OPTN Ad Hoc Disease Transmission Advisory Committee
Patient Safety Contact & Duplicate Reporting Workgroup
Meeting Summary
July 17, 2023
Conference Call

Lara Danziger-Isakov, MD, MPH, Chair
Stephanie Pouch, MD, MS, Vice Chair

Introduction

The OPTN Patient Safety Contact and Duplicate Reporting Workgroup (the Workgroup) met via Citrix GoToMeeting on 07/17/2023 to discuss the following agenda items:

1. Background, purpose, and Workgroup goal

The following is a summary of the Workgroup discussions.

1. Background, purpose, and Workgroup goal

The Workgroup heard an overview of the patient safety contact and duplicate reporting project. OPTN Policy 15.1 Patient Safety Contact (PSC) requires each organ procurement organization (OPO) and transplant program to identify a patient safety contact and develop and comply with a written protocol for the patient safety contact to fulfill all the following responsibilities. However, protocols are inconsistent across OPOs and transplant programs and can lead to difficulty and increased time spent contacting the PSC or receiving confirmation of successful notification. Additionally, OPTN Policies 15.4.B and 15.5.B require both OPOs and transplant programs to report recipient diseases or malignancies; this results in duplicate reporting and causes an increased burden on the OPTN system.

The patient safety contact and duplicate reporting project is a referral from the OPTN Membership and Professional Standard Committee (MPSC) and highlights the need for consistency in the type of contact provided. Several PSCs currently listed are incorrect and out of date. The MPSC also expressed the necessity of establishing a consistent policy for reporting disease transmissions, including notification, follow-up, and receiving and disseminating information needed to effectively ensure timely communication of potential disease transmission. The goal of the Workgroup is to ensure that the patient safety contact is regularly updated and audited and to reduce OPO and transplant program duplicate reporting of potential donor-derived transmission events in the OPTN patient safety portal.

Summary of discussion:

Decision #1: The Workgroup determined that further discussion is needed to establish an approach on how to address the patent safety contact and the duplicate reporting component of the project.

Patient Safety Contact

A member asked how this project will be addressed. The Chair replied that the Workgroup is trying to tackle ensuring the external facing contact is identified, accessible, and reachable at all times of the day. Another member noted that identifying a PSC is a nonuniform process and suggested setting expectations for OPOs and transplant programs so that the process is consistent, efficient, and effective.

When considering *OPTN Policy 15.1: Patient Safety Contact*, Staff asked if a backup contact should be required by policy. She explained that a backup contact is not required but is listed as an option in the OPTN Computer System. She also inquired about what constitutes a notification. She asked if there should be some form of acknowledgment from the OPO or transplant program that should be required when an organ recipient is suspected of having a disease transmission. Sometimes certain programs will acknowledge this while others do not.

Another member noted that this project entails reporting disease transmission events and patient safety contact concerns. He inquired if these two issues should be handled separately. Staff replied that this is a concern that has been raised previously. She explained that when attempting to contact a program, there has been confusion around who to contact for a particular issue, as the PSC may not be the most up-to-date contact on file.

The Chair asked what other interactions the PSC would be utilized for. A member explained that there is routine reporting and other incidences that require a higher level of scrutiny by transplant programs and OPOs. These pathways should be distinguished for routine reporting and other incidents that need to escalate to the team differently. For example, reporting is required for a positive strongyloidiasis, however; routine cultures may not need to undergo the same pathway. Another member agreed and clarified that there should be a clear difference in the pathway on how incidents are handled when addressing expected routine cultures versus a potential donor derived transmission event.

Another member shared that at their center, the PSCs are comprised of procurement coordinators who rotate on and off; therefore, it's never the same person that a potential disease transmission event is being reported to. She inquired if there should be a designated person for reporting versus multiple people. The Chair responded that some programs may have multiple people taking calls.

The Chair asked what should be considered an emergent disease transmission reporting versus routine cultures. A member responded that when considering emergent versus routine reporting, it depends on who is making the decision at the program. He explained that there is variability among transplant programs, and the same system will not work at every center because they're organized differently. For example, at their center, the PSC is a manager who is not clinical, and they could not distinguish what was classified as emergent and what was not. He further explained that unless it is specified who the PSC is and what the requirements of this role are, it could be challenging to require them to distinguish between emergent and routine reporting. Another member agreed and stated that it would be difficult for transplant programs to agree on standards of what is emergent versus what is not.

Another member suggested that improving the PSC should be in the context of the upcoming programming to the OPTN Computer System, which will enable electronic notifications, and the process will allow transplant programs to receive results through a system enhancement. Another member noted that confirmation of receipt of reporting is not required in OPTN policy. He expressed the need for acknowledgement, so the OPO or transplant program can acknowledge and react to potential disease transmission notifications.

Duplicate Reporting

A member asked what issue the Workgroup is trying to solve with duplicate reporting. The Chair replied that if a sick recipient is identified at a transplant program, they are required to report this in the OPTN Improving Patient Safety Portal. When the transplant program reports the event to the OPO, the OPO is also required to report that event. This requires both institutions to input significant information to initiate the process. A member noted that an essential component from a patient safety standpoint is the communication between OPOs and transplant centers to share that information. He explained that receiving the report from the transplant program and ensuring that everyone is communicated with

regarding the event is critical. Therefore, the communication between the OPTN members needs to be more robust and clarity on what is required for reporting is crucial. Another member agreed and suggested some standards for patient safety and reporting expectations. The Chair agreed and explained that the two main components the Workgroup will address are eliminating duplication of reporting to the OPTN Improving Patient Safety Portal and clarifying communication efforts once the event is recognized by OPOs and transplant programs.

Another member suggested if a transplant program reports a potential donor-derived transmission event it may be more effective for the OPO to get a notification stating that the recipient has been reported and ask the OPO to confirm this event and add any additional information instead of reporting the same event. Staff agreed and suggested that recipient reporting information could be collected through the Data System for Organ Procurement and Transplantation Network instead of emailing the centers for follow-up information. The Chair stated that the Workgroup would need to determine what policy and process look like to achieve the Workgroup's goals. She explained that some project components are process-related and will help with policy implementation. Staff commented that the Workgroup could consider addressing the project goals separately; the first could be a PSC policy-focused project and then a process-focused project for duplicate reporting.

A member commented that the concern is that the process does not work and inquired if the process could be included in the policy. Staff replied that the Workgroup could consider what is a good process and then explore how it could be incorporated into policy.

Next steps:

The Committee will continue to discuss how they will approach the project.

Upcoming Meetings

- August 21, 2023
- September 18, 2023

Attendance

- **Workgroup Members**
  - Anna Hughart-Smith
  - Chris Curran
  - Emily blumberg
  - Lara Danziger-Isakov
  - Maheen Abidi
  - Marty Sellers
  - Megan Fairbank
  - Michael Ison
  - R. Patrick Wood
  - Riki Graves
  - Sara Geatrakas
  - Sara Langham
  - Stephanie Pouch
  - Victoria Hunter
- **HRSA Representatives**
  - Marilyn Levi
- **SRTR Staff**
- **UNOS Staff**
  - Laura Schmitt
  - Logan Saxer
  - Rebecca Brookman
  - Robert Hunter
  - Sally Aungier
  - Sandy Bartal
  - Sharon Shepherd
  - Tamika Watkins
  - Taylor Livelli
- **Other Attendees**