August	September	Q3	YTD Current Actual	2014 Outcomes
Transplant Volume Kidney	48	M	2	3	4	9	3	4	4	11	7			7	27	55
Deceased	23	M	0	2	1	3	0	2	1	3	3			3	9	28
Living	25	M	2	1	3	6	3	2	3	8	4			4	18	27
NRC Survey: Staff Treated me With Courtesy	97%	M														
Survey: Staff Explained Things Understandably	89%	M														
Survey: Staff Listened Carefully	90%	M														
Candidates on the UNOS Waitlist at the end of the month	NA	M	97	99	99	99	97	98	101	98	96				96	NA
TPQR: UNOS Data Submission with 90 days of due date*	95%	Q				100				100					100%	100%
Process Indicators																
Prior to Tx Process																
2 ABO's prior to listing	100%	M	100	100	100	100	100	100	100	100	100			100	100%	100%
Social Work evaluation w/in 12 mos. prior to listing	100%	M	100	100	100	100	100	67	100	89	100			100	96%	100%
Selection criteria worksheet (patient listing form) completed prior to transplant & signed by MD	100%	M	88	100	100	93	100	100	100	100	100			100	93%	NA
Pharmacy evaluation w/in 12 mos. prior to listing	100%	M	100	100	100	100	100	100	100	100	100			100	100%	100%
Nutrition evaluation w/in 12 mos. prior to listing	100%	M	100	100	100	100	100	100	100	100	100			100	100%	100%
Waitlist Removal within 24 hours	100%	M	100	NA	100	100	100	100	100	100	100			100	100%	100%
Wait list notification letter sent to candidates within 10 days of UNOS listing	100%	M	100	100	100	100	100	100	100	100	100			100	100	100%
Time of Tx Process:																
ABO validation at time of transplant - Recipient	100%	M	100	100	100	100	100	100	100	100	100			100	100	100%
MTP SW Assessment in Record	100%	M	100	100	100	100	100	100	100	100	100			100	100	100%
Discharge planning note	100%	M	100	100	100	100	83	100	100	92	100			100	100	100%
Nutrition evaluation prior to discharge	100%	M	100	100	100	100	100	100	100	100	100			100	100	100%
Pharmacy evaluation	100%	M	100	100	100	100	100	100	100	100	100			100	100	100%
R5 NRC Overall Rating	82	Q				84				84					84	NA
Post Tx Process:																
UNOS FU forms 90 Day Delinquent	0	M	1	0	1	2	1	0	0	1	0			0	3	8
MMP Surgeon: Courtesy and Respect	90%	M					95	100	100	98	100			100	95	NA
MMP Surgeon Survey: Explained Things	90%	M	100	NA	98	99	95	100	95	96	100			100	95	98%
Patient Outcome Indicators																
Pre Tx Outcomes:																
Mortality rate (per year on waitlist)	0.05	S								0					0	0.05
Median Days from referral to evaluation	43	S								61					61	43
Median Days from evaluation to presentation	109	S								95					95	109
Median Days from presentation to listing	4	S								7					7	4
Median Months from listing to transplant	18.9	S								6					6	18.9
Ratio of active:inactive waitlist	>50%	M	56	56	51	54	52	55	59	59	56			56	56	NA
Time of Tx Outcomes:																
# of Patients with Surgical Complications		M	NA	NA	1	1	0	0	1	1	0			0	2	9
Recipient Mean LOS	7.1	Q				3.8				3.8					3.8	4.0
Living Donor Mean LOS	3	Q				2.9				2.9					2.9	2.4
Cold ischemic time (<24 hrs)	100%	M	100	100	100	100	100	100	100	100					100	100%
% Deceased Donor DGF Dialysis within 1 week	34%	M	NA	50	100	67	NA	50	100	67	33			33	67	25%
% Living Donor DGF Dialysis within 1 week	3%	M	0	0	0	0	0	0	0	0	0			0	0	7%
Post Tx Outcomes (Most Recent SRTR):																
Readmission within 30 days	29.1%	Q				0				18					10	19%
Adult Graft Survival -1 Year Hazard Ratio	.36, 1.93	S								0.99						
Adult Patient Survival - 1 Year Hazard Ratio	.17, 1.97	S								0.82						

* Reflects most recent data reported (through March 31, 2015)

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

Appendix B: Quality Reporting Structure