

OPTN Membership and Professional Standards Committee (MPSC) Meeting Summary May 22, 2023

Zoe Stewart Lewis, M.D., Chair Scott Lindberg, M.D., Vice Chair

Introduction

The Membership and Professional Standards Committee (MPSC) via Citrix GoToTraining in both open and closed session on May 22, 2023. The following agenda items were discussed during open session portion of the meeting:

- 1. Organ Offer Accepance Collaborative Update
- 2. Require Reporting of Patient Safety Events Project

1. Organ Offer Accepance Collaborative Update

The Committee received an update on the OPTN Offer Acceptance Collaborative to include a review of the project timeline and highlights of various project activities. Some of the noted highlights were that the Collaborative Improvement Team has hosted two webinars and 14 collaborative calls as well as conducted over 60 individual coaching sessions with participants to date. Examples of improvement projects were shared to provide insight on the types of work the programs were conducting in order to improve offer acceptance rates. The Committee was also informed that active engagement will end in July and then project evaluation will begin and take several months. Findings from the project as well as resources will be shared with the community to support overall improvement in this area.

2. Require Reporting of Patient Safety Events Project

The Committee reviewed the proposed policy language for the Require Reporting of Patient Safety Events project and voted on two items:

- The definition for identifying "near miss" transplant of the incorrect organ or the incorrect potential transplant recipient to include in the proposal
- To submit the proposal for the Summer 2023 public comment cycle

The Committee reviewed the results of the consensus poll that was distributed to members while reviewing the policy.

Summary of discussion:

A member asked what happens if an organ was delivered to the wrong hospital and then redelivered to the correct hospital. That event would be in addition to when it was delivered to the incorrect hospital and the organ wasn't used but it seems like the Committee would still want to capture it even if the organ was used. Staff stated that the event "the accepted organ was not delivered to the accepting transplant hospital" is meant to capture the extreme cases in which an organ may not have been shipped or could have gotten lost in transit. The member asked if that would also be captured in the organ was delivered to the incorrect hospital and resulted in non-use. For example, there could be two transplant hospitals a few miles apart and an organ is delivered to the wrong adult transplant hospital but is then delivered to the correct children's transplant hospital and is still used as compared to an organ that was supposed to be delivered to a transplant hospital in Boston but ended up in Miami. If the

organ gets delivered to the wrong place, it should be a reported event whether the organ was used as not. Staff explained that both events ("an organ was delivered to the incorrect transplant hospital and resulted in non-use of the organ" and "the accepted organ was not delivered to the accepting transplant hospital") capture this error but from two different perspectives. The accepted organ was not delivered to the accepting transplant hospital would be reported from the perspective of the hospital that didn't receive the organ and that hospital would not know if that error resulted in non-use. An organ was delivered to the incorrect transplant hospital and resulted in non-use of the organ would be from the perspective of the receiving transplant hospital and resulted in non-use of the organ would be from the perspective of the receiving transplant hospital not expecting the organ.

A member stated that there are a lot of other issues, besides transportation, that could cause the accepted organ not to be delivered to the accepting transplant hospital. The member stated, if the Committee feels this event is necessary to include, the language needs to be more specific that the event was caused due to transportation issues, as opposed to allocation or medical issues.

Staff asked if the accepted organ not being delivered to the accepting transplant hospital would be captured in the event "an organ did not arrive when expected and resulted in the intended candidate not receiving a transplant from the intended donor because of the transportation issue". Not arriving when expected could be that the organ either arrived late or did not arrive at all. Members supported removing the event "the accepted organ was not delivered to the accepting transplant hospital" as that information would be captured in the other event.

A member asked what would happen if the hospital that receives an unexpected organ was not a transplant hospital. Where the organ was delivered would be lost since the hospital that received it isn't an OPTN member. Staff stated that that is correct. It's conceivable that that hospital might report it to the OPTN; however, the OPTN does not have the authority to require them to.

A HRSA representative asked if the date of the event will be available since the Committee is requiring reporting based on when the member becomes aware. Staff stated that the date of the event is typically included in the report through the OPTN Improving Patient Safety Portal and if it's not then staff will ask about it during their investigation. Staff also mentioned that members will be required to report the event within 24 hours of becoming aware of the event.

A member stated that they aren't sure how the second near miss definition would apply for patients that are already hospitalized, as heart or liver patients typically are. This language may be too specific to outpatients. Staff stated that they have seen several reports over the years of the wrong patients being called in because patients at the hospital have the same name. It seems that that error is less likely to happen when patients are already admitted; however, staff stated that that is a question that can be asked during public comment since both near miss definitions will be outlined in the proposal due to similar support for both.

The Committee voted on the definition for near miss transplant of the wrong candidate they would like to include in this proposal.

- Option 1: The potential transplant recipient is identified as incorrect during pre-transplant processes conducted according to either Policy 5.8.A: *Pre-Transplant Verification Prior to Organ Receipt* or Policy 5.8.B: *Pre-Transplant Verification Upon Organ Receipt*
- Option 2: The potential transplant recipient is identified as incorrect at any time from communication with potential transplant recipient to report to hospital for transplant through the pre-transplant processes conducted according to either Policy 5.8.A: *Pre-Transplant Verification Prior to Organ Receipt* or Policy 5.8.B: *Pre-Transplant Verification Upon Organ Receipt*

The Committee voted: 16 Option 1, 14 Option 2.

The Committee also voted to submit this proposal for the Summer 2023 Public Comment cycle by a vote of 30 Approve, 1 Oppose, 0 Abstensions.

Upcoming Meetings

- o June 21, 2023, 3-5pm, ET
- o July 25-27, 2023, Detroit, MI
- o August 29, 2023, 2-4:00pm, ET, Conference Call
- o September 27, 2023, 2-4:00pm, ET, Conference Call
- November 1-3, 2023, Chicago, IL
- o December 6, 2023, 2-4:00pm, ET, Conference Call

Attendance

o Committee Members

- o Alan Betensley
- o Emily Blumberg
- o Timothy Bunchman
- o Anil Chandraker
- o Todd Dardas
- o Reginald Gohh
- o Barbara Gordon
- Lafaine Grant
- o Robert Harland
- o Rick Hasz
- o Kyle Herber
- o Victoria Hunter
- o lan Jamieson
- o Christopher Jones
- o Andrew Kao
- o Peter Kennealey
- o Catherine Kling
- o Michael Kwan
- o Carolyn Light
- Scott Lindberg
- o Melinda Locklear
- o Gabriel Maine
- o Amit Mathur
- o Kenneth McCurry
- o Nancy Metzler
- o Dan Meyer
- o Regina Palke
- o Elizabeth Rand
- o Sara Rasmussen
- o Pooja Singh
- o Jason Smith
- o Zoe Stewart Lewis
- o Sean Van Slyck
- o J. David Vega
- Candy Wells

• HRSA Representatives

- o Jim Bowman
- o Marilyn Levi
- o Arjun Naik

o SRTR Staff

- o Ryo Hirose
- o Jonathan Miller
- o Jon Snyder
- o Bryn Thompson
- o UNOS Staff

- o Robert Albertson
- o Sally Aungier
- o Matt Belton
- o Kate Breitbeil
- o Rebecca Brookman
- o Elinor Carmona
- o Aileen Nunez-Corrigan
- o Robyn DiSalvo
- o Nadine Drumn
- o Katie Favaro
- o Liz Friddell
- o Jasmine Gaines
- o Lauren Guerra
- o Asia Harden
- o Madeline Holder
- o Krissy Laurie
- o Trung Le
- o Ann-Marie Leary
- o Amy Minkler
- o Rebecca Murdock
- o Alan Nicholas
- o Samantha Noreen
- o Jacqui O'Keefe
- o Beth Overacre
- o Rob Patterson
- o Michelle Rabold
- o Shawn Richman
- o Sharon Shepherd
- o Mike Stanley
- o Stephon Thelwell
- o Marta Waris
- o Betsy Warnick
- o Trevi Wilson
- o Claudia Woisard
- o Emily Womble
- o Karen Wooten
- o Amanda Young

o Other Attendees

o Robert Walsh – Senate Finance Committee Staff