OPTN/UNOS Operations and Safety Committee
Meeting Minutes
April 6, 2017
Conference Call

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Introduction

The Operations and Safety Committee met via Citrix GoToTraining teleconference on April 6, 2017 to discuss the following agenda items:

1. Follow Up In Person Meeting (March 28, 2017)
    - UNet survey user results
    - TransNet/UNet IT follow up from meeting

The following is a summary of the Committee's discussions.

1. Follow Up In Person Meeting (March 28, 2017)

UNet survey user results:

TransNet usability data from part of the latest UNet user survey were reviewed by the Director of Customer Advocacy. The survey is distributed each February through Survey Monkey to all UNet users from the previous year. The goals of the survey are to obtain feedback on all UNet applications including ease of use and suggestions for enhancements. Out of 1,978 respondents, 81% were from transplant hospitals and 19% were from OPOs.

Nearly three-quarters of OPO respondents stated that TransNet was easy to use (14% completely agree/ 60% agree). Only six percent disagreed with that TransNet was easy to use (2% completely disagree/4% disagree). Sixteen percent of OPO respondents indicated that there was a need that IT should be working on for TransNet. Needs identified were:

- Phones
- Label verification for repackaged organs
- VCA
- Multiple organ
- Self-password reset
- Ability to package and label living donor organs

Out of 1,599 transplant hospital respondents, only 3% reported using TransNet. One of out of five respondents did not know if their institution was using TransNet. Out of 474 transplant hospital respondents, the following programming needs were identified:

- EMR Integration 46%
- OPTN Policy 5.8.A 18%
- Other 17%
- Living Donor OR Verifications 13%
- Vessel Disposition Reporting 6%

The comments from the "Other" category did not reveal anything specific.

It was noted that the OPO responses appeared on target with plans and next steps. The same would appear to be true with the transplant hospital side where the top priorities named are

EMR, ABO, and Living Donor. It was explained that UNOS IT staff reached out to EPIC and have learned that if they were to build an API that touches ABO that it would be within their OR module and not in the Phoenix transplant specific module.

Members commented that this would make sense as most of the data required are in the OR module and that more programs have EPIC in general versus EPIC including the Phoenix module. It will get the product faster to the most people by building the interface to the OR module.

TransNet/UNet IT follow up from meeting

At the recent Operations and Safety in-person meeting, members were tasked with going back to their individual institutions and talking with key players (e.g. OR, IT) regarding next steps for getting TransNet into institutions. The goal is to identify the most efficient way to accomplish this given hospital complexities. The second question from the in-person was would it be easier to put DonorNet in the OR versus TransNet? IT wants to work on things useful to the community.

One member spoke with his transplant surgeons. The prospect of having Donor Net accessible with all check in and verifications requirements would make more sense to them rather than integrating into their EMR. The issue identified is DonorNet access as they do not want to create individual accounts, but perhaps have staff sign in using a match ID for example. They want to be able to train and have staff access the product without having to maintain accounts.

IT states that this is technically feasible; however, the concerns might appear from the auditing perspective. IT can create a generic OR function that OR personnel could access but that it might still be important to know who accessed the information. It is possible to develop a limited specific OR role that would only allow access to needed meaningful information (e.g. required for check-in, verification) without overexposing all data.

The committee member requested that it would document licensed personnel who performed the ABO verification. In this case, the data would be immediately accessible and UNOS could theoretically audit without a site visit. Again, it was shared that from the IT functionality that this was doable but hospitals would need to confirm that process wise this would meet auditing needs. It was shared that the Centers for Medicaid and Medicare Services (CMS) might have issues as they have previously stated that all documentation must live within the patient EMR. The documentation could be printed and scanned into the EMR. This is not ideal. Follow up will also be conducted with Member Quality for their opinion on these questions.

Another member stated that the surgeon must be part of the ABO verification process. It was suggested that the surgeon be the primary log on and the scanner. After the scan, all of the information could be brought up for the second person (OR personnel) to verify without logging in. Potential issues could be that the surgeon might be scrubbed in when the organ arrives although the log on could be done prior to surgery start since DonorNet often stays open for a period that could make this practice feasible. Another question was brought up about the verification when surgery starts prior to organ arrival and the surgeon is not required to be there. These are legitimate questions to be worked through but it seemed that perhaps the surgeon access might be an entry point worth modeling. One member stated they were not in favor of this idea as over 50% of their surgeons are scrubbed in when organs arrive.

Members did feel that if a safe solution was developed that this group should petition CMS or others to accept it versus requiring the documentation in the medical record. It was acknowledged that while this would be hard that the chance for error is greater when you must print and then put into a record. If we could come up with safe practice, the member thought that auditing bodies would agree and it would be an interpretation change only as the rules will not be going to change.

The TransNet project lead explained that current functionality allows a check in and a match to be performed without a UNet login. TransNet is a different URL address. A question that has been previously asked: Can IT do an unauthenticated type of log on with regulatory/audit personnel ability to access behind that first level.

This problem is somewhat solved with the current TransNet design. A member asked if we could see who does the check-in as CMS will want to see who signed in. The audit trail is needed. For organ check-in, it is a self-entered name (not electronically documented). A report can be printed for all. It would need to be shared with both Member Quality (MQ) and CMS. Members have shared issues where the transplant community is receiving push back on documentation for situations such as when the surgeon is scrubbed in, performs the verification, and then documents after the case. The pushback has been on the lack of authentication. How do the auditors or transplant coordinators know who was actually present or who actually verified the information? If someone signs their name (or electronically signs their name) but there is no log in to tie the person back to the signature, that has been problematic in some cases.

The TransNet verification form was viewed and explained section by section. It is very specific for the primary and secondary documentation of verification as well as when an attestation needs to be included. The form is specific to the verification times and has separate signature times. The form had been signed off on by both CMS and MQ.

A suggestion was made to incorporate barcodes from current patient identification bands into the process. This could be scanned and then the box could be scanned. The verification would be recorded by the scan with a time stamp. The signature could happen afterwards. It was explained that the current system and form as described does allow for this process.

At the in-person meeting, some Committee members had expressed a desire to possibly doing these functions without TransNet. A desire was expressed to avoid dealing with the time, cost, priority, and technical complexities of EMR interfaces that could end up taking many years. The Committee had started to discuss how the check in and verifications could be achieved in DonorNet.

One member stated that they already have too many systems. Documenting within DonorNet without anything else would be the ideal. The concern is trying to wait for building things with an EMR interface could take a very long time as corporate systems may have different priorities than transplant. It would be better to build this electronically within the systems we have access to already. It was stated that living donor functionality should be a higher priority than an EPIC or Cerner interface.

It is possible to add access to TransNet from Secure Enterprise.

Another member stated that she envisioned just entering data (without scan) and then being able to do both verifications. The check-in can be performed without a scan but match requires a scan in TransNet. Everyone acknowledged that scanning is safer but some members did still discuss possibly having a data entry option. Manually enter case numbers could be a path of least resistance for the transplant community as they would be operating within a window they already know (DonorNet). The group also reiterated that data entry means less time stamps and security. It is also prone to user error. Scanning is safer and the desired option.

One point is to eliminate the need for seeking additional devices in OR. It is hard to convince hospital staff that we need another monitor etc. Seeking permission for scanners and interfaces will take much longer. One member shared that the OR does not know how to use DonorNet and some surgeons do not know how to use DonorNet but it would be easier to teach them this versus a completely new system.

It was noted that functionality exists to use mobile phones or tablets for scanning. It was noted that mobile phones are generally allowed in ORs. Persons can access EMRs through their phone. Often the phone goes to a portal where credentials are entered before allowing into the system. It was also noted that security teams are often more concerned about data footprints. It was stated that no data would be left on mobile devices.

It was noted that staff are having a hard time getting to electronic signatures. The benefit of a log in is that it is an easy step to electronic signatures. It is not a problem to give access to OR staff in a limited data access role.

One member shared that she had concerns that her staff might have issues remembering two log ins. Another person thought that having simpler verification would be enough motivation to help OR staff remember two log ins. Members also requested that solutions have recorded or web-based training to get many people trained quickly.

It was noted that the OPO success with TransNet was in part due to the leadership and experience of having the chair's OPO be the first adopter. Staff would like more transplant hospital representatives from the Committee to help develop, promote, and troubleshoot for the transplant hospital side. Dean Henderson, Laura O'Melia, and Michael Marvin volunteered to assist with these efforts. (Boston Children's Hospital is currently doing organ check-in using TransNet)

Staff will reach out to pilot transplant hospital TransNet sites and invite representatives to a meeting. Both small and large volume representatives will be contacted to capture the variation in process and experience.

IT reiterated that they want to make systems usable. They are not entrenched with any specific names or ways to access. They want to build what works. Whatever solution is deployed, it will evolve using an iterative process. It is never perfect the first time. IT's approach to building solutions is more agile. They do it in a tangible way and get input to make systems better incrementally. The build might start with something small and use customer feedback to continuously improve the product versus a year's effort for the entire functionality. This effort will be optional in the development phase. They will also take into consideration other hospital practices following first efforts to get to more sophisticated and smart functionality after developing a simple functional product.

The take away from the discussion was to document these conversations, share it back with members to reflect and comment further on the ideas and concepts discussed. Volunteers will be contacted for further steps with TransNet. IT will look into whether options for building no authentication/authorization processes as well as ones with certain credentials and what would need to be in place. They will bring back sample mock ups for next meeting.

Committee members were also asked to volunteer to help develop and edit a kidney-paired donation scenario for infectious disease verification for the next patient safety series. It was asked that the first draft vignette be shared as an example. It was noted that the Committee is no longer taking a longer policy approach. They are pursuing only an education effort through the patient safety series. This effort was decided independent of any policy proposal decisions. The goal is to educate on potential risks and to help viewers think about effective practices. Several members volunteered to help.

Upcoming Meeting

- May 4, 2017