Interview Notes: HTS#1

(b)(6),(b)(7)(C)

(b)(6),(b)(7)(C)

This center had outcome issues in 2015 (only 70% patient survival rate). Personnel issues were determined to be one of the causes – he was hired at that time, hired as (b)(6),(b)(7)(C)

Responsibilities:

- Rounds daily on inpatients
- Three transplant surgeons
- Attends MRB
- Reviews ALL organ offers where they are primary. Consults with Medical Director for acceptance of organ.
- Policy/procedure review
- Participates in QAPI initiatives

ABO Verification Process:

- Use source materials
- Verification done at donor site, when organ arrives, and in OR before transplant
- Verification in OR before transplant: done by circulator and transplanting surgeon.
  --Surgeon is scrubbed, does visual verification
  --Circulator signs with date and time at time of verification
  --Surgeon signs with date and time at end of case
  --Documented on paper form. Includes other info: pt in room time, organ in room time, 1st anastomosis
- He generally stays in the OR for a long time after transplant is complete to monitor

After 2015 outcomes issues:

- Explained that one surgeon had bad outcomes; were not reviewing organ

offers carefully; 6-8 deaths in a short time

- Initiated process/procedures to correct
- Recruited new surgical director
- MRB discussion of potential recipients is now "exhaustive" There
- are usually 2 surgeons on each transplant
- Heavy review of organ offers
- Round every day with many services to catch potential recovery issues early on
- Trying to standardize care pathway
- Have improved patient survival from 70% to 94% after first year (with 2x the volume of 2015); stroke rate down to 0%; LOS decreased by 14 days
- Hospital is providing a lot of time and resources in support of their program. Get lots of oversight.
- Data continues to be skewed by the 6-8 deaths over a short period in 2015

Interview Notes: HTP#1

(b)(6),(b)(7)(C)

Responsibilities:

- Guides transplant program Reviews
- and updates guidelines Organizes
- call schedules
- Attends MRB – lead coordinator documents discussion and decision Has
- an "Active List" Clinic
- Does pre-transplant evaluations
- Quality:

  --Committee meets bi-weekly to discuss issues

  --Meet quarterly with whole MD group

  There are eight transplant cardiologists.

Outcome issue in 2015:

Explained that a retiring surgeon ("a legend", unnamed) wouldn't stop performing transplants. A replacement surgeon, "very good", was hired to replace him, but eventually left in frustration. That left the program with an old surgeon and an inexperienced surgeon. Had many deaths in a short period of time. This was addressed immediately with an extensive RCA; did not just blame surgeons.

- He explained that the institution started with private practice MDs; he believed that this was part of the issue – presents a challenge in the transplant setting to get cooperation. Counted himself as member of this group.
- Changes made: now have a 24/7 intensivist in ICU (hospital stepped up for this); MDR now daily; MRB – used to get substandard data from private MDs using outside facilities for testing – now have tests done in-house; Med and Surg Dir have veto power in MRB, despite full discussion of candidates by team.

At this time 4 MDs are part of Baylor College of Medicine, 3 are private practice, 1 is St. Luke's employee.

Have recently brought in TMG as part of ongoing process of rebuilding program. Would like to re-gain prestige reputation of program.

End of surveyor notes.

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