

[Below is a 2019 audit of New York organ procurement organization LiveOnNY prepared by the Gift of Life Institute. The Markup re-typed the document to help maintain the confidentiality of its source. Our version does not include appendices provided in the original document.]

## **I. Background and Introduction**

### **A. Gift of Life Institute Assessment Process**

Established in 2004, the Gift of Life Institute (GOLI) is an international training center offering skills-based learning, continuing education, and consulting services. GOLI utilizes industry experts from across the country, including several through its affiliation with Gift of Life Donor Program (GLDP), one of the most experienced OPOs in the nation.

GOLI was engaged in October 2018 to conduct a review and analysis of the clinical operations at LiveOnNY. The scope of our engagement was limited to the organ donation process from initial hospital referral through family authorization. The GOLI team members involved in this on-site review included the following GLDP leadership team members:

Howard Nathan	President, CEO
Richard Hasz	Vice President, Clinical Services
Jan Weinstock	Vice President, Administration and General Counsel
John Edwards	Clinical Administrator
Patti Mulvania	Manager, Training and Development
Gweneth O'Shaughnessy	Director, Hospital Services
Steve Tornone	Associate Counsel
Virignia Robertson	Institute Faculty (writing/construction of report)

Collectively, the GOLI team brings over 160 years of OPO operations and leadership experience to this evaluation. The diversity of subject matter expertise within our team was wide ranging and included: critical care nursing, senior operational leadership, hospital relations, clinical and family consent training, legal counsel and senior administrative leadership. Team composition was broad to ensure reliability of our findings under the circumstances of CMS de-certification and operational jeopardy. (For GOLI Team bios, see Appendix A: Engagement Letter)

To prepare for the on-site component of our assessment of LiveOnNY and to efficiently evaluate the operational practices, we gathered quantitative and qualitative information including:

- Review of relevant policies and procedures
- Review of operational objectives, goals, strategies, and metrics by department within the clinical division
- Analysis of referral, donation, and transplant data and associated OPO-generated reports
- Conference calls with key staff members and organizational leadership
- Meetings with key organizational leaders

From November 2018 through February 2019, our senior clinical leaders were given access to iTransplant to observe referral and case activity. Additionally, we participated remotely via telephone in key staff meetings, facilitated on-site interviews with staff and donor hospitals, and had extensive interactions with leadership.

All of this was required to help us gain a fuller understanding of both the culture and practices including: practice standards, consistency in practice over time, core messaging for staff and hospitals, leadership oversight of cases, decision making and internal review processes, staff performance and accountability, competencies and skills, staffing configurations, data integrity and review, and to capture the unique challenges faced by LiveOnNY within the DSA. In total, this included:

- Confidential interviews with 44 OPO staff (see Appendix B: Interview Chart)
- Interactive presentations by each department leader with the entire GOLI team present
- Telephonic participation in staff meetings and on-site participation
- Daily review of clinical activity and referral disposition spanning three months
- On-site real-time participation in the organ donor referral process
- Telephonic participation in leadership conference calls
- Telephonic participation in team huddles on multiple cases
- Confidential interviews with 37 hospital staff members including several transplant surgeons (see Appendix B: Interview Chart)
- Confidential interviews with 20 Medical Advisory and Governing Board Members

During the assessment period, our own team convened to identify themes and key findings, chart and evaluate practices surrounding organ referral intake, triage, response, authorization and case management procedures, consolidate impressions extracted from qualitative interview findings, and organize information for review of accuracy and completeness.

Subsequently, subsets of our team met to verify information, corroborate findings, and prioritize areas for recommended change. We discussed key elements of our impressions across functional lines to ensure reliability of findings.

## **B. Gift of Life Institute Reporting Format**

We recognize that there will be a broad range of professional backgrounds among the end-users of this report. We have attempted to reduce OPO jargon and nomenclature for readability and comprehension. We are providing our findings and recommendations in three major topic areas. Our aim is to both facilitate clear understanding and to provide a tool that serves as a blueprint for implementing change.

Our report is intended to simplify a very complex set of findings and also to create a departure point for LiveOnNY to develop a performance improvement plan required by CMS. Our key findings and recommendations are grouped into three categories:

1. Donor evaluation process
2. Clinical strategic framework

### 3. Hospital partnerships

#### C. The Impact of LiveOnNY's Internal Narrative

We now have a broader and fuller understanding of the cultural, ethnic and religious diversity of the DSA population; it poses unique challenges for both community education and donor registry management.

There is an increased incidence of complicating factors in the clinical setting surrounding family decision-making. These factors range from multiple language barriers that may interfere with donation conversations, prevalence of cultural differences that impact family support and communication, diversity of hospital care team staff, and religious traditions and belief systems that may collide with donation discussions.

The population diversity in New York City will always account for some degree of underperformance relative to a more homogenous DSA. ***However, we are optimistic that improvements in clinical operations have potential to significantly increase the number of organ donors without necessarily increasing the rate of authorization.***

First, we want to address the organizational narrative for underperformance that seems to be a prevailing ethos; it extends beyond the OPO interviews to the hospital stakeholders. It is consistent within LiveOnNY throughout the vertical hierarchy, from the board level to the front line staff. The perceived reasons for LiveOnNY's chronic underperformance were enumerated to us as:

1. Challenges posed by the diversity of population & disproportionately high percentage of foreign-born residents in the DSA
2. Insufficient community or public education
3. Difficulties and impediments with the donor registry
4. Inadequate hospital engagement; lack of prescriptive guidance for improvement

This narrative regarding the challenges of the DSA is counterproductive and leads hospital partners and LiveOnNY staff to anticipate and expect poor outcomes. *It is our strong opinion that none of these factors, either in isolation or collectively, account for the degree of underperformance at LiveOnNY.* We are confident that donation can improve significantly with a revitalization and overhaul of clinical operations.

The first three factors above are associated with long-term strategies for increasing donation and do not fall under clinical operational functions. Only the fourth factor, hospital partnerships, should be moved to a high organizational priority. OPOs are responsible for building relational hospital partnerships of reciprocal respect, grounded in best practices. The strength of these partnerships is a vital driver of overall performance. LiveOnNY is accountable for the current state of relationships and has the capacity to improve.

LiveOnNY serves the ‘melting-pot’ of our nation and supports world-class transplant centers. Leveraging the diversity of the resident donor population within the DSA to the advantage of patients awaiting transplant in these renowned centers should be considered as a long-term organizational vision. In the interim, short-term interventions to improve operationally are achievable.

#### **D. Summary of Findings**

After several months of monitoring clinical activity, interviewing staff and hospital partners, reviewing policies and procedures, and observing the clinical process in real time, we have identified systemic problems which can be addressed to improve donation outcomes immediately. Our recommendations are embedded in the report and organized in a chart before the appendices.

First, LiveOnNY must address its **overly complex and highly variable process** for donor evaluation and authorization. Donation opportunities are lost due to variability in clinical donor management, inopportune family decision making, or ineffective communication regarding donation.

The over-specialization in clinical roles at LiveOnNY results in three to four different front line staff members on-site for a single donor. During periods of high clinical activity, specialization compounds the organization’s issues with having a qualified team member on-site at critical junctures in the donation process. Specialization has also created silos within the organization that inhibits real accountability and focus on organizational objectives. There was a sense among Family Services Coordinators (FSCs) that supporting grieving families and obtaining authorization for donation could be mutually-exclusive (they are not). There also are known issues with FSCs delaying cases to avoid “getting the ‘no’” on their scorecard. This lack of urgency or intentional delay puts donation at risk and has certainly resulted in lost donation opportunities.

Lack of clear standards and clinical triggers has allowed variation in practice to persist. With a simplified system and well-taught, easily understood clinical triggers, variability can be minimized. Likewise, the complexity and lack of urgency inherent in a heavy dependence on electronic communication systems can be corrected by simplifying communications and focusing on one-on-one problem solving. Consistency in practice will lead to consistent results: a single Administrator-on-Call guiding a single front line coordinator through donor evaluation, donor management, and planning family approach – all while following clear standards.

Second, **the structure of clinical operations must be realigned** to serve the goal of increasing donation. In the absence of a unifying strategy, leaders are operating independently and practice standards are unclear or fail to be enforced. LiveOnNY needs a single chief clinical officer under whom all functions of the donation process will be organized. This single individual will serve as the architect for aligning all functions properly and revitalizing the vision. They will

also ensure that operational planning includes establishing clear action steps for the organization to meet benchmarks.

The organization must also strengthen its leadership bench through intensive training which includes leadership development components. This group of leaders will then have the capability to implement an effective performance management system that has been lacking in the clinical division. The revised clinical hierarchy will reinforce accountability at each level and in particular with front-line staff.

Hospital and LiveOnNY staff reported varying on-site response times, manipulations surrounding authorization rate scorecards, and delays surrounding case management. Leadership is reportedly aware of certain performance issues but according to staff interviews, fails to address them. These patterns contribute to the culture lacking accountability.

The current training system is widely reported as inadequate and under-resourced. This is in-part due to the loss of skilled preceptors to the alternative donation model at Mt. Sinai. Uniformity and consistency in advocating for best donation practices cannot occur in the absence of robust training and professional development. A significant investment in training and professional development should be one of the highest short-term priorities for improving donation rates and outcomes. Skills-based training for family communication, navigating conversations with the care team, and hospital services messaging are clear operational priorities. Leadership development in these areas should occur simultaneously.

Outside of the organization, varying donation models have emerged in centers as a result of chronic dissatisfaction in service delivery from LiveOnNY. In accommodating these models, LiveOnNY has essentially outsourced the most critical driver of donor volume by relegating the referral response and authorization function in high donor potential hospitals to individuals outside of the LiveOnNY reporting hierarchy. This misaligns resources from the community as a whole to a few influential centers while compromising service delivery.

Third, **best practices must be hardwired into hospital systems** through strategic engagement. LiveOnNY's current approach emphasizes compliance. Adopting a more strategic and more proactive approach will yield significant improvements. Current Strategic Action Plans (SAPs) for each hospital are regulatory in their focus. The format should be revised to emphasize evaluations of the hierarchy, physician and clinician relationships, and detailed plans on performance improvement utilizing carefully cultivated donation champions. LiveOnNY data analytics are not currently formatted to provide adequate detail on actionable improvement in support of this planning process, but the data is available.

Hospital interviews revealed that resources are dedicated to promoting donor awareness days, community education, and other public initiatives. It was our impression that some senior leaders in hospitals lacked a fundamental understanding of their roles for improving donation rates, citing external factors in the DSA for underperformance. In several instances, hospitals were focusing efforts on public education and had minimal knowledge of clinical processes

within their own institutions or their impact on donation. At one center with a very low conversion rate, the donor council chair stated, "We need more community engagement and education and to get politicians involved."

Resources in donor hospitals must be dedicated to optimizing the internal clinical donation process to ensure educational access and hardwire best practices into existing emergency services/critical care delivery systems. This will yield increases and ensure more significant gains in the short-term; public awareness is a longer-term strategy for improvement and not best-suited to the hospital services function.

## II. Donor Evaluation Process is Overly Complex and Highly Variable

### Introduction

We observed a highly complex system for managing the organ donation process from referral intake through family authorization. LiveOnNY's clinical process has not adequately adapted to the pace of change in end-of-life decision making within the critical care setting.

The process is unreliable; wide variability in practice at LiveOnNY is a function of poor historical structural alignment but also a fundamental lack of simplicity in process definition and clear standards. Practice standards and the associated clinical triggers were difficult to navigate and in some cases they were indiscernible. An over-reliance on specialized staff skill sets further complicates the process; too many experts are involved and it becomes impossible to deploy properly matched skill sets to the hospital clinical scenario with any efficiency. Furthermore, it is confusing and burdensome to hospital care teams.

Cases are segmented by specializations and needlessly protracted beyond reasonable limits. There is a lack of urgency built into the system for moving cases forward, often hinging on family "readiness." It is an artificial barrier and often precludes the preservation of donation opportunities. Leadership oversight and direction is diffuse and inadequate. Dependence on electronic communication systems reflects the lack of urgency and does not support reinforcement of accountabilities.

This section of our findings will focus on the process details from our perspective as subject matter experts.

### A. Referral Intake and Initial Assessment Process

#### *Referral intake system is cumbersome and compromises the initial assessment*

The initial donor referral intake is a lengthy process requiring eight to fifteen minutes on the telephone with the referring hospital person and the Donor Center Coordinator. We heard reports that hospital staff perceives this call could be as long as twenty five minutes. Hospital clinicians reported delaying the referral due to the excessive time burden. The duration of the call is a deterrent to receiving a timely referral.

Intake currently captures a wide range of information including patient demographic data, clinical and neurologic status, and family circumstances. It is currently facilitated by a coordinator who is not adequately trained to conduct a thorough clinical assessment with precision. The Donor Center Coordinator is populating data fields in iTransplant that are not needed at the time of the initial call.

An electronic notice of the referral is sent, often with a delay of 15-20 minutes, to the Referral Coordinator (RC), who is the assigned Transplant Coordinator (TC) serving in the capacity of an RC for that shift. This RC reviews electronic information via iTransplant and dispatches one of the following coordinators via text or email:

Family Services Coordinator  
Donor Evaluation Coordinator (I or II)  
Transplant Coordinator  
Hospital Services Coordinator  
In-House Coordinator (Mt. Sinai Hospital)

**Recommendation:** Referral intake should be streamlined immediately. It should include minimum data collection and the referring hospital employee should be on the phone for no more than two minutes with the Donor Center. If the patient is on a ventilator, a singular trigger, the call should be directed immediately via voice call to a trained Transplant Coordinator for more thorough initial assessment. (R01)

*The Referral Coordinator (Transplant Coordinator) is not in telephone dialogue with the hospital care team for initial assessment*

A thorough assessment is currently not occurring until the responding coordinator is on-site at the hospital. This is a late juncture. Initial assessment of organ referrals requires trained transplant coordinators in telephone dialogue with the hospital care team. The current process does not allow for any probing questions or interaction with the care team to accurately assess the clinical circumstances. The RC is operating off of notes provided by the Donor Center, absent dialogue with either the Donor Center or the referring hospital contact.

In our experience, many referrals require immediate intervention over the phone at the time of referral in order to preserve organ donation opportunities for the family. These interventions generally fall into three major categories: clinical management, family decision-making, and hospital care team communication. In the current critical care environment, the following examples illustrate common scenarios.

1) Clinical management:

In an effort to preserve hemodynamic stability and prevent the patient from experiencing a cardiac arrest, the Transplant Coordinator has to work collaboratively with the care team to advocate for the use of fluids and/or vasopressors to increase the patient's blood pressure. The goal is to ensure that hemodynamic deterioration does not limit the family's opportunity to donate or reduce the scope of their gift. Additionally, if a limitation of care order has been written this also needs to be addressed in the context of opportunities to donate.

2) Family decision making:

Sometimes patients are referred following the family's decision to discontinue ventilator support. Often families make the decision to withdraw support without any understanding of how that decision may limit donation opportunities. After making this decision, most families want the withdrawal of support to occur quickly. Although rare, and not ideal, Transplant Coordinators may need to intervene by phone and speak directly with the family to discuss organ donation opportunities.



### 3) Care team communication:

Once it is determined that the patient's injury is non-recoverable and that further care is futile, it is not unusual for the care team to shift their focus from curative to comfort therapies. In some instances, it is essential for the Transplant Coordinator to collaborate with the care team and develop a family communication plan. Coordinated communication between the OPO and the hospital care team helps to prevent a premature mention of organ donation or a limitation of care order described above, which may impact organ donation opportunities.

The RC should collect the clinical information necessary to determine whether or not an onsite response is warranted and whether any interventions are needed before a LiveOnNY staff member can arrive at the hospital. One-way communication of information electronically is an inadequate mechanism for rapid and thorough assessments of these multi-dimensional clinical scenarios. They require critical thinking and immediate responses. Furthermore, the Donor Center Coordinator does not have the skill set or knowledge base for performing this assessment as it requires probing questions and critical evaluation.

Without the full picture, LiveOnNY on-call staff cannot be strategically deployed by the AOC on the initial assessment but rather deployed according to what seems like a pre-set algorithm. The initial referral intake is a vital juncture for the AOC to make decisions on dispatch.

**Recommendation:** The Referral Coordinator should be in immediate dialogue with the referring person at the hospital after referral intake by the Donor Center. This conversation will provide an opportunity to determine if an intervention is required prior to LiveOnNY's arrival at the hospital. It will also provide a more accurate picture for the AOC to identify deployment needs. (R02)

## B. Staff Specialization and Strategic Deployment

*The system does not allow for strategic deployment: coordinator resources are both over-deployed and under-deployed*

Donation is not a linear process. It is difficult to predict which skill set will be needed at any given time. We observed high variability in determining which LiveOnNY coordinators and how many coordinators were dispatched to an initial referral; this variability also applied to the determination of re-dispatch to a previously referred patient.

In some instances multiple coordinators, a Transplant Coordinator or Donor Evaluation Coordinator I/II, a Family Services Coordinator, and a Hospital Services Coordinator were all dispatched to one case. These specialized roles are focused on clinical management, family support and hospital relations respectively; they can improve donation outcomes by providing hospitals and families with uniquely qualified experts typically only in a single aspect of the donation process. In other instances however, we observed only one coordinator was

dispatched and that their skill set was poorly matched to the circumstances of the clinical scenario.

When there is a high referral volume during short time intervals (i.e. peak activity) there are routinely adequate numbers of LiveOnNY staff to respond. The AOC however, isn't able to match their skill set to the clinical situation. We witnessed multiple inefficiencies in redeployment of staff to a referral in order to get the proper skill set there. This delays on-site response times. It also places an incredible burden on the AOC to ensure they have the right people on the right case in times of peak clinical activity. It is further complicated for the AOC by Family Services Coordinator work hours that are restricted to a 10:00am through 10:00pm shift.

At times a Family Services Coordinator is in critical need but not present; in others they are on-site to manage family communication but a transplant coordinator is needed to drive clinical management recommendations. Beyond that, HSCs, DEC's and other specialists are often finding themselves in circumstances at the hospital where they need to draw on another level of expertise via phone due to the unexpected clinical course of events they encounter. ***It is inherently unpredictable which area of expertise will be needed in donation during certain phases of the process.***

The complexity of deploying specialists with varying work shift parameters is challenging for AOC case management. In the current configuration, it is causing case delays and inefficiencies in resource utilization. Ultimately, it is negatively impacting both the process and outcomes.

*Involving too many specialists is confusing and blurs accountability: delineate roles and responsibilities*

At any one time, a Family Service Coordinator, Transplant Coordinator, Donor Evaluation Coordinator 1 or 2, a Hospital Services Coordinator, and an Advance Practice Coordinator can be on-site. This is excessive and confusing for both the LiveOnNY staff and hospitals. It was reported widely in both internal and external hospital interviews that, "there are too many cooks in the kitchen."

Hospital staff also reported confusion about which LiveOnNY staff could perform what duty, frequently complaining that when multiple coordinators were on site, they were unsure of their roles. They reported frustration with communication breakdowns and multiple coordinators' use of hospital resources. (This includes space in the ICU, computer and phone use.)

The intricacies of specialized LiveOnNY functions are embedded into the process without job-specific performance standards. They appear to be absent of clear role delineation in practice. This blurs the lines of accountability to the case outcome. It also narrows the scope of experience for each specialist, and appears to have created a technician mindset. Each specialist owns their small segment of the process and seems poorly equipped to handle situations that arise outside of that scope.

Too much specialization at LiveOnNY, in our observation, deprives staff of a sense of ownership to the case outcome. In some instances, their accountability to their own segment of the process is unclear. It is also a limiting factor in building experience for professional development.

Gift of Life operates without specialized transplant coordinator roles. This allows us to be more flexible in our rapid response to disparate critical care environments and constantly changing clinical circumstances. Fluid family dynamics and medical management needs are inherently difficult to predict for the purpose of assigning specialized skill sets. The current staffing deployment model at LiveOnNY does not take this fully into consideration or afford the leaders needed flexibility for strategic rapid response. We find there is an over reliance on specialization, compromising both the dispatch process and service delivery to hospitals.

While specialized skill-sets can improve outcomes, over-specialization puts staff in situations where they are potentially inexperienced advocating for clinical management with the care team or skillfully talking to a family. *These two functions must occur in parallel.* Inability to navigate the circumstances is delaying the process and compromising hospitals' perception of LiveOnNY's expertise. While the OPO industry trend has moved toward increased specialization, careful analysis of human resource management has become increasingly complex. This is particularly true in OPOs with a high volume of organ referrals.

To drive the process efficiently on an appropriate timeline we are recommending an evaluation of this model and several immediate changes. This will ultimately reduce the number of staff needed on site, expand the skill bank of the on-call contingent on a given day, and broaden organizational capability to respond more strategically.

**Recommendation:** Transition to a generalist model where staff can skillfully manage multiple situational challenges for rapid response. Consider cross-training for clinical staff (TC and DEC) in family communication for the purpose of enabling them to effectively speak with families and secure authorization when needed. Deploy FSCs more strategically for higher potential referrals or complicated family dynamics. Eliminate Hospital Services Coordinators from on-site involvement. (R03)

*Teams are functioning in silos: properly align them within the current reporting structure for improved synergy*

Interviews revealed that staff responding onsite to hospitals are functioning within their own silos and remain insular in their day-to-day work from other team functions. Staff perceives considerable variability in practice and reports a general lack of accountability.

FSC leaders are authorized to dispatch FSCs to referrals but there is wide latitude for interpreting urgency for on-site response and family readiness. FS leadership decisions surrounding dispatch and initiation of family request are often in conflict with the AOC or in the absence of AOC knowledge. It was reported in a number of LiveOnNY staff interviews that a

subset of Family Service Coordinators habitually delay on-site response in the morning, arriving at the hospital close to the 1:00pm conference call deadline while others are prompt and arrive rapidly when dispatched. In our review of records this was difficult to confirm because an iTransplant user cannot determine the location of a LiveOnNY staff member at the time they enter a note in iTransplant. It was reported that FSC team leads were aware of this practice but that no corrective action is taken for these FSC performance issues.

TCs/DECs are not operating in a synchronized manner with FSCs. The clinical preservation of donation opportunities is not addressed in parallel with family assessment. Often, TCs or DECs arrive on-site, offering management suggestions that had gone unaddressed previously as a result of insufficient FSC knowledge base, or poor communication. LiveOnNY communications with care teams are splintered and compromised by the number of LiveOnNY staff involved. Continuity seems to be lost and cases are extended beyond reasonable or expected limits. Hospital Services staff did not seem to have a working knowledge of case dynamics other than iTransplant notes.

It was difficult to distinguish reality from perception during interviews however our review of iTransplant and our on-site observations suggested a wide variability in practices both within and between silos or job functions. While huddles occur during cases for the purpose of coherent planning, they appear to be verbal checklists reported off by each clinical specialist via phone. They lack strategic discussion between specialists for cohesive team planning to navigate barriers. This includes orchestrating care team collaboration, clinical management, family communications, and other key determinants of donation outcomes.

Structural alignment is addressed in the next section of this report. The lack of proper alignment of clinical functions manifests in practice. In the short term, we have already recommended re-alignment of the FSC team under the clinical director, increased voice communication, stronger standards and oversight to improve the team synergy and the hospital experience, and also clearly defined accountability for improved outcomes.

**Recommendation:** Re-align Family Services Coordinators under the clinical department. Move Hospital Services to a single departmental function with a director-level leader. (R04)

### **C. Variability in Practice**

#### *Clinical practice varies dramatically as reported by staff and hospitals*

We did not observe clearly defined practice standards or expectations related to the core steps in the donation process. Written standards exist in some areas within the SOP, however we observed variable practices in the following areas:

- Timely hospital referral
- Critical review on initial assessment: intervention for preserving donation opportunities prior to family authorization
- Rapid on-site response

- Care team communications for proactive set-up of family request
- Initiation of physician consultation for proactive management
- Triggers for initiation of a family request
- Family conversation elements and standards for authorization
- Surveillance for following cases, checkpoints, or triggers for returning to hospital
- Requirements for AOC review, oversight and direction

Variability in practice was largely attributable to poorly defined or insufficiently communicated standards of practice. In many cases, there *is* no standard of practice where there should be. Operationally, significant latitude is granted to the individual front-line specialist to subjectively determine the best course of action. For example, some FSCs initiate family request as soon as possible. Others delay it for days. Transplant Coordinators initiate consultations with the care team with observable variability. Some are more assertive in advocacy for preserving donation opportunities. Others tend to defer to the care team entirely. These variations are compounded by differing practices within the leadership team that provides oversight.

The language and messaging surrounding all of these core issues is absent. Practice standards within an OPO encompass both the practice and the *communication of the practice* to the hospital and to the families. This ensures consistency and uniformity for effective advocacy and long-term sustained changes in behavior with hospital partners. During interviews, staff could not clearly articulate the specific practice standards beyond citing practices outlined on the team huddle checklist or by citing, “typical” practice, or their own practice.

This variability is transparent to hospital partners based on our interviews. The building blocks of strong OPO partnerships with hospital care teams are trusting relationships grounded in consistent clinical experiences together with fulfilled expectations and commitments. The bedrock of ensuring reciprocal trust with hospital partners must include well-defined standards based on hardwired best donation practices.

Donation is a low-frequency event in hospitals; discernible variability in OPO coordinator practice erodes hospital trust and negatively impacts their ability to learn or implement best practices.

‘Timely referral’ and ‘effective request’ is the typical nomenclature assigned to best practice metrics. We maintain that there is an intricate subset of detailed communications and clinical triggers required to attain these. These practice standards and correlating triggers reside with the OPO and are the responsibility of the OPO to define, teach and reinforce.

We did not find these standards or triggers to be well defined in policies or training materials. They were not described during internal discussions with staff and they were conspicuously absent from hospital interviews. In many donor hospital interviews, staff reported a need for direction and specific actions, beyond the metrics of CMS regulatory compliance, in the interest of improving outcomes. In some hospital interviews, frustration was expressed with failure to

obtain this basic information from LiveOnNY, such as standing orders or elements of family request timing.

Clear standards with expectations that are both well understood and easily explained by everyone on the front-line are essential for a reliable process.

**Recommendation:** Create standards for preserving donation opportunities in a variety of clinical scenarios and for initiating family request on a more rigorous timeline. (R05)

**Recommendation:** Review and revise the current standards for: referral intake and initial assessment; rapid on-site response; continued presence at the hospital; care team communications; set-up of family conversation; and effective request process. (R06)

## D. Case Timelines and Delays

### *Urgency is lacking in the donation process and the culture*

There is a concerning lack of urgency within the process. This is related to the absence or delay for intervening to preserve donation opportunities and slow reaction to time sensitivities in pursuit of each potential donor referral. There were frequent incidents of delays evidenced in:

- on-site response times
- initiation of family request
- protracted brain death pronouncements when families were interested in donation
- departures from the hospital when families had expressed interest in donation or patient stability was unpredictable
- coordinator deference to care teams' preferences for waiting
- lulls in operations and interventions during overnight hours

There is also no discernible or prevailing sense of urgency in the organizational culture that drives the organ donation process forward. The reasons seem to be multi-factorial and differ depending on the case, the staff involved or both. From our view, the causal factors include: lack of knowledge on advocating for proactive interventions effectively; inadequate skill or training; insufficient leadership oversight, direction and accountability; and the creation of arbitrary boundaries and barriers between LiveOnNY, hospital care teams, and families.

We have outlined below the two predominant scenarios we encountered where cases are needlessly extended putting donation opportunities at risk. They require immediate attention and correctional action.

### *1. LiveOnNY lacks basic standards requiring continued presence at hospitals*

One of the most concerning trends that emerged during our assessment was the conscious decision to allow LiveOnNY staff to leave cases where patients appeared brain dead and the family was interested in organ donation or there was a gift document. Staff interviews revealed that this may be a function of two factors: clinical leaders are attempting to protect coordinator

downtime or leaders do not believe it is essential to maintain a LiveOnNY presence at the hospital if the patient's blood pressure is stable, describing it as 'babysitting.'

In our experience, this practice results in lost donor opportunities and should immediately change. It is widely understood that patients being evaluated for brain death often experience significant physiological changes that require optimal management to preserve organ donation opportunities. It is also well known that the family's understanding of the gravity of the situation and grim prognosis is fluid. As a result, families often change their plan of action and choose to withdraw support *regardless of the time of day*.

We observed multiple case examples where donation opportunities were lost because LiveOnNY coordinators were not on site; appropriate clinical interventions were not initiated to prevent a patient from experiencing cardiac arrest and potential donation opportunities were missed. These patient arrests are not currently evaluated in LiveOnNY's potential for donation, but should be. We found instances of the hospital calling back to LiveOnNY inquiring where the coordinator was, as patient had been pronounced and the family either wanted to withdraw or donate but no coordinators were on site.

To effectively advocate for patients awaiting transplant, preserve donation opportunities for families, and provide service to hospital partners, it is crucial that LiveOnNY establishes guidelines and staffing schedules to provide continued coordinator presence in appropriate situations. These situations take into consideration both the family decision-making and the patient's clinical presentation. They include but are not limited to the following scenarios:

1. Patient appears brain dead and the family has expressed interest in donation and/or there is a gift document
2. Family has been counseled by the care team about the patient's poor prognosis and is actively contemplating withdrawal of support
3. Patient is experiencing instability; this includes hemodynamic instability, oxygenation issues, acid base disturbances, and profound electrolyte imbalances
4. Family is coming into the hospital for the first time and will likely be provided information regarding their loved one's prognosis
5. Care team has indicated that they will be meeting with the family to discuss level of care and the patient's code status

**Recommendation:** Establish a standard for maintaining a continued on-site presence at the hospital in circumstances that warrant it to preserve donation opportunities that may otherwise be lost. Add patients who appear brain dead but arrested into your donor potential denominator. (R07)

## 2. Emotional 'readiness' of families for a donation request is subjective, creating artificial barriers

There is a troubling lack of proactive advocacy at this step of the donation process involving family request for donation. We observed that LiveOnNY FSCs subjectively and independently determine 'family readiness' for donation conversations. Their determinations are variable and

poorly assessed; they seem to occur in a void of direction or guidance. This is occurring consistently and is a rate limiting factor for donation.

'Family readiness' determinations appear to drive timelines for the entire donation process. We found FSCs habitually assessing a family as "not being ready." Countless examples occurred despite brain death being pronounced, donation already being mentioned by hospital staff, and even family members bringing up donation. Delays were concurrent with limitations being placed on the patient's care – limitations that may eliminate the donation opportunity altogether. In these cases the family is disempowered because donation opportunities are not preserved, often without their knowledge. It further extends the process, requiring the hospital to support brain dead patients for days until a request for donation is made. We observed common delays following brain death pronouncement of 24 hours and some as long as 48 to 72 hours.

The triggers driving initiation of family request for donation were indecipherable to us. Often, 'readiness' was dictated by the hospital without pushback or advocacy from LiveOnNY; at other times, 'readiness' was determined solely by the FSC in the absence of consultation with the care team or even an AOC.

In one instance, the authorizing person was deemed to be unapproachable because they lacked a fundamental understanding of brain death. Brain death had been determined and communicated by the treating physician. This case was shut down without ever offering donation to the family despite the fact that the FSC had spent time with the authorizing person. While this is an extreme example, it underpins that the FSCs over-assess and over-value readiness. It needlessly and significantly delays the request for donation. These delays are inconsistent with the regulatory requirement that families of medically suitable potential donors are offered the donation option.

The concept of "early support" to provide families with basic needs during a loved one's hospitalization and in their early stages of grief is a laudable goal. We found no evidence that it leads to higher authorization rates, hospital staff satisfaction or improved donation outcomes. The concept itself was poorly defined and the level of care provided by FSCs during early family interaction varied. It was unclear from hospital and staff interviews when it should be employed or what the core elements of "early support" were.

Today the dynamics and complexity of end-of-life decision-making in critical care require a multi-dimensional approach and not a linear one that is anchored in family readiness. Effective case management requires preserving opportunities for donation; this should supersede and even precede the assessment of family readiness for a request. FSCs routinely practice as if they perceive there is a conflict between providing compassionate care and informing families of their donation opportunity. Compassionate end-of-life care and advocacy for donation are *not mutually exclusive*. They should be positioned accordingly by LiveOnNY FSC staff in practice.

As family involvement in the decision to withdraw or decelerate care has increased, often families make decisions in the absence of understanding that it precludes donation



opportunities. According to one study published in the Society of Critical Care Medicine, 90% of patients who die in the ICU now do so after the decision to limit therapy. It is the role of the OPO to advocate for optimizing this process, ensuring opportunities for families to donate are not lost based on decisions made without full knowledge of their impact. This is not happening at LiveOnNY in a proactive manner.

It is our understanding that FSCs are hired with social work backgrounds but many have no experience in healthcare. Currently, they are insufficiently trained to perform this vital advocacy function that dictates outcomes for patients awaiting transplant. It was reported to us that there is no training, oversight or practice standard. This explains the suspected failure of this initiative to improve authorization rates. While employing social workers that have specialized training in family communication has potential to be successful it requires careful implementation, vigilant oversight and constant performance feedback.

FSCs reported little training but know they are being held accountable for outcomes. This has likely contributed to an avoidance tendency surrounding family approach. Staff reported a mindset of FSCs wanting to “let someone else request the next day and get the ‘no’.” Evidently, there is a fear their employment will be terminated if they don’t “produce.” This avoidance maneuvering is well known and reported within the FSC group but goes unaddressed by leadership. It may be an underlying cause for the delays described above but requires further investigation.

There are at least six clinical circumstances encountered by FSCs that should trigger initiating a family request:

1. Family understands death or non-survivable nature of injury
2. Brain death pronounced and family verbalizes understanding
3. Decision is made to limit, decelerate or withdraw treatment
4. Health care team shares donation opportunity with family
5. Family brings up donation
6. Pulmonary or hemodynamic instability

Within each of these circumstances, there are varying situations that require a specific strategy, approach, and scripting. Each of these scenarios can present themselves at any juncture during the patient’s course. Effective donation advocacy requires vigilance, presence, and strong communication skill sets, in addition to supporting the family’s needs. Intensive training and performance management will be required for both front line staff and leadership. The AOCs will be required to provide daily oversight to ensure consistent practice is implemented across departments and communicated to hospital partners with accuracy.

**Recommendation:** Clearly define family request triggers along with standards for timing of approach. Communicate these standards to hospital partners. Immediately provide intensive training for any staff members who may be tasked with requesting authorization. (R08)

## E. Case Management and Oversight

### Leaders are not aligned in philosophy, decision making, or practice: case management requires a singular voice of direction and coordination

Multiple leaders are involved in case management and coordination at varying points throughout the day. Despite this configuration for oversight and review of clinical activity, coordinators are not continuously present at hospitals when they should be and proper on-site interventions are not consistently occurring. The oversight should be streamlined to designate one clinical leader per shift. This person needs to be both broadly authorized and fully accountable for all decisions made during that shift.

We observed functional misalignments and a considerable number of redundancies in directing the organ donation process. This affects work process at the leadership levels for case management down through on-call front line staff. Some functions were repeated, others left undone due to the silos in which each function appears to operate.

Team leaders of one function, typically family services, are providing direction to staff on-site while the AOC may be offering differing direction. This lack of alignment appears to create confusion, friction, and discord at several levels. Staff reported that it was “like watching their parents fight.” There is considerable disagreement on how the process should unfold, the timing of family request, how many specialists are needed on-site, and the timing of consultation with the care team for management interventions.

FSCs report they are directed to practice by AOCs in ways that sometimes feel uncomfortable. From our perspective, this arises from their lack of knowledge surrounding how family communication merges with the clinical donation pathways during end-of-life care. It is also a symptom of poor functional alignment within clinical services. FSCs expressed a reluctance to take direction from an AOC on the timing or readiness of a family for a donation conversation merely because they had no social work training.

Clinical AOC leaders may be accountable for outcomes with little authority to influence the family request process; other leaders are responsible for the processes but lack any accountability to the outcomes. *Responsibility, authority and accountability should all be aligned.* Currently they are not.

**Recommendation:** Immediately transition to a single administrator-on-call who has full scope of authority and accountability for all decision-making on case management. (R09)

### Leadership direction is repetitive: despite checkpoints and huddles, direction and guidance is insufficient for on-site interventions

Despite checkpoints, huddles, and conference calls, there is inadequate direction for case management. In its current design insufficient guidance and oversight is provided to the front

line staff. Communications between front-line coordinators and leaders during cases is rife with redundancies. Coordinators suggested almost universally that there are too many leaders involved in case management from referral to authorization. Decisions that should fall to a clinical leader are often made by committee or independently by front line staff. Direction is muddled and neither time nor expertise is utilized for maximum benefit.

On-site staff initiates huddles via phone that occur during pre-established junctures on a case. They occur: pre-consent, pre-allocation, and pre-operating room recovery. The huddle time is driven by the staff on site and other participants include one or more members of the leadership team, depending on which huddle is occurring. It may include only the Family Services Manager or both the FS Manager and the AOC. More than one person at the hospital may be involved in a huddle.

We observed minimal value in holding these huddles. Coordinators report that they do not see the value in this forum because the information is already available on iTransplant. In huddles, we observed a rote verbal review of details by each specialist against the checklist, with almost no strategic re-framing, mentoring, or direction offered by leaders. By contrast, at Gift of Life, the on-site coordinator calls the AOC with greater frequency to conduct a critical, strategic one-on-one review and collaborative discussion of the plan.

**Recommendation:** Group huddles should be reconfigured or eliminated and replaced with one-on-one AOC conversations. (R10)

*Daily leadership communication and shift reporting is too complex*

Additionally, there is a separate system for daily leadership communication surrounding clinical activity and case management. There are three daily conference calls. The first occurs at 9:00am for hand-off of cases from the previous 24 hour period and includes; AOC off-going and on-coming, Family Services Manager, Donation Center Leader, Referral Coordinator off going and on-coming, Hospital Services Manager, Vice President, CMO and occasionally, CEO. At 1:00pm, all cases are reported off and this call includes on-site staff and the Referral Coordinator reviewing cases that are followed by phone. Again, at 8:00pm a subset of leaders convenes via phone to determine where to send staff the next morning. This call includes AOC, FSM and RC.

By contrast, shift transition is simpler at Gift of Life. The off-going and on-coming AOC conduct a shift report at one juncture during the 24-hour shift for continuity. At 7:00am, this call occurs and participants are limited to the clinical AOC off-going and on-coming. AOCs meet weekly for critical reviews of all referrals and cases, and are held accountable for decision-making and outcomes. Daily reports are also reviewed by executive clinical leaders to provide timely oversight and feedback.

Too many directives from different leaders compromises clarity and creates frustration at the staff level. A singular person should be accountable and authorized to direct all case activity

during a 24- hour period. Their authority should cross all reporting lines. A singular point of contact and direction will improve staff performance and efficiency.

Additionally, we recommend that this single AOC provide more intensive involvement and direction at mandatory checkpoints. Currently, staff 'check-in' on progress. Critical determinations are made, implemented and then reported. Instead, each high acuity event should be discussed to confirm a *proactive* strategy with the AOC. (see **Appendix C: Policy for GLDP communication checkpoints with AOC**)

LiveOnNY has seven people currently functioning in the role of AOC and we found variability in their decision-making as well as their skill levels to provide guidance and feedback. They were all extremely committed to their role and displayed a willingness to learn from experience and from other AOCs. With training and guidance from Executive Clinical Leadership and other high performing large OPOs, this team of AOCs can capably perform the expanded AOC function.

**Recommendation:** Identify the core group of leaders who will serve as AOCs. Allow additional time for AOC shifts to provide more intensive guidance and direction via phone. Identify performance standards for AOCs, conduct training sessions and weekly reviews to review decisions, outcomes, front-line staff performance, and ensure consistency. (R11)

*Electronic communications lack the capability for urgent and critical information exchange: transition to real-time 1:1 voice communications*

The dispatch determination is transmitted via iTransplant and SendWordNow via text and email respectively. Subsequent communication for case management occurs electronically, precluding real-time collaboration or strategic decision-making. The initial dispatch requires acknowledgment electronically for some referrals and not others from what we could discern. It is not sufficient for clinical operations.

Critical information is falling through the cracks. The absence of real-time conversation reinforces a lack of urgency for the staff. It prevents the leaders and coordinators from asking probing questions on initial referral and gaining an in-depth handle on the patient, hospital, and family dynamics. Voice calls and direct, real-time information exchange affords the opportunity for instant confirmation, clarification, collaboration, and guidance; it eliminates the potential for missing a dispatch alert, a critical change in patient status, family dynamics, decision making, or care team plans.

Reliance on a system of entering and reading case notes, transmitting electronic messaging, and depending on these notes to manage cases is indicative of the lack of urgency that permeates clinical operations. The iTransplant system, while robust in its functionality, only affords one-way written communication that is subject to wide and varying interpretation by all users.

One-way communication, generated by front line staff entering case notes remotely, affords the opportunity for staff to cloak their skill deficits and give a false sense of the reality of on-site activity. It also compromises the ability of leadership to assess what is actually happening at the hospital. There is no opportunity to provide guidance, redirect or correct plans of action, or assess the critical thinking or planning skills of the front line staff.

**Recommendation:** Transition to voice communication system for case management, coordination, communication and AOC oversight. Reduce reliance on text, email, and other modes of electronic communication. (R12)

### **III. Clinical Operations Needs an Overarching Strategic Framework.**

#### **Introduction**

Historically, the clinical arm of LiveOnNY was not organized in an aligned structure for optimal synergy. The byproduct is compartmentalized silos operating without a unifying strategic framework and performing variably. A Chief Clinical Officer is needed to serve as the architect for aligning all functions properly and revitalizing the vision.

In the absence of a unifying strategy, leaders are operating independently and practice standards are unclear or fail to be enforced. Investing in leadership, development and a robust training initiative will be essential. Creating a culture of accountability will necessitate the implementation of a performance management system and leaders that are skilled in using it.

Varying donation models have emerged in large centers as a result of chronic dissatisfaction in service delivery from LiveOnNY. This further complicates the referral response and authorization process. In accommodating these models, LiveOnNY has essentially outsourced the most critical driver of donor volume by relegating the referral response and authorization function to unknown individuals in high donor potential hospitals.

Innovation occurs but is overriding the basic foundations of internal operations. We are confident and optimistic that a few changes and strategies will generate a significant improvement in donation and organ availability for patients awaiting transplant.

#### **A. Organizational Structure and Alignment**

The organizational structure at LiveOnNY is not aligned for effective management of the organ donation process. The clinical reporting structure has been a systemic impediment to strong processes that lead to improved outcomes. Strong clinical leadership is needed to reconstitute the current structure, optimize operations, and unify all leaders behind these critical functions.

In the absence of an aligned structure, leaders and staff have independently interpreted or defined practice standards within their own disciplines. This encompasses Transplant Coordinators, Family Services Coordinators, and Hospital Services. They have evolved into independent practitioners under the oversight of multiple leaders. The current variability we observed from referral to family authorization stems from structural flaws, and is a consequence of this misalignment.

When we evaluated the core donation process, as many as three departments or functions were involved at the same time during any one step of that process, and they were not always functioning in synergy. (see **Appendix D: Core Process Diagram**) This extended from hospital education and referral through authorization. *It represents the most critical phase of the process because it drives donor volume and outcomes.*

During interviews, leaders and front-line employees reported that they operate in silos and have insufficient knowledge of the how their neighboring functions operate. Most leaders reported that there are no overarching strategies that guide practice; front-line staff had difficulty describing how their own performance impacted the larger donation process or how that was measured. “We have too many chiefs, too many systems, too many titles, and too many cooks in the kitchen.” This was a recurring theme in our interviews both at LiveOnNY and at hospitals.

Strong structural alignment will be the most important precursor to correcting this issue. All functions impacting the organ donation process must report to a single leader and operate against the same well-defined standards. This leader is accountable for defining the role of each function in the donation process, eliminating redundancies between functions for greater efficiency, defining the standards of practice, and holding everyone accountable to these standards in day-to-day operations.

Beyond improving internal operations, aligning these clinical leaders will improve the organizational evaluation of innovative change. The design and introduction of new donation systems and models appear to have been initiated in isolation, at times organized by a single LiveOnNY department head. Often these changes have been executed in the absence of evaluating feasibility or impact on the full clinical operation. For example, hospital models for in-house coordination, designated requestor models and other changes are introduced and implemented, only later to determine their full impact on other aspects of operational sustainability. LiveOnNY staff reported the frequency of “effective immediately” emails which changed practice without explanation. Proper alignment will afford oversight and in-depth analysis; the impact of innovation in one functional area or center must be evaluated against the effect on the entire operation.

Recently the Hospital Services function was moved under a Vice President of Clinical Services at our recommendation. This change occurred in the fourth quarter of 2018, but more strategic evaluation of the organizational structure is warranted. All functions that impact the organ donation process must be aligned under a singular executive clinical leader. This includes:

- Clinical Services
- Transplant Coordinators
- Donor Evaluation Coordinators
- Advance Practice Coordinators
- Family Services
- Hospital Services
- Donor Center
- Clinical Education and Training
- Quality Assurance

A CCO will serve as the architect for a strategic vision that revitalizes the LiveOnNY way, establishes guiding principles, and defines practice standards; this leader will be responsible for holding all stakeholders accountable to these standards, including donor hospital and transplant center partners. They in turn will be accountable for clinical performance. The creation of a

robust internal performance management system will be required. It will ensure all clinical staff, across disciplines, is well trained and operating against clear uniform standards with measurable outcomes. Strong routine performance feedback loops for continuing development will also ensure accountability to outcomes.

**Recommendation:** Conduct a national search for a Chief Clinical Officer with a record of demonstrated success and deep experience in the OPO industry. Based on the interviews we conducted, we don't believe LiveOnNY has an internal candidate who possesses the demonstrated leadership accomplishments to succeed in this role. (R13)

**Recommendation:** Perform talent inventory and competency assessment for the leadership team. Seek outside support immediately for areas identified as having insufficient expertise. Develop leaders or transition them out of their current roles as needed in phases. (R14)

## **B. Clinical Strategy and Performance Management**

### *Leaders are not unified behind a strategy: practice standards are not reinforced*

Considering the history of the structure, it appears clinical departments that were not working synergistically or in opposition, promulgated a climate where clinical functions established their own standards or strategies. Functions are compartmentalized and leaders differ in their philosophies, practices and decision-making. More recent transitions in leadership have most likely caused this to devolve even further. It will require strong leadership over time to unify clinical operations.

We could not identify guiding principles or a strategic approach within the leadership ranks. In some instances, managers who have been in the industry for years were unfamiliar with best practices for their own discipline. Causes include operating in an insular environment, disconnection from national learning, lack of tenure in their current position, or lack of training.

In the absence of an overarching clinical strategy that unifies functions in the execution of the organ donation process, we observed philosophies driving practice as opposed to clear standards. They are often in opposition or conflict. The standards of practice that are outlined in standard operating procedures may be limited in scope but they provide the foundations. Staff reported that they are rarely referenced after initial training; in many cases, they do not reflect the actual practice. More notably, we did not observe clearly defined standards of practice with associated clinical triggers that are being used operationally. Metrics for staff performance were noticeably absent from interview discussions and do not appear to be embedded in job descriptions.

### *Performance management systems are needed to hold staff accountable to standards and reinforce learning*

In daily operations there is a noticeable lack of performance management. This was evident in meetings, clinical review forums, AOC conversations, and in staff and leadership interviews. It was widely reported that staff are not held accountable to standards of performance, that



sub-optimal performance goes unchecked and unaddressed. We did not observe any feedback loops in daily operations for constructive feedback or performance development. Coordinators and leaders reported that they were unsure how their performance was measured. The only exception to this was the FSC group with clear performance metrics on authorization rates.

We observed and learned in both hospital and staff interviews that there are varying on-site response times, manipulations surrounding authorization rate scorecards, and delays surrounding case management. Leadership is reportedly aware of certain performance issues, but according to staff interviews, fails to address them. These patterns contribute to the culture lacking accountability.

A vigorous performance management system with intensive leadership training on proper implementation will be essential. A tenured employee commented, “We had our best donation years (2007, 322 donors) when we had a leader who made people do the things they didn’t like to do and held them accountable for doing it!”

**Recommendation:** The CCO and clinical leaders must define LiveOnNY’s overarching operational plan including the action steps needed to meet associated goals, practice standards, and metrics. Clearly communicate metrics and expectations to staff. (R15)

### **C. Staff Competencies and Training**

#### *Current training process is insufficient: navigating challenges in the clinical setting requires practiced, strong communication skills*

The clinical division staff needs to develop more sophisticated communication skills and competencies to navigate the challenges in the current critical care setting. Instituting a more proactive clinical approach will require strong communicators and advocates to effectively remove barriers to donation while simultaneously cultivating care team partnerships.

It appears the coordinators view their roles as very limited in scope to influence the course of events that drive the process. We observed multiple clinical incidents where coordinators were present on-site but did not exhibit the skill or understanding of the need for LiveOnNY to intervene for a family approach or to prevent a potential donor from experiencing cardiac arrest.

Coordinators had difficulty explaining basic best practice standards with any consistency to us; hospital staff expressed that LiveOnNY coordinators struggled to clearly articulate needed interventions. This held true for both real-time clinical interface as well as teaching interface with hospitals. Several hospital clinicians interviewed reported, “I just need them to tell us what to do.”

Our review revealed that training is a somewhat loosely assembled system of checklists, policies and didactic presentations with required documentation for regulatory compliance. It is accompanied by shadowing and field observation, essentially an ‘on-the-job’ training model,

which can include training with travelers. It appears to be absent of competency checks particularly as it relates to communication skills and framing of OPO practices for effective advocacy.

*Training is inconsistent: staff competencies are largely unknown*

There appears to be no specific clinical curriculum or training pathway for each job function with substantive, multimodal offerings tied to core competencies or job proficiencies. Apart from a three-day orientation session, eight didactic classroom training days, field observations, and simulation labs, the bulk of training for family communication is outsourced. There is reportedly no customization of this outsourced training for LiveOnNY; leadership has little oversight of the family communication content and is not present at these trainings because it is defined by the vendors as 'safe space' despite pushback from LiveOnNY leadership. Moreover, some training roles at LiveOnNY are filled by individuals with no clinical donation experience.

A role play simulation laboratory for family authorization is conducted by LiveOnNY staff. This reportedly occurs once per week for request staff (FSC and TC) to improve their authorization skills. Again, leaders do not attend and do not provide any feedback or coaching to participants.

From our perspective, this model deprives leaders of the chance to match LiveOnNY's family communication practice standards to the training content. If not present, leaders cannot mentor staff, model the way, or assess skill levels which would enable them to strategically deploy strong communicators as needed to hospitals.

There are some online offerings, but it is uncertain if department leaders observe the staff competencies or merely sign off and document completion. The accountability for any reinforcement of training or its success is non-existent as reported during interviews across the division. It appears that the responsibility for training rests solely with the Clinical Education Specialist. She is significantly under-resourced in the current configuration.

Responsibility for training should rest with each member of the leadership team, both inside and outside of the classroom. Training was described as an 'afterthought' and leaders were described as being too caught up in their own work to contribute in a meaningful way. Coordinators reported that the standards of practice are vague and that they are hungry for more definition, direction and guidance to improve their individual performance.

*Family authorization training is the most immediate need*

It is our understanding that many of the social workers had little or no experience in a health care setting communicating with critical care teams. While they are skilled in emotionally supporting bereaved families, they may lack the attributes for advocacy in the context of this position. This should be carefully evaluated in the hiring process.

Authorization training emerged in most interviews. LiveOnNY staff is perplexed at their own lack of internal training on a clearly identified standard. The variability in family approach was

attributed partially to the absence of clear standards and the corresponding training and skills-based review system.

**Recommendation:** Once standards of practice have been reviewed and redefined as needed, invest in an expansion of LiveOnNY's training program. In the short term, invest in skills-based family authorization training programs that will allow for meaningful assessment of competencies. General clinical training should follow as soon as feasible. Reassess utilization of providers who insist on training that excludes leadership involvement or observation. (R16)

**Recommendation:** Address recruitment, interviewing, selection, and hiring practices to ensure a deep and continuous pipeline of qualified candidates in order to maintain operational stability. Consider phasing out social work model for FSC; phase out and ultimately eliminate travelers. (R17)

#### **D. Variable Hospital Models**

LiveOnNY has failed to remediate core service issues. There is a history of hospitals expressing concern over service delivery from LiveOnNY. Service shortfalls include delays in responding on-site, inability to effectively interact with families, inconsistencies in providing clear direction to care teams, and an overall frustration with variable practice. We directly observed multiple cases where hospitals expected a LiveOnNY coordinator to return to the hospital but they needed to call repeatedly to request on-site support. Additionally, it was reported in hospital interviews that basic information about standards of practice or clinical triggers were requested but not made available to clinical leaders in hospitals.

**Referral response and authorization: the most critical driver of donor volume has been relegated to outside individuals under varying hospital models**

As a result of these core service issues failing to be remediated by LiveOnNY, large dissatisfied centers have devised their own in-house models for donation. Hospitals and health systems have designed customized models that range from in-house coordinator structures to physician designated requestors for authorization. The oversight by LiveOnNY of the training and strategic implementation seems to have differed dramatically for each center's initiative.

Specifically, Mt. Sinai re-constituted their system by acquiring five LiveOnNY coordinators to fill positions for their in-house coordinator model. It established a precedent for Columbia Presbyterian to replicate the system although ostensibly, it is not off the ground after more than one year. Other hospitals have designed systems where their own physicians are designated requestors. For example, Jamaica utilizes Palliative Care physicians to request organ donation and NYU initiated the POD model.

The creation of new and variable donation systems lends itself to additional layers of complexity in managing the referral response and family authorization process. This is particularly true

when people outside of the LiveOnNY's [sic] direct oversight are involved. The referral response and authorization process – the most critical driver of donor volume – is now diffusely relegated to an unknown number of individuals in donor hospitals. Many of them are inadequately trained or skilled. *To relinquish responsibility for this clinical function to hospital staff or individuals who are not trained or directly supervised by LiveOnNY risks organizational performance.*

We observed multiple instances where a systems revision was implemented in response to a complaint rather than a careful problem analysis and resolution. We were left with the impression that customer service commitments can override advocacy for benefit of the whole DSA; in the interest of customer service, LiveOnNY appears to bend and adapt to accommodate customers, either donor hospitals or transplant centers, even if it is incongruent with strategic goals. For example, the implementation of the Mt Sinai in-house coordinator model required LiveOnNY to forfeit a cohort of five top-performing Transplant Coordinators. This restricted the scope of their impact to only one hospital system, deleteriously impacting LiveOnNY's capability to deploy best talent to the other 90+ hospitals and hindering organizational capacity to train new coordinators.

We admire LiveOnNY for embracing innovation in an effort to adapt to the challenges in the DSA environment. It seems there have been numerous changes in hospital models, staffing configurations, clinical roles, and family support systems. From our perspective, too much change can be disruptive and we found no evidence any of the models initiated produced superior results.

**Recommendation:** Define more robust strategies within the existing planning process. Conduct careful analysis to ensure initiatives are well-resourced and able to be measured and monitored to determine success. Clarify metrics on all new interventions or initiatives and communicate them clearly to all stakeholders impacted. (R18)

**Recommendation:** Recalibrate resource sharing agreements with centers that have in-house models funded by LiveOnNY. Halt the development of additional variable models and move toward a model where LiveOnNY-trained coordinators are dispatched for all organ referrals. Eliminate designated requestor models for organ donation. (R19)

*The foundational OPO basics require leaders to simplify and unify: define standards, teach intensively, reinforce consistently*

Innovation and change is good, but not in the absence of mastering the basics. Foundations that create sustained gains can readily be overlooked in the face of innovation ; we believe this is true at LiveOnNY. New models, PDSAs, and innovative methods have been introduced with great frequency but the foundations seem to be eroded.

The foundations or building blocks of increasing donation and sustaining those increases require constant focus, intensive resource investment and diligent reinforcement by leaders.

This reinforcement and advocacy occurs on a consistent daily, monthly, and annual basis with all stakeholders – 24/7/365.

This disciplined and perpetual hyper-vigilance over executing on the basics, the ABC's of best donation practice, is the simplest strategy. It is not innovative or revolutionary. It is very frequently overlooked or abandoned in the OPO industry as a result of distractions and OPO efforts to accommodate the voluminous incoming needs and requests placed on donation advocates. In our view, this is a common syndrome that plagues OPOs generally and LiveOnNY specifically.

**Recommendation:** Adopt a Back to the Basics mode of operation and institute best practice standards and associated support systems described above. (see **Appendix E: Back to Basics Strategy**) (R20)

## **IV. Best Donation Practices are Not Hardwired into Hospital Systems**

### Strategically Engage Hospitals as Partners in Clinical Operations

#### **Introduction**

We observed an energized team of hospital services staff specialists that is deployed in multiple directions, often distracted from the core mission of the traditional hospital development work function. The core mission of this OPO function is setting the stage for an optimal hospital donation process to increase donation rates. It requires that best practices are widely understood by clinicians, hardwired into systems and consistently implemented in hospitals. The current utilization of this team diverts significant resources from this mission and distracts them from strategic planning.

Most importantly, in hospital staff interviews, clinicians and administrators appeared to be unclear how to improve or to hardwire best donation practices into their systems. Interviews revealed across the board that hospitals staff is frustrated about the void of information and direction that is provided to them by LiveOnNY. There has been considerable transience in HS leadership; strong accelerated leadership development will be necessary to reconstitute the model and set standards for service delivery to hospitals. Current leaders do not have the record of achievement to succeed in a short timeframe.

The current approach emphasizes compliance. Adopting a more strategic and more proactive approach will yield significant improvements. Strategic Action Plans (SAPs) for each hospital are regulatory in their focus. The format should be revised to emphasize evaluations of the hierarchy, physician and clinician relationships, and detailed plans on performance improvement utilizing carefully cultivated donation champions. LiveOnNY data analytics are not currently formatted to provide adequate detail on actionable improvement in support of this planning process but the data is available.

Hospital interviews revealed that resources are dedicated to promoting donor awareness days, community education, and other public initiatives. It was our impression that some senior leaders in hospitals lacked a fundamental understanding of their roles for improving donation rates, citing external factors for underperformance. In several instances, hospitals were focusing efforts on public education and had minimal knowledge of clinical processes within their own institutions or their impact on donation. At one center with a very low conversion rate, the donor council chair stated, "We need more community engagement and education and to get politicians involved."

The majority of resources in hospitals must be dedicated to optimizing the internal clinical donation process to ensure educational access and hardwire best practices into existing emergency services/critical care delivery systems. This will yield increases and ensure more significant gains in the short-term; public awareness is a longer-term strategy for improvement.

We are recommending that LiveOnNY reposition hospital services to lead this crucial initiative. It will require center-specific strategies for redirecting focus and resources towards engaging

hospital partners and harnessing the expertise of physicians, clinicians and leaders. (Note: a restructuring of the model for service delivery is underway.)

## **A. Hospital Services Staffing Model**

### *Individual hospital assignments will promote accountability to hospital performance*

The current model assigns a team of specialists to a group of hospitals in a designated region. This approach includes Hospital Services staff allocated to specific functions. These areas of dedicated work function appeared to include strategy, tissue development, professional education and on-site response. On-site response includes only a subset of hospital referrals, including DCD.

The team model introduces too many specialists to the hospital at all levels, creating layers of confusion for hospital staff about the 'go-to' person. It complicates customer service delivery and was a recurring theme in our interviews. Furthermore, multiple Hospital Services staff members are attending donor council meetings and other events, inefficiently utilizing staff resources. There seemed to be inadequate time for interpersonal contact and an over-reliance on email and alternative modes of communication.

The team model does not afford adequate opportunities for relationship management or strategic planning. A transition to an account-based model is underway and will serve to convert this group into a stronger team of advocates for building hospital partnerships throughout the DSA. Performance metrics for Coordinators will improve accountability to center-specific outcomes. It will require a considerable investment of resources for job re-structuring, revised LiveOnNY branding of materials, professional education initiatives for clinicians and other resources. LiveOnNY will need support from outside sources to provide the development required.

**Recommendation:** Shift emphasis almost entirely to organ donation process and improvement activities. Eliminate distractions including: on-call, on-site response, community and public awareness activities, tissue donation. (R21)

**Recommendation (in progress):** Transition to an account based model, assigning highest organ potential hospitals to top performing HS Coordinators. Perform talent inventories and review performance in consideration of assignments and structural change. (R22)

### *Performance measures are unclear: define clear metrics*

Performance metrics were not clear to us or to the HS staff. Individual accountability to hospital processes and outcomes will improve under a revised model. Interviews revealed that HS coordinators and leaders are unsure about how they were evaluated. Two Coordinators expressed, "I am not sure how we are evaluated – that has to be worked out. I can't imagine [outcomes] would fall on us...maybe the directors." Under the new model, individual coordinator

hospital assignments will be linked to clear metrics for both hospital process and donation outcomes to include:

- referral rate
- timely notification rate
- planned approach and authorization rates
- conversion rate
- number of organ and tissue donors

Additionally, HSCs should be held accountable for relationship management, strategic planning, after action reviews, HD business practices, reporting and ultimately, the number of organ and tissue donors.

We understand that there is a transition underway toward this account-based model. In the short term, assignment of hospital portfolios to Hospital Services staff members should be carefully evaluated. Match top performing staff members to highest organ potential hospitals; base this match on tenure, demonstrated performance, existing relationships, and the analytic and communication skills of the HS Coordinator. Ensure there is a pipeline of qualified candidates in the onboarding process as this transition is implemented.

*Evaluate leadership structure: implement accelerated leadership development and staff training plan*

Both leaders and coordinators in this department seemed unfamiliar with best hospital development practices. During our interviews they did not demonstrate a solid working knowledge of the clinical practices that they are promoting in their daily jobs. We attributed this to historical structural misalignments, transitional leadership, and leaders who themselves are not seasoned in this discipline. The absence of a strong training program for onboarding compounds this issue.

Despite training or knowledge deficits, the team demonstrates a commitment to service delivery; they need a stronger guiding hand and clear direction. Reconstituting this department will require intensive training on the basics of hospital development to include:

- Demonstrated ability to teach clinical processes and strong working knowledge of practice
- Analysis and interpretation of referral data for strategic planning and performance improvement
- Effective communication skills for advocacy and medical academic presentation
- Hospital development business practices and processes
- Relationship management and strategic cultivation of physician and clinician champions

Hospital Services staff members lead change and performance improvement efforts at all levels within DSA hospitals. By design, they are the customer service managers and conduits for LiveOnNY's messaging. They set the stage for optimal clinical processes that drive organizational performance. Hiring for the right attributes, and training to the complex responsibility of this position provides each hospital, in essence, with an in-house coordinator.



A revised model will free the Hospital Services staff resources for strategic planning, relationship development, and quality after-action reviews. This will create the vital feedback loop of consistent, mutual critique and dialogue with hospital partners after each clinical interface.

**Recommendation:** Prior to a conversion of the model, establish clear performance measures for hospital services staff and perform a talent inventory that includes leadership. Implement an accelerated leadership development plan and evaluate available training for front line hospital services staff to improve competencies concurrently. (R23)

**Recommendation:** Identify strategic communication plan for introducing changes to hospitals. Identify Hospital Services on-site support functions; transition the information that is needed in real time on referrals into a repository of easily accessible hospital-specific data for on call reference by AOC, and clinical staff on-site. (see **Appendix F: Hospital Fast Facts**) (R24)

## **B. Strategic Planning and Data Analytics for Hospitals**

### *Eliminate compliance reporting: define and adopt core messages that engage clinical partners*

The language of compliance and variance reporting is uninspiring for clinicians and fails to define best practices or supporting rationale for them. Compliance conversations should be reserved for administrative level hospital personnel and used in support of regulatory reviews. Apart from that, expand messaging to include clear and simple definitions of best clinical practice. These messages should be communicated in the context of ensuring all families have opportunities to make fully informed decisions at the end of life and preserving donation opportunities for both families and the patients awaiting transplant. This is the foundational core message for strategic planning in hospital services.

Core messaging for hospitals around LiveOnNY practice standards are currently not well defined or uniformly disseminated. Hospital Services should help define them in collaboration with clinical leadership. Consider simplifying the clinical trigger for referrals to exclude the Glasgow Coma Scale and to widen the criteria. This will ensure capturing all referrals in time for adequate LiveOnNY intervention. Messaging encompasses referral, initial assessment, effective planned family communication, and clinically preserving donation opportunities. Professional education and associated teaching materials should be branded with these core messages.

Simple, well-designed upgraded teaching and presentation materials that support this will need to be created. All communication and teaching should routinely incorporate transplant academia to be effectively engaging and motivational. Teaching should be aligned with traditional medical academic formats including after action reviews, case studies, and performance improvement data.

**Recommendation:** Eliminate the language of compliance from the LiveOnNY lexicon for advocacy. Define strong messaging that inspires clinicians to incorporate best practices and promotes relationships of reciprocal trust. Train staff and develop correlating professional education materials with this common branding for proactive advocacy. (R25)

*Adopt a Strategic and Proactive Approach for Preventing Variability in Hospital Practices*

There is a currently strong emphasis on reporting variances, on process breakdowns, after they occur with hospital partners. These variances are presented in donor council meetings, on hospital dashboards and electronically after clinical events. This contributes to a punitive tenor in communication from LiveOnNY; this was widely reported by hospitals in interviews and should stop.

There is not an observable prescriptive process of required hospital development practices for LiveOnNY to promote and hardwire best donation practice standards in hospitals. This contributes to variability in front line Hospital Services staff practice and impedes ability [sic] of Hospital Services leadership to monitor and measure effectiveness of practices directly on hospital processes or outcomes.

To effectively engage clinicians as partners, a proactive strategic approach will be required for relationship management and ongoing dialogue. Shifting the approach [to] a more strategic work process, will promote an environment for engaging hospitals as partners, in relationships of reciprocal respect, particularly at the clinician level.

We observed minimal level of strategy to communicate best donation practices in a concrete actionable format, to evaluate processes in a meaningful way, or to maintain a constant assessment against these standards with clinician partners. It was reported that 'covering today' is a predominant mindset in the Hospital Services department, consuming the majority of staff resources. Performing hospital development in 'real-time' is suboptimal for a Hospital Services operation. Deploying staff members in a referral response capacity deprives staff of valuable time for other more strategic activity in hospitals and should be eliminated from their daily responsibilities.

**Recommendation:** Establish business practices for Hospital Services Coordinators that focus on strategic prevention of variance in the process; outline quarterly and annual expectations for meetings, after action reviews, and professional education offerings. (R26)

*Hospitals Need Actionable Plans and Practice Standards*

It was a recurring theme in hospital interviews that they seemed unclear about how they could impact improvements in the donation process. We suspect this was due to a lack of direction and clear messaging on practice standards related to the timing of approaching families, preserving donation opportunities, standing orders, and overall collaboration with LiveOnNY coordinators. Without standards, Hospital Services staff members are dispatched to support

real-time processes. One physician remarked, “Brian is the glue – things fall apart when he’s not here. It’s like we’re doing things on the fly.”

Hospital development initiatives should focus on defining expectations and standards for the organ donation process, formulating strategic plans for cultivating relationships with critical care and ER clinicians, and systematizing or hardwiring these practices in highest potential hospitals. Once defined, these strategies and practices should be spread to all hospitals in the service area.

**Strategic Action Plans are CMS-Centric: Modify SAP’s [sic] to Focus on Cultivating Champions and Hardwire Best Practices**

Hospital strategic action plans are currently compliance oriented and grounded in CMS requirements. They lack a comprehensive strategic assessment or actionable plans for performance improvement based on data analysis. An effective SAP includes the following components:

- Comprehensive assessment of donor potential, processes and outcomes by unit, physician service and other factors
- Targeted areas for process improvement
- Map of organizational hierarchy, points of informal influence and power within the hospital, prospective champions, and a relationship management plan
- Annual plan with goals, actions and narrative strategies
- Plan for hardwiring best practices
- Standardized reviews that reinforce joint accountability through mutual critique

Strategic plans need to include one-on-one scheduled meetings with hospital leaders and clinicians most frequently involved in referral and family communication processes. These individuals will need to be identified by carefully analyzing referral data. The leadership infrastructure for influencing behavioral change with these clinicians should be leveraged to formulate a targeted approach. Donor Councils in some instances, while effective, should re-constituted [sic] to eliminate transplant leaders and be comprised of influential critical care physicians, nursing leaders and front-line clinicians. This evaluation should be included in modifying SAPs.

**Recommendation:** Revise strategic action plans as described above. (R27)

**Strategy is Based on Data Analysis: Simplify Data Analytics to Isolate Needed Improvements**

There is an excellent system in iTransplant for data collection from hospital medical records and LiveOnNY’s referral base. Despite the abundance of data, we observed minimal analysis in a user-friendly format. Identifying meaningful trends in data analysis is a crucial component of process improvement and strategy development.

Dashboards are standardized but include a high volume of raw data. They are difficult to navigate and too complex in formatting. They lack depth in analysis and interpretation of where

the actionable steps for improvement are needed within the hospital. The average physician or clinician typically has only a few minutes to assimilate a presentation on how the process unfolds across all critical care units and physician services. Gift of Life presents simple PowerPoint graphics that include benchmarking and can be interpreted rapidly for identifying actionable improvement. (see **Appendix G: Sample Hospital Presentation**)

**Recommendation:** Revise hospital dashboard presentations to provide simpler data analysis and interpretations for clinicians that profile actionable performance improvement opportunities. (R28)

**Recommendation:** Eliminate all CMS data from presentations to clinicians and restrict the dual-rate reporting of CMS and full outcomes to administrators. Utilize one denominator: medically suitable potential organ donors for all clinician presentations outside of administration. Link processes to outcomes routinely enabling hospital partners to understand the impact of best practices and consequence of variability on donation rates, family decision making and transplant patients. (R29)

### **C. Physician Partnerships**

Hospital administrations, particularly senior leaders, are generally in strong support of donation, committed to improvement, and actively involved in many of the large centers. CEO-level relationships exist with the CEO of LiveOnNY, however it our understanding [sic] that those interactions occur outside of the hospital services staff relationship. These should be better aligned for maximum leveraging; a strategic CEO-level campaign should be a routine part of hospital services annual planning. Beyond that, relationships with physicians, particularly in critical care, are scarce or non-existent based on our review; critical care physicians were absent from interview schedules and observably seem inadequately informed about the clinical donation process and best practices.

Most concerning is the absence of direct dialogue with treating physicians by coordinators on-site for referrals. It was our impression that the treating physician is generally approached through either the bedside nurse or nurse manager versus directly from the on-site Coordinator. Despite the procedure outlined in the SOP for donor management requiring direct communication, more often Coordinators are initially interfacing with intermediaries based on our observations. One physician remarked that the organ donation process was, “bad under previous leadership – the communication was horrible. I’d given up and stopped getting involved. There wasn’t a good process with clinicians.”

This leaves a deficit in LiveOnNY’s ability to effectively communicate direction and recommendations in real time, and in parallel with family communication processes.

**Recommendation:** Proactively cultivate physician champions and advocates within each center to formulate a plan for strengthening engagement with them in the SAP. This includes how to utilize physicians in peer influence throughout their own hospitals and real-time clinical case advocacy. (R30)

**Recommendation:** Evaluate referral data and identify hospital-specific trends in physician involvement on referrals. Map the physician leadership structures and prioritize meetings by fiscal quarter to spread best practice messaging and identify educational opportunities. Prioritize evaluation of neuroscientists with emphasis on neuro-critical care as a departure point. (R31)

*Hospital Administrative Support is Strong; Leverage this for Physician Engagement*

The organizational system seems to be restricted to peer-level physician interactions with either LiveOnNY's EVP/CMO or peer-to-peer within the hospital setting. While peer influence is always optimal, it is not required in clinical cases to drive the donation process. Coordinators must be proficient, skilled and prepared to effectively advocate directly with the treating physician; the hospital services team sets the stage for this in advance.

Hospital Services staff members should routinely meet with physicians to ensure understanding and commitments to incorporating best practice. Establishing this open dialogue for reciprocal feedback and critique is essential for long-term working partnerships. Working through champions for peer level influence complements these partnerships by replicating them and expanding the scope of physician influence throughout a hospital and at times, between hospitals.

Hospital leadership and administration can effectively be leveraged in support of this physician relations initiative. It will require identification of individual physicians in specific hospitals and strategic plans for cultivating and involving them. In large academic centers, routine close surveillance of residents, fellows and other rotating physicians who are frequently involved in the donation process will be more time intensive. It will necessitate frequent presence, quality medical academic teaching and should include education on *communication of brain death* for residents.

**Recommendation:** Develop standard presentation materials for uniformity in messaging on evidence-based best donation practices. (R32)

**Recommendation:** Initiate professional education offering for residents in Communication of Brain Death to Families. Prioritize offerings based on data analysis of family communication process and outcomes. (R33)

### Recommendation Chart

Ref.	Recommendation	Priority
<b>R01</b>	Referral intake should be streamlined immediately. It should include minimum data collection and the referring hospital employee should be on the phone for no more than two minutes with the Donor Center. If the patient is on a ventilator, a singular trigger, the call should be patched through immediately via voice call to a trained Transplant Coordinator for more thorough initial assessment.	<b>1</b>
<b>R02</b>	The Referral Coordinator should be in immediate dialogue with the referring person at the hospital after referral intake by the Donor Center. This conversation will provide an opportunity to determine if an intervention is required prior to LiveOnNY's arrival at the hospital. It will also provide a more accurate picture for the AOC to identify deployment needs.	<b>1</b>
<b>R04</b>	Re-align Family Services Coordinators under the clinical department. Move Hospital Services to a single departmental function with a director-level leader.	<b>1</b>
<b>R05</b>	Create standards for preserving donation opportunities in a variety of clinical scenarios and for initiating family request on a more rigorous timeline.	<b>1</b>
<b>R06</b>	Review and revise the current standards for: referral intake and initial assessment; rapid on-site response; continued presence at the hospital; care team communications; set-up of family conversation; and effective request process.	<b>1</b>
<b>R07</b>	Establish a standard for maintaining a continued on-site presence at the hospital in circumstances that warrant it to preserve donation opportunities that may otherwise be lost. Add patients who appear brain dead but arrested into your donor potential denominator.	<b>1</b>
<b>R08</b>	Clearly define family request triggers along with standards for timing of approach. Communicate these standards to hospital partners. Immediately provide intensive training for any staff members who may be tasked with requesting authorization.	<b>1</b>
<b>R09</b>	Immediately transition to a single administrator-on-call who has full scope of authority and accountability for all decision-making on case management.	<b>1</b>
<b>R11</b>	Identify the core group of leaders who will serve as AOCs. Allow additional time for AOC shifts to provide more intensive guidance and direction via phone. Identify performance standards for AOCs, conduct training sessions and weekly reviews to review decisions, outcomes, front-line staff performance, and ensure consistency.	<b>1</b>
<b>R12</b>	Transition to voice communication system for case management, coordination, communication and AOC oversight. Reduce reliance on text, email, and other modes of electronic communication.	<b>1</b>

<b>R13</b>	Conduct a national search for a Chief Clinical Officer with a record of demonstrated success and deep experience in the OPO industry. Based on the interviews we conducted, we don't believe LiveOnNY has an internal candidate who possesses the demonstrated leadership accomplishments to succeed in this role.	<b>1</b>
<b>R21</b>	Shift emphasis almost entirely to organ donation process and improvement activities. Eliminate distractions including: on-call, on-site response, community and public awareness activities, tissue donation.	<b>1</b>
<b>GR1</b>	Dispatch decisions for the following day should be made at 5am that day versus 8:00pm the previous evening.	<b>1</b>
<b>R03</b>	Transition to a generalist model where staff can skillfully manage multiple situational challenges for rapid response. Consider cross-training for clinical staff (TC and DEC) in family communication for the purpose of enabling them to effectively speak with families and secure authorization when needed. Deploy FSCs more strategically for higher potential referrals or complicated family dynamics. Eliminate Hospital Services Coordinators from on-site involvement.	<b>2</b>
<b>R10</b>	Group huddles should be reconfigured or eliminated and replaced with one-on-one AOC conversations.	<b>2</b>
<b>R15</b>	The CCO and clinical leaders must define LiveOnNY's overarching operational plan including the action steps needed to meet associated goals, practice standards, and metrics. Clearly communicate metrics and expectations to staff.	<b>2</b>
<b>R16</b>	Once standards of practice have been reviewed and redefined as needed, invest in an expansion of LiveOnNY's training program. In the short term, invest in skills-based family authorization training programs that will allow for meaningful assessment of competencies. General clinical training should follow as soon as feasible. Reassess utilization of providers who insist on training that excludes leadership involvement or observation.	<b>2</b>
<b>R17</b>	Address recruitment, interviewing, selection, and hiring practices to ensure a deep and continuous pipeline of qualified candidates in order to maintain operational stability. Consider phasing out social work model for FSC; phase out and ultimately eliminate travelers.	<b>2</b>
<b>R20</b>	Adopt a Back to the Basics mode of operation and institute best practice standards and associated support systems described above.	<b>2</b>
<b>R30</b>	Proactively cultivate physician champions and advocates within each center to formulate a plan for strengthening engagement with them in the SAP. This includes how to utilize physicians in peer influence throughout their own hospitals and real-time clinical case advocacy.	<b>2</b>
<b>R31</b>	Evaluate referral data and identify hospital-specific trends in physician involvement on referrals. Map the physician leadership structures and	<b>2</b>

	prioritize meetings by fiscal quarter to spread best practice messaging and identify educational opportunities. Prioritize evaluation of neuroscientists with emphasis on neuro-critical care as a departure point.	
<b>R14</b>	Perform talent inventory and competency assessment for the leadership team. Seek outside support immediately for areas identified as having insufficient expertise. Develop leaders or transition them out of their current roles as needed in phases.	<b>3</b>
<b>R18</b>	Define more robust strategies within the existing planning process. Conduct careful analysis to ensure initiatives are well-resourced and able to be measured and monitored to determine success. Clarify metrics on all new interventions or initiatives and communicate them clearly to all stakeholders impacted.	<b>3</b>
<b>R19</b>	Recalibrate resource sharing agreements with centers that have in-house models funded by LiveOnNY. Halt the development of additional variable models and move toward a model where LiveOnNY-trained coordinators are dispatched for all organ referrals. Eliminate designated requestor models for organ donation.	<b>3</b>
<b>R22</b>	(in progress) Transition to an account based model, assigning highest organ potential hospitals to top performing Hospital Services Coordinators. Perform talent inventories and review performance in consideration of assignments and structural change.	<b>3</b>
<b>R23</b>	Prior to a conversion of the model, establish clear performance measures for hospital services staff and perform a talent inventory that includes leadership. Implement an accelerated leadership development plan and evaluate available training for front line hospital services staff to improve competencies concurrently.	<b>3</b>
<b>R24</b>	Identify strategic communication plan for introducing changes to hospitals. Identify HS on-site support functions; transition that information that is needed in real time on referrals into a repository of easily accessible hospital-specific data for on-call reference by AOC, and clinical staff on-site.	<b>3</b>
<b>R25</b>	Eliminate the language of compliance from the LiveOnNY lexicon for advocacy. Define strong messaging that inspires clinicians to incorporate best practices and promotes relationships of reciprocal trust. Train staff and develop correlating professional education materials with this common branding for proactive advocacy.	<b>3</b>
<b>R26</b>	Establish business practices for Hospital Services Coordinators that focus on strategic prevention of variance in the process; outline quarterly and annual expectations for meetings, after action reviews, and professional education offerings.	<b>3</b>
<b>R27</b>	Revise hospital development strategic action plans as described in the report.	<b>3</b>



<b>R28</b>	Revise hospital dashboard presentations to provide simpler data analysis and interpretations for clinicians that profile actionable performance improvement opportunities.	<b>3</b>
<b>R29</b>	Eliminate all CMS data from presentations to clinicians and restrict the dual-rate reporting of CMS and full outcomes to administrators. Utilize one denominator: medically suitable potential organ donors for all clinician presentations outside of administration. Link processes to outcomes routinely enabling hospital partners to understand the impact of best practices and consequence of variability on donation rates, family decision making and transplant patients.	<b>3</b>
<b>R32</b>	Develop standard presentation materials for uniformity in messaging on evidence-based best donation practices.	<b>3</b>
<b>R33</b>	Initiate professional education offering for residents in Communication of Brain Death to Families. Prioritize offerings based on data analysis of family communication process and outcomes.	<b>3</b>
<b>GR2</b>	Consider retention bonuses for all staff that respond to referrals during the period of transition to ensure LiveOnNY maintains adequate call coverage capacity and allow time for aggressive recruitment and on boarding of additional proficient, trained coordinators.	<b>3</b>