
Hospital Organ Donor Programs Push the Envelope

Cheryl Clark, for HealthLeaders Media , March 27, 2014

Organ procurement organizations can get donor organs to transplant teams quickly, safely, and at a cost savings.

Of all the procedures in hospital medicine that actually keep sick people alive, perhaps the most audacious is the organ transplant.

Organ procurement and transplantation have always pushed the envelope. Those who work in this field seem to be constantly finding more creative ways to utilize organs and maximize their potential through science and strategy, and downright chutzpah. Where 10,794 patients received an organ from a deceased donor in 1988, nearly 23,000 got one or more in 2013, according to [United Network for Organ Sharing](#) data.

So it isn't surprising that the people who organize and perform transplants, those working in this country's 58 regional organ procurement organizations (OPOs) and the hospitals they supply, would always be thinking of safer, cheaper, more efficient ways to retrieve scarce donated organs. They've organized ways to get organs into patients faster, minimizing stress on the family. And in ways that improve organ viability in the recipient.

After all, they deal with life and death every day. What's to lose?

[Organ Recovery Centers Reduce Transplant Costs 37%](#)

That was the approach taken 13 years ago by Mid-America Transplant Services in St. Louis, a solution borne out of frustration that the system was slow, annoying, and cumbersome for everyone. MTS figured out a way to streamline the organ donation process so that brain-dead donors didn't clog up precious hospital critical care units and surgical suites during organ recovery, freeing those resources for living patients.

MTS found a way to transport brain-dead donors out of the hospital to a free-standing mini-surgical suite, keeping them alive until surgeons from recipient hospitals could arrive to retrieve the organs allocated to their patients. To date, organs from more than 1,100 brain-dead donors have been recovered there.

And because imitation is the biggest form of flattery, three other programs have started in other cities and two other programs in Chicago and Philadelphia are trying to do the same. But for concerns about the way Medicare reimburses transplant centers that recover organs from brain-dead donors, many more would be operating now, I'm sure.

[Medicare Rules Make Offsite Organ Recovery Costly](#)

In a phone call last week, Diane Brockmeier, MTS's long-time chief operating officer, explained how the idea evolved, from a complaint from an irritated critical care physician at a busy, large trauma hospital in St. Louis, to what she called "a cocktail napkin conversation," to feasibility studies, to reality.

The frustrated and concerned critical care doctor was gripping at her. He complained, "I go home, and your staff tells me they're working (on assessing the donor), and I come back the next morning, and your staff is still working on things. You're staying in the ICU too long, absorbing a lot of resources. And I leave in the afternoon and your staff is still here, using a lot of high level nursing staff. Can't you shorten this process so it requires fewer resources from our staff and hospital?"

Brockmeier was not unfamiliar with that impatience. She started investigating solutions. "Could I find a lab that could turn around the serology testing faster? Could we minimize some of the treatment modalities (that keep the donor breathing)? Was there a way to leverage technology?" she recalls.

Over the OPO's history, it had gone from mainly procuring kidneys to livers, hearts and lungs, and the process required more testing, which meant it took even longer.

It occurred to her that the OPO was moving bone and tissue donors out of the hospital with no problem. Their hearts were no longer beating, and their lungs didn't require ventilation. They could do the same thing with brain-dead donors by replicating the life-support the donors were getting in the hospital. And she had support from MTS's chief executive officer, Dean Kappel.

People in transplant, she says, "have a reputation for having kind of an innovative culture. We take some intelligent risks in the way we look at things." To be sure, she adds, "Some of our colleagues were skeptical of what we were doing." Would family members agree to let their loved ones leave the hospital to

have organs recovered somewhere else rather than in the familiar surroundings of their hospital?

But the positives outweighed the negatives by a long shot. Moving donors out of the hospital to their facility would mean doctors had shorter distances to drive. It was, she says, like a balloon appeared over Kappel's and her heads "with a big 'Duh.' "

In the years since, MTS has added a lot. It has a new building with a full cardiac cath lab, a CT scanner to see if the donors' lungs might have emphysema. There's a full serology lab, all kinds of backup services, and sterilization capabilities, "everything you need to run a small mini hospital," she says.

It's a fascinating concept, and one that hospitals transplant program officials tell me they support. Though there is a major glitch with finances affecting financial reimbursement at transplant centers, clearly there's a way for Medicare to fix that, so other OPO programs large enough to support such efforts can follow suit.

According to the United Network for Organ Sharing, there are 121,680 individuals on one or more waiting list for an organ transplant, nearly 100,000 of them waiting for a kidney, with the rest hoping for a liver, pancreas, heart, lung, or intestine. The faster the process can happen for them, the better.

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