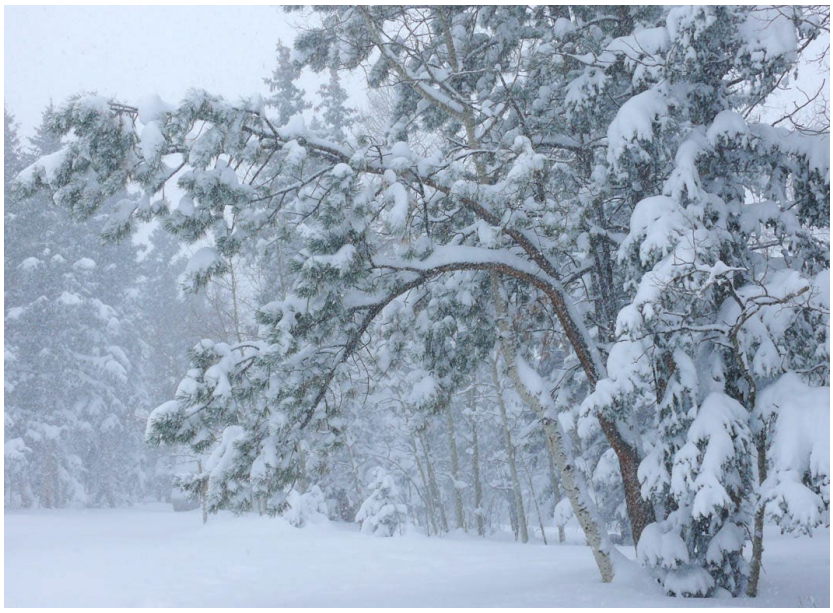
TRANSPLANT PROGRAM

DISASTER/EMERGENCY PLAN

OCTOBER 2023

(Updated Annually in October)

Annex to the MMC Emergency Operations Plan



POLICY AND PROCEDURE: MAINE TRANSPLANT DISASTER PLAN (TDP)

INITIAL PLAN: OCTOBER, 2017

Purpose: The purpose of the Disaster Plan is to outline action steps needed to minimize disruption of care for transplant patients served by the Maine Transplant in the event of a disaster. It is understood that transplant patient needs are unique, and vary depending on phase of transplant, i.e. evaluation, waiting list, transplant event, or post-transplant. This plan focuses on overall continuity of care for transplant patients and does not include details and a comprehensive step by step plan for each disaster or emergency.

Responsibility for TDP: The following individuals are primarily responsible for successful execution and maintenance of this plan: MD Program Director, Surgical Director, and Administrator. Multiple Key Partners are included in this plan and essential to its success : MMC Senior Leadership, Risk Management, Communications, Human Resources, Emergency Management, Inpatient care units (e.g. R5) and Operating Room, and Pharmacy; Maine Health Information Services, NorDx HLA lab, Maine Medical Partners, New England Donor Services, UNOS, CMS, and external transplant program partners such as Partners Healthcare Hospitals.

Annual Update: The TDP will be updated annually at the October Transplant QAPI Meeting.

Primary Goals of the Plan:

1. Continued safe and expert care for patients who are inpatient at MMC and have just been transplanted;
2. Continued access to organ offers and transplantation for patients active on the UNOS waiting list;
3. Continued safe and expert care for patients who have received a transplant and are being seen on an outpatient basis; and,
4. Effective communication with all affected parties including pre and post-transplant patients, patients scheduled for appointments, referring physicians, MMC Risk Management, MMC Communications, community dialysis centers, NorDx lab, program and inpatient/operating room staff, MMC leadership, MMC Safety and Emergency Management, UNOS, New England Organ Bank, and CMS.

Definition of a Disaster: Disasters are categorized as follows:

- Naturally occurring events
- Technological events
- Events involving Hazardous Materials
- Human Related Events

The relative threat of each of these types of events is assessed annually by the Safety and Emergency Management Department of Maine Medical Center. This threat is calculated on a 0-100% scale with

100% being the highest relative threat. Events are further categorized by likelihood of occurrence, magnitude, and mitigation needs. A summary of each of these assessments is included in **Appendix A.**

Scope: The scope of this Plan will include events with:

- A high probability of occurrence
- A high or moderate human, property, or business impact

Events in this Category in 2023:

- Severe Thunderstorm
- Ice Storm
- Flood, External
- Epidemics of Existing Disease
- Global Pandemics of Disease
- Fire Alarm Failure
- Information Systems Failure
- Workplace Violence

Assumptions:

1. The TDP does not replace the MMC Emergency Operations Plan; it is a part of this plan specific to the care of MMC transplant patients. The MMC Emergency Operations Plan is available 24/7 on the MMC Policy and Procedure intranet page.
2. The MMC Emergency Operations Plan includes a plan for interruption of data capabilities and medical record back up; it is not specifically addressed in this plan.
3. A disaster occurring at the 22 Bramhall hospital building will be subject to procedures identified in the MMC Emergency Operations Plan, however specific actions related to the care and potential transfer of transplant patients will be included in this plan.
4. Any disaster occurring at the Transplant Program offices and outpatient center at 43 Baxter Blvd in Portland will be included in this plan.
5. Any disaster which significantly disrupts the operations of the Maine Transplant Program and affects the Program's ability to facilitate organ offers and/or care for transplant patients will be communicated to the United Network for Organ Sharing (UNOS) within the same business day. UNOS operates 24/7 and can be reached at (804) 782-4800. It is understood that communication of inactivity is not **required** until the inactivity period exceeds 14 days.
6. All program staff will be responsible to update their contact information with the Transplant Program Administrative Coordinator annually. In this contact information (**Appendix B**), a cell or pager number will be required.
7. All program staff with clinical, patient scheduling, or financial responsibilities will be required to secure and maintain remote EMR access.
8. A list of Important Phone Numbers, Key Contacts, and Mandatory Notification List information (**Appendix C**) will be included in this plan and updated annually by the Administrative Coordinator or as needed.

9. All Transplant Program staff will be aware of this plan and knowledgeable about its contents.
10. For any disaster requiring an evacuation of the Transplant Program offices and outpatient clinic at 43 Baxter Blvd, a Command Center will be established at MMC in the Department of Nephrology. Please see details in "Command Center Establishment" section of the Disaster Plan Procedure.
11. In the event of a disaster affecting transplant program operations, all staff will be required to assist as needed and directed to provide safe and continuous patient care. This may entail duties that are not typical of their day to day work.

Location of the Transplant Disaster Plan

The Plan will be located on the external Maine Transplant Program website and internally on the Shared Drive. The Emergency Management team will also post the plan in a location that is fully visible to their team.

Declaration and Communication of a Disaster

1. If a disaster occurs, an emergency will be declared. The MD Director, Surgical Director, or Administrative Director may declare an emergency.
2. Immediate communication of an emergency will occur to the following parties by the Administrative Director or a Designee; see Appendix C for required notifications:

   Notification List:

   - MMC Service Line Vice President
   - MMC Physician Leader Service Line
   - MMC Communications
   - MMC Risk Management
   - MMC Accreditation
   - NorDx HLA Lab Director
   - New England Donor Services
   - MMC R5 and Operating Room Nursing Leadership
   - MMC Property Management
   - MMC Emergency Management
   - MMP Nephrology Medical Director and Practice Manager
   - MH Information Services Help Desk
   - MMC Human Resources
   - MMC Inpatient and Outpatient Pharmacy
   - Referral physician offices and dialysis centers; ESRD Network

3. All program staff will be notified via text messaging or pager; if the 43 Baxter Blvd Clinic and administrative offices are uninhabitable; staff will be notified to await direction on specific Command Center location.

4. Not all program staff may need to report to the Command Center or report for duty during an Emergency. Depending on the nature and scope of the Emergency, team members may be asked to work remotely or remain on call for assigned duties.

Evacuation

1. During an emergency, evacuation may be necessary to ensure safety of patients and staff. The MMC Emergency Operations Plan addresses evacuation from the main hospital campus at 22 Bramhall St. in Portland.
2. If evacuation from the 43 Baxter Blvd office is required, site specific emergency plans will be followed.

Command Center Establishment

1. The first choice for Command Center is the Transplant Administrative office at 43 Baxter Blvd
2. If the 43 Baxter Blvd offices are not inhabitable, the following locations will be assessed for availability:
   - Department of Nephrology at MMC
   - Dana Center Conference Rooms
   - MMC East Tower Conference Rooms
   - Maine Health Corporate Offices at 110 Free Street in Portland
   - Maine Health Business Center at 301 Route 1 in Scarborough
3. Requirements for Command Center
   - Telephone
   - Access to Internet and Epic EMR
   - Fax and Copy Machine
   - Physical workspace for up to 10 team members
   - Ongoing availability until disaster is resolved
4. If additional laptop PCs are required, a High Priority request will be made to Information Services for equipment needed.
5. A Command Center telephone line will be established ASAP and communicated to all parties listed above.

Mandatory Daily Huddle

1. A Daily Huddle will be held at the Command Center to address the status of the emergency, tasks completed and to be completed, and any alterations needed in the Disaster Plan.
2. The Huddle will include at minimum, the following: MD Director, MD Associate Director, Surgical Director, Administrator, Pre RN Coordinator, Post RN Coordinator, Administrative Coordinator, Transplant Nurse Practitioner, Transplant Pharmacist, Transplant Social Worker, and Transplant Financial Counselor. Ad Hoc attendance will include the HLA Director, NEDS liaison, and MMC Emergency Management and other affected areas. Required attendees may be altered based on the nature of the emergency.

Media and External Communications

1. During an emergency, it is recognized that communication to patients, the community, and the media is crucial to maintain public confidence, educate existing and potential patients, and establish timely, consistent and accurate information transmission.
2. A Communications Plan will be established in collaboration with the MMC Communications and Public Affairs Department within 48 hours of the emergency or sooner if possible.
3. **ALL** media and external communications regarding the emergency will be directed and provided by the MMC Communications and Public Affairs Department.
4. A variety of communication methods will be utilized: media, website, written communication, email, and telephone.

Mandatory Activities: Transplant Program Activities That Require Continuation during a Disaster

Activity	**How Often**	**Responsible Transplant Team Member**
Organ acceptance, logistics, tissue typing, ABO verification	Daily and 24/7	On Call RN Coordinator and On Call Surgeon
Waitlist Management	Daily	Pre Transplant RN Coordinator
Transplantation	On Demand	Transplant Surgeons and Surgical Team
Inpatient management of pre and post-transplant patients	Daily	Transplant Nephrology and Surgery
Financial eligibility and insurance determination	On Demand	Transplant Financial Counselor
Adverse Event Review and Notification	On Demand	Quality Business Analyst and Transplant Team Members
Post-Transplant patient management, including biopsies	On Demand and as Scheduled	Post-Transplant RN Coordinator; Nephrologist and Surgeon
Patient medical record documentation	Daily	All Team Members
UNOS and CMS communications and notification (incoming and outgoing)	On Demand	Transplant Director
UNOS Reporting (TIEDI) Activities	On Demand and per UNOS posted schedule	RN Coordinators; Medical Assistant
Dialysis Center communication	On Demand	Pre Transplant RN Coordinator; Medical Assistant
National Kidney Registry activities	Daily	Living Donor RN Coordinator

Activities that May be Temporarily Suspended during a Disaster

Activity	How Often	Responsible Transplant Team Member
Referral processing	On Demand	Administrative Coordinator
Pre Transplant Education	On Demand Class	Pre Transplant Coordinator
Outpatient social work evaluations	On Demand and As Scheduled	Transplant Social Worker
Outpatient pharmacy evaluations	On Demand and As Scheduled	Transplant Pharmacist
Outpatient nutrition evaluations	On Demand and As Scheduled	Transplant Dietitian
Transplant Candidate Review	Every other week	Full transplant team
Transplant Evaluation Visits	On Demand and As Scheduled	Multiple Transplant Team Members
Living Donor Evaluation Visits	On Demand and As Scheduled	Multiple Transplant Team Members
Quality Committee Meetings and Activities	Monthly	Quality Business Analyst

Mandatory Activities Plan

Activity: Organ Acceptance, logistics, tissue typing, ABO verification

Key Team Members and Partners: Pre Transplant Coordinators, Transplant Nurse Practitioner, HLA Lab Director and Staff, UNOS, New England Donor Services (NEDS), Transplant Surgeons, UNOS, MMC Communications

Procedures:

1. The Administrator will contact New England Donor Services (NEDS) and the HLA Lab immediately upon determination of an emergency that may affect organ acceptance and management activities.
2. NEDS and MMC transplant program clinical and administrative leadership will collaborate on the most appropriate course of action given the nature of the emergency and limitations presented. This collaboration is outlined in the *Maine Transplant Program/NEDS Emergency Organ Acquisition Protocol* (**Appendix D**)
3. If the Program is unable to accept organs or engage in other transplant activities for less than 15 days, it is not required that UNOS be notified. The program may voluntarily inactivate for no more than 14 days by changing its UNet waiting list status to *inactive*.
4. If the program is inactive for 15 more consecutive days, UNOS and patients must be identified per specific requirements of UNOS Bylaws: Appendix K *Transplant Program Inactivity, Withdrawal, and Termination* (**Appendix E)**.
5. The Surgical Director and MD Program Director will determine if it is possible to continue transplantation activities during the emergency.

6. Every effort will be made to continue transplantation of patients at MMC during the emergency and maintain UNet organ screening and placement activities.
7. All MMC policies and procedures regarding ABO verification will remain in effect during an emergency with the exception of procedures that require completion at an alternate location (i.e. transplantation at an alternate facility).
8. If transplantation is not possible at MMC, arrangements will be initiated to have the patient/organ travel to another transplant center in the area (See #3, Transplantation).
9. The transplant team will partner with MMC Communications to post any relevant information and updates on the Maine Transplant Program website.
10. Patients on the waiting list will be notified via one of the following methods: letter, text, phone call and/or the Maine Transplant website of the emergency and any impact on their waitlist status or ability to receive an organ offer.
11. The Pre Transplant Coordinator and Surgeon on call will be primarily responsible to continue organ acceptance activities during an emergency.

Activity: Waitlist Management

Key Team Members and Partners: Associate Medical Director, Pre Transplant Coordinators

Procedures:

1. The Associate Medical Director, who leads the Pre Transplant Team, will direct waitlist management activities and priorities during an emergency.
2. Candidates who are active on the waiting list will be considered a priority for management during an emergency.
3. Unless the Program is in an inactive status, patients on the waiting list will continue to be managed during the emergency according to program policies and procedures.
4. Any change in the Program's ability to provide transplantation services to patients on the waiting list will be communicated to all listed patients via one of the following methods: letter, text, phone call, and/or the Maine Transplant website.
5. Patients on the waiting list with upcoming appointments will be contacted by the Pre Transplant Coordinator or Patient Services Representative as soon as possible if access to the outpatient clinic has been affected by a disaster.
6. Pre Transplant Coordinators will maintain 24/7 access to UNet and Epic if possible to access information regarding patients on the waiting list
7. All regulatory requirements regarding documentation and communication with waitlisted patients will continue during an emergency.
8. Pre Transplant Coordinators and the Transplant Social Worker will communicate with dialysis centers regarding the emergency and any modifications needed in communication method or process

Activity: Transplantation and Inpatient Management of Pre and Post-Transplant Patients

Key Team Members and Partners: MD Program Director; Surgical Director, Surgeons, Transplant Nurse Practitioner, Transplant Pharmacist, Transplant Social Worker, Transplant Financial Counselor, Transplant Nutrition, Operating Room, External Transplant partners

Procedures:

1. In the event that MMC is unable to provide transplantation, the MD Program Director and/or Surgical Director will contact Partners Health Care transplant programs in Massachusetts to assess their ability to provide this service to patients on our waiting list.
2. The Administrator will promptly notify New England Donor Services (NEDS) of the emergency and status of plans to transplant patients at another transplant facility.
3. The Transplant Financial Counselor will communicate with the insurance companies of affected patients to secure necessary approval and authorization for care outside of MMC.
4. Medical records of MMC patients can be accessed via the *Care Everywhere* functionality of Epic.
5. Waitlist patients who are called for deceased organ offers will be informed of their options for transplantation, and may choose to decline based on geographic distance.
6. Living Donor surgeries will be suspended if MMC is unable to provide transplantation services.
7. The MMC Emergency Management Plan addresses plans to evacuate hospital patients if needed, or transfer patients to other units if an emergency is confined to a select area. The TeleTracking System will be utilized to assess available beds and resources.
8. If transplant patients are in the hospital, on the transplant service, and need to be transferred to another hospital, the MD Program Director, Surgical Director, and Inpatient Nephrologist will convene to review patient care plans. Patients may be transferred to another Maine Health hospital, local community hospital, or another transplant hospital (Partners Healthcare) depending on care plan and individual needs. Per the hospital Emergency Management Plan, transport of these patients will be provided via an established Incident Command Center.
9. Arrangements may also need to be made with outside hospitals or transplant centers to provide dialysis.

Activity: Financial Eligibility and Insurance Determination

Key Team Members and Partners: Transplant Financial Coordinator; Director, Network Development and Contracting

1. The Transplant Financial Coordinator will be primarily responsible to complete financial and insurance verification functions during an emergency, and notifying insurance companies as needed.
2. All patient specific financial and insurance activities will continue to be documented in the EMR.
3. The Maine Health Managed Care Department (Director, Network Development and Contracting) may be contacted for assistance in securing emergency authorizations or contacting current payer network representatives to notify them of service unavailability or changes.

4. If an alternate transplant facility must be utilized, the Financial Counselor will review authorizations for patients active on the waiting list and identify needs for any change in authorization. If payer authorization is delayed or denied, the patient/candidate will be informed and may need to be inactivated on the UNOS waiting list until insurance arrangements are verified.

Activity: Adverse Event Review and Notification

Key Team Members and Partners: MMC Risk Management

1. The Maine Transplant Program *Adverse Event Policy* and the following MMC Policies will continue to be in effect during an emergency:
    a. *Reporting Patient Safety Concerns: Adverse Event Reporting*
    b. *Sentinel Events*
2. Transplant program staff will continue to collaborate with the Risk Management department and other relevant departments to report and address adverse and/or safety events in a prompt and appropriate manner.
3. Any disaster impacting any aspect of transplant operations will be considered an Adverse Event and will be reported and reviewed accordingly (see also Debriefing, below).

Activity: Post-Transplant Patient Management

Key Team Members and Partners: MD Director; RN Post Transplant Coordinators; Medical Assistant, Transplant Pharmacist; NorDx

1. The MD Director will direct post-transplant patient management activities and priorities during an emergency.
2. During an emergency, immediate post-transplant patients will be considered a priority (most recent to one year post-transplant).
3. A report of post-transplant patients and date of transplant will be produced by the Quality Business Analyst or Transplant Administrator for review. The post-Transplant RN Coordinator and MD Director will review the patient list and assess patient needs requiring action.
4. With the assistance of the Medical Assistant and Administrative Office Coordinator, the outpatient clinic schedule will also be reviewed for upcoming post-transplant appointments. Patients with scheduled appointments will be contacted ASAP to assess needs and communicate alternate clinic arrangements if access to the outpatient clinic has been affected.
5. A list of pharmacies capable of dispensing immunosuppression and antiviral drugs will be maintained as part of this plan (**Appendix F**) and consulted as needed should access to a particular pharmacy, such as the MMC pharmacy, be curtailed.
6. A list of NorDx draw locations will also be maintained as part of this plan (**Appendix G**) and posted on the Maine Transplant website. Patients will be directed to this list as an alternative to the 43 Baxter Blvd outpatient clinic lab if the outpatient clinic has been affected.
7. If the MMC campus is unavailable to complete a post-transplant biopsy, the MD Director will initiate contact with Southern Maine Health Center to have biopsies completed by Radiology

with consultation from transplant nephrology. Results would be sent to Pathology at MMC or Brigham Women's pathology as an alternate.

8. If the outpatient clinic is unavailable due to an emergency, and expected to be unavailable for a period greater than one week, alternate office arrangements will be made at the MMP Nephrology clinic.

Activity: Patient Medical Record Documentation

Key Team Members and Partners: All team members; MMC HIM

1. During an emergency, documentation in the patient record of all activities is crucial to maintaining care continuity.
2. All providers, clinical care, and support staff will be required to document all activities related to patient contact and communications in the EMR as per medical record documentation guidelines.
3. Unavailability of the EMR for documentation is addressed in department downtime procedures and the MMC Emergency Operations Plan.
4. All team members will be expected to utilize agreed upon methods of communication via the EMR including in basket and staff messaging.

Activity: UNOS and CMS Communications

Key Team Members and Partners: Administrative Director; UNOS; CMS Regional Office; CMS Central Office Representatives; MMC Accreditation; Adult Medicine Service Line Leadership

1. The Administrative Director will be primarily responsible for notification of UNOS and CMS during an emergency. Notification will occur via email with confirmed delivery. If email is unavailable, telephone communication may be utilized.
2. Prior to communication with UNOS and/or CMS, communication with MMC Accreditation will occur regarding the type, purpose, and requirements for communication.
3. UNOS will be notified if there is a substantial change in the program's ability to function, i.e. accept organ offers and care for transplant patients. This notification is not required until the program is inactive for longer than 14 days, but will be communicated to our UNOS Regional Representative as a courtesy.
4. UNOS Bylaws: Appendix K *Transplant Program Inactivity, Withdrawal, and Termination* (**Appendix E** of this document) will be followed if the program is determined to be inactive.
5. CMS Regional Representatives and the CMS Central Office will be notified within 7 business days of any changes in the program that affect the program's ability to meet the transplant Conditions of Participation. If the program is determined to be inactive, per UNOS policy guidelines, CMS notification is required within 7 business days.
6. Any communication to UNOS and/or CMS will be copied to the MMC Accreditation office and VP and Physician Leader of the Adult Medicine Service Line.
7. Any incoming communication from UNOS and/or CMS will also be copied to the MMC Accreditation office and VP and Physician Leader of the Adult Medicine Service Line.

Activity: UNOS Reporting Activities

Key Team Members and Partners: RN Coordinator; APNP, Medical Assistant; UNOS

1. UNOS Reporting activities need to continue during an emergency to ensure patient safety and accuracy of clinical information.
2. Reporting activities will be assigned to a RN Coordinator, APNP, Medical Assistant, or a combination.
3. If UNOS reporting functions are interrupted during the emergency, or additional assistance is needed, the UNet 24 hour resource line will be contacted: 1-800-978-4334.

Activity: Dialysis Center Communication

Key Team Members and Partners: Community Dialysis Centers; Medical Assistant

1. Dialysis Centers for listed patients are recorded in the EMR and a report can be generated of waiting list patients and their dialysis centers. This report (Epic BI Portal: *TXP Dialysis Unit Referrals*) is routinely generated on a monthly basis for purposes of status updates with dialysis centers.
2. A listing and contact numbers of dialysis centers for patients on the waiting list will be maintained and is included in **Appendix H**.
3. Any emergency that affects the status of patients on the waiting list will be communicated to the dialysis centers listed via email or phone as soon as possible, but no later than 72 hours after the declaration of an emergency.
4. A Transplant Program team member will be assigned to contact dialysis centers for patients on the waiting list, with priority given to notification for patients on the active waiting list at the time of the emergency. The dialysis center will be provided with any information available at that time: nature of the emergency, impact upon patients, plans for resolution, estimated time of resolution, and the Command Center telephone number.
5. Although individual communication will occur with each patient on the waiting list, the dialysis center will be asked to confirm receipt of communication with affected patients.

Activity: National Kidney Registry (NKR) Activities

Key Team Members and Partners: RN Living Donor Coordinator; MD Director Living Donation; NKR Director of Education and Development

1. Continued participation in the National Kidney Registry is important for enrolled patients to ensure maximum access to available organs and matches.
2. The current status of NKR participants will be reviewed within 24 hours of the declaration of an emergency by the RN Living Donor Coordinator and Living Donor MD Director. The MD Director will make a decision as to the feasibility of continued participation in NKR during the emergency, and communicate this decision to the Medical Director and Administrative Director, and NKR.

3. Any change in status of enrolled patients will be communicated to the patients via telephone and in writing.

Mandatory Debriefing

Key Team Members and Partners: Transplant Program Leadership; team members; Adult Medicine Service Line Leadership; all parties in the Mandatory Notification List

Anytime an emergency occurs, a team debriefing will be held as soon as possible following the resumption of regular operations. This debriefing will include the following:

- Review of adherence to the Disaster Plan
- Need for revisions to the plan
- Appreciation to participants, both external and internal
- Identification of resource offerings for staff or patients who could benefit from additional counseling or support
- MMC Risk Management may be invited to facilitate the debriefing

Created: 10/2017

Revised: 10/2019, 10/2020, 10/2021, 10/2022, 10/2023

Approved by the Transplant Quality Assessment and Performance Improvement Committee on 12/15/2023

Champion: John P. Vella, MD, FRCP, FACP, FASN, FAST

Director, Nephrology and Transplantation, Maine Medical Center

APPENDIX A

MAINE MEDIAL CENTER HAZARD VULNERABILITY ASSESSMENT TOOL

Maine Medical Center
Maine Transplant Program
43 Baxter Blvd., Portland, ME

Maine Medical Center Hazard Vulnerability Assessment Tool

2023

Naturally Occuring Events

EVENT	PROBABILITY	MAGNITUDE			MITIGATION			RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood of occurance	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Mitigation Planning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat*
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = None Required 1 = Mitigation Plan in place 2 = Needs Improvement 3 = Need to Develop*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Hurricane	2	1	2	2	2	1	1	33%
Tornado	1	2	2	2	2	1	1	19%
Severe Thunderstorm	3	1	1	1	1	1	1	33%
Snow Fall	2	1	1	1	1	1	1	22%
Blizzard	2	2	1	2	1	1	1	30%
Ice Storm	3	2	2	2	1	1	1	50%
Earthquake	1	1	1	1	1	1	1	1%
Tidal Wave/Tsunami	1	1	1	1	1	1	1	11%
Temperature Extremes Coldwave	2	1	1	1	1	1	1	22%
Temperature Extremes Heatwave	1	1	1	1	1	1	1	11%
Drought	1	1	0	1	1	1	1	9%
Flood, External	3	1	2	2	2	1	1	50%
Wild Fire	0	0	0	0	0	0	0	0%
Landslide	0	0	0	0	0	0	0	0%
Dam Inundation	0	0	0	0	0	0	0	0%
Volcano	0	0	0	0	0	0	0	0%
Epidemics of Existing Disease	3	2	0	2	1	1	1	39%
Epidemics of Emerging Disease	2	2	1	3	1	1	1	33%
Global Pandemics of Disease	3	2	1	3	1	1	1	50%
AVERAGE SCORE	1.58	1.11	0.89	1.32	0.95	0.79	0.79	22%

RISK = PROBABILITY x SEVERITY (Magnitude - Mitigation)
0.17 0.53 0.32

Maine Medical Center

Maine Transplant Program

43 Baxter Blvd., Portland, ME

Maine Medical Center Hazard Vulnerability Assessment Tool

2023

Technological Events

EVENT	PROBABILITY	MAGNITUDE			MITIGATION			RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood of occurance	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Mitigation Planning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat*
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = None Required 1 = Mitigation Plan in place 2 = Needs Improvement 3 = Need to Develop*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Electrical Failure	2	1	3	3	1	1	1	37%
Generator Failure	0	0	0	0	0	0	0	0%
Transportation Failure	1	0	0	1	0	0	0	2%
Fuel Shortage	1	1	1	2	1	1	1	13%
Natural Gas Failure	1	2	1	2	1	1	1	15%
Water Failure	2	0	0	3	1	1	1	22%
Sewer Failure	2	0	2	3	1	1	1	30%
Steam Failure	0	0	0	0	0	0	0	0%
Fire Alarm Failure	3	3	3	3	1	1	1	67%
Communications Failure:Internal*	0	0	0	0	0	0	0	0%
Communications Failure:External**	2	1	0	2	1	1	1	22%
Medical Gas Failure	0	0	0	0	0	0	0	0%
Medical Vacuum Failure	0	0	0	0	0	0	0	0%
HVAC Failure	2	1	2	2	1	1	1	30%
Information Systems Failure	3	1	0	3	1	1	1	39%
Fire, Internal	2	3	3	3	1	1	1	44%
Flood, Internal	2	1	3	3	1	1	1	37%
Hazmat Exposure, Internal	2	1	1	1	1	1	1	22%
Supply Shortage	2	1	0	2	2	1	1	26%
Structural Damage	2	1	1	2	1	1	1	26%
Explosion	2	3	3	3	1	1	1	44%
AVERAGE SCORE	1.29	0.83	0.96	1.58	0.67	0.63	0.63	23%

*Overhead paging, alpha numeric paging, etc.

**Telephone, cellular, radio systems, etc.

RISK = PROBABILITY x SEVERITY (Magnititue - Mitigation)		
0.17	0.49	0.34

Maine Medical Center
Maine Transplant Program
43 Baxter Blvd., Portland, ME

Maine Medical Center Hazard Vulnerability Assessment Tool

2023

Events involving Hazardous Materials (Chem/Rad/Nuclear)

EVENT	PROBABILITY	MAGNITUDE			MITIGATION			RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood of occurance	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Mitigation Planning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat*
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = None Required 1 = Mitigation Plan In place 2 = Needs Improvement 3 = Need to Develop*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Hazmat Incident *(> 5 victims)*	0	0	0	0	0	0	0	0%
Small Casualty Hazmat Incident *(< 5 victims)*	1	1	1	2	2	1	1	15%
Chemical Exposure, External	1	2	1	3	2	1	1	19%
Small-Medium Sized Internal Spill	2	1	1	1	1	1	1	22%
Large Internal Spill	1	2	2	3	1	1	1	19%
Terrorism, Chemical	1	3	3	3	3	1	1	26%
Radiologic Exposure, Internal	0	0	0	0	0	0	0	0%
Radiologic Exposure, External	1	1	0	1	2	1	1	11%
Terrorism, Radiologic	1	2	2	2	2	1	1	19%
Terrorism, Nuclear	1	3	3	3	3	2	2	30%
AVERAGE	0.69	1.15	1.00	1.38	1.23	0.69	0.69	16%

RISK = PROBABILITY x SEVERITY (Magnitude - Mitigation)

0.13 0.30 0.44

Maine Medical Center

Maine Transplant Program

43 Baxter Blvd., Portland, ME

Maine Medical Center Hazard Vulnerability Assessment Tool

2023

Human Related Events

EVENT	PROBABILITY	MAGNITUDE			MITIGATION			RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood of occurance	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Mitigation Planning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat*
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = None Required 1 = Mitigation Plan in place 2 = Needs Improvement 3 = Need to Develop*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Incident (trauma)	2	3	1	2	2	2	2	44%
Mass Casualty Incident (medical/infectious)	2	3	1	3	2	2	2	48%
Terrorism, Biological	2	3	2	3	2	2	2	52%
VIP Situation	0	0	0	0	0	0	0	0%
Infant Abduction	1	3	0	3	1	1	1	17%
Hostage Situation	2	3	1	3	1	1	1	37%
Civil Disturbance	1	2	1	2	1	1	1	15%
Labor Action	0	0	0	0	0	0	0	0%
Forensic Admission	1	1	0	0	1	1	1	7%
Workplace Violence*	3	1	1	2	1	1	1	39%
Bomb Threat	2	1	1	3	1	1	1	30%
AVERAGE SCORE	1.45	1.82	0.73	1.91	1.09	1.09	1.09	26%

** Threat, Assault, rape, homicide*

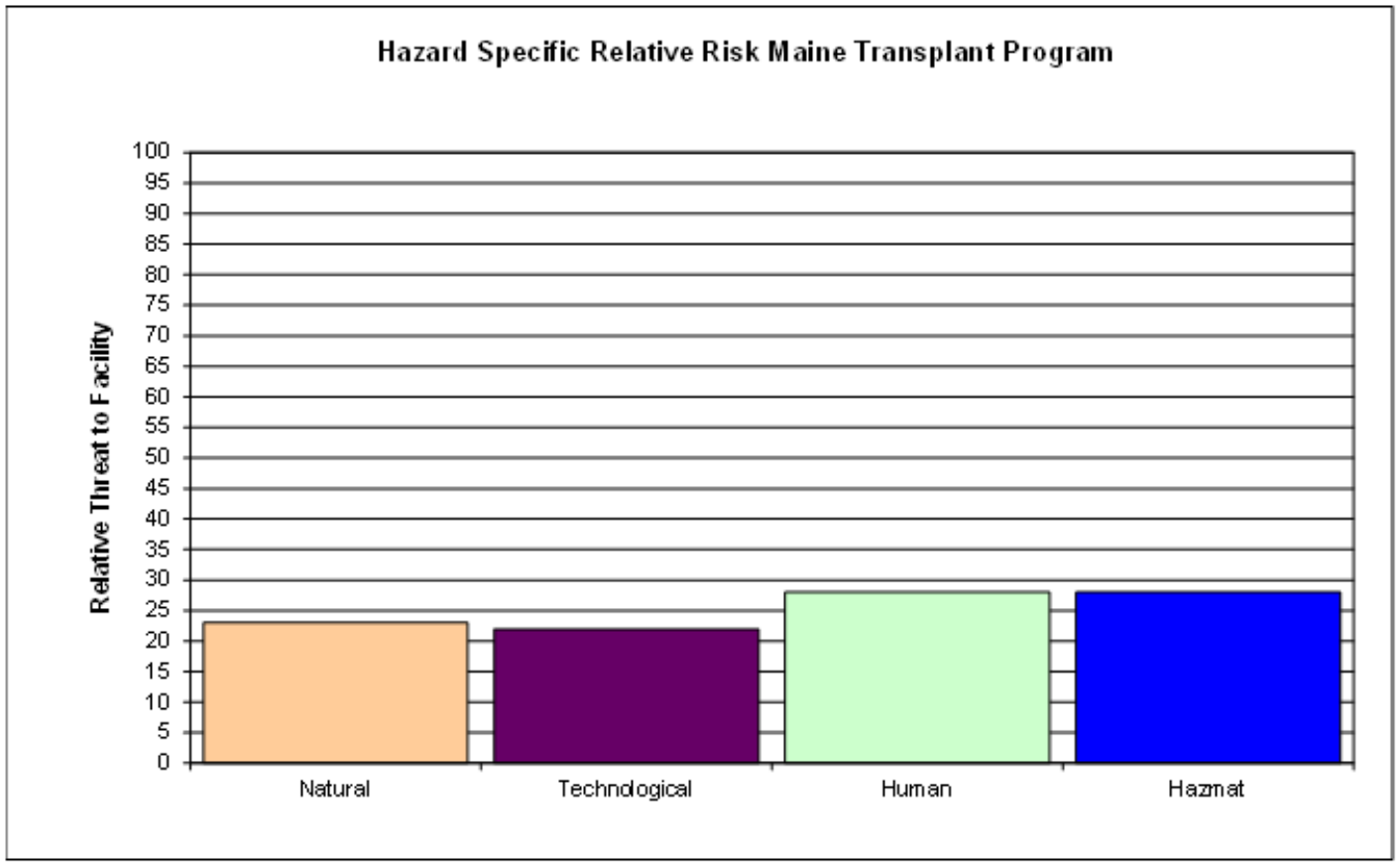
RISK = PROBABILITY x SEVERITY (Magnitude - Mitigation)

0.21 0.48 0.43

Maine Medical Center

Summary of Hazards

	Natural	Technological	Human	Hazmat	Average
Hazard Specific Relative Risk:	23	22	28	28	25



Appendix B

Maine Transplant Program

Contact Information

October 2023

Name	Title/Position	Contact Number; Cell or Pager
John Vella, M.D.	Medical Director/Nephrologist	207-838-5132
Mike Akom, M.D.	Nephrologist	207-210-7382
Mark Parker, M.D.	VP – Quality & Safety/Nephrologist	207-671-4112
Juan Palma-Vargas, M.D.	Surgical Director/Living Donor Director/	207-420-7220
Faysal Elgilani, M.D.	Transplant and Living Donor Surgeon	517-488-8895
Larry Melton, M.D.	Nephrologist	214-621-7446
Hassan Mahmoud, M.D.	Nephrologist	207-239-0153 or pager 207-741-0600
Deborah Hoch, DNP, CCRN, ACNP-BC	Transplant Nurse Practitioner	207-286-6846 or pager 207-767-8411
Ardyce Peters, M.S.	Administrative Director	414-588-5209
Heather Stephen, RN	Living Donor Coordinator	207-632-7124
Andrew Pixley, RN	Living Donor Coordinator	207-712-5488
Nicole Irvin, RN	Pre-Transplant Coordinator	207-232-4626
Terry Boulos, RN, BSN, CCRN	Pre-Transplant Coordinator	207-233-0935
Sarah Heywood, RN	Pre-Transplant Coordinator	207-951-5695
Heidi Algara, RN, BSN	Post-Transplant Coordinator	207-831-4530
Don Price	Post-Transplant Coordinator	207-607-9701
Elizabeth Bernazzani, RN	Post-Transplant Coordinator	617-775-2100
Patricia Messer	Practice Supervisor	207-891-9235
Ashley White	Financial Coordinator	207-595-4230
Sarah Moran, LCSW	Transplant Social Worker	207-332-9687
Marizela Savic, Pharm. D., BCPS	Transplant Specialty Pharmacist	207-408-9962
Felicia Bryant, RD	Transplant Dietician	207-662-6504
Alexandra Marcotte, RD	Transplant Dietician	207-662-2349
Ron Rubocki, PhD	Director HLA Lab	207-653-7573 or pager 207-741-3025

Shelby Mc Donnell, MS	Quality Business Analyst	971-331-9690
David Clark, M.D.	Clinical Research Institute; SRTR Support	207-661-7609
Jackie Lapointe, RN	Research Coordinator	508-633-8048
Frank Chessa, PhD	Living Donor Advocate	207-239-5643
Laura Madigan-McCown, M.A., LCSW	Living Donor Advocate	207-838-2734
Paul Arthur, PhD, BSN	Living Donor Advocate	207-882-9789
Klaryssa Bryan	Medical Assistant	207-604-3381
Marie Simoneau	Medical Assistant	207-396-0381
Shellylee Remington	Medical Assistant	207-294-1785
Kaitlin Remington	Phlebotomist	207-321-9730
Jana Jacobs Drake, MBA, BSN, RN	Director, R5 Patient Care Unit	207-662-4209
Sarah Dennison, RN, BSN	Nurse Manager, R5 Patient Care Unit	207-749-5871

Appendix C

Maine Transplant Program

Important Phone Numbers, Key Contacts, and Mandatory Notification List (People Outside the Transplant Program)

October 2023

Name	Title/Position	Contact Number; Cell or Pager	Notification
Wendy Osgood	VP, Adult Service Line	Pager 207-767-6721	ANY DISASTER
Natasha Bartlett	Director, Accreditation and Regulatory	Pager 207-807-4783	ANY DISASTER
Jennifer O'Neill	Patient Safety Specialist	207-662-2617	ANY DISASTER
Mark Parker, MD	VP - Quality & Safety	207-671-4112	
Ron Rubocki	Director, NorDx HLA Lab	207-662-2711, Pager 207-741-3025	ANY DISASTER
Jana Jacobs Drake, MBA, BSN, RN	Director, R5 Patient Care Unit	207-662-4209	ANY DISASTER
Caroline Cornish	Manager, Communications and Public Affairs	207-662-5146	ANY DISASTER
Marilyn Flanders, BSN	VP Patient Care Services	207-662-2217	ANY DISASTER
John Vella, MD	Director, MMP Nephrology	207-662-7189	ANY DISASTER
Thomas Hatch	Director Safety and Emergency Management	207-662-4560	ANY DISASTER
Jill Worsham	Human Resources Partner	207-662-6958	ANY DISASTER
Michelle Hendrix	Director, Practice Operations, MMP	207-874-2466	Outpatient Clinic Need
Posy Durning, PA	Regional Director, New England Donor Services	617-558-2000	Disaster affecting organ offers, acceptance, and transplantation at MMC

UNOS 24/7 Contact	United Network for Organ Sharing	804-782-4800	Disaster affecting organ offers, acceptance, and transplantation at MMC
Emily McDonnell	Manager, Nursing OR	207-662-2241	Disaster affecting organ offers, acceptance, and transplantation at MMC
ESRD Network	ESRD Network	203-387-9332	Disaster affecting organ offers, acceptance, and transplantation at MMC
Renee Fallon, Pharm D	Director Clinical Services, MMC Pharmacy	Pager 207-767-6912	Disaster affecting organ offers, acceptance, and transplantation at MMC
Alison Perry	Property Manager, 43 Baxter Blvd.	207-662-8065	Disaster affecting operations or facilities at 43 Baxter Blvd.
Help Desk	Information Services	207-662-6400	Disaster affecting access to EMR, PCs, or other electronic communication devices

APPENDIX D

Date 10/13/2017

Dear Transplant Administrator,

The Center for Medicare and Medicaid Services ("CMS") issued revised Emergency Preparedness regulations for participating providers, including transplant centers and organ procurement organizations ("OPOs"). New England Donor Services, Inc., on behalf of its two OPOs, LifeChoice Donor Services, Inc. and New England Organ Bank, Inc. (New England Organ Bank) undertook a thorough review of its Emergency Preparedness Plan ("Plan") and has revised the Plan to ensure compliance with the new regulations which are effective November 17, 2017. The regulations provide that the transplant center and the OPO must develop agreed upon protocols to address each entity's obligations in the event of an emergency. See 42 C.F.R. § 486.360(e) (OPOs); 42 C.F.R. §§ 482.15(g), 482.78. This letter outlines our mutual commitment to collaboration and protocols for meeting our respective responsibilities during an emergency interfering with standard operating procedures. Throughout this letter, your organization is referred to as "Transplant Center".

General

1. The Transplant Center and New England Organ Bank agree to cooperate in all areas of mutual interest related to emergency management, e.g., sharing data, information, planning, response, recovery and other operational support to enhance and maximize the emergency management capabilities of each organization for the purposes of protecting public health and safety and ensuring business continuity for both of our organizations.

2. New England Organ Bank shall notify Transplant Center of any emergency affecting New England Organ Bank operations that also impacts Transplant Center, using the method provided by Transplant Center.

3. Transplant Center shall notify New England Organ Bank of an emergency affecting its operations and/or activation of Transplant Center's emergency plan by calling New England Donor Services, Inc.'s Operations Center (NEDS) 1-800-446-6362 and asking for the Clinical Director on Call (CDOC).

New England Organ Bank Commitments

1. New England Organ Bank has reviewed its operations and responsibilities and has identified the following essential functions which will be maintained under the procedures set forth in its Plan during an emergency affecting its operations:

    a. Receive referrals from donor hospitals in its Designated Service Area at its Operations Center, at an alternative site, or through a third party. The New England Organ Bank Plan provides a mechanism to continue to receive calls through the standard protocol, e.g., through the 1-800 number, during an emergency. Any

changes in protocol will be communicated to Transplant Center at the time of the change using the method identified by Transplant Center.

b. Screen referrals from donor hospitals and respond onsite as appropriate, subject to safety of the donor hospital environment.
c. Obtain authorization for donation from, or provide disclosure of registry status to, the donor's legal next of kin.
d. Assist Transplant Center in facilitating import organ offers.

2. In the event of an emergency impacting the Transplant Center's ability to carry out its transplant related services and requiring utilization of an alternative site for recovery and transplant, New England Organ Bank shall:

a. Attempt to arrange for transportation of Transplant Center staff to alternative locations to perform organ recoveries and transplants.
b. Deliver organs accepted by the Transplant Center to the designated operating room at the hospital location specified by Transplant Center.
c. Support the Transplant Center in reviewing organ offers if access to DonorNet has been impacted by the emergency circumstances.
d. Collaborate with the Transplant Center to facilitate candidate infectious disease testing, at Eurofins VRL - East Coast, or an alternative available laboratory, until such testing may be performed at a laboratory specified by the Transplant Center. This may include the transport of specimen from the Transplant Center's specified location to the laboratory.
e. New England Organ Bank will collaborate with the Transplant Center to facilitate candidate tissue typing specimen transport until such time as Transplant Center's standard processes for tissue typing resume.
f. Provide living donor organ packaging services as needed in the event that emergency circumstances have disrupted the Transplant Center's capability to perform living donor organ nephrectomy or hepatectomy at the same location as the transplantation of the organs.
g. The above laboratory testing or courier/transport activities will be billed as direct costs to the Transplant Center after the emergency circumstances have resolved and Transplant Center services have resumed.

<u>Transplant Center Commitments</u>

The Transplant Center agrees to perform the following functions during an emergency affecting Transplant Center or New England Organ Bank operations:

1. Provide New England Organ Bank with a point of contact to receive information when New England Organ Bank experiences an emergency or activates its Emergency Management Plan.
2. Notify New England Organ Bank regarding the Transplant Center's process for organ offer acceptance during an emergency.

3. Notify OPTN/UNOS of the emergency and provide all emergency contact numbers to OPTN/UNOS.
4. Work with New England Organ Bank to ensure, to the extent possible, the continued availability of recovery and transplant services at the Transplant Center or an alternative location.

Please identify a contact person (email and phone number) for notifications and acknowledge your commitment to the protocol set forth in this letter by signing this document (utilizing the Docusign instructions attached) no later than November 3, 2017.

Feel free to contact me if you have any questions.

Regards,

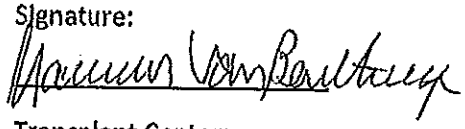
Laine Krislunas

Laine Krislunas

Sr. Vice President OPO Regulatory Compliance
lkrislunas@neds.org

Acknowledged by:

Name:
Maureen VAN Benthuysen

Signature:


Transplant Center:
MAINE TRANSPLANT CENTER, MAINE MEDICAL CENTER

Key contact for related communications:

Name:
ARDYCE PETERS

Position:
DIRECTOR

Phone:
207-662-7181

Email:
APETERS@mmc.org

APPENDIX E

Appendix K:
Transplant Program Inactivity, Withdrawal, and Termination

This appendix defines transplant program inactivity, withdrawal, and termination, and outlines what members must do to be in compliance with OPTN obligations during these periods.

K.1 Transplant Program Inactivity

Transplant programs must remain active in transplantation to maintain membership in the OPTN. There are two types of member inactivity:

1. Short-term Inactivity
2. Long-term Inactivity

A member may voluntarily inactivate a transplant program, on a short-term or long-term basis, for reasons including but not limited to:

- The inability to meet functional activity requirements.
- The inability to serve potential candidates, candidates, recipients, potential living donors, or living donors for a period of 15 or more consecutive days.
- Temporarily lacking required physician or surgeon coverage.
- A substantial change in operations that requires an interruption in transplantation.

For more information about the functional activity requirements for transplant programs, see *Section D.11: Review of Transplant Program Functional Activity* of these Bylaws.

A. Program Component Cessation

Programs that cease performing a specific type of transplant (e.g. the living donor component of a transplant program, or cessation of only pediatric or only adult transplants in a transplant program that performs both), must notify every patient affected by the cessation, including:

- Potential candidates, including those currently in the referral or evaluation process
- All candidates registered on the waiting list
- Potential living donors, including those currently in the referral process, in the evaluation process, or awaiting donation

Ceased Component*	**All Affected Patients Being Treated or Evaluated by the Transplant Program Including:**
Living Donor Component	• Potential Living Donors • Potential and waitlisted candidates who have already expressed interest in LD
Deceased Donor Component	• Potential and waitlisted deceased donor candidates
Adult Component	• Potential and waitlisted adult candidates • Potential and waitlisted pediatric candidates who may turn 18 during the component cessation period
Pediatric Component	• Potential and waitlisted pediatric candidates

*In instances when a program elects to cease transplant for a subset of patients within a program component, such as infants in a pediatric component, the affected group would be further defined to only include that specific patient population.

For more information about the notification content and timing requirements, see *Appendix K, Section K.3: Long-term Inactive Transplant Program Status* and *Section K.4: Withdrawal or Termination of Designated Transplant Program Status* of these Bylaws.

K.2 Short-term Inactive Transplant Program Status

Short-term inactivity is defined as a transplant program that is inactive for no more than 14 consecutive days. A transplant program may voluntarily inactivate for no more than 14 days by changing its UNet^{SM} waiting list status to *inactive*.

When a member intends to voluntarily inactivate a transplant program on a short-term basis, the member is not required to notify the OPTN.

A. Notice to Patients

A transplant program must provide candidates and recipients with a written summary of its Program Coverage Plan at the time of listing and any time there are substantial changes in program or personnel. If a transplant program knows that it will have periods of short-term inactivity, this should be clearly stated as part of the Program Coverage Plan provided at the time of listing. For more information about the Program Coverage Plan, see *Section D.7.B: Surgeon and Physician Coverage (Program Coverage Plan)* of these Bylaws.

K.3 Long-term Inactive Transplant Program Status

Long-term inactivity occurs when a transplant program is inactive for 15 or more consecutive days.

Members should voluntarily inactivate a transplant program that is not able to serve potential candidates, candidates, living donors, or recipients for 15 or more consecutive days. Voluntary inactivation may extend for a period of up to 12 months.

Long term inactivation results in an inactive waiting list status and an inactive membership status.

A. Notice to the OPTN of Long-term Inactive Status

When a member will voluntarily inactivate a transplant program for 15 or more consecutive days, it must provide written notice, including the reasons for inactivation, to the OPTN Executive Director.

B. Notice to the Patients of Long-term Inactive Status

When a member intends to inactivate a transplant program for 15 or more consecutive days, it must provide written notice to the transplant program's potential candidates, candidates, recipients, and living donors currently being treated by the transplant program. Written notice should be provided at least 30 days prior to the planned inactivation date by a method that can be tracked and that provides proof of receipt, such as:

- Commercial overnight delivery service
- Secure electronic communication
- Registered or certified mail, return receipt requested

Written notice must be provided no later than 7 days after inactivation and include *all* of the following:

1. The reasons for inactivating the transplant program.
2. Explanation that although the patient is still on the waiting list, the candidate cannot receive an organ offer through this program while it is inactive.
3. Options for potential candidates, candidates, recipients, and living donors to transfer to another transplant program.
4. Prior to being registered as an active candidate at another transplant program, the accepting transplant program will complete an evaluation to determine suitability for registration.
5. The phone number of the inactive program's administrative office that can help with transferring to another transplant program.

The member must provide to the OPTN a sample of each type of patient notice it sends to potential candidates, candidates, recipients, and living donors along with a list of patients who received the notice.

If a natural disaster adversely affects the function of a transplant program, the patient

notification requirements will be applied reasonably and flexibly.

C. Reactivation after Voluntary Long-term Inactive Status

A member transplant hospital may reactivate its program after long-term voluntary inactivation by submitting the application materials required by the Membership and Professional Standards Committee (MPSC). The MPSC will decide if all criteria for membership are met and that the program can reactivate. The MPSC will then recommend that the Board of Directors notify the Secretary of Health and Human Services (HHS) of the member's reactivation.

D. Extension of Voluntary Long-term Inactive Status

A transplant hospital that voluntary inactivates may request an extension beyond 12 months by making a request to the MPSC. The request must explain how the extension will benefit the program, and include a comprehensive plan with a timeline for resuming transplantation at the hospital. The program must document that all membership criteria will be met when transplantation is resumed. Requests are subject to the MPSC's review and approval.

K.4 Withdrawal or Termination of Designated Transplant Program Status

Designated transplant program withdrawal means that a member voluntarily gives up its designated transplant program status and provides written notice to the OPTN. Members that withdraw from designated transplant program status are voluntarily closing the transplant program.

Termination of designated transplant program status means that a member's designated transplant program status is terminated by the Secretary of HHS. In the case of noncompliance with policies covered by *Section 1138* of the Social Security Act, the MPSC may recommend that the Board of Directors or the Executive Committee request approval from the Secretary to terminate a member's designated transplant program status as described in *Appendix L: Reviews and Actions* of these Bylaws. The Board of Directors or the Executive Committee may, at its own discretion, request this approval from the Secretary.

Once a member voluntarily withdraws from designated transplant program status or is terminated by the Secretary of HHS, that transplant program may no longer perform organ transplants. At this time, the member must also assist candidates in transferring to another transplant program, as described in *Section K.5: Transition Plan during Long-term Inactivity, Termination, or Withdrawal* below.

A. Notice to the OPTN

A transplant hospital must provide written notice to the OPTN within 30 days of the intent to withdraw its designated transplant program status, including the effective date and reasons for the withdrawal.

B. Notice to the Patients

When a transplant hospital intends to withdraw its designated transplant program status, or its designated transplant program status is terminated, it must provide written notice to the transplant program's potential candidates, candidates, recipients, and living donors currently receiving care.

Written notice should be provided at least 30 days prior to the anticipated date of withdrawal or termination by a method that can be tracked and that provides proof of receipt such as:

- Commercial overnight delivery service
- Secure electronic communication
- Registered or certified mail, return receipt requested

Written notice must be provided no later than 7 days following withdrawal or termination and include:

1. The reasons for loss of designated transplant program Status.
2. Explanation that although the patient is still on the waiting list, the candidate cannot receive an organ offer through this program.
3. Options for potential candidates, candidates, recipients, and living donors to transfer to another transplant program.
4. Prior to being registered as an active candidate at another transplant program, the accepting transplant program will complete an evaluation to determine suitability for registration.
5. The phone number of the program's administrative office that can help with transferring the candidate or potential candidate to another program.

The member must provide to the OPTN a sample of each type of patient notice it sends to potential candidates, candidates, recipients, and living donors along with a list of patients who received the notice.

K.5 Transition Plan during Long-term Inactivity, Termination, or Withdrawal

When a member transplant hospital experiences long-term inactivity, withdraws its designated transplant program status, or its designated transplant program status is terminated, it must:

1. Immediately suspend organ transplantation for the transplant program.
2. Assist potential candidates and candidates in transferring to other designated transplant programs.
3. Provide a list to the OPTN of all of the transplant program's candidates on the waiting list at the time of long-term inactivity, withdrawal, or termination and update it throughout this process. The program should indicate on the list of each candidate if:

- A candidate or potential candidate chooses not to transfer to an alternative transplant program, provide the reason and indicate whether the candidate has been completely informed of the implications of this decision before they are removed from the waiting list.
- A candidate or potential candidate chooses to transfer, indicate the transplant program to which the candidate is transferring. Periodic status updates will be required that documents each candidate's transfer progress until the candidate is evaluated and accepted on the waiting list by another transplant program or removed from the waiting list.

a. Expedite removal of all candidates from the transplant program's waiting list, or, if the patient requests, transfer the candidate to another OPTN member transplant hospital.
b. Initiate transfer of all active candidates hospitalized at the transplant program to an accepting transplant hospital within 7 days of long-term inactivity, withdrawal, or termination. The transplant program must complete the transfer process within 14 days unless transfer would be unsafe or discharge is anticipated within that time, or circumstances outside of the program's control exist that prevent transfer within 14 days. The program must document and submit to the OPTN all efforts to transfer its hospitalized candidates, if it is unable to meet these time periods.
c. Provide a priority list of the most urgent candidates listed at the transplant program with an individualized plan of transfer, potential alternative transplant programs, and a timeline for transferring these candidates according to the following priorities:

    - For liver candidates, all Status 1A and 1B candidates must be transferred within 7 days of long-term inactivity, withdrawal, or termination, followed by all active candidates in descending MELD/PELD score order, with all candidates whose MELD/PELD score exceeds 25 to be transferred within 30 days, followed by all inactive candidates.
    - For lung candidates, active candidates should be transferred according to descending Lung Allocation Scores with highest scores first, followed by inactive candidates.
    - For kidney candidates, those whose PRA (measured or calculated) is over 80 percent should be transferred first, followed by all other active candidates in order of waiting time, then transfer of all inactive candidates last.
    - For heart candidates, all pediatric status 1A and 1B and adult status 1, 2, 3, and 4 must be transferred within 7 days of long-term inactivity, withdrawal, or termination.
    - For multi-visceral organ transplant candidates, transfer must be completed within 30 days of long-term inactivity, withdrawal, or termination.
    - All active candidates should be transferred within 60 days of long-term inactivity, withdrawal, or termination without considering these guidelines.
    - The program must document and submit to the OPTN all efforts made for transfer of its candidates if it is unable to meet these deadlines.
    - Document all efforts to transfer candidates to an alternative designated transplant program including all contacts made to facilitate the transfer of candidates.

- Remove every transplant candidate from the transplant program's waiting list within 12 months of the program's long-term inactivity, withdrawal, or termination date.

A member that experiences long-term inactivity, withdrawal, or termination of a designated transplant program may still have the ability to temporarily provide care to transplant candidates, and provide follow-up care as necessary to transplant recipients and living donors. Should the transplant program continue to provide follow-up care to transplant recipients and living donors, the program must continue to submit OPTN follow up forms through UNet^{SM}. Alternatively, transplant recipients may transfer care to another hospital.

K.6 Transferred Candidates Waiting Time

To ensure equity in waiting times and ease the transfer of candidates from the waiting list, the candidates at programs that voluntarily inactivate, withdraw or lose designated transplant program status will:

1. Retain existing waiting time.
2. Continue to accrue waiting time according to their status on the waiting list at the time of the program's inactivation, withdrawal, or termination of designated transplant program status.

This total accrued waiting time can be transferred to the candidate's credit when the candidate is listed with a new transplant program.

The OPTN may collectively transfer patients from a transplant program, with a status of long-term inactive, withdrawal, or termination, and in other circumstances upon request to one or more active transplant programs.

The transferring transplant program must complete *all* of the following before a collective transfer:

1. All required patient notifications according to *Section K.3: Long-term Inactive Transplant Program Status* or *Section K.4: Withdrawal or Termination of Designated Transplant Program Status.*

2. A written agreement with each accepting transplant program that includes *all* of the following:

a. Request for collective transfer of candidates' waiting times
b. List of patient names and identifiers to be transferred
c. Mutually agreed upon transfer date
d. Assurance of notification and patient consent to transfer according to *Section K.5: Transition Plan during Long-term Inactivity, Termination, or Withdrawal*
e. List of active candidates that the transferring program agrees to change to inactive status if requested by the accepting transplant program
f. Acknowledgement that all patient information and records available to the OPTN will be transferred without modification
g. Acknowledgement that the transplant program accepting the patients accepts responsibility for

patient notification and management according to all applicable OPTN Policies and Bylaws

Each accepting transplant program must develop and implement a plan that includes *all* of the following:

1. Procedure and timeline for reviewing the status on each collectively transferred candidate and amending this status as appropriate until an evaluation is completed in accordance with the accepting program's selection and listing protocol.
2. If the transferred candidate's status is changed from active to inactive as part of the collective transfer agreement or part of implementing the accepting transplant program's plan, then the accepting transplant hospital must notify the candidate about the status change. The notification must include what the candidate must do to be considered for an active status at the accepting transplant program. The notification must be completed within 14 days after the collective transfer date or after the status change date if it occurs post-collective transfer as part of this plan.
3. Expected timeline for completing evaluations and subsequent waiting list status adjustments on collective transfer candidates according to the accepting program's selection and listing protocol.

Upon receipt of the written agreement and plan, the OPTN will review the information and provide an expected collective transfer completion date to all the transplant programs involved. After the collective transfer process has been completed, the OPTN will provide written notification to the transplant programs.

The accepting hospital must submit a progress report to the OPTN that contains an update on the evaluation status of each collective transfer candidate at day 90 following the collective transfer. The accepting hospital must submit this report within 14 days after day 90 following the collective transfer. Additional updates may be requested from the OPTN to monitor progress until all collective transfer candidates are evaluated and accepted on the waiting list by a transplant program or removed from the waiting list.

If the transferring transplant program no longer qualifies as a designated transplant program and does not complete the requirements according to *Appendix K*, the OPTN may approve and complete a collective transfer of candidates' registrations and waiting times if the accepting transplant program requests in writing to complete the transfer.

K.7 Laboratory Tests

If a transplant program is inactivated, terminated or withdraws from membership, it is still responsible for evaluating its candidates. This includes, but is not limited to, performing laboratory tests and evaluations required to maintain the candidate's appropriate status on the waiting list until the time of transfer.

APPENDIX F

MAINE PHARMACIES DISPENSING ANTIVIRALS AND IMMUNOSUPPRESSANT DRUGS

Specialty Pharmacies:

1. The Pharmacy @ Maine Medical Center, Portland
   207-662-2626

2. Apothecary By Design
   207-899-0939

Local retail pharmacies may also be used (Hannaford, Walgreens etc.)

NorDx Patient Service Centers (as of October 2023)

Patient Service Centers

We accept walk-ins at some locations, while others are by appointment only. Select a location for more information.

Location	Hours	Walk-In	By Appointment
Falmouth: 5 Bucknam Road, Falmouth, ME 04105	Monday - Friday: 7:30 am -Noon, 1 pm - 3:30 pm	X	Schedule Now
Freeport: 23 Durham Road, Freeport, ME 03801	Monday - Friday: 10 am - Noon, 1 pm - 2 pm		Schedule Now
Lewiston: 198 Main Street, Lewiston, ME 04240	**Temporarily Closed**		Schedule Now
Portland: 22 Bramhall Street, Portland, ME 04102	Monday - Friday: 10 am - 2 pm	X	
Portland: 887 Congress Street, Portland, ME 04102	Monday - Friday: 8 am - Noon, 1 pm - 4 pm	X	
Scarborough: 100 Campus Dr, Ste 126, Scarborough, ME 04074	Monday - Friday: 7 am - 6 pm Saturday: 8 am - Noon	X	Schedule a semen collection appointment Walk in for all other services.
Westbrook: 1 Harnois Avenue, Westbrook, ME 04092	Monday - Friday: 8 am - Noon, 1 pm - 4 pm	X	Schedule Now
Windham: 584 Roosevelt Trail, Windham, ME 04062	Monday - Friday: 7:30 am - Noon, 1 pm - 3:30 pm	X	Schedule Now
Wiscasset: 35 Water Street, Wiscasset, ME 04578	Monday, Wednesday, Friday: 7:30 am - 12:15 pm, 1:15 pm - 4 pm	X	Schedule Now

*Online scheduling details at https://www.mainehealth.org/NorDx/Patient-Service-Centers/Online-Scheduling

APPENDIX H

DIALYSIS CENTERS IN MAINE

Dialysis Unit	Address	Phone
Androscoggin Kidney Center	1100 Minot Avenue, Auburn, ME 04210	(207) 795-1315
Boyd Dialysis	925 Union Street, Suite 1, Bangor, ME 04401	(207) 941-1298
Brewer Dialysis	403 Wilson Street Brewer, ME 04412	(207) 989-0027
Casco Bay Dialysis Facility	1 Chabot Street, Westbrook, ME 04092	(207) 854-9822
Coastal Dialysis Center	55 Congress Avenue, Bath, ME 04530	(207) 443-7485
Northern Light Dialysis	23 North Street, Suite 5, Presque Isle, ME 04769	(207) 768-5863
Damariscotta Dialysis	4 Edward Avenue, Damariscotta, ME 04543	(207) 563-2601
DCI Skowhegan Dialysis Clinic	27 Research Drive, Skowhegan, ME 04924	(207) 474-6002
DCI Greater Waterville	205 Ridge Road, Fairfield, ME 04937	(207) 238-9321
DCI Belfast	125 Northport Avenue, Suite 101, Belfast, ME 04915	(207) 338-1170
Eastern Maine Dialysis	11 Short Street, Ellsworth, ME 04605	(207) 667-9294
Fresenius Kidney Care Freedom Center	1600 Congress St. Suite C, Portland, ME 04102	(207) 761-0203
Fresenius Kidney Care Gardiner	46 Summer St., Gardiner, ME 04345	(207) 582-0148
Kennebec Kidney Center	164 Civic Center Drive, Augusta, ME 04330	(207) 622-7097
Lewiston Auburn Kidney Center	710 Main Street, Lewiston, ME 04240	(207) 784-2268
Lincoln Lakes Region Dialysis	250 Enfield Rd, Lincoln, ME 04456	(207) 794-6432
Southern Maine Dialysis Facility	1600B Congress Street, Portland, ME 04102	(207) 774-5985
Sunrise County Dialysis	19 Vanasse Road, Eastport, ME 04631	(207) 853-9600
Umbagog Kidney Center	73 Allen Street, Wilton, ME 04294	(207) 645-2102
York County Dialysis Center	29 Barra Road, Biddeford, ME 04005	(207) 282-3908

DIALYSIS CENTERS IN NEW HAMPSHIRE

Dialysis Unit	**Address**	**Phone**
Fresenius Medical Care of Mount Washington Valley	21 B Poliquin Drive, Conway, NH 03818	(603) 447-3976
Fresenius Medical Care of Cocheco River	343 6th Street, Dover, NH 03820	(603) 742-9765
FMC Seacoast Dialysis	155 Borthwick Avenue, Suite 100, Portsmouth, NH 03801	(603) 436-4567
FMC Strafford County Dialysis	27 Sterling Drive, Rochester, NH 03867	(603) 330-0483
Central New Hampshire Kidney Center	87 Spring Street, Laconia, NH 03246	(603) 528-3738