Maine Medical Center
Maine Transplant Program
Policies and Procedures
Quality Assessment and Performance Improvement (QAPI) Policy

Policy Summary
This policy defines the people and methods by which transplant recipient and living donor patient care processes and outcomes are continuously reviewed and improved upon and communicated throughout Maine Medical Center.

Policy
A multidisciplinary team (see below) consisting of members who are involved in the care of kidney transplant patients will be responsible for establishing and monitoring targeted performance improvement activities. Performance improvement activities will be established based upon the review of outcome and process measures as well as identified program deficiencies and reported adverse events and their corrective action plans. Evaluation of program performance will be made using baseline performance measures, benchmarking and best practice data where available. The team will act upon results of performance improvements and track performance to ensure that improvements are sustained. Quality measures and their benchmarks will be reviewed on an annual basis for tracking on the QAPI dashboard.

Transplant Program QAPI Team Membership

Medical Director of Transplant	Nephrologists
Administrative Director of Transplant	Transplant Surgical Director and Surgeons
Nursing and/or Adult Medicine Service Line Leadership Rep. (Ad Hoc)	Transplant Coordinators (Pre- and Post-Transplant)
Practice Supervisor for Transplant	Anesthesiologists
Cardiology (Ad Hoc)	Quality Business Analyst
Pharmacy Specialist for Transplant	Living Donor Coordinators
Transplant Unit RN Manager or Rep.	Clinical Dietitians
Psychiatry (Ad Hoc)	NorDx HLA Laboratory
Transplant Social Worker	Maine Medical Center Risk Management (Ad Hoc)

Procedures
The QAPI Team will be responsible for the following:

- Develop Annual Transplant QAPI Plan in collaboration with Adult Medicine Service Line Quality Council and hospital and hospital Annual Implementation Plan
    - Reviewing program data: Collect, present, and review transplant data to reflect practices throughout the transplantation pathway
    - Monitor compliance with regulatory body requirements (e.g., UNOS, CMS)
    - Analyze and track measures that are not meeting or exceeding expected standards
    - Analyze and track all adverse events and actions resulting in critical review
- Utilize program data, adverse event analyses and standard level deficiencies found during surveys to identify key quality improvement initiatives.
- Collaborate with other departmental teams involved in the transplant process to identify, monitor, and analyze process and outcomes data
- Establish outcomes and process measures to be used in quality improvement activities. The QAPI Team will annually establish objective process and outcome measures that address all three phases of

the transplant process (pre-transplant, peri-transplant and post-transplant). The kidney transplant dashboard will reflect these measures (see Appendix A).

- The QAPI team will assure that the Living Donor (LD) QAPI team establishes outcome and process measures for all three phases of living donation. The measures will be reflected in the LD QAPI Dashboard (refer to Living Donor Quality Assessment and Performance Improvement (QAPI) policy for specifics)
- Review standard level deficiencies cited in surveys and ensure that policies, procedures, protocols and staff work reflect changes necessary.
- Monitor progress made in quality initiatives.
- Charge working subgroups with improvement work as appropriate.

Frequency of Meeting and Performance Evaluation

QAPI team will meet at least 8 times a year. Meetings will be used for multidisciplinary review of the transplant dashboard (see Attachment B), review of all adverse and critical events, and other issues as identified by Committee members. The QAPI Committee will use Microsystems approach (with ongoing activities fitting into the Plan-Do-Study-Act method) to study and implement improvement activities.

Communication of QAPI Activities (see Appendix B: Quality Reporting Structure) and Interface with Maine Medical Center Quality and Risk Management

- The QAPI Committee will report at least annually to the Maine Medical Center Adult Medicine Service Line Quality Council
- Adverse events will be reported in the RL Solutions Event online system and reviewed by the Maine Medical Center Risk Management team.
    - QAPI will review details of reported adverse events, and will include members of the Committee during meetings to formulate corrective action plans and monitoring processes
    - The Maine Medical Center Risk Management team will collaborate with the transplant team to review select significant events and any event requiring a Root Cause Analysis.
    - The RL Solutions system includes a mandatory identification of each Maine Medical Center event entered as "yes" or "no" involving a transplant patient; all events involving a transplant patient will be automatically forwarded to the Director of Transplant Services for review
- QAPI will monitor Living Donor QAPI metrics and performance improvement activities
- QAPI will review working subgroup activities
- QAPI will ensure that transplant policies are reviewed at least once every three years, and updated more frequently as needed
- QAPI will oversee the creation and ongoing use of Dashboards, Nephrology website, transplant data reports, and balanced scorecards to communicate the performance and improvement related activities of the Maine Transplant Program.

Definitions

Centers for Medicare and Medicaid Services, Organ Transplant Program Interpretive Guidelines, Regulations 482.70: Adverse Event Definition: "an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof."

References

Nelson, Batalden, Godfrey. Quality by Design: A Clinical Microsystems Approach. 2007
Maine Medical Center's Sentinel Event Policy and Procedure
Maine Transplant Program's LD QAPI Policy
Maine Medical Center's Sentinel Event Policy and Procedure

Maine Transplant Program's Adverse Event Policy
Maine Medical Center's Reporting Patient Safety, Concerns, Incident Reporting and Prevention
Maine Medical Center's Annual Implementation Plan

Review Dates: 9/11/13, 2/13/12, 5/26/15, 9/25/18

Updated: 10/15/20, 9/15/23

Approval Committee(s) and Dates:
Maine Transplant Program QAPI Committee: 11/14/11, 10/11/13
Institutional Policy Review Committee: 12/2/13, 9/14/15

Policy Champion: John P. Vella, MD, FACP, FRCP, FASN, FAST – Director, Nephrology and Transplantation

Appendix A: QAPI Kidney Transplant Dashboard

2023 Kidney Transplant Dashboard	Benchmark	Frequency	January	February	March	Q1	April	May	June	Q2	July	August	September	Q3	YTD Current	2022 Outcomes
Total Transplants	n/a	M	3	4	3	10	5	5	6	16	2	3	3	8	34	45
Deceased Donor Transplants	n/a	M	3	2	1	6	2	1	4	7	1	1	2	4	17	23
Living Donor Transplants	n/a	M	0	2	2	4	3	4	2	9	1	2	1	4	17	22
Candidates on the Waitlist at the end of the month	n/a	M	249	253	257	257	258	263	260	260	267	264	261	261	261	243
Percent active (status 1) patients on waitlist	>50%	M	53%	54%	53%	53%	50%	54%	52%	52%	53%	55%	53%	53%	53%	51%
Mandatory UNOS reporting compliance rate	≥95%	Q				100%				100%						
Count of recipients in Referral phase at end of month	n/a	M	57	46	56	56	52	71	52	52	58	60	71	71	71	67
Count of recipients in Evaluation phase at end of month	n/a	M	36	37	34	34	41	37	37	37	36	34	36	36	36	40
Count of recipients who are Ready for transplantation at end of month	n/a	M	28	35	33	33	28	25	22	22	28	31	32	32	32	24
Process Indicators																
Visit #1 recipients with signed Consent to Participate in chart	100%	M	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Signed Consent to Participate is complete/completed in chart at MDC List Visit	100%	M	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Waitlist removal within 24 hours due to event or decision	100%	M	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%
Percent of candidates who were denied at TCR sent letter within 10 days of TCR date?	100%	M	100%	n/a	100%	100%	n/a	100%	100%	100%	100%	100%	n/a	100%	100%	100%
Removal date in delisting letter is the same as the removal date in UNet (for ALL removal reasons except transplant and death)?	100%	M	n/a	100%	n/a	100%	n/a	n/a	100%	100%	100%	n/a	100%	100%	100%	100%
Patient notification letter sent within 10 days of removal from UNet (for reasons other than transplant or death)?	100%	M	n/a	100%	n/a	100%	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	100%
Notification letter sent to candidates within 10 days of decision for candidates deferred at TCR	100%	M	n/a	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%	100%
Percent of waitlisted patients who are Active, and Ready or On Deck with complete HLA monthly draw	≥70%	M	75%	78%	78%	78%	91%	93%	90%	90%	87%	71%	87%	87%	87%	78%
Percentage of patients with cPRA ≥ 80% who are inactive	n/a	M	77%	68%	69%	69%	68%	71%	63%	63%	63%	67%	67%	67%	67%	76%
Prior to Txp Process - Transplanted in Month																

Appendix B: Quality Reporting Structure