OPTN ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK

Meeting Summary

OPTN Ad Hoc Disease Transmission Advisory Committee
Standardize the Patient Safety Contact & Duplicate Reporting Workgroup
Meeting Summary
August 21, 2023
Conference Call

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

Introduction

The OPTN Standardize the Patient Safety Contact and Duplicate Reporting Workgroup (the Workgroup) met via Citrix Webex on 08/21/2023 to discuss the following agenda items:

1. Post Cross Clamp Test Results Enhancement
2. Duplicate Reporting Solution

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

1. Post Cross Clamp Test Results Enhancement

The Workgroup heard a presentation on the post-cross clamp test results enhancement. The Workgroup discussed a system enhancement that could help standardize the patient safety contact and make the process more efficient.

Culture reporting involves an inefficient and redundant process that is manually repeated for each organ transplanted. Currently, culture reporting is not standardized by organ procurement organizations (OPO) in the methodologies used for local and non-local transplant centers. The project aims to provide a notification system that OPOs can initiate when results are obtained post-cross-clamp that may affect the recipient. This would allow:

- OPOs notify transplant hospitals of test results such as, cultures, pathology results, and infectious disease results.
- Transplant hospitals to acknowledge that they have received notification and reviewed updated test results.
- An audit log to see when notifications are sent and if they have been acknowledged by transplant hospitals.

Additionally, the Workgroup was asked if they support mandating the enhancement to incorporate acknowledgment of receipt in the patent safety contact (PSC) policy (OPTN Policy 15.1 *Patient Safety Contact*).

Summary of discussion:

Decision #1: The Workgroup supports mandating the enhancement to incorporate acknowledgment of receipt into OPTN policy.

A member asked if the system adjusts for the time when an OPO notifies a center of a test result. He explained that if a result is entered in the system at 5 p.m., the patient safety contact may not have reviewed the result to acknowledge it within the given timeframe. The Chair commented that a future

enhancement could include an urgency level for the information sent to the transplant center. Another member expressed concerns that if the center needed to acknowledge an urgent level of information, it might be challenging because the PSC may not have medical expertise, so they may be unable to make that determination in real time. The presenter replied that text message opportunities are being explored and may be considered for future enhancements. A member inquired if a policy change is required to address the PSC issue. He also asked if there was a way to add enhancements to the system, such as text messages to the patient safety contact, which may be helpful to get people to react quickly.

Members expressed interest in requiring a patient safety backup contact. A member noted that a backup contact would be helpful, especially for busy and bigger transplant programs. Another member shared a different perspective and commented that if there was a backup contact required, then it may result in someone less ideal receiving this information. He explained that some PSCs do not have medical expertise, and if a backup is required, then they may not have medical expertise either. Another member noted that centers must understand what a backup contact means. Another member expressed concerns with the timing of reporting changes in the primary or backup PSC. She explained that there could be staff turnover and outdated information about who to contact, which should be included in the policy to ensure accurate information. A member suggested requiring a timeframe for when the PSC should confirm and update their information.

Next steps:

The Workgroup will continue to discuss the standardization of the Patient Safety Contact.

2. Duplicate Reporting Solution

The Workgroup reviewed OPTN Policies 15.4.B and 15.5.B, which require OPOs and transplant programs to report recipient illness, thus, increasing the system's burden. The Workgroup also reviewed potential solutions for duplicate reporting. The possible solutions are as follows:

- Establish a specific process in policy on how to report these events.
- Add a system enhancement that shows when a donor has a patient safety event reported.
- Have a system to eliminate reports submitted for the same UNOS ID.

Summary of discussion:

Decision #2: There were no decisions made by the Workgroup.

A member asked if an OPO shares with a transplant center that a donor has an illness, whether the center reports it as a potential transmission, or waits until the recipient becomes ill to report it. Staff replied that while the OPO is responsible for notifying the transplant center of the donor's illness, the center is not responsible for reporting the donor. The transplant program is required to report in the instance that the recipient is suspected to have or is confirmed positive for the potential disease transmission event. The Chair clarified that if the event is initiated by the OPO, it is the OPO's responsibility to report. A member asked about the goal of reporting to the OPTN Improving Patient Safety Portal. Members agreed that the goal is to flag potential disease transmissions.

Staff commented that there was consideration for having the OPOs be responsible for reporting recipient illness. However, there have been challenges when OPOs report for a sick recipient, which results in extra communication with the OPO than when a transplant center reports an ill recipient.

Next steps:

The Workgroup will review duplicate reporting processes to help inform decision-making.

Upcoming Meeting

- September 18, 2023

Attendance

- **Workgroup Members**
  - Megan Fairbanks
  - Emily Blumberg
  - Greg Veenendaal
  - Anna Hughart
  - John Gutowski
  - Lara Danziger-Isakov
  - Maheen Abidi
  - Michael Ison
  - Riki Graves
  - Patrick. R. Wood
  - Sara Geatrakas
  - Stephanie Pouch
  - Vicki Hunter
- **HRSA Representatives**
  - Marilyn Levi
- **SRTR Staff**
- **UNOS Staff**
  - Taylor Livelli
  - Tamika Watkins
  - Kevin Daub
  - Laura Schmitt
  - Logan Saxer
  - Rebecca Brookman
  - Sally Aungier
  - Sandy Bartal
  - Sara Langham
  - Susan Tlusty
- **Other Attendees**